Johnson Chiropractic &
Holistic Health Center, LLC.
Chiropractic – Acupuncture – Nutrition & Functional Medicine – Injury Rehab

Dr. Kody R. Johnson, DC, MTAA

FILE #: _____

Clinic Use: INS: _____ DOI: _____

General Information

Full Name (First, MI, Last): _____ DOB: _____ Gender: M F

Mailing Address: _____ SS # (for insurance): _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Email: _____ Cell Phone: _____

Emergency Contact Name & #: _____ Work Phone: _____

Who is your primary care physician (PCP)? _____ Occupation: _____

How did you hear about us? If referred please put their name: _____

Nutritional Consulting / Functional Medicine Intake

☐ In the order of importance to *you*, please list your top 5 health concerns / issues

1 _____

2 _____

3 _____

4 _____

5 _____

☐ What treatment have you received for these health concerns / issues

1 _____

2 _____

3 _____

4 _____

5 _____

☐ What have you done on your own to help these health concerns / issues

1 _____

2 _____

3 _____

4 _____

5 _____

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☐ Please all providers that you have seen in regards to these health concerns / issues

- _____
- _____
- _____
- _____
- _____

☐ Please list what lab testing and imaging you have had completed, or attach a copy of the reports

- _____
- _____
- _____
- _____
- _____

☐ Please list **ALL** supplements, herbs, over the counter medication and prescription medication that you take. Include the dosage and frequency. (or attach a list)

Supplement / Medication	Dosage	Frequency

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☐ Please list **ALL** surgeries and procedures you have had performed

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

☐ On a scale of 0 to 10 how motivated are you to commit to improving your health? _____

0 = unmotivated – 10 = extremely motivated

Why did you choose that number?_____

_____

☐ Please list all physical and mental health conditions that you have been diagnosed with

- _____
- _____
- _____
- _____
- _____
- _____

☐ **Family History**: Please **check** which conditions other members of your family have or had. Please list the relationship next to those conditions marked off.

o High Blood Pressure	o High Cholesterol	o Stroke
o Migraines	o Allergies	o Digestive Problems
o Thyroid Problems	o Kidney Problems	o Food Sensitivities
o Cancer	o Heart Attack	o Obesity
o Back Pain	o Diabetes	o Insomnia / Sleep Issues
o Multiple Sclerosis	o Other: _____	

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Other Health History

If a condition below applies to you please mark it as: **C** = Current Condition OR **P** = Had in the Past and put age if known

- o _____Acid Reflux
- o _____ADD / ADHD
- o _____Allergies
- o _____"Always Cold"
- o _____"Always Hot"
- o _____Anemia
- o _____Anorexia
- o _____Anxiety
- o _____Appendicitis
- o _____Arthritis
- o _____Asthma
- o _____Back Pain
- o _____Bedwetting
- o _____Belching / Gas
- o _____Blood Clots
- o _____Blood Disorders
- o _____Blood in Stool
- o _____Blood in Urine
- o _____Broken Bones
- o _____Bronchitis
- o _____Bulimia
- o _____Bursitis
- o _____Cancer
- o _____Chest Pain
- o _____Chicken Pox
- o _____Chills
- o _____Colds, Chronic
- o _____Convulsions
- o _____Constipation
- o _____Depression
- o _____Diabetes
- o _____Diarrhea
- o _____Dizziness
- o _____Eczema
- o _____Emphysema
- o _____Epilepsy
- o _____Fainting
- o _____Fatigue
- o _____Fever, Frequent
- o _____Fibromyalgia
- o _____Fractures
- o _____Glaucoma
- o _____Growing Pains
- o _____Halitosis
- o _____Heart Attack
- o _____Hepatitis
- o _____Hernia
- o _____Herniated Disc
- o _____Herpes
- o _____Hip Dysplasia
- o _____HIV / AIDS
- o _____Hyperactivity
- o _____Jaundice
- o _____Jaw Pain
- o _____Kidney Infections
- o _____Kidney Stones
- o _____Light-Headedness
- o _____Loss of Balance
- o _____Loss of Smell
- o _____Lymphedma
- o _____Mononucleosis
- o _____Multiple Sclerosis
- o _____Muscle Aches
- o _____Nausea
- o _____Neck Pain
- o _____Night Sweats
- o _____Numbness
- o _____Osteoporosis
- o _____PDD / Autism
- o _____Pneumonia
- o _____Polio
- o _____Poor Appetite
- o _____Prosthesis
- o _____Psoriasis
- o _____Scoliosis
- o _____Stomach Aches
- o _____Stroke
- o _____Tendonitis
- o _____Tuberculosis
- o _____Tumors
- o _____Ulcers
- o _____Varicose Veins
- o _____Weakness
- o _____Yeast Infecstions
- o _____Behavioral Problems
- o _____Breathing Difficulty
- o _____Chemical Dependancy
- o _____Brusing, Increased
- o _____Decreased Mental Clarity
- o _____Dental / Gum Problems
- o _____Digestive Problems
- o _____Ear Aches, Chronic
- o _____Ear Infections, Chronic
- o _____Headaches / Migraines
- o _____Heart Disease / Condition
- o _____Hearing Problems, Recent
- o _____High Cholestoral
- o _____High Blood Pressure
- o _____Infections, Chronic
- o _____Insominia / Sleep Issues
- o _____Joint Swelling / Pain
- o _____Learning Difficulities
- o _____Memory Problems
- o _____Parkinson's Disease
- o _____Poor Coordination
- o _____Postural Imbalances
- o _____Rheumatoid Fever
- o _____Ringing in Ears
- o _____Shortness of Breath
- o _____Sinus Problems, Chronic
- o _____Skin Itching / Problems
- o _____Sore Throat, Chronic
- o _____Sweating, Excessive
- o _____Temper Tantrums
- o _____Thyroid Probmlems
- o _____Tonsillitis, Chronic
- o _____Upper Respiratory Infections
- o _____Urinary Problems
- o _____Walking Problems

