Dr. Mikell Adams, D.C., P.A.
Adams Chiropractic and Wellness Center
1201 Wakarusa Dr, Suite A1
Lawrence KS 66049
Ph: 785-838-9000 Fax: 785-838-4177

Welcome to our office!

After you have called our office to schedule an appointment, please download, print and fill out the "Registration Form". Every new patient must complete pages 1-3. If you have insurance, read and sign page 4, our "Financial Arrangements" policy. If the new patient is a minor, please have both parents (if available) sign page 5, the "Consent to Treat a Minor" form.

Please come in a few minutes early so we can finish setting up your files. Bring your insurance card(s) and medication list with you so we may copy them.

If, for ANY reason, you would need to cancel your appointment—even if it is just a few hours, or minutes away—Please call (785-838-9000). We usually have a waiting list, and some very happy person is waiting to fill that time slot.

This is a scent-free office. In consideration of our patients, please refrain from wearing scented products (this includes the parents and caregivers of our patients). If you smoke, please do not smoke an hour or more, prior to your appointment. The smoke and scented products may cause serious reactions in our allergy and asthma patients.

We have included a page of driving directions at the end of this section. Please call us with any questions about directions and we will get you here!

THANK YOU

ADAMS CHIROPRACTIC & WELLNESS CENTER
1201 Wakarusa Drive, Suite A1 Lawrence KS 66049 Ph: (785) 838-9000 Fax: (785) 838-4177

REGISTRATION FORM

(Please Print)

Today's date:	Patient ID # (Office use only)

PATIENT INFORMATION

Patient's first name	M.I.	Last name	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid / Partner

Preferred name	Home phone number	Cell phone number	Work / School phone number
	( )	( )	( )

Home street address	City	State	ZIP Code

Birth date	Age	Sex	Social Security number	Email address
		❑ M ❑ F		

Occupation:

Employer / School name:

Employer / School address:

City, State, Zip:

Spouse, Parent or Partner's Name:

Referred to clinic by:

RESPONSIBLE PARTY

Person responsible for bill:						Home phone number
Home address (if different):						( )
City, State, Zip:						Cell phone number
Employer:						( )
Work address:		City, State, Zip:				Work phone number
Relationship to patient:	❑ Self	❑ Parent	❑ Spouse	❑ Partner	❑ Child	( )

INSURANCE INFORMATION

Is this patient covered by insurance?	❑ Yes	❑ No	**Please bring your card(s) so we may copy them.**

Name of Insurance Company:

Subscriber's name (as it appears on card)	Subscriber's S.S. number	Birth date	**Subscriber's employment:**
			Work address:
			City, State, Zip:

Patient's relationship to subscriber:	❑ Self	❑ Parent	❑ Spouse	❑ Partner	❑ Child

Name of **Secondary** Insurance (if applicable)	**Secondary** Subscriber's name	Birth date	**Secondary** Subscriber's employment:
		/ /	Work address:

Patient's relationship to **secondary** subscriber:	❑ Self	❑ Parent	❑ Spouse	❑ Partner	❑ Child	City, State, Zip:

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone number	Work / Cell phone number
		( )	( )
		( )	( )

Symptoms

Reason for visit:					When did you first notice the symptoms?			
Is this condition getting progressively worse?								
Where specifically is the problem(s) located?								
Which activities are difficult to perform?	❑ Sitting	❑ Standing	❑ Walking	❑ Bending	❑ Lying down	❑ Other: _____		
Type of pain?	❑ Sharp	❑ Dull	❑ Throbbing	❑ Numbness	❑ Aching	❑ Shooting	❑ Burning	❑ Tingling
	❑ Cramps	❑ Stiffness	❑ Swelling	❑ Other: _____				
Rate the severity of your pain. (1, mild pain or discomfort, to 10, severe pain):				Please circle: 1 2 3 4 5 6 7 8 9 10				
Is the pain constant or does it come and go?								
What treatment have you already received for your condition?			❑ Medication (please list):					
❑ Surgery	❑ Physical Therapy	❑ Other (please list):						
Name and address of other doctor(s) who have treated you for your condition:								

Health History

Please mark all that apply for the patient.

❑ AIDS/HIV	❑ COPD	❑ Gout	❑ Mononucleosis	❑ Rheumatic Fever
❑ Alcoholism	❑ Crohn's, Colitis, IBS	❑ Heart Disease	❑ Multiple Sclerosis	❑ Shingles
❑ Anemia	❑ Depression	❑ Hepatitis	❑ Mumps	❑ Stroke
❑ Appendicitis	❑ Diabetes	❑ Hernia	❑ Osteoporosis	❑ Suicide Attempt
❑ Arthritis	❑ Digestive Problems	❑ Herniated Disc	❑ Pacemaker	❑ Thyroid Problems
❑ Asthma	❑ Eating disorder	❑ Herpes	❑ Parkinson's Disease	❑ Tonsillitis
❑ Blood Disorders	❑ Emphysema	❑ High Blood Pressure	❑ Pinched Nerve	❑ Tuberculosis
❑ Breast Lump	❑ Epilepsy	❑ High Cholesterol	❑ Pneumonia	❑ Tumors, Growths
❑ Bronchitis	❑ Fatigue of long duration	❑ Kidney Disease	❑ Polio	❑ Ulcers
❑ Cancer	❑ Fibromyalgia	❑ Liver Disease	❑ Prostate Problems	❑ Vaginal Infections
❑ Cataracts	❑ Fractures	❑ Measles	❑ Prosthesis	❑ Venereal Disease
❑ Chemical Dependency	❑ Glaucoma	❑ Migraine Headaches	❑ Psychiatric Care	❑ Whooping Cough
❑ Chicken Pox	❑ Goiter	❑ Miscarriage	❑ Rheumatoid Arthritis	❑
❑ Other: _____		❑ Other: _____		

