Chiropractic FRONTIER INTEGRATED HEALTH CENTER

R. James Ottomeyer III, DC, NMD
David Hadden, DC
Christopher Weilandich, DC, LAT
Andrew J Drysdale, DC
Kathleen Brooks, FNP

Cassidy Renner, LMT
Lauren Dale-Derks, LMT
Amy Cathey, LMT

"You Deserve Good Health"

New Patient Information

PERSONAL INFORMATION Date _____

Last Name:_____ First Name:_____ M.I.:____

Street:_____ Email Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____

Social Security Number:_____ Birth Date:_____ Current Age:_____

Race: _____ Preferred Language:_____ Ethnicity:_____

Sex: ☐ Male ☐ Female Student Status: ☐ Non ☐ Full time ☐ Part time

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced Number of Children:_____

Mother Maiden Name: First Name _____ Last Name _____

Emergency Contact Name: _____ Phone: _____ Relation_____

Occupation:_____ Employment Status: ☐ Full time ☐ Part time

Employer Name:_____ Work Phone:_____

Employer Street:_____ City:_____ State:_____ Zip Code_____

Spouse Name:_____Employer:_____Work Ph:_____

Medical Physician's Name: _____Previous Chiropractor's Name:_____

HOW DID YOU HEAR ABOUT FRONTIER INTEGRATED HEALTH CENTER

Referred By:_____

☐Family ☐ Friend ☐ Co-Worker ☐ Attorney ☐ Yellow Pages ☐ Mail Coupon

☐Newspaper ☐ Direct Mailer ☐ Friend of Doctor ☐ Street Sign ☐ Other:_____

INSURANCE INFORMATION

Insured:_____ Insurance Company:_____

Patients Relationship To Primary Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:_____

IF YOUR SYMPTOMS ARE DUE TO AN AUTO ACCIDENT OR WORK INJURY PLEASE STOP AND NOTIFY OUR STAFF

CURRENT HISTORY/TREATMENT (Please be brief)

Present Complaint:_____

This Condition Is Due To: _____

Date Symptoms Appeared/Accident Occurred:_____ ☐ Gradual ☐ Sudden

Have You Had Similar Symptoms Previous To This Incident? ☐ Yes ☐ No Date:_____

Have You Been Unable To Work Due To This Incident? ☐ Yes ☐ No Dates Missed Work From:_____ To:_____

Have You Been Hospitalized Due To This Incident? ☐ Yes ☐ No Place/Dates:_____

Have You Had X-Rays Taken Due To This Incident? ☐ Yes ☐ No Place/Date :_____Results:_____

Is this condition getting progressively worse or better?_____

CURRENT HISTORY/TREATMENT(CONT): **Name:**

_____

Which daily activities are difficult to perform? ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down ❑Other(please describe)_____

PREVIOUS HISTORY/TREATMENT

What treatment have you already received for your condition?

❑ Medication ❑ Surgery ❑ Chiropractic Care ❑ Physical Therapy ❑

Other_____

GENERAL HEALTH HISTORY *check only those conditions which are applicable:*

❑ AIDS/HIV	❑ Cataracts	❑ Hepatitis	❑ Osteoporosis	❑ Suicide Attempt
❑ Alcoholism	❑ Chemical Dependency	❑ Hernia	❑ Pacemaker	❑ Thyroid Problems
❑ Allergy Shots	❑ Chicken Pox	❑ Herniated Disc	❑ Parkinson's Disease	❑ Tonsillitis
❑ Anemia	❑ Depression	❑ Herpes	❑ Pinched Nerve	❑ Tuberculosis
❑ Anorexia	❑ Diabetes	❑ High Cholesterol	❑ Pneumonia	❑ Tumors, Growths
❑ Appendicitis	❑ Emphysema	❑ Hypertension	❑ Polio	❑ Typhoid Fever
❑ Arthritis	❑ Epilepsy	❑ Liver/Kidney Disease	❑ Prostate Problems	❑ Ulcers
❑ Asthma	❑ Fractures	❑ Measles	❑ Prosthesis	❑ Vaginal Infections
❑ Bleeding Disorders	❑ Glaucoma	❑ Migraine Headaches	❑ Psychiatric Care	❑ Venereal Disease
❑ Breast Lump	❑ Goiter	❑ Miscarriage	❑ Rheumatoid Arthritis	❑ Whooping Cough
❑ Bronchitis	❑ Gonorrhea	❑ Mononucleosis	❑ Rheumatic Fever	❑ Stroke
❑ Bulimia	❑ Gout	❑ Multiple Sclerosis	❑ Scarlet Fever	❑ Mumps
❑ Cancer	❑ Heart Disease	❑ Other_____		

