Generations Chiropractic
826 2nd Ave. North
Onalaska, WI 54650
p 608.781.9555
generationsonalaska.com

Patient Profile

Full Name: _____*Jr / Sr*

First *M.I.* *Last*

Birth Date: _____ **Gender**: Male Female

Marital Status: Single Married **Employment Status**: FT PT Student Retired

Race: White Asian African American Pacific Islander Declined Other: _____

Ethnicity: Hispancic or Latino Not Hispanic or Latino Declined Other: _____

Primary Language: English Spanish Other_____

Address:_____

Street Address Apartment/Unit #

_____

City State ZIP Code

Primary Phone:_____ **Cell/Alternate Phone:** _____

Email Address:_____

Emergency Contact:_____

Emergency Contact Phone:_____

Have you received Chiropractic care elsewhere this year? Yes No

How did you choose our office? (circle one)

Phone book, radio ad, newspaper,

internet, referral, other _____

If referred who may we thank for your referral? _____

Patient Name _____ Date_____

Regarding Personal Health Information:

Is it okay for the office staff to send you a text reminder for your appointment and/or email other pertinent information?

Yes No

Is it okay for the office to leave a voice mail about upcoming appointments or other pertinent information?

Yes No

Health Insurance?

Yes No

Insured Party: You Other (parent, spouse, etc.)

Insured Information:

Relationship to You:_____

Full Name:_____

First M.I. Last

Same as your address? Yes No

Address:_____

Street Address Apartment/Unit #

_____

City State ZIP Code

*Phone number*_____

Date of Birth _____

Employer of Insured Party: _____

For Work Comp Injury Only Is this injury related to a Work Comp YES NO

Employer

Employer Name:_____

Employer Phone:_____ Ext. _____ Fax:_____

Is this injury related to an auto accident? YES NO If yes, tell us there is one more form to fill out.

Generations Chiropractic
826 2nd Ave. North
Onalaska, WI 54650
p 608.781.9555
generationsonalaska.com

Patient Name: _____

Authorizations and Releases

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPAA) is available here: http://www.cms.hhs.gov/SecurityStandard/Downloads/securityproposedrule.pdf

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their 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. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
5. Patients have the right to file a formal complaint with our privacy official about any suspected violations.
6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Initial _____

Consent to Professional Treatment

The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. The patient may refuse treatment at any time.

The nature of the chiropractic adjustment.

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures: palpation, orthopedic testing, postural analysis, hot/cold therapy, vital signs, basic neurological testing, spinal manipulative therapy, range of motion testing, muscle strength testing, EMS, Ultrasound, and X-rays.

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation 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 some stiffness and soreness following the first few days of treatment. I 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 my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I 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. This is the same rate of stroke determined in studies for people getting their hair washed at a salon, looking behind you while driving, and as determined in one study it the same rate of occurrence when patients went to their MD without being adjusted. Here at Trempealeau and Independence Family Chiropractic we offer light force neck adjustments using an instrument when you have increased risk factors to stroke or other conditions. The