Date of last medical or chiropractic exam(s):		
(Women) Are you pregnant? ❑ Yes ❑ No	Nursing? ❑ Yes ❑ No	Taking birth control pills? ❑ Yes ❑ No
List any types of surgeries which you have had and the dates which they occurred:		
Please list all medications you are currently taking:		
Please list any allergies:		

Daily Habits

What types of exercise do you perform on a daily basis?	❑ None	❑ Light	❑ Moderate	❑ Heavy
What do your daily work habits include? (ex: sitting, standing, light labor, heavy labor, computer work)				
What vitamins do you currently take?				
What kind of other nutritional supplements do you take?				
How much liquor do you consume on a weekly basis?		Do you smoke? ❑ Yes ❑ No		How much per day?
How many cups of coffee or caffeinated beverages do you consume on a daily basis?				
How much artificial sweetner (Equal, Sweet-N-Low, etc.) do you consume on a daily basis? (packets, scoops, etc)				
How many diet soft drinks do you consume on a daily basis?				

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with: (Insurance company(ies) _____ and assign directly to Dr. Mikell Adams all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Mikell Adams may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative | Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative | Relationship to Patient

FINANCIAL ARRANGEMENTS
AND HEALTH INSURANCE POLICY

Thank you for joining us at **Adams Chiropractic and Wellness Center**, we are interested in providing you and your family with the best possible care. Our goal is to encourage your participation in your health and wellness program. The following represents our policies regarding insurance and patient financial responsibility.

Payment is expected when services are performed, unless other payment arrangements have been made in advance. You can pay the services by cash, check (returned check fees are $30.00), credit or debit card. A 1.5% monthly finance charge will be applied (18% annually) to any outstanding balance.

**** Please note, we are a NON-participating provider for all HMO insurance programs, therefore you will need a referral from your primary care physician (PCP). ****

We will strive to help you receive the maximum allowable benefits from your health insurance company; however, you must realize that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. Any inquiries from the insurance company will be handled in a timely manner.

2. We offer an alternative method of evaluation and treatment that **may not** be covered by your insurance company. The diagnosis code(s) provided **may not** be accepted by your insurance company. Some insurance companies arbitrarily select certain services they will not cover.

3. We must emphasize that as chiropractic health care providers, our relationship is with **YOU**, not your insurance company.

4. The filing of insurance claims is a courtesy that we extend to our patients; however, **ALL charges incurred are your responsibility.** Please have your current card(s) ready to be photocopied at your first appointment.

If you are uncertain about your insurance coverage, please call the number on your card. **Understand that your insurance card is not a guarantee of payment by your insurance company (as printed on your insurance card). All charges are your financial responsibility.**

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. Please call **785.838.9000**.

Without the proper HIPAA Waiver form in place, we are unable to discuss your account with anyone but yourself. If you have any questions regarding the above information, PLEASE ask us. We are here to help you.

I understand and agree that, regardless of my insurance status, **I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED.** I have read all of the information on this sheet. I will notify you of any changes in my insurance provider.

Signature _____ Date _____

Parent / Caregiver (if a minor) _____ Date _____

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CONSENT TO TREAT A MINOR

I (we) being the parent(s), guardian or custodian of the minor child:

_____ age: _____,

do hereby authorize, request and direct this office and staff to perform examinations, diagnostic x-rays, laboratory tests, and any treatment that, in their judgment, is deemed advisable or is required while said minor is under the care of this office's Doctor and staff until legal age or until authorization is rescinded by responsible party. All charges for services and care given to said minor child will be charged directly to me (us) and I (we) will be personally responsible for payment for them.

We require the signatures of **both parents** or guardian or custodian:

_____ _____

Date: _____

Witness: _____

Date: _____

From Eudora (coming west on Hwy 10)

- Highway 10 W becomes 23rd Street, and then becomes Clinton Parkway
- Stay on this same street until it intersects with Wakarusa Drive.
- Turn right (north) onto Wakarusa Drive.
- Proceed through the stop light at Bob Billings Parkway, staying on Wakarusa Drive.
- You will come to another four-way stop at Legends and Inverness Drives. Just past this four way stop on the left, you'll see the Free State Business Center, a group of Spanish looking buildings.
- Enter the business center. Building A is on the left as you enter and we are in Suite 1, which is closest to the driveway.

From Lecompton exit on I-70 (coming east or west on I-70)

- Take the Lecompton exit, and after the toll booth turn south on Highway 10.
- Take the first exit off Highway 10 at US 40.
- At the top of the off ramp, turn left so that you are heading east, toward Lawrence.
- At the first stoplight (by McDonalds), turn right, heading south on Wakarusa Drive
- Stay on Wakarusa through the four-way stop at Harvard Road.
- After you pass Emprise Bank on your, right, turn in the next driveway, at the Free State Business Center. Building A is on the left as you enter and we are in Suite 1, which is closest to the driveway.

From Baldwin City (coming north on Hwy 59)

- Take Hwy 59 to the Highway 10 turnoff. This is a left turn after the overpass.
- Stay on Highway 10 until you get to the 6th street exit.
- At the top of the ramp, turn right onto 6th street heading east into Lawrence.
- At the first stoplight (by McDonalds), turn right, heading south on Wakarusa Drive
- Stay on Wakarusa through the four-way stop at Harvard Road.
- After you pass Emprise Bank on your right, turn in the next driveway, at the Free State Business Center. Building A is on the left as you enter and we are in Suite 1, which is closest to the driveway.

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