

Welcome to 50<sup>th</sup> & France Chiropractic & Wellness

***New Patient Information***

\*Name: \_\_\_\_\_ Date: \_\_\_\_\_  
*First Last MI*  
I prefer to be addressed as: \_\_\_\_\_ Birthdate: \_\_\_\_\_ \*Male/Female  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ ZIP: \_\_\_\_\_  
Primary Phone: \_\_\_\_\_ Work/Cell/Other Phone: \_\_\_\_\_  
e-mail: \_\_\_\_\_ Contact Preferences (circle): phone e-mail text  
How did you hear about us? \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
\*Marital Status: Single Married Divorced Widowed Partnered  
Spouse/Partner Name: \_\_\_\_\_ Children? Yes/ No How Many? \_\_\_\_\_  
\*Preferred Language: English Spanish Other: \_\_\_\_\_ Race: \_\_\_\_\_  
\*Ethnicity (circle): Hispanic or Latino NOT Hispanic or Latino  
\*Circle one:  
Current Every Day Smoker Current Some Day Smoker Former Smoker Never Smoked

***About Today's Visit***

The reason for this visit: \_\_\_\_\_  
Please describe pain and location: \_\_\_\_\_  
When did it begin? \_\_\_\_\_ Is it getting worse? Yes No Constant Comes/goes  
Does it interfere with your daily routine? Yes No If yes, please explain \_\_\_\_\_  
\_\_\_\_\_  
Have you had similar symptoms in the past? Yes No If yes, please explain \_\_\_\_\_  
\_\_\_\_\_  
Have you been treated by a chiropractor previously? Yes No  
If yes, whom? \_\_\_\_\_ Address or phone \_\_\_\_\_  
Any additional information you would like to include? \_\_\_\_\_  
\_\_\_\_\_

***In Case of Emergency***

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
Medical Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

**Health History**

\*Are you currently taking any medications? Yes No If yes, please list medications and dosages:

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If you have had any of the following conditions, please circle:

- |                    |                |                     |                  |
|--------------------|----------------|---------------------|------------------|
| Heart Attack       | Stroke         | Cong. Heart Defect  | Alcohol Abuse    |
| HIV+               | Neck Pain      | High Blood Pressure | Drug Abuse       |
| AIDS               | Headaches      | Low Blood Pressure  | Shingles         |
| Fainting           | Seizures       | Epilepsy            | Diabetes Type I  |
| Low Back Pain      | Emphysema      | Glaucoma            | Diabetes Type II |
| Psychiatric Issues | Sinus Problems | Artificial Valves   | Cancer           |
| Anemia             | Ulcers         | Asthma              | Arthritis        |

\*Please list any medical conditions or surgeries you have had with dates: \_\_\_\_\_

\_\_\_\_\_  
\*Known Allergies (list all) \_\_\_\_\_

\_\_\_\_\_  
Family Health History: \_\_\_\_\_

\_\_\_\_\_  
Do you take supplements or vitamins? Yes No If so, what? \_\_\_\_\_

What is your typical exercise routine? \_\_\_\_\_

Are you on a special diet? Yes No If so, what is it? \_\_\_\_\_

**For Women:** Are you taking birth control? Yes No

Are you pregnant? Yes No How far along? \_\_\_\_\_ Nursing Yes No

*I understand the above 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.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Records Release**

*50th & France Chiropractic & Wellness 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.*

Signature: \_\_\_\_\_ Date \_\_\_\_\_

**Thank you for choosing 50<sup>th</sup> & France Chiropractic & Wellness**

**\*Required information for Medical Necessity.**

# PAIN CHART

## ABOUT YOU

Name: \_\_\_\_\_ File #: \_\_\_\_\_

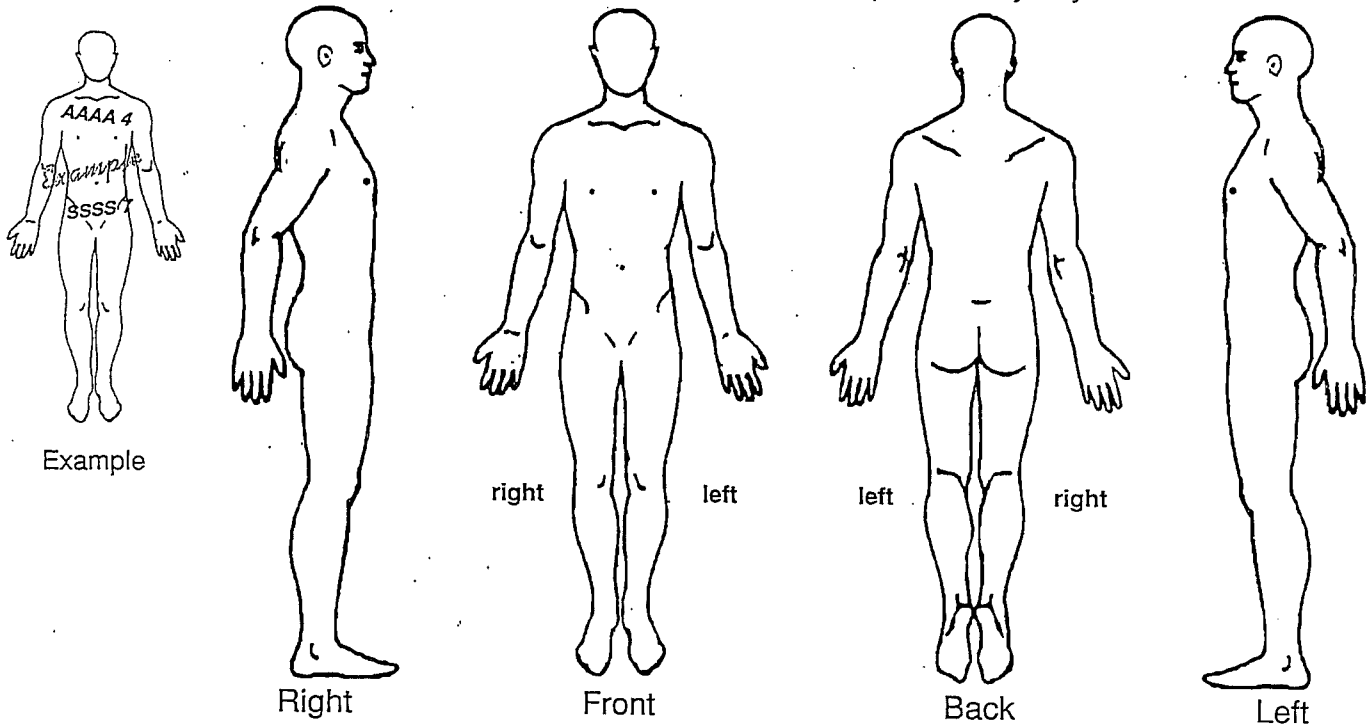
What is your current weight: \_\_\_\_\_ lbs., and height, \_\_\_\_\_ Ft. \_\_\_\_\_ In..  
Please describe your condition:

Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## SHOW US WHERE IT HURTS

Please mark **area(s)** of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

- |               |          |                |         |        |          |
|---------------|----------|----------------|---------|--------|----------|
| Description → | Numbness | Pins & Needles | Burning | Aching | Stabbing |
| Symbol →      | NNNN     | PPPP           | BBBB    | AAAA   | SSSS     |
- Circle any area of pain not represented by a symbol.




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# Financial Agreement 50<sup>th</sup> & France Chiropractic

Our billing system is arranged with the patient's percentage automatically calculated for your convenience. When all insurance checks have been received, we will refund any overpayment to you.

## PATIENTS WITHOUT INSURANCE

1. We request that 100% of the first visit be paid at the time of the first visit.
2. We are happy to accept cash, check, Mastercard, Visa or Discover Card.

## MEDICARE

We are providers of Medicare. For chiropractors this includes only manual manipulation of the spine. Medicare pays 80% of the allowable fee once the \$162 deductible has been met, and the patient will be required to pay the remaining 20% if it is not covered by a secondary insurance. The subsequent services will be payable at the end of each week or from a monthly statement. Our office will complete the necessary forms and file them with the Medicare provider at no charge.

## MASSAGE THERAPY

There is a 24-hour cancellation policy for massage. Cancellation with less than 24-hour notice will result in a \$45.00 charge that is the responsibility of the PATIENT regardless of insurance or cash.

**I HAVE READ AND/OR BEEN EXPLAINED THE ABOVE FINANCIAL POLICY AND AGREE TO ACCEPT THE TERMS AND CONDITIONS.**

**SIGNED:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**WITNESS:** \_\_\_\_\_

## “ON THE JOB” INJURY

Worker's compensation pays in full chiropractic care. Upon being released from care, a 3- month time period is allowed for settlement of your claim. If settlement has not been reached within this time period, or if you have suspended or terminated your care without your doctor's approval, payment for services is due immediately.

## PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please present your auto insurance forms as soon as possible. If an attorney is handling your case, please notify the front desk as soon as possible. Although you are ultimately responsible for your bill, our office will wait for settlement to be paid as long as you are an active patient. If you suspend or terminate care, any fees for services are due immediately.

## GROUP OR INDIVIDUAL INSURANCE

Your insurance is an agreement between YOU AND YOUR INSURANCE COMPANY, NOT BETWEEN YOUR INSURANCE COMPANY AND THIS CHIROPRACTIC OFFICE. As a courtesy to our patients, our office will complete any necessary insurance forms at no charge, and file them with your company to help you collect. It is to be understood and agreed that services rendered are charged to you directly and you are personally responsible.

We are not certain if your insurance covers chiropractic, although most policies **do** provide coverage. The amount they pay varies from one policy to another. Because of this difference between policies, we expect that each patient who wishes to file insurance claims through this office, pay the insurance policy deductible and the patient's percentage as stated on your policy.

## **50<sup>th</sup> & France Chiropractic Notice of Privacy Practices**

50<sup>th</sup> & France Chiropractic 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. Please be advised, however, that 50<sup>th</sup> & France Chiropractic is not required to agree to the restriction that you requested.
2. You have the right to your health information received or communicated through an alternative method or sent to an alternative location.
3. You have the right to inspect and copy your health information.
4. You have a right to request that your health information be amended. However, 50<sup>th</sup> & France Chiropractic 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.
5. You have a right to receive an accounting of disclosures of your protected health information.
6. 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. Christopher Jo and complaints and concerns can be presented to him at 952-920-4528. 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 50<sup>th</sup> & France Chiropractic.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

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

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

**50th & France Chiropractic & Wellness**  
**3948 West 50th Street, Suite 203, Edina, MN 55424**

**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 toward the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. 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 so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

**Chiropractic** is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship 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.

One disturbance to the nervous system is called a **vertebral subluxation**. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **adjustment**. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

**The material risks inherent in chiropractic adjustment.**

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.

**The probability of those risks.**

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 and X-ray. Stroke 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. The other complications are also generally described as rare.

If during the course of 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.

*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.*

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Print Name	Signature	Date
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**Consent to evaluate and adjust a minor child:**

I, \_\_\_\_\_ being the parent or legal guardian of \_\_\_\_\_ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

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Signature	Date
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