Date of last medical examination_____/_____/_____

Family History:

Mother: □ Alive □ Dead Age _____ Health Conditions:

_____

Father: □ Alive □ Dead Age _____ Health Conditions:

_____

Number of Siblings: _____

□ M □ F ___ Alive Dead ____ Age ____ Health Conditions: _____

□ M □ F ___ Alive Dead ____ Age ____ Health Conditions: _____

□ M □ F ___ Alive Dead ____ Age ____ Health Conditions: _____

Clinical Summary of Care Wavier

I waive my right to receive a summary of care on each of my office visits with Frontier Integrated Health Center. Therefore my provider will have this summery for each day that I am treated saved and available should I request it in the future.

X_____ _____

Patient Signature Date

PAIN DRAWING

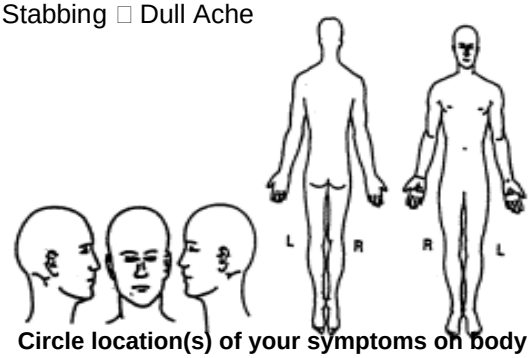
.Describe your pain (check all that apply):

□ Constant □ Intermittent □ Deep Ache □Throbbing □ Tingling □ Sharp □ While Resting □ Daily
□ During Exercise □ Nightly_____ □ Recurring □ Stabbing □ Dull Ache

Onset of Pain: □ Sudden □ Gradual

(1 = Mild, 10 = Intense)
On a scale of 1 to 10 how would you rate your pain level? _____

What if anything gives you relief? _____



Circle location(s) of your symptoms on body drawing.

Patient Prescription and Vital Information

Height:_____ Weight:_____ Last Known Blood Pressure Reading:_____/_____

Have you ever smoked?_____ Do you still smoke? _____ Pack per day_____

List Allergies: (Medications, Foods or Products)

Allergic **Reaction** **Severity** (Mild, Moderate, Severe)

_____
_____
_____
_____
_____

List all Prescription Medications: (or attach a list of medications)

Name **Dosage per day** **Milligrams**

_____
_____
_____
_____
_____

List all over the counter vitamins and medications: (or attach a list of vitamins/OTC)

_____
_____
_____
_____
_____

FRONTIER INTEGRATED HEALTH CENTER, INC. **Phone: (636)379-5934**
199 Frontier Park Dr, O'Fallon, MO 63366 **Fax: (636)410-3323**

OUR MISSION STATEMENT

Our MISSION is to provide the best care possible to every patient, regardless of race, creed, religion, social background or sexual orientation which is accomplished by supporting our staff and providers in every way possible to allow them to practice efficiently and dedicate their time to the individual needs of the patient.

HEALTH CARE PRIVACY NOTICE

This office is committed to providing patients with quality health care services delivered with dignity and concern. Fulfilling this commitment requires the efforts of the doctors, therapists, staff and patient working together as a team to obtain the maximum results. Patient satisfaction is a vital interest to The Health Centers.

This Facility is required by law to abide by the terms of this Health Care Privacy Notice as well as other applicable federal and state laws governing privacy practices in health care. Our Facility may change and/or modify the terms of this Notice at any time without additional notice to you except to publically post in our Facility and/or make available to patients any updated notices. Photocopy of this Notice is available to you upon request. The term Facility refers to this office or clinic. The term Provider refers to doctors and/or licensed professionals of this Facility.

Our Facility & staff are committed to maintaining the privacy of your protected health information (PHI). PHI is information about you, including demographic information that may identify you and that may be related to your present, future and past physical or mental health or condition and the care and treatment you receive from our practice. This Notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read this Notice and direct questions, misunderstandings or concern to the Compliance Officer of this Facility.

Our Facility may use & disclose your PHI for health care delivery purposes. Your PHI may be used and/or disclosed without your written authorization by the doctors and staff of this Facility for the purposes of your care and treatment; paying your health care bills; and to support the operations of this practice. Your doctor and the staff will take all reasonable measures to maintain the confidentiality of your PHI.

