Patient Information

Date: _____

Name: _____ ❑ M ❑ F

Address: _____

City: _____ State: _____ Zip Code: _____

Home: _____ Cell: _____

Work: _____ ❑ Married ❑ Widowed ❑ Single

Birthdate: _____ Age: _____ ❑ Separated ❑ Divorced ❑ Minor

E-Mail Address: _____

Occupation: _____ Spouse's Name: _____

Whom may we thank for referring you? _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____ Relationship: _____

Home: _____ Cell: _____

Patient Condition

Reason for visit: _____

Is this condition due to an accident? ❑ Yes ❑ No / ❑ Auto ❑ Work ❑ Home ❑ Other

Date of accident? _____ Have you reported your accident? ❑ Yes ❑ No

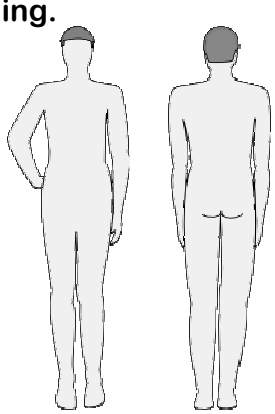
When did your symptoms appear? _____

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Unknown

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching ❑ Shooting
❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other

Mark an X on the picture where you continue to have pain, numbness or tingling.



How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your

❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation

Activities or movements that are painful to perform:

❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down

What treatment have you already received for your condition?

❑ Medications ❑ Surgery ❑ Physical Therapy ❑ Chiropractic ❑ None ❑ Other _____

Are you pregnant? ❑ Yes ❑ No Due Date _____

Health History

Date of Last:

Physical Exam _____ **Spinal X-Ray** _____ **Blood Test** _____

Spinal Exam _____ **Chest X-Ray** _____ **Urine Test** _____

Dental X-Ray_____ **MRI, CT-Scan, Bone Scan** _____

Mark "Yes" or "No" to indicate if you have had any of the following:

Alcoholism	❑ Yes ❑ No	Fractures	❑ Yes ❑ No	Osteoporosis	❑ Yes ❑ No
Arthritis	❑ Yes ❑ No	Heart Disease	❑ Yes ❑ No	Pacemaker	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Herniated Disk	❑ Yes ❑ No	Pinched Nerve	❑ Yes ❑ No
Bleeding Disorders	❑ Yes ❑ No	High Cholesterol	❑ Yes ❑ No	Prostate Problem	❑ Yes ❑ No
Breast Lump	❑ Yes ❑ No	Kidney Disease	❑ Yes ❑ No	Rheumatoid Arthritis	❑ Yes ❑ No
Cancer	❑ Yes ❑ No	Liver Disease	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Type(s) _____		Migraine Headaches	❑ Yes ❑ No	Other _____	
_____		Miscarriage	❑ Yes ❑ No	_____	
Chemical Dependency	❑ Yes ❑ No	Multiple Sclerosis	❑ Yes ❑ No	_____	

Has any family member had any of the above listed conditions?

Father _____

Mother _____

Sister _____

Brother _____

Grandfather _____

Grandmother _____

EXERCISE
- ❑ None
- ❑ Moderate
- ❑ Daily
- ❑ Heavy

WORK ACTIVITY
- ❑ Sitting
- ❑ Standing
- ❑ Light Labor
- ❑ Heavy Labor

HABITS
- ❑ Smoking — Packs/Day _____
- ❑ Alcohol — Drinks/Week _____
- ❑ Coffee/Caffeine Drinks — Cups/Day _____
- ❑ High Stress Level — Reason _____

Injuries/Surgeries you have had:	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided. This enables you to make an informed decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic, and well as all other types of health care, is associated with potential risks in the delivery of treatment. Therefore, it is necessary to inform the you of such risks prior to initiating care. While chiropractic treatment is remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptoms, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Specific Risk Possibilities Associated with Chiropractic Care:

Soreness—Chiropractic adjustments and physical therapy procedures are sometime accompanied by post treatment soreness. This is normal and acceptable accompanying response to chiropractic care and physical therapy. While it is not generally dangerous, please advise your doctor if you experience soreness and discomfort.

Soft Tissue Injury—Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint ligament, tendon or other soft tissue injury.

Rib Injury—Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

Physical Therapy Burns—Heat generated by Physical Therapy modalities may cause minor burns to the skin. This is rare but if it occurs you should report it to your doctor or a staff member.

Stroke—Stroke is the most serious complication of chiropractic treatment. The most recent studies estimate that the incidence of this type of stroke is 1 in every 5 million upper cervical adjustments.

Other Problems—There are occasionally other types of side effects associated with chiropractic care. While these are rare, the should be reported to you doctor promptly.

