Patient Introduction

Name: _____ Date:_____
Address: _____
City: _____ State: _____ Zipcode: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email Address: _____

Sex (circle one): Male Female

Race (circle only 1): American Indian Alaska Native Asian
Black or African American White Native Hawaiian
Other Pacific Islander Declined to state

Ethnicity (circle only 1): Declined to State Hispanic or Latino **Not** Hispanic or Latino

Preferred Language: _____
Marital Status: Single Married Other_____
Date of Birth: _____/_____/_____ Age: ____ # of Children: _____
Social Security # (used for insurance billing only): _____- _____ - _____
Occupation: _____ Employer: _____
Work address: _____
City: _____ State: _____ Zipcode: _____

Is your visit work related (worker's comp)? Yes___ No___
We must contact your employer to verify worker's comp.

Insured Information (the person that carries the insurance):
Name of Insured: _____
Address of Insured: _____
Phone number of Insured: _____
Insured's Date of Birth: _____/_____/_____ Sex: Male Female
Patient is the *Same/Self* *Husband* *Wife* *Child* *Other* of insured

Reference: Nearest relative NOT living with you:
Name: _____ Phone #:_____
Address: _____
Relationship: _____

How did you hear about us? _____

Symptom Description

Main Complaint: _____
_____

When did this begin? _____
How did this begin? _____

Is the pain (circle one): Constant Frequent or Occasional?

Describe the pain (circle all that apply):
Dull Sharp Achy Shooting Tingling Burning Numb

Is the pain (circle one): Mild Moderate or Severe?

Does the pain travel to any other parts of your body? _____
Have you had pain like this before? Yes No
If yes, when? _____
What makes the pain better? _____
What makes the pain worse? _____
What have you done to treat the pain? _____
Have you seen any other health professionals for this condition? Yes No
If yes, who? _____

Other Complaint: _____
_____

When did this begin? _____
How did this begin? _____

Is the pain (circle one): Constant Frequent or Occasional?

Describe the pain (circle all that apply):
Dull Sharp Achy Shooting Tingling Burning Numb

Is the pain (circle one): Mild Moderate or Severe?

Does the pain travel to any other parts of your body? _____
Have you had pain like this before? Yes No
If yes, when? _____
What makes the pain better? _____
What makes the pain worse? _____
What have you done to treat the pain? _____
Have you seen any other health professionals for this condition? Yes No
If yes, who? _____

Do you take any Medications? Yes No

If Yes, please list below:

Medication:_____ Medication:_____
Condition treated:_____ Condition treated:_____

Medication:_____ Medication:_____
Condition treated:_____ Condition treated:_____

Medication:_____ Medication:_____
Condition treated:_____ Condition treated:_____

Do you have any Medication allergies? Yes No

If Yes, please indicate the following:

Allergy:_____ Allergy:_____
Reaction:_____ Reaction:_____

Allergy:_____ Allergy:_____
Reaction:_____ Reaction:_____

List any hospitalizations/surgeries/illnesses and their dates:

_____
_____
_____

Smoking Status (circle one): Current Smoker Former smoker Never Smoker

<u>Family History</u>

Please describe any family history of illnesses (cancer, diabetes, high blood pressure etc.) and who in your family has them. Please list blood relatives only.

Condition:	Relative:
_____	_____
_____	_____
_____	_____

Ideal Chiropractic Policies

All appointments must be cancelled by 3 p.m. of the previous day (or by 12 p.m. on Friday for a Monday appointment), to avoid a **$30.00** no-show or late-cancellation fee. After-hour messages regarding cancellations may be left at (920) 907-1700. Insurance will not cover charges for no-show/late-cancellation or eligibility fees.

Please be aware that any accounts sent to a collection agency are subject to an additional 35% charge added to the account balance.

By signing below, you acknowledge that you read and understand the policies stated above.

