Northland Chiropractic Clinic, L.L.C.

PATIENT INFORMATION & CASE HISTORY FORM

Patient Information: Date: _____

Name: _____
Address: _____
City, State, Zip_____
Sex: □ F □ M Age: _____ Birthdate: _____
□ Single □ Married □ Widowed □ Divorced
Occupation: _____
Employer: _____
Spouse's Name: _____ Birthdate:_____
Occupation: _____
Employer: _____
Children (Age): _____
How did you hear about us? _____
□ phonebook □ website □ insurance comp. □ referral
Would you like TEXT or E-MAIL apt reminders?
E-mail address: _____

Phone Numbers:

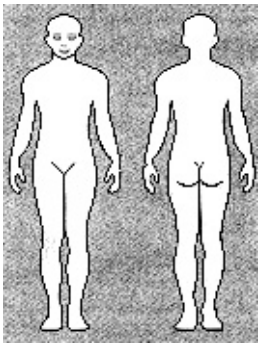
(H): _____ (C): _____
Best time & place to reach you: _____
IN CASE OF EMERGENCY, CONTACT:
Name: _____ Relationship: _____
(H): _____ (C): _____

Accident Information:

Is condition due to an accident? □ Y □ N Date: _____
Type of accident? □ Auto □ Work □ Home □ Other
To whom have you made a report of your accident?
□ Car Insurance □ Employer □ Worker Comp. □ Other
Attorney Name (If Applicable): _____
_____

Patient Condition:

Reason for Visit: _____
When did your symptoms appear? _____
Is this condition getting progressively worse? □ Y □ N □ Not Sure
Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (most pain): _____
Type of pain: □ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting
□ Burning □ Tingling □ Cramps □ Stiffness □ Swelling □ Other _____
How often do you have this pain? _____
Is it: □ Constant □ Comes and Goes □ Present While Resting □ Present only with Motion
Does it interfere with your: □ Work □ Sleep □ Daily Routine □ Recreation
What else does it prevent you from doing? _____
Activities or movements that are painful to perform: □ Sitting □ Standing □ Walking □ Bending □ Lying down

Medication: (Rx / Condition)

_____
_____
_____
_____
_____
_____
_____

Supplements/Vitamins/Herbs

_____
_____
_____
_____

Allergies:

_____
_____
_____

Previous Injuries / Surgeries:

_____
_____
_____
_____
_____
_____
_____
_____

Previous Chiropractic Care:

Condition: _____
_____
Doctor: _____
Results: _____
_____
Reason Stopped Going: _____
_____
What did you like about care:
_____
_____
What did you dislike about care:
_____
_____

Health History:

What treatment have you already received for your condition: □ Medications □ Surgery □ Physical Therapy
□ Chiropractic □ Acupuncture □ Massage □ None □ Other: _____
Name and location of other doctor(s) who have treated you for your condition: _____
_____
Date of Last: Physical Exam: _____ Spinal X-ray: _____ Blood Test: _____
Spinal Exam: _____ Chest X-ray: _____ Urine Test: _____
MRI, CT-Scan, Bone Scan: _____ Other: _____

Place a mark on "Y" or "N" to indicate if you have had any the following:

AIDS/HIV	□ Y □ N	DIABETES	□ Y □ N	LIVER DISEASE	□ Y □ N	RHEUMATIC ARTH.	□ Y □ N
ALCOHOLISM	□ Y □ N	EMPHYSEMA	□ Y □ N	MEASLES	□ Y □ N	RHUEMATIC FEVER	□ Y □ N
ALLERGY SHOTS	□ Y □ N	EPILEPSY	□ Y □ N	MIGRAINES	□ Y □ N	SCARLET FEVER	□ Y □ N
ANEMIA	□ Y □ N	FRACTURES	□ Y □ N	MISCARRIAGE	□ Y □ N	STROKE	□ Y □ N
ANOREXIA	□ Y □ N	GLAUCOMA	□ Y □ N	MONO	□ Y □ N	SUICIDE ATTEMPT	□ Y □ N
APPENDICITIS	□ Y □ N	GOITER	□ Y □ N	MULTI. SCLEROSIS	□ Y □ N	THYROID PROBLEMS	□ Y □ N
ARTHRITIS	□ Y □ N	GONORRHEA	□ Y □ N	MUMPS	□ Y □ N	TONSILITIS	□ Y □ N
ASTHMA	□ Y □ N	GOUT	□ Y □ N	OSTEOPOROSIS	□ Y □ N	TUBERCULOSIS	□ Y □ N
BLEEDING	□ Y □ N	HEART DISEASE	□ Y □ N	PACEMAKER	□ Y □ N	TUMORS	□ Y □ N
BREAST LUMP	□ Y □ N	HEPATITIS	□ Y □ N	PINCHED NERVE	□ Y □ N	TYPHOID FEVER	□ Y □ N
BRONCHITIS	□ Y □ N	HERNIA	□ Y □ N	PARKINSON'S	□ Y □ N	ULCERS	□ Y □ N
BULIMIA	□ Y □ N	HERNIATED DISC	□ Y □ N	PNEUMONIA	□ Y □ N	VAGINAL INFECTION	□ Y □ N
CANCER	□ Y □ N	HERPES	□ Y □ N	POLIO	□ Y □ N	VENEREAL DISEASES	□ Y □ N
CATARACTS	□ Y □ N	HIGH CHOLESTEROL	□ Y □ N	PROSTATE	□ Y □ N	WHOOPING COUGH	□ Y □ N
CHICKEN POX	□ Y □ N	KIDNEY DISEASE	□ Y □ N	PSYCHIATRIC CARE	□ Y □ N	OTHER: _____	

Exercise:

□ None
□ Light
□ Moderate
□ Heavy
# of times/weeks: _____

Are you pregnant? □ Y □ N
Due Date: _____

Work Activity:

□ Sitting
□ Standing
□ Light Labor
□ Heavy Labor
Safety Devices Utilized:
_____
_____
_____

Habits:

□ Smoking Packs / Day: _____
□ Alcohol Drinks / Week: _____
□ Coffee / Caffeine Cups / Day: _____
□ High Stress Level Reason: _____
□ Other: _____
_____
_____
_____

Past Traumas or Conditions:

Was **Your** Birth Difficult? _____ Date: _____
Childhood Ailments: _____ Date: _____
Any Car Accidents or Whiplash: _____ Date: _____
Falls: _____ Date: _____
Head Injuries: _____ Date: _____
Broken Bones: _____ Date: _____
Dislocations: _____ Date: _____
Any Reoccurring Infections? _____ Date: _____
Any Family History of diseases or conditions? _____ Date: _____
Other: _____ Date: _____
_____

□ "70% of our patients have their children or spouses spines checked for hidden health problems. Select the box if you would like a complimentary consultation for a family member.

Northland Chiropractic Clinic

Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. Regardless of your coverage, we'll suggest the chiropractic care we think you need. We ask that you read and understand our policy as it applies to your particular situation.

Patients are responsible for payment in full. This can be in the form of: Cash, Check, Charge, or Insurance.

UTILIZATION OF INSURANCE

We will submit the appropriate forms necessary to utilize your insurance benefits, but the patient is responsible for satisfying all co-pays, deductibles, etc. at the time of service. We are currently a provider for:

- Blue Cross Blue Shield
- Medicare
- Health Partners
- U-Care
- Cigna Health Care
- Medica
- United Healthcare
- PreferredOne
- Patient Choice
- SelectCare
- WEA Trust

We will utilize all other insurances as a non-provider as per patient insurance coverage. Please inquire about your insurance if you have any questions or concerns.

PATIENTS WITHOUT INSURANCE

We request that 100% of the visit be paid at the time of the visit. On other visits, payment may be made at the end of the week if you sign a credit guarantee form. We are happy to accept your check, Master Card or Visa.

GROUP OR INDIVIDUAL INSURANCE

You are responsible for knowing you own chiropractic insurance benefits. The benefits quoted by your insurance company are not a guarantee of payment. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles, or co-pays at the time of service.

"ON THE JOB" INJURY (Worker's Compensation)

If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within 3 months, or if you suspend or terminate care, any fees and services are due immediately.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please notify your auto insurance carrier of your visit to our office immediately. Notify our insurance department immediately if an attorney is representing you. Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to six months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

FLEX PLANS/ MEDICAL SAVINGS ACCOUNT

Please inform us if you have a medical savings account, sometimes known as a 'flex plan'. We will be happy to provide you with a statement of your charges for reimbursement.

It is up to you to keep your account current, keep your appointments as scheduled, and make up any missed visits within five days. It is clinic policy to do a re-examination every twelve visits to monitor your progress and re-evaluate your treatment plan.

Please read, initial, and sign:

1. **CONSENT FOR TREATMENT / AGREEMENT FOR PAYMENT:**

_____ By signing this form, I voluntarily consent to care, including treatment and performance diagnostic procedures at Northland Chiropractic Clinic. I understand I am under the care and supervision of the doctor and it is the responsibility of the staff to carry out instructions of said doctor. Additionally I understand and agree that services rendered to me are charged directly to me and that I am personally responsible for payment (see #3 below).

2. **RELEASE OF PROTECTED HEALTH INFORMATION:**

_____By signing this form, I acknowledge I have read the Patient Health Information Consent Form (HIPPA) and grant consent to the clinic to use my protected health information for purposes of treatment, collection of fees and healthcare operations. I understand that I have a legal right to review my medical file and the right to revoke this consent in writing, except to the extent the clinic has previously used or disclosed my protected health information for purposes of treatment, collection of fees and healthcare operations.

3. **ASSIGNMENT OF PAYMENT – for insured patients:**

_____ By signing this form, I understand and agree that my health and accident insurance policies are an arrangement between them and myself. I understand the clinic will assist me in receiving collection for services rendered, however I clearly understand and agree all services rendered to me are charged directly to me and I am personally responsible for payment. My insurance company and**/**or my attorney are hereby requested and authorized to pay directly to Northland Chiropractic Clinic any monies due on my account.

4. **MASSAGE THERAPY SCHEDULING POLICY**

_____ By signing this form, I understand and agree that if I ever schedule a massage at Northland Chiropractic there is a $25.00 rescheduling/cancellation fee if I change or cancel my appointment within 24 hours of my massage.

5. **MEDICARE PATIENTS <u>ONLY:</u>**

_____ By signing this form, I understand x-rays, exams, and/or therapies are sometimes not covered. Having been so informed, I request payment of medical benefits from a government source paid directly to Northland Chiropractic Clinic.

I have read and understand the payment policy of Northland Chiropractic Clinic. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Northland Chiropractic Clinic and my insurance company. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctors at Northland Chiropractic Clinic that fees will be due and payable immediately. This includes fees not paid by third parties whom deem care as not medically necessary. Our clinic reserves the right to charge 8% A.P.R. on any unpaid balances after 60 days.

I HAVE READ AND UNDERSTAND ALL OF THE ABOVE.

_____

Patient's signature (or guardian if patient is a minor) Date

CREDIT CARD GUARANTEE / AUTOMATIC BILL PAY

PLEASE SELECT ONE OF THE FOLLOWING OPTIONS:

☐ *Credit Card Guarantee for Personal Balances*

I, the patient choose to pay by cash or check at the end of the month and will guarantee my account by a credit card. (This card will only be charged if an outstanding balance is 60 days old. Otherwise a monthly bill will be sent each month and require payment within 15 days).

☐ *Automatic Bill Pay of Personal Balance*

I, the patient understand as a service and to keep my account current, any balance not paid by the last Friday of the month will be automatically charged to my designated card below. (This procedure will enable you to spread out your payments if you wish and make them smaller while keeping your account current).

CREDIT CARD: ☐ VISA ☐ MASTERCARD ☐ DISCOVER

CARDHOLDER NAME _____

CARD # _____ EXP. DATE _____

CVC # ON BACK OF CARD _____ BILLING ZIP CODE _____

I agree to the above terms and authorize you to charge any payment that exceeds 60 days to the above credit card. If a balance that exceeds 60 days is applied to this credit card, a copy of the bill and receipt of payment will be mailed to the patient.

_____ _____

SIGNATURE DATE

Patient Health Information Consent Form (HIPPA)

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

SIGNATURE DATE