Is there anything else regarding your health you feel we should know?

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PATIENT TREATMENT AGREEMENT FORM &
CLINIC PAYMENT POLICY – OUT OF POCKET PAYMENT & INSURANCE PROCESSING POLICY

INFORMED CONSENT:

- NUTRITION / FUNCTIONAL MEDICINE IS A SYSTEMS BASED APPROACH TO HEALTHCARE. AS WITH ALL HEALTHCARE TYPES, FOLLOWING THE PRESCRIBED TREATMENT PLAN DOES NOT CONSTITUTE NOR GUARANTEE A CURE.
- SIDE EFFECTS ARE MINIMAL WITH THE FUNCTIONAL MEDICINE APPROACH. MOST PATIENTS WILL NOTICE LITTLE TO NO SIDE EFFECTS. SOME PATIENTS MAY NOTICE DETOXIFICATION EFFECTS FROM A PRESCRIBED PROTOCOL. OTHER SIDE EFFECTS SUCH AS SKIN RASHES, DIFFICULTY BREATHING, OR HIVES WOULD INDICATE ALLERGIC REACTION AND THE PATIENT IS REQUIRED TO CONTACT THE DOCTOR AND REPORT IT ANY OF THESE SYMPTOMS WERE TO APPEAR.
- BY BEGINNING TREATMENT IN OUR CLINIC YOU, THE PATIENT, ARE TAKING RESPONSIBILITY FOR ANY BENEFITS OR RISKS OF CARE. IN NO EVENT, IS FOLLOWING THE CARE PLAN IN OUR OFFICE A SUBSTITUTION OR REPLACEMENT FOR OTHER TYPES OF MEDICAL CARE THAT A PATIENT MAY HAVE BEEN ADVISED TO FOLLOW. IF YOU HAVE BEEN ADVISED TO OTHER MEDICAL TREATMENT AND HAVE DECIDED TO INSTEAD RECEIVE CARE ONLY IN OUR CLINIC, YOU ARE AGREEING THAT YOU ARE OF SOUND MIND, AND HAVE DECIDED TO DO THIS ON YOUR OWN ACCORD. BY SIGNING THIS FORM, YOU ARE RELIEVING JOHNSON CHIROPRACTIC & HOLISTIC HEALTH CARE, LLC AND / OR DR. JOHNSON OF OTHER LIABILITY ASSOCIATED WITH YOU MAKING THESE DECISIONS.

