

Patient Information

Name _____ Age _____ DOB ____ / ____ / ____ Male Female
(First) (Middle) (Last)
 Address _____ City _____ State ____ Zip _____
 Home Phone _____ Cell _____ Work _____
 Name and Number of Emergency Contact _____
 Name of Partner _____ Names & Ages of Children _____
 Referred to this office by _____ Have you ever received chiropractic care? Y N

Payment Information

Who is responsible for payment? Self and Partner Auto Insurance Worker's Comp
 Do you have Health Insurance? No (many of our patients do not) Yes (please complete the box below)
 If you are interested in using your health insurance for any part of your financial obligation please fill in the box below and also please provide us a copy of the insurance card

Insured's Name _____	DOB ____ / ____ / ____	SSN ____ - ____ - ____
Insured's Employer _____	Insured's Phone Number _____	
Insurance Company _____	Policy Number _____	
Relation to the Patient: _____		

Chiropractic Case History

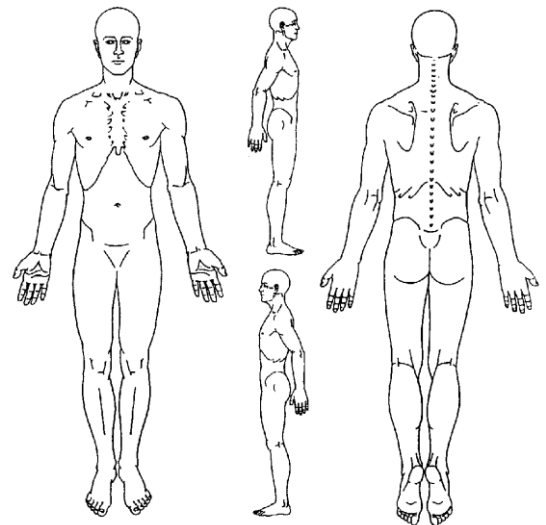
Describe your major complaint: _____

*Outline all areas of discomfort on the figure to the right.

When did this condition begin? _____

Has it ever occurred before? Yes No

Is condition related to? Auto Accident Work Injury



No Injury Other_____

When this problem is at its worst, please explain exactly how it feels

Intensity/Severity of Problem (0 = no pain, 10 = worst pain imaginable) 0 1 2 3 4 5 6 7 8 9 10

Quality of the complaint is (check all that apply) Burning Diffuse Dull/Achy Localized
 Sharp Tingling Radiating Constant Occasional Other_____

The problem is worse in: AM PM At Night With Activity (bending, lifting, sitting, standing)

How often do you find yourself suffering with this problem?_____

How long does the problem last (please provide all details)?_____

What makes you feel better?_____ What makes you feel worse?_____

What have you done for this complaint?_____

Primary Care Physician:_____ Phone:_____

Physician's Address:_____

May we contact your primary care Physician about your medical history? Yes No

Other Complaint(s)_____

DAILY ACTIVITIES What kind of effect does your condition have on the following? Check all that apply.

Bathing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Carrying Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climbing Stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Computer Use	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Concentration	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Exercising	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Hobbies	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Household Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lifting Children	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Pet Care	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Playing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sexual Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sitting / Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleep	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Yard Work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

Walking No Effect Painful (can do) Painful (limits) Unable to Perform

Occupation

Employer _____ Occupation _____ Hours/week _____

Lifting Requirements Minimal (<5 lbs) Light (5-20 lbs) Moderate (20-50 lbs) Heavy (>50 lbs)

Lifting Frequency Constant (66-100% of day) Frequent (33-65% of day) Occasional (0-32% of day)

Lifting Postures Knee Torso Arm Shoulder Awkward Position

How many hours per day do you spend in the following postures?

Bending Over _____ Climbing _____ Kneeling _____ Pulling _____ Pushing _____

Reaching _____ Sitting _____ Standing _____ Twisting _____ Walking _____

How many hours per day do you spend performing the following activities?

Assembly _____ Computer _____ Grasping _____ Hand Tools _____ Machinery _____

Phone _____ Other (describe and provide hours per day) _____

Describe impact of current condition on work capacity: No Effect Painful Limits Unable

Any additional information you may want the doctor to know about you, your family, or your health? _____

On a scale of 1 to 10 with 10 being the highest, rate your commitment to getting rid of the problem: _____

Personal Health History

Check all past or present health problems that apply.

- | | | | | |
|--|---|---|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer | <input type="checkbox"/> Circulation |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Digestion | <input type="checkbox"/> Ear / Hearing | <input type="checkbox"/> Heart Problem | <input type="checkbox"/> Hormone |
| <input type="checkbox"/> Irritability/Mood | <input type="checkbox"/> Kidney Problem | <input type="checkbox"/> Liver Problem | <input type="checkbox"/> Low Energy | <input type="checkbox"/> Muscle Spasm |
| <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Sinus |
| <input type="checkbox"/> Sleep | <input type="checkbox"/> Swollen Joints | <input type="checkbox"/> Thyroid | <input type="checkbox"/> TMJ | <input type="checkbox"/> Weight Gain / Loss |

Check surgeries or procedures that apply. I have never had any surgeries or procedures.