The Privacy Rule allows you the right to review and receive copies of your health care records as it relates to your health care. The request must in writing, allowing your provider 30 days to respond. Your provider may deny your request if it will cause harm to you or to another person. Your provider may charge a copy fee, which will be in compliance with State law. Your provider will comply with any reasonable request to have confidential communication by alternative means or at an alternative location if not doing so endangers you.

You may request to have an amendment placed in your record if you disagree with anything in your record. This does not mean that anything will be removed, or changed and the provider has the right to respond with a rebuttal statement if he/she feels it is necessary. You may revoke authorization, in writing, at any time, except in the event that the provider has acted as indicated in the doctor's Authorization Notice.

You have the right to file a written complaint with our Compliance Officer if you believe that any of your privacy rights have been violated. You can obtain a complaint form from the Compliance Officer and/or the Office of the Civil Rights. All complaints must be filed within 180 days of when you knew or should have known that the violation occurred. The Privacy Law prohibits our Facility from taking any retaliatory actions against anyone who files a complaint. A more detailed, updated & comprehensive Health Care Privacy Notice is available for your review in this Facility.

I, the assignee, being the patient or legal guardian for said minor listed below, do hereby irrevocably authorize, direct, assign and give a full lien to the office named above and listed below, hereinafter referred to as the "Facility" against any & all insurance benefits, proceeds of any settlement, judgment or verdict which may be paid to the undersigned as a result of the injuries or illness for which I have been treated by the Facility.

I, the assignee further authorizes any and all insurance company, attorney and any & all third party payer to pay directly to the Facility all sums of money due them for any & all services rendered to me or minor by whom I am responsible for by reason of accident, illness and by any & all reason of any other bills that are due or may become due, and to withhold such sums from any health & accident, workers compensation and or including all insurance or third party benefits.

Assignee agrees that this Facility & staff may deliver medical records, consultations, depositions and/or court appearances which must be paid in full in advance and authorizes this Facility to release any information pertinent to said health care to any insurance company, adjuster, attorney or legal service bureau to facilitate collections under the terms of this document. Assignee grants the Facility a full power of attorney to endorse &/or sign my name on any & all checks for payment of any indebtedness owed this office & assignee. All providers for this facility to wave all insurance provider contractual obligations, including any fee reduction and/or provider discounts.

Frontier Integrated Health Center
R. James Ottomeyer lll, D.C., NMD
199 Frontier Park Dr.
O'Fallon, MO 63366
Phone: (636)-397-5934 Fax: (636)-410-3323

PRIVACY PRACTICES ACKNOWLEDGEMENT

By my signature below I acknowledge that I have read or have had read to me and have received a photocopy upon my request of the HIPAA / Health Care Privacy Notice.

Name_____

Signature_____

Date_____

I authorize the following persons to receive information on my medical record history, medical condition, appointments, test results, medical treatments, and health information. The following persons may also receive my medical records.

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Signature of Patient Date

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INFORMED CONSENT/PERMISSION TO TREAT

I understand that this Facility, its doctors & staff are accepting my case based on examination findings & believe the outlined treatment should produce change and/or improvement. However as with any diagnostic test, procedure, examination or doctors care a guarantee of improvement or complete recovery cannot be made and it is even possible that no change will occur.

I further understand that in the practice of medicine, chiropractic, psychological counseling, massage therapy & physical therapy there are some risks including but not limited to fractures, disk injuries, strokes, dislocations, sprains-strains, drug interactions & reactions and/or other injuries or side effects which cannot be pre-determined.

I do not expect the doctor/provider to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor/provider to exercise judgment during the course of the procedure(s) which the doctor/provider feels at the time is in my best interest.

In addition, because psycho-social, spiritual, and cultural values affect a patient's response to care, patients are allowed to express and follow spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of treatment.

Patients have the right to refuse treatment, but must be aware of the probable consequences of refusing treatment and/or failing to cooperate with the prescribed treatment. Should you refuse and/or fail to comply with prescribed treatment your provider will discuss specific consequences with you.

Therefore I give my full consent to the doctor/provider to render treatment on me or the minor for whom I am legally responsible by a health care provider of this Facility.