CONSENT TO PRIVACY PRACTICES:

- YOUR HEALTH INFORMATION IS CONSIDERED TO BE PROTECTED AND CONFIDENTIAL. UNDER FEDERAL LAW (HIPAA), OUR CLINIC MUST KEEP YOUR PROTECTED HEALTH INFORMATION (PHI) CONFIDENTIAL AND CAN ONLY USE IT WITHIN CERTAIN GUIDELINES, WHICH MAY BE SUBJECT TO YOUR PRIOR APPROVAL. OUR CLINIC WILL USE YOUR PHI IN ORDER TO FORMULATE AN APPROPRIATE DIAGNOSIS AND TREATMENT PLAN, MAKE ANY NECESSARY REFERRALS; COLLECT PAYMENT FROM YOUR INSURANCE COMPANY, ATTORNEY, YOURSELF, OR ANY OTHER NECESSARY COLLECTIONS AGENCY, OR INDIVIDUAL. OF COURSE, YOU MAY LIMIT HOW WE USE AND TO WHOM WE DISCLOSE YOUR PHI TO. YOU MUST PUT ANY EXCEPTIONS IN WRITING AND GIVE TO OUR FRONT DESK STAFF. BY SIGNING THIS FORM YOU ARE AGREEING TO OUR PRIVACY PRACTICES. YOU ARE ALSO GIVING OUR OFFICE THE ABILITY TO CONTACT YOU BY ANY MEANS NECESSARY, INCLUDING BUT NOT LIMITED TO: MAIL, EMAIL, TELEPHONE, FAX, ETC. IF YOU WOULD LIKE A COPY OF OUR CLINIC'S "PRIVACY PRACTICES POLICY", PLEASE ASK ANY OF OUR STAFF AND THEY WILL PROVIDE YOU WITH ONE.

SCHEDULING, ATTENDANCE & PAYMENT POLICY; INSURANCE AND OUT-OF-POCKET:

- ANY APPOINTMENT YOU MAKE IS RESERVED SPECIFICALLY FOR YOU. ARRIVING MORE THAN **FIVE** MINUTES LATE TO AN APPOINTMENT WILL RESULT IN YOUR APPOINTMENT BEING TREATED AS A "WALK-IN", AND YOU WILL BE SEEN AT THE NEXT AVAILABLE TIME.
- IF YOU WILL BE UNABLE TO BEEN SEEN AT YOUR SCHEDULED APPOINTMENT TIME, YOU ARE REQUIRED TO CALL AND INFORM OUR CLINIC AT LEAST **FOUR** HOURS BEFORE YOUR SCHEDULED APPOINTMENT TIME TO CANCEL OR RESCHEDULE. FAILURE TO DO SO WILL RESULT IN A NO-CALL-NO-SHOW, AND WE RESERVE THE RIGHT TO CHARGE YOU THE FEE EXPECTED AT TIME OF SERVICE.
- PAYMENT IS EXPECTED IN FULL AT THE TIME OF SERVICE. FEES ARE NOT NEGOTIABLE. ACCOUNTS THAT ARE DUE PAST 30 DAYS WILL INCUR A $10 LATE FEE AFTER EACH 30 DAYS. AFTER 90 DAYS, THE AMOUNT WILL BE TURNED INTO COLLECTIONS. ACCOUNTS IN THE COLLECTIONS PROCESS WILL ACCRUE 15% INTEREST PER ANNUM UNTIL COLLECTED FULLY. THE PATIENT IS ALSO RESPONSIBLE TO PAY COURT COSTS, ATTORNEY FEES, AND ANY OTHER FEE ASSOCIATED WITH THE COLLECTIONS PROCESS IN addition TO THE FEES OF THEIR DELINQUENT ACCOUNT. IF YOUR HEALTH INSURANCE, CAR INSURANCE, PERSONAL INJURY SETTLEMENT, WORKER'S COMPENSATION INSURANCE, PAYMENT OR SETTLEMENT AMOUNT, ATTORNEY, OR ANY OTHER PAYING ENTITY FAILS TO PAY OUR CLINIC COMPLETELY FOR SERVICES RENDERED, YOU ARE STILL RESPONSIBLE TO PAY ALL OF THE DIFFERENCE DUE. WE HAVE NO CONTROL OVER WHAT YOUR INSURANCE COMPANY OR OTHER PAYING ENTITY WILL OR WILL NOT PAY, AND OUR CLINIC WILL NOT BE HELD RESPONSIBLE AS SUCH. YOUR SIGNATURE INDICATES YOUR AGREEMENT WITH THESE POLICIES AND CLAUSES.
- PAYMENT IS REQUIRED FOR YOUR AMOUNT OWED AT TIME OF SERVICE.
- OUR CLINIC WILL GLADLY SUBMIT INSURANCE CLAIMS ON YOUR BEHALF FOR SERVICES RENDERED. HOWEVER, *IN THE EVENT YOUR HEALTH INSURANCE OR OTHER PAYING ENTITY DOES NOT COVER OUR SERVICES, YOU (THE PATIENT) WILL BE REQUIRED TO PAY, IN FULL, ANY AMOUNT NOT COVERED. IT IS YOUR RESPONSIBILITY TO KNOW YOUR OWN INSURANCE BENEFITS, AND OUR CLINIC DOES NOT ASSUME RESPONSIBILITY IN THE EVENT WE ARE GIVEN INCORRECT INSURANCE BENEFIT QUOTES* FROM AN INSURANCE COMPANY. THE ACT OF OUR OFFICE LOOKING UP HEALTH INSURANCE BENEFITS IS A COURTESY TO YOU, OUR PATIENT, BUT IS NOT A REQUIREMENT.

