Name of Patient: _____ Date of Birth of Patient: _____ 1:

FIRST VISIT REGISTRATION

Thank you for completing

wellbodyKC looks forward to getting you well soon!

email: support@wellbodykc.com www.wellbodykc.com 2111 East KC Road, Olathe, Ks 66061

fax: 913-222-1907

Name of Patient: _____ Date of Birth of Patient: _____ 2:

wellbodyKC

Sport: _____ **Level:** _____

Team/ Club: _____ **Practice schedule Hours per week:** _____

Competition Season: (Place an "X" after the correct time when you are "in season")

Year Round ☐ Winter ☐ Summer ☐ Spring ☐ Fall ☐ I don't compete ☐

Next scheduled event: _____ **I plan to compete/perform at this event:** YES ☐ NO ☐

1. **Past Medical History:** (include fractures, dislocations, asthma, diabetes, hospitalizations, etc.)

2. **Past Surgical History:** (include ear tubes, tonsillectomy, appendectomy, orthopedic procedures)
   Procedure Date

3. **Medicines I take every day:** (include prescription, over the counter, supplements, vitamins, alternative)
   Medicine Dosage (if you know it)

4. **Medicines I take every once in a while:** (include Tylenol, ibuprofen, creams, alternative)
   Medicine Frequency (daily, weekly, monthly, rarely)

5. **Allergies** to medicines/ foods/ environmental: _____ None ☐

6. I received **immunizations** and am up to date: Yes ☐ No ☐

7. **During every week I eat something in this food group:** (Place "X" after each of what you eat/drink)
   Meat/Fish ☐ Fruits ☐ Vegetables ☐ Grains ☐ Water ☐ Desserts ☐ Soda/Pop ☐

8. **I have had this many stress fractures diagnosed:** (extremity/back): _____ Never had ☐

9. **I have had this many concussions:** Number: _____ Never had ☐

10. **School:** "X" after correct response: Public/Private ☐ Home ☐ College ☐ I don't go to school ☐

11. **I get this kind of treatment at least once a month:** (Place an "X" after all that apply)
    Massage ☐ PT ☐ Chiropractor ☐ Dry needling ☐ Cryotherapy ☐ Other: _____

12. **Today's appointment**: My question / my problem / my concern/ my goals for today:

Name of Patient: _____ Date of Birth of Patient: _____ 3:

wellbodyKC CONSENT FOR EXAMINATION, MEDICAL TREATMENT

I authorize wellbodyKC health care providers to consult, examine, and recommend a treatment plan for the patient/athlete above. I realize that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examination in this practice. I understand that communication with anyone other than the patient and patient's guardian (if the patient is under 18 years old) is protected by HIPAA unless permission is granted below.

If marked below, I hereby authorize the following people to bring my child to appointments without a parent or guardian present. I authorize them to consent to any and all examinations, tests, procedures and treatments deemed necessary by the provider. Removing a person from this list can be done with a written request.

If marked below, I hereby authorize wellbodyKC to discuss the diagnosis and/or treatment recommendations with the following people. I understand this may be done by mail, fax, email, or phone. I realize that not all communication is secure and unintended parties could possibly access the information without Dr. Randall Goldstein or wellbodyKC, LLC knowledge or permission. I do not hold Dr. Randall Goldstein or wellbodyKC, LLC liable (for financial, personal information, HIPAA protected information), for unintended access of information by a third party. I do not hold Dr. Randall Goldstein or wellbodyKC, LLC liable for how a third party obtains, uses, or disseminates information unintended for their access.

This form has no expiration date for Dr. Randall Goldstein / wellbodyKC, LLC to communicate with permitted contacts you provide below. Please send a signed and dated request if you would like to remove permission to support@wellbodykc.com or mail to wellbodyKC, LLC, 2111 East Kansas City Road, Olathe, Kansas 66061.