Patient signature:_____ Date:_____

I understand and agree that the health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the Doctor's office will prepare any standard forms to assist me in asking collection from the insurance company. Any payments received by the Doctor's office from my insurance company will be credited to my account upon receipt. However, I clearly understand that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable and any legal fees necessary to collect outstanding balances. I hereby authorize the Doctor to treat my condition as he deems appropriate through the use of chiropractic care of my spine and joints. It is understood and agreed that all records, including x-rays, are property of this office. I am entitled to request copies of any or all of my records and am aware that there are fees associated with obtaining any copies. I also agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I understand that if my insurance is an HMO plan, I will be switched to a cash patient upon reaching maximum coverage with the HMO. I understand that appropriate credit reports may be obtained, when credit is extended.

Patient's Signature_____ Date_____

Guardian or Spouse's Signature authorizing care _____ Date_____

TERMS OF ACCEPTANCE INFORMED CONSENT FOR CARE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the methods that will be used to attain it. This will prevent any confusion or disappointment.

Care: Care may consist of Exercise, Adjustment, and/or Traction. These are specific applications of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by exercise, adjustment and traction of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or symptom.

Vertebral Subluxation: A misalignment of one or more of vertebra in the spinal column which causes alteration of nerve function and interferes in the transmitting of mental impulses, resulting in a lessening of the body's innate ability to express maximum health potential.

Results: The purpose of chiropractic services is to promote health through the release of maximum nervous energy. Since there are so many variables, it is sometimes difficult to predict the time schedule and efficiency of chiropractic procedures. Sometimes results are phenomenal. In some cases, there is a more gradual response; occasionally the results are mediocre or dismal. Many people find results with chiropractic care, in turn we must admit that conditions which do not respond chiropractically, may come under the control of medical science. We will do our best in determining if you need chiropractic care, however we cannot be held responsible for a medical diagnosis, or under Wisconsin trial law be responsible for a medical referral.
We do not offer to diagnose or treat any disease or condition other than vertebral subluxation, however, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. In remote instances, chiropractic manipulative treatment has aggravated disc conditions, and cardiovascular conditions. Literature shows this to be very infrequent, but can happen.

Regardless of what the disease is called, we do not treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our method is specific exercises, adjustments and or tractions to correct vertebral subluxation.

I, _____ have read and fully understand the above statements.

All questions regarding the Doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction and I agree with the above statements.

I therefore accept chiropractic care on this basis.

(Signature)_____ (Date) _____

USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION ACKNOWLEDGEMENT AND CONSENT

The federal laws that protect your protected health information ("HIPAA") do not provide you with complete privacy. HIPAA allows your health care provider to use or disclose your protected health care information without further authorization or consent from you in a number of circumstances, such as:

- In the course of providing you treatment;
- In the event a referral to another health care provider if/as necessary for the diagnosis, assessment, or treatment of your health condition;
- For insurance and billing purposes;
- For internal clinic purposes (related to quality control or operations); and
- In limited and unusual circumstances related to public health matters and research.

Our privacy policy. We are very concerned with protecting your privacy, and always will respect the privacy of your health information. Along with this consent form, you will be given a copy of our privacy policy, in detail. You have the right to review our privacy policy before you sign this consent form. We reserve the right to change our privacy policy. If we make a change, we will notify you in writing when you come in for treatment or by mail.

Your right to limit uses or disclosures. You have the right to restrict our ability to use or disclose your protected health information with specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, you must inform us in writing.

Your right to authorize us to disclose your protected health information. You have the right to authorize us to disclose your protected health information to specific individuals, companies, or organizations. If you would like to make an authorization, we will ask you to complete an authorization form.

Your right to revoke any limitation, authorization, or consent. You have the right to revoke any limitation or authorization to use or disclose your protected health information at any time. Your revocation must be in writing. If you refuse to give us an authorization or consent or revoke any authorization or consent in the future, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

Please check one option below to either CONSENT or DECLINE CONSENT

☐ I **CONSENT** to my personal health information being used in the manner described above**.**

☐ I **DECLINE** to give my chiropractor and members of the practice staff consent to use my protected health information for any purpose other than treatment and those required by federal law.

I ACKNOWLEDGE receipt of the PRIVACY POLICY. I am also acknowledging that I may receive a copy of this consent upon request.

_____	_____
Patient Name	Date
_____	_____
Patient (or Personal Representative) Signature	Authorized Provider Representative
_____	_____
Personal Representative's Name Printed	Personal Representative's Authority