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PATIENT TREATMENT AGREEMENT FORM &
CLINIC PAYMENT POLICY - OUT OF POCKET PAYMENT & INSURANCE PROCESSING POLICY (CONTINUED)

- IF YOU (THE PATIENT) ARE MEETING YOUR DEDUCTIBLE ON YOUR INSURANCE PLAN, YOU WILL BE ASKED TO PAY THE FULL AMOUNT OF YOUR VISIT AT THE TIME OF SERVICE. IF WE ARE EVER IN DOUBT OF THE DEGREE OF INSURANCE COVERAGE PRESENT, YOU (THE PATIENT) WILL BE REQUIRED TO PAY THE FULL AMOUNT DUE ON THE SAME DATE OF SERVICE.
- IF YOUR INSURANCE CLAIM IS DENIED, YOU WILL BE ASKED TO PAY THE OUTSTANDING BALANCE ON YOUR ACCOUNT. IF YOU BELIEVE THE SERVICES SHOULD HAVE BEEN APPROVED AND PAID FOR BY YOUR INSURANCE YOU MAY REQUEST THAT WE RESUBMIT YOUR CLAIM(S). IF CLAIMS ARE RESUBMITTED AND APPROVED BY YOUR INSURANCE YOU WILL BE REIMBURSED OR CREDITED BACK FUNDS, IF AND WHEN THOSE DATE(S) OF SERVICE ARE PAID FOR BY YOUR INSURANCE.
- IN NO INSTANCE SHALL OUR CLINIC EVER BE REQUIRED TO RESUBMIT A PREVIOUSLY DENIED CLAIM IF WE EXPECT THE RESUBMITTED CLAIM WILL ALSO BE DENIED.
- WE ARE IN-NETWORK AND / OR ARE PARTICIPATING PROVIDERS WITH MOST, BUT NOT ALL INSURANCE *PLANS*. BEING AN IN-NETWORK / PARTICIPATING PROVIDER MEANS THAT WE WILL ACCEPT THE CONTRACTED AMOUNT ON CONTRACTED COVERED SERVICES AS PAYMENT IN FULL IN ADDITION TO ANY REQUIRED COPAYS / COINSURANCE PAYMENTS. HOWEVER, IN THE EVENT A SERVICE IS NOT COVERED OR IS NOT A CONTRACTED SERVICE, YOU (THE PATIENT) ARE OBLIGATED TO PAY OUR CLINIC IN FULL FOR SERVICES RENDERED AT OUR CLINIC'S TYPICAL FEE SCHEDULE. IF INSURANCE IS BILLED AND DOES NOT PAY FOR SERVICES RENDERED, YOU (THE PATIENT) WILL BE REQUIRED TO PAY THE AMOUNT OUTSTANDING THAT WAS BILLED TO INSURANCE.

FEE SCHEDULE FOR NUTRITION CONSULTING / FUNCTIONAL MEDICINE VISITS:

THE FEE SCHEDULE PROVIDED IS A QUOTE, AND SUBJECT TO CHANGE AT PROVIDER DISCRETION

- NO INSURANCE – CASH / OUT-OF-POCKET: $95.00 INITIAL VISIT $45.00 FOLLOWING VISITS

BY SIGNING BELOW, I AM ACKNOWLEDGING THAT I HAVE READ, UNDERSTAND, AND AGREE WITH ALL THE STATEMENTS, POLICIES, AND PROCEDURES LISTED ABOVE.

PATIENT NAME PRINTED: _____ DATE: _____

PATIENT SIGNATURE: _____

IF SIGNING FOR A MINOR

GUARDIAN NAME & RELATIONSHIP PRINTED: _____

GUARDIAN SIGNATURE: _____ DATE: _____

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