(continued on reverse side) ➔

Informed Consent for Chiropractic Care

(continued from reverse side)

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as it may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

I hereby authorize physicians and staff at Shakopee Family Chiropractic to treat my condition as they deem appropriate. To the best of my knowledge, there is no pregnancy, confirmed or suspected at this time. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the information provided is correct to the best of my knowledge. I will not hold my doctor or any staff member of Shakopee Family Chiropractic responsible for any errors or omissions that I may have made in the completion of these forms.

All questions regarding the doctor's objective, pertaining to my care in this office, have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____

Print Name

_____ _____

Signature **Date**

Date of last menstrual cycle: _____

Consent to Treatment of a Minor Child

I, _____ hereby authorize Dr_____

(Parent or Guardian)

and whomever they may designate as assistants to administer chiropractic care as deemed necessary to my son/daughter, _____.

(Name of child)

_____ _____

Signature **Date**

_____ _____

Witness **Date**

HIPAA Patient Consent Form

TO OUR PATIENTS: Before you begin treatment at Shakopee Family Chiropractic (SFC) federal law requires that we explain your rights and responsibilities while a patient at SFC. If you have a complaint or concern about your care, please discuss it with your health care provider.

CONSENT FOR TREATMENT: By signing this form, I consent to and authorize my health care provider to examine and treat me today. I understand that this could include lab tests, x-rays, education or other diagnostic procedures. I understand that my provider is available to explain the purpose of the procedures and treatment and that I have the right to refuse the recommended treatment.

RELEASE OF MEDICAL RECORDS FOR MY MEDICAL CARE OR AS REQUIRED BY LAW: I understand that it is important that my medical providers have access to any of my medical records which will help them to safely treat me and manage my medical care. I agree that a copy of my medical records, with the exception of psychotherapy notes, may be sent to any of my physicians or health care providers. This includes release to any hospital in which SFC may be contacted for purposes of medical care and for business operations relating to my health. I also agree that SFC can release my medical records to accrediting or regulatory agencies if those agencies request my records and if the law allows those agencies access to my records. **(Records are not automatically sent to your referring physician. They must be requested.)**

INSURANCE/MEDICARE/MEDICAID ASSIGNMENT OF BENEFITS - PAYMENT OF SFC MEDICAL BILLS: I would like a "third party payor" (for example, my insurance company/Medicare/Medicaid or its related organizations) to pay the bills for my services at SFC, to the extent the Payor is required to do so under my policy of insurance or the law. Therefore, I request that payment of my bills by the "third party payor" be made to SFC on my behalf for any services furnished to me by or in SFC. I assign the benefits payable for physician services to the physician or organization furnishing the services. In consideration of clinic visits, I agree to pay SFC for all charges not covered by any third party payor and waive the statue of limitations on collection and/or recovery in the State of Minnesota.

RELEASE OF MEDICAL RECORDS FOR BILLING PURPOSES: In many instances, a "third party payor" may pay a portion of my entire medical bill related to today's visit. Examples of "third party payors" are medical and auto insurance companies, worker's compensation insurance carriers, Medicare, Medicaid or its related organizations. In order for a "third party payor" to pay any or all of my bills related to today's visit at SFC, I understand the "third party payor" may require information about the medical care and treatment I received.
I authorized SFC to release to the "third party payor" any information needed to determine the payments related to the medical treatment I receive.

_____
Print Name

_____ _____
Signature **Date**

Office Financial Policy

1. **The doctor will give the you an estimate of the fees for services before they are performed or rendered if requested.**
2. **It is your responsibility to take care of the co-payment or co-insurance and any non-covered services on a weekly basis. This office may make payment plan arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings. If you do not comply with these arrangements the full balance, including any service charges, collection and/or legal fees will be due and payable by you. Interest charges of 1.5% monthly will be assessed on the unpaid balance after 30 days.**

   **** If you need assistance from a family member or parent with making a decision about your care, it is advisable that they come with you when the doctor speaks to you about your case.**
3. **We accept assignment as a courtesy to you. Should your insurance company not pay any of the anticipated charges for any reason, you are responsible for your entire bill. We are not a mediator between you and your insurance company and will not enter into any dispute with them, as your contract is between you and your insurance company.**
4. **This office does not warrant or guarantee that insurance will pay. Nor does this office promise that an insurance company will or should pay the fees charged. Insurance policies are an arrangement between an insurance carrier and a patient or insured.**
5. **All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due. This means that refunds are made only after your balance is completely cleared with this office.**
6. **If you receive any correspondence or checks from your insurance company, you agree to bring these into our office so that it may be determined if any action needs to be taken or if the check is an assignment to our office.**
7. **If you are referred to another specialist or discontinue care for any reason other than discharge by the doctor, the bill is due and payable in full immediately; regardless of any claims submitted.**
8. **If you change insurance companies or employers, you agree to provide our office with current information immediately.**
9. **This office accepts Visa, MasterCard, cash and personal checks.**
10. **If you have questions concerning this or any other matter, you should speak with the doctor.**

I have read and understand the Office Financial Policy and agree to abide by these terms.

_____

Print Name

_____ _____

Signature **Date**