By my signature below I acknowledge that I have read or have had read to me and have received a photocopy upon my request of this document including the Health Care Privacy Notice, Facility terms & conditions, credit policies and Informed Consent and fully understand and have had all of my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valid as an original

Print Name of Patient _____

_____ _____

Signature (If patient is minor – parent must sign) Date

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ASSIGNMENT OF BENEFITS - AUTHORIZATION & LIEN

The assignee, being the patient or legal guardian for said minor listed below, do hereby irrevocably authorize, direct, assign and give a full lien to the office named above and listed below, hereinafter referred to as the "Facility" against any & all insurance benefits, proceeds of any settlement, judgment or verdict which may be paid to the undersigned as a result of the injuries or illness for which I have been treated by the Facility.
I, the assignee further authorizes any and all insurance company, attorney and any & all third party payer to pay directly to the Facility all sums of money due them for any & all services rendered to me or minor by whom I am responsible for by reason of accident, illness and by any & all reason of any other bills that are due or may become due, and to withhold such sums from any health & accident, workers compensation and or including all insurance or third party benefits.
Assignee agrees that this Facility & staff may deliver medical records, consultations, depositions and/or court appearances which must be paid in full in advance and authorizes this Facility to release any information pertinent to said health care to any insurance company, adjuster, attorney or legal service bureau to facilitate collections under the terms of this document. Assignee grants the Facility a full power of attorney to endorse &/or sign my name on any & all checks for payment of any indebtedness owed this office & assignee. All providers for this facility are granted permission to waive all insurance provider contractual obligations, including any fee reduction and or provider discounts

INSURANCE BENEFITS - CREDIT POLICIES - PAYMENT TERMS & CONDITION

As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us but some third party payers miss-quote benefits, coverage and liability. Our Facility & staff are not responsible for what a third party payer and/or representative may tell us. Any contractual, written, verbal or other obligations or arrangements between you and an attorney, insurance company, liable or third party payer are between you and said person. Your insurance company quote of benefits does not guarantee payment on any claims incurred by this or any facility. Benefits are determined when claims are processed and paid by the insurance carrier.
Our Facility will file initial insurance claims for you. Secondary claim submission and/or additional reports or documents sent for your benefit may result in an additional filing medical report charge which you are responsible to pay.
Co-pays, deductibles and all non-covered service charges are due the day the service is rendered.
Patients are responsible for charges on all service(s) and/or product(s) which may exceed the maximum allowable and/or when a third party and/or insurance carrier does not reimburse this Facility enough to meet our cost of service.
All account balances, including automobile and work injury claims must be paid in full within 90 days of treatment. Patients are fully responsible for all money owed this office and such payment is not contingent on any settlement, claim, judgment, or verdict by which they may eventually recover said fee and it is also regardless of any attorney liens or pending settlement(s). If a third party payer fails to pay said balance in full within the 90 day period, the patient must pay the balance in full. Assignee is fully responsible for all money owed this Facility for any and all treatment, products & services rendered to the patient or minor shown below. I fully understand that if there is a 3rd party payer or responsible party that I have given permission for Frontier Integrated Health Center, Inc. and all providers for this facility to wave all Insurance provider contractual obligations, including any fee reduction and or provider discounts when concerning the full recovery of the fee's for the provided services. Our office is not responsible for filing claims with your secondary health insurance.
A non-discriminatory "Time of Service Discount" is offered to anyone who pays for services the day they are rendered. The "TOS" is only offered on the day the service is rendered. This discount does not apply to orthopedic supports, orthotics, physical therapy equipment rentals or purchases, vitamins, supplements, ointments, acupuncture treatments, weight loss programs, psychological counseling services and massage therapy.
A service charge is computed by a 'periodic rate' of 11-1/2 % per month — 18% per annum & is added to all balances owed 60+ days. Any balance past due 90 days or more will be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all monthly service charges, costs related to but not limited to all collection related expenses, attorney fees, court & filing fee's. Returned checks, debit & credit charges made payable to this Facility for insufficient funds, stop payments or other reasons of non-payment will be assessed a $30.00 charge.
Patients are eligible for a maximum $250 personal credit limit when approved. For your convenience we accept most major credit & debit cards.

PATIENT CONSENT & SIGNATURE

By my signature below I acknowledge that I have read or have had read to me and have received a photocopy upon my request of this document including the Health Care Privacy Notice, Facility terms & conditions, credit policies and Informed Consent and fully understand and have had all of my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valid as an original.

Print Name Of Patient: _____

Signature (if minor, parent must sign) **Date**

Signature of Attorney_____Date_____