Welcome to 50th & France Chiropractic & Wellness

New Patient Information

Today's Date: _____

First Name: _____ Last Name: _____ MI: _____

I prefer to be addressed as: _____ Birthdate: _____ Sex: _____

Address: _____ City: _____State: ___ ZIP: _____

Cell Phone: _____ Other Phone: _____

Email: _____ Appointment Reminders: ☐ Text ☐ Email

How did you hear about us? _____

Occupation: _____ Employer: _____

Marital Status: Partnered Spouse/Partner Name: _____

Children? ◯ Yes ◯ No How Many? _____

Preferred Language: _____ Race: _____ Ethnicity: NOT Hispanic or Latino

Choose: Current Every Day Smoker

Emergency Contact: _____ Phone: _____

Medical Doctor: _____ Phone: _____

The reason for this visit: _____

Please describe pain and location: _____

When did it begin? _____ Is it getting worse? ◯ Yes ◯ No

Does it interfere with your daily routine? ☐ Yes If yes, please explain _____

Have you had similar symptoms in the past? ☐ Yes If yes, please explain _____

Have you been treated by a chiropractor previously? ☐ Yes If yes, whom? _____

Are you currently taking any medications? ◯ Yes ◯ No

If yes, please list medications and dosages: _____

Please select if you have had any of the following conditions:

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

Please list any medical conditions or surgeries you have had with dates: _____

Known Allergies (list all): _____

Family Health History: _____

What is your typical exercise routine?

_____

Do you currently take any vitamins or supplements? ☐ Yes If so, what? _____

_____

Are you on a special diet? ☐ Yes If so, what? _____

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

Are you pregnant? ☐ Yes 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. 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

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. 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***

50th & France Chiropractic & Wellness
Financial Agreement

"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.

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, Discover, or American Express.
3. We have a number of packages available for ongoing wellness care. The front desk can help you decide.

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 & ACUPUNCTURE
There is a 24-hour cancellation policy for massage and acupuncture. 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.

_____ _____ _____
Signature ***Date*** ***Witness Signature***

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.

Notice of Privacy Practices

50th & France Chiropractic & Wellness 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 50th & France Chiropractic & Wellness 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, 50th & France Chiropractic & Wellness 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 available at the front desk.

I have read, understand, and agree to the HIPAA policies at 50th & France Chiropractic.

_____ _____ _____

Signature ***Date*** ***Witness Signature***

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. 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.

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

_____

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 affect 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. 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*** ***Witness***

Consent to evaluate and adjust a minor child:

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

_____ _____

Parent/Guardian Signature ***Date***