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inform my coach → ☐ **Coach Contact:** _____ **Email or Phone:** _____

inform my doctor → ☐ **Primary Care Provider:** _____ **Email or Phone:** _____

can bring to clinic in Parent's absence → ☐ **Name of Adult Chaperone:** _____ **Email or Phone:** _____

I have read and consent to the above information. I was offered access to the wellbodyKC HIPAA information handout

Signature of Parent/Guardian: _____ **Date:** _____
(or Patient/athlete if over 18 years)

To sign- select Draw above- after signing select Draw again to return to next field

Printed name of Parent/Guardian: _____
(or Patient/athlete if over 18 years)

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number: _____ **Email:** _____

[_____] Initial here to permit NON encrypted communication to the contacts listed for the above patient

To initial- select Draw above- after initialing select Draw again to return to next field

Name of Patient: _____ Date of Birth of Patient: _____ 4:

wellbodyKC Financial Policy- All Members

7/2024

wellbodyKC participates in several Commercial Insurance Company plans. Each plan has different benefits as well as different financial obligations by you, the subscriber to the plan. It is your responsibility to understand your insurance policy and coverage. **Please bring your insurance card to each visit to the clinic.** For the remainder of this form, the parent/guardian (or if the patient is over 18 and the subscriber of the insurance plan) is described as "subscriber" or "you" or "your".

1. Please be ready to cover co-payments, and any owed deductibles and co-insurance at the time of your visit. Copays not paid on the day of service may incur a $50.00 charge.
2. wellbodyKC, LLC requires a payment card on file. You will receive an email from Square to collect this information. Your payment card information is stored by Square encrypted merchant service. wellbodyKC, LLC only has access to the last 4 digits of your card.
3. If you choose not to leave a payment card on file you will be required to leave a $175.00 deposit. Each visit you will be asked to replenish your deposit to the $175.00 balance.
4. After each visit we will file a claim with your insurance company for services provided by wellbodyKC, LLC. Your insurance company is required to provide you and wellbodyKC, LLC with an EOB (Explanation of Benefits) explaining your responsibility after they have processed our claim. After reviewing your EOB if you believe there is a processing error, please contact our office immediately.
5. Amounts owed up to $175.00- wellbodyKC, LLC will charge your payment card on file 14 days after we receive the EOB from your insurance company. If you would like to pay with a different method than the card on file, this can be done before the 14th day after the EOB statement is sent out. If your responsibility is more than $175.00, wellbodyKC, LLC will deduct $175.00 as explained above, and then notify you prior to processing your card for the remainder due.
6. Statement balances will be sent as a courtesy to the email on file; payment is due upon receipt. If you receive a courtesy statement this serves as notification of balance due. We will email you a receipt showing the amount paid on your account.
7. You are responsible for providing us any updates to your insurance. If any charges are denied because you did not provide current insurance information, the parent or guardian of the patient will be responsible for any unpaid balances.
8. If, for any reason, the EOB states that the services provided are not covered or allowable by your plan, you will be billed for a clinic visit (and other appropriate charges incurred during the visit) without insurance coverage. An example of this could occur if your insurance policy is not active, wellbodyKC does not participate with your plan, or information you provided at the time of filing was incorrect.
9. If your payment card is declined a $50.00 charge may be applied to your account balance for each declined transaction. You are responsible for updating your address and telephone numbers on file. If we are not notified and your payment card is denied for a change or expiration, this charge will be applied to your account. If your payment card is expired, we will notify you with an email or phone call, whichever communication you marked as 'preferred' on the Patient intake form. You will have 48 hours after being contacted to provide us the new payment card information or a charge of $50.00 may be applied to your account.
10. Any account unpaid over 30 days from the date of the EOB will incur a $50.00 charge. Any account unpaid over 45 days from the EOB will receive a non-payment letter and will need to be settled within 7 business days by paying the amount due or setting up a payment plan. If this notice is ignored your account will be sent to a collection agency and all legal fees and collection expenses will be added to your balance. At that time, wellbodyKC will require that you find a new health care provider. Urgent matters will be addressed for 30 days after notification. You may request medical records at that time- see #12.
11. If a patient is over 20 minutes late to their scheduled appointment, fails to keep appointment ("no show"), or does not reschedule within 24 hours of late or "no show" appointment- a $25.00 fee will be assessed. If unable to accommodate the late time, rescheduling may be requested. If there are two occurrences, wellbodyKC will require that you find a new health care provider and will notify you in writing to the address on file. You may request medical records at that time- see #12.
12. Medical records release- wellbodyKC will send medical records to one health care provider upon your signed request without charge. Upon your signed request, there will be a fee of $25.00 plus 66 cents per page (paper or electronic) prior to sending to subsequent health care providers, or medical records requested by the patient or a non-health care person/entity.