- | | | | | |
|-----------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Appendix | <input type="checkbox"/> C-Section | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Heart |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Reproductive | <input type="checkbox"/> Spine | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Vaccinations |

Other _____

List any diseases _____

List all medications currently used:

Provide reason for use:

FEMALES ONLY Irregular Period Painful Period No Period Hot Flashes

Are you pregnant? Yes No Not Sure

Pregnant: Y N Name of OBGYN/Midwife: _____ Due Date: _____

Wellness Profile

Rate your stress level on a scale of 1-10: _____ Cause of stress _____

Alcohol amount/day _____	<u>EXERCISE</u>	<u>FAMILY HISTORY</u>	Spine	Cancer	Diabetes	Heart
Coffee amount/day _____	<input type="checkbox"/> None	Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoking amount/day _____	<input type="checkbox"/> Moderate	Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water amount/day _____	<input type="checkbox"/> Daily	Siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Exercise amount/Wk _____ Type of exercise: _____

Current Diet 0-10 please rate _____

Please list your health goals:

Tell us about your family: Are you interested in helping any family members with their health goals? If so, Please explain: _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize Renewed Life Chiropractic, SC to provide me with chiropractic care, in accordance with Wisconsin's statutes.

Signature _____ Date _____

Informed Consent for examination and treatment:

Any procedure intended to help may also do harm. While chiropractic examination and therapeutic procedures are usually considered remarkably safe and effective, please understand that occasionally there may be adverse reactions. Although the chances of experiencing any of these complications are extremely small, it is practice of this chiropractic office to fully inform and educate all patients. By signing below, I understand that these complications include, but are not limited to, muscle strains and sprains, fractures, dislocations, disc injuries, and strokes. I do not expect the doctor to be able to anticipate or explain all the possible risks and complications. I wish to rely on the doctor to exercise judgement during the course of my treatments which they feel at the time, based upon the facts then known, in my best interest. I understand there is no guarantee or warranty for a specific cure or result. I understand that any time, I can request further explanation regarding the risks and benefits of care in this office, alternative courses of care, and the consequences of not having the proposed treatments.

PRINT NAME: _____ SIGNATURE: _____ DATE: _____

Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful.

Please understand that payment of your bill is considered to be part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. All patients who do not pay in full at the time of service must complete our information and insurance form before services are rendered.

Payment Policy

We accept Cash, Checks, Visa, MasterCard, and Discover
We charge a \$35 fee for returned checks

Regarding Insurance

Full payment of estimated deductible and co-payments are expected at the time of service. We may accept assignment of insurance benefits for your visit: WPS, Alliance, Aetna, Wea-Trust. However, we do require that any unmet deductible and/or co-payments be paid at the time of service. The balance is your responsibility, whether your insurance company pays or not. We will bill your insurance company when you give us the required insurance information. Your contract is between you and your Insurance Carrier. Although, we will assist you with your claim by a courtesy filing you should contact your insurance regarding payment of a claim. Therefore, if your insurance company has not paid your account in full within forty-five (45) days, we require that you remit the full balance due yourself. Should your insurance pay less than you expected, or not at all, it is your responsibility to confer with your carrier should you wish to dispute your claim. However, you are still obligated to remit your balance immediately.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Liability Cases

In the event you are relying on court settlement to cover your medical expenses, our practice requires complete attorney and claim information, as well as a lien with payment at time of service of one hundred dollars or 10%

of the fee, whichever is greater. We also require information regarding other health information you may have. In all cases we require that you set up payment arrangements for the period of time you case is in litigation.

Accounts Referred for Collection

All unpaid balances are subject to 1.5% monthly fee. In the event your account is referred to a collection agency and/or attorney, you will be responsible for any additional expense incurred by Renewed Life Chiropractic and Wellness, SC in the course of obtaining payment on your account including, but not limited to, court costs, collection agency and/or attorney fees. Any such costs will be added to you unpaid debt.

Authorization

I authorize Renewed Life Chiropractic and Wellness, SC and its centers to release any information required in the course of my examination of treatment. I permit a copy of this authorization to be used in place of the original and request payment of benefits to Renewed Life Chiropractic and Wellness, SC. However, I do acknowledge I am responsible for payment of all services regardless of insurance coverage.

I have read the financial policy, I understand and agree to ALL the terms of this document.

Patient's Signature (or Parent/Guardian if applicable) Date

HIPAA Notice of Privacy Practices

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights. Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

I authorize Renewed Life Chiropractic, SC and it's agents to give information regarding my treatment at to Renewed Life Chiropractic, SC family members, work associates or others over the telephone. I also authorized Renewed Life Chiropractic, SC and it's agents to leave information regarding my treatment on my home, cellular, and office voicemail and other messaging systems that may be appropriate. This information may include, but not limited to, appointment reminders and incoming calls concerning your treatment and appointment times. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.
Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

PRINT NAME: _____ SIGNATURE: _____ DATE _____