ANNANDALE FAMILY & SPORTS CHIROPRACTIC

NEW PATIENT INFORMATION

Today's Date: _____

First Name: _____ Last Name: _____ MI: _____

I prefer to be addressed as: _____ Birth Date: _____ Sex: M F

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Other Phone: _____

Email: _____ Would you like appointment reminders? Yes No

How did you hear about us? _____

Occupation: _____ Employer: _____

Marital Status: Single Married Divorced Widowed

Spouse/Partner Name: _____ Children: Yes No How Many? _____

Smoking Status? Every Day Some Former Never

Emergency Contact: _____ Phone: _____

Medical Doctor: _____ Phone: _____

I understand the intake information and have accurately completed it to the best of my knowledge. It is my responsibility to inform this office of any changes to the information I have provided. Entering/typing name in the signature field above constitutes signing the document, confirming the signer has read, understands, and agrees to the terms and conditions stated.

_____ _____

Signature Date

RECORDS RELEASE

Annandale Family & Sports Chiropractic, PA is authorized to release any information deemed appropriate concerning my physical condition, including diagnosis and records of treatment or examination, to my insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred. Entering/typing name in the signature field above constitutes signing the document, confirming the signer has read, understands, and agrees to the terms and conditions stated.

_____ _____

Signature Date

Patient Health Questionnaire

Patient Name _____ ***Date*** _____

1. When did your symptoms start: _____ ***Describe your symptoms and how they began:***

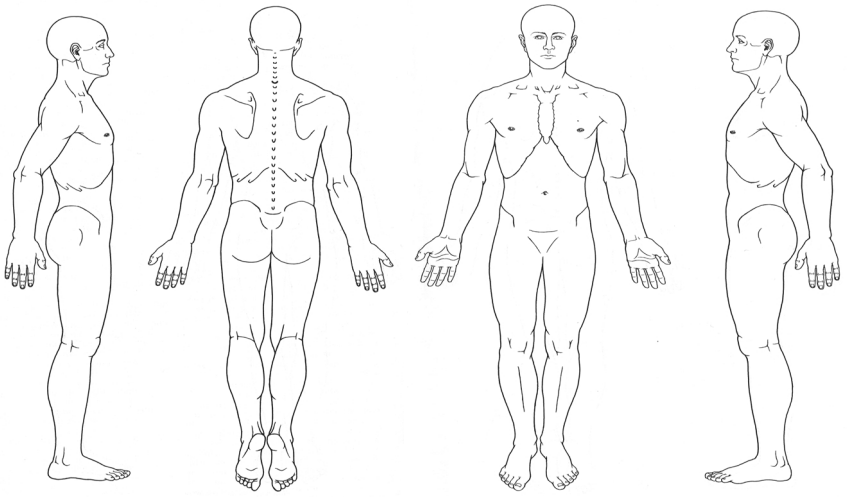
_____

_____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. How bad are your symptoms at their:

None *Unbearable*

a. worst: ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
b. best: ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

6. How do your symptoms affect your ability to perform daily activities?

⓪ *No complaints* ① ② *Mild, forgotten with activity* ③ ④ *Moderate, interferes with activity* ⑤ ⑥ *Limiting, prevents full activity* ⑦ ⑧ *Intense, preoccupied with seeking relief* ⑨ ⑩ *Severe, no activity possible*

7. What activities make your symptoms worse: _____

8. What activities make your symptoms better: _____

9. Who have you seen for your symptoms?

① No One
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. When and what treatment?

b. What tests have you had for your symptoms and when were they performed?

① Xrays
② MRI _____
③ CT Scan *date:* _____
④ Other *date:* _____

10. Have you had any injuries or surgeries since your last visit? ① Yes ② No

11. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Other Chiropractor
③ Other

12. What is your occupation? _____

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

13. What do you hope to get from your visit/treatment *(select all that apply):*

① Reduce symptoms
② Resume/increase activity
③ Explanation of condition/treatment
④ Learn how to take care of this on my own
⑤ How to prevent this from occurring again

Patient Signature _____ ***Date*** _____

Patient Health Questionnaire - page 2

Patient Name _____ ***Date*** _____

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height [ ][ ][ ] Weight [ ][ ][ ] lbs.
Feet *Inches*

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	*Present*	
○	○	Headaches
○	○	Neck Pain
○	○	Upper Back Pain
○	○	Mid Back Pain
○	○	Low Back Pain
○	○	Shoulder Pain
○	○	Elbow/Upper Arm Pain
○	○	Wrist Pain
○	○	Hand Pain
○	○	Hip/Upper Leg Pain
○	○	Knee/Lower Leg Pain
○	○	Ankle/Foot Pain
○	○	Jaw Pain
○	○	Joint Swelling/Stiffness
○	○	Arthritis
○	○	Rheumatoid Arthritis
○	○	General Fatigue
○	○	Muscular Incoordination
○	○	Visual Disturbances
○	○	Dizziness

Past	*Present*	
○	○	High Blood Pressure
○	○	Heart Attack
○	○	Chest Pains
○	○	Stroke
○	○	Angina
○	○	Kidney Stones
○	○	Kidney Disorders
○	○	Bladder Infection
○	○	Painful Urination
○	○	Loss of Bladder Control
○	○	Prostate Problems
○	○	Abnormal Weight Gain/Loss
○	○	Loss of Appetite
○	○	Abdominal Pain
○	○	Ulcer
○	○	Hepatitis
○	○	Liver/Gall Bladder Disorder
○	○	Cancer
○	○	Tumor
○	○	Asthma
○	○	Chronic Sinusitis

Past	*Present*	
○	○	Diabetes
○	○	Excessive Thirst
○	○	Frequent Urination
○	○	Osteoporosis
○	○	Aneurysm (abdominal or other)
○	○	Bleeding disorder
○	○	Inflammatory arthritis
○	○	Smoking/Use Tobacco Products Drug/Alcohol Dependence
○	○	Allergies
○	○	Depression
○	○	Systemic Lupus
○	○	Epilepsy
○	○	Dermatitis/Eczema/Rash

Females Only

○	○	AIDS
○	○	Birth Control Pills
○	○	Hormonal Replacement
○	○	Pregnancy

Other Health Problems/Issues

○ ○

Indicate if an immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○_____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

Patient Signature _____ ***Date*** _____

Doctor's Additional Comments

_____

_____

_____

Doctors Signature _____ ***Date*** _____

ANNANDALE FAMILY & SPORTS CHIROPRACTIC

CONSENT TO EVALUATE & TREAT A MINOR CHILD

Minor's Name: _____

I, the undersigned, attest that I am the custodial parent or legal guardian of the above-referenced minor ("the minor"), and hereby authorize Annandale Family & Sports Chiropractic, PA to evaluate and administer treatment as it so deems as necessary to the minor. In the event that the minor has received treatment at this practice previous to the date of this consent form, I hereby authorize such evaluation and treatment. I further authorize the minor to complete and sign any documents at Annandale Family & Sports Chiropractic, PA which are customarily completed and signed by patients at your practice as a condition to treatment, and such signature shall serve as my own. In no event shall my signature to any other such document have any effect on this consent form. I have also read, reviewed, and fully understand the statements within the "Informed Consent" form.

Relationship to the minor: Custodial Parent Legal Guardian

Address of the Parent/Guardian: _____

City: _____ State: _____ Zip: _____

Parent/Guardian Date of Birth: _____

Home Phone #: _____ Work/Cell #: _____

_____	_____	_____
Parent/Guardian Written Name	Parent/Guardian Signature	Date

Witness: _____

INFORMED CONSENT FORM

As with any healthcare procedure, there are certain complications which may arise during chiropractic adjustment and therapy. These complications include but are not limited to fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel stiffness and soreness following the first few days of treatment. We will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us.

Doctors of Chiropractic, Medical Doctors and Physical Therapists using manual therapy treatments for patients with headache and cervical spine (neck) complaints, are required to specifically explain that there have been rare cases of injury to a vertebral artery as a result of treatment. The topic of stroke and cervical manipulation has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments.

Fractures are rare occurrences and generally result from some underlying weakness of a bone which we check for during the taking of your history and during examination. The other complications described above are also generally described as rare. If, during care, we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

In signing this document, I in no way compromise my protection against negligence.

I have read and understand the above statement and hereby consent to evaluation and treatment at Annandale Family & Sports Chiropractic, PA.

_____	_____	_____
Parent/Guardian Written Name	Parent/Guardian Signature	Date

Witness: _____

ANNANDALE FAMILY & SPORTS CHIROPRACTIC

FINANCIAL POLICY

All insurance

- I will complete the necessary paperwork required by my insurance required to reimburse AFSC, PA care rendered. If my insurance company required a medical doctor's referral, I will obtain a referral from my primary care physician.
- AFSC will file my insurance claims in a timely manner.
- I will promptly pay all amounts that have been determined my responsibility by my insurance carrier upon receipt of my statement. I understand that my health insurance contract is between my insurance company and myself. If my insurance does not pay for the services rendered by the practice within 45 days, the practice may look to me for payment. The practice agrees to refund any overpayment that I have made on my account in the event that it my insurance eventually pays. Any balance remaining after my health insurance pays, denies, or deems non-covered under my plan will be my responsibility. If my account has been delinquent for more than 90 days and I have not arranged for a payment plan, my account is turned over to a collection agency, where I will be responsible for my balance and any collection agency fees.
- Annandale Family & Sports Chiropractic, PA does not verify insurance benefits for patients. As the insurance companies state that "verification is no guarantee of payment', the only true indicator of coverage is the EXPLANATION OF BENEFITS (EOB) which is mailed to the patient and our office. We strongly encourage the patient to review their insurance handbook and to call their insurer to directly question their level of coverage.

Medicare

- It is Medicare's policy to pay for **only** acute care. Medicare requires an examination to document that an acute injury or an acute exacerbation of a chronic recurrent condition has taken place, and that treatment is necessary for this acute injury. Dependent upon the nature of the injury, the acute phase of care may last a few weeks to a few months. Once this phase of care is complete, **Medicare will not pay** for any further treatment as it will be considered maintenance care. Though an exam is required to document the need for acute care, **it is Medicare's policy,** not to pay for these examinations. As this is a chiropractic clinic, coverage of examinations may be different than coverage at a medical clinic.
- As Medicare is a federal program, we are not allowed to give a discount on treatment services rendered to Medicare patients.

Medical Assistance/MinnesotaCare

- The only services currently covered by MnCare and MA are the following: Spinal Manipulation, Acupuncture, 1 Exam per year, and X-rays. MnCare and MA DO NOT cover extremity manipulation. 1 exam per calendar year is independent of which chiropractic clinic you had your exam.

Work Comp / Personal Injury

- If my work comp carrier/auto carrier denies coverage of any or all healthcare services at any time, I understand that I am personally responsible for payment of any or all non-covered services. If I have a private insurance carrier, I understand that I can have AFSC send any services denied by my work com/auto carrier to my private insurance. However, if my private insurance also denies any or all healthcare services, I understand that I am ultimately responsible for payment.

Cash

- Payment is expected at the time of service. Annandale Family & and Sports Chiropractic will accept cash, check, or credit card. Annandale Family & Sports Chiropractic offers a cash fee schedule only for payment made at the time of service. ***A cash discount cannot be offered to those whose insurance is or follows Medicare's guidelines***

ASSIGNMENT OF BENEFITS

I, _____ (print name), hereby authorize and assign the payment to AFSC for any sum I now owe or hereafter owe AFSC by my insurance for the charges for services provided by AFSC.

PATIENT SIGNATURE_____ Date _____

ANNANDALE FAMILY & SPORTS CHIROPRACTIC

NOTICE OF PRIVACY PRACTICES

Annandale Family & Sports Chiropractic, PA is required, by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of your legal duties and privacy practices with respect to your protected health information.

There are certain times that we will disclose your healthcare information. These times include: for purposes of treatment, payment, workers compensation, public health, marketing (includes reminder phone calls and missed appointment phone calls), and change of ownership.

Your Rights:

1. You have the right to request restrictions on certain uses and disclosures of your health information.
2. Please be advised, however, that Annandale Family & Sports Chiropractic, PA is not required to agree to the restriction that you requested.
3. You have the right to your health information received or communicated through an alternative method or sent to an alternative location.
4. You have the right to inspect and copy your health information.
5. You have a right to request that your health information be amended. However, Annandale Family & Sports Chiropractic, PA is not required to agree to the amendment. If your request has been denied an explanation will be provided along with measures as to how to disagree with your denial.
6. You have a right to receive an accounting of disclosures of your protected health information.
7. You have a right to a paper copy of this Notice at any time upon request.

Any changes made to this notice must be presented to you. Our privacy officer is Dr. Mitchell Uecker and complaints and concerns can be presented to him at 320-274-3060. This paper is a modified version of our HIPAA policies. A full copy can be obtained upon request and is always displayed at the front desk.

I have read, understand, and agree to the HIPAA policies at Annandale Family & Sports Chiropractic, PA. Entering/typing name in the signature field below constitutes signing the document, confirming the signer has read, understands, and agrees to the terms and conditions stated.

Signature	Date	Witness

I am opting NOT to sign this agreement for the following reason(s):

Signature	Date	Witness