I acknowledge I have read and agree to follow the wellbodyKC Financial Policy.

Signature of Parent/Guardian_____ **Date:** _____
(or patient if over 18 years old and Guarantor)

To sign- select Draw above- after signing select Draw again to return to next field

Name of Patient: _____ Date of Birth of Patient: _____ 5:

IN NETWORK COMMERCIAL INSURANCE PLANS

(BCBS, Anthem, UHC, UMR, Aetna, Cigna), **not in network with Medicaid products within these plans**
not in network with Exchange Benefit or Marketplace plans

The Guarantor for the Insurance Policy is: _____ _____

Name of Guarantor (usually Mother or Father) **Date of Birth** (if CIGNA insurance)

INFORMATION CONCERNING FILING A CLAIM WITH YOUR INSURANCE COMPANY

If wellbodyKC, LLC participates with your primary insurance, wellbodyKC, LLC will gladly file a claim for you. We will allow your insurance company up to 45 days from the date of service to pay the claim. If your company fails to fully compensate wellbodyKC, LLC within this time frame, any unpaid balance becomes your sole responsibility.

AUTHORIZATION TO FILE INSURANCE CLAIMS, RELEASE MEDICAL INFORMATION, ASSIGNMENT OF BENEFITS

· I authorize wellbodyKC, LLC to file insurance claims for services and supplies rendered to and for my/our child(ren).

· I authorize wellbodyKC, LLC to release information, including my/our child(ren) medical and billing information, to referring or consulting physicians and to patient's insurance company. The transmission of all information may be done electronically.

· I authorize that payment of all third party benefits otherwise payable to me be made directly to wellbodyKC, LLC

· I assign to wellbodyKC, LLC all payments for medical services and supplies provided to my dependent child(ren). I understand that I am financially responsible to wellbodyKC, LLC for the above named patient (s). If my insurance company fails to fully compensate wellbodyKC, LLC any unpaid balance becomes my sole responsibility. I agree to pay all amounts not covered or paid by a third party payer within 14 days. If I fail to pay within 14 days, wellbodyKC, LLC has the right to charge my credit card or debit card that I have on file with them (or use the deposit if I choose not to leave a credit card on file). If payment is not completed within 45 calendar days from the Explanation of Benefits, a non-payment letter will be sent to the address on file. If payment is not received within 7 days from the date of the non-payment letter, wellbodyKC, LLC will turn the account over to a collection agency. In the event wellbodyKC, LLC refers my account to a collection agency to collect any monies owed to wellbodyKC, LLC, wellbodyKC, LLC shall be entitled to recover reasonable attorney's fees and costs of litigation.

AGREEMENT AS TO CO-PAYMENTS, NON-COVERED OR NON-PAID SERVICES, AND GUARANTEE OF PAYMENT

I understand that wellbodyKC, LLC cannot bill for co-payments. Any co-payments or payments for non-covered services are due at the time medical services are provided.

I acknowledge reading above and understand the policy.

Signature of Parent/Guardian: _____ **Date:** _____
(or Patient/athlete if over 18 years old and Guarantor)

To sign- select Draw above- after signing select Draw again to return to next field

Thank you- See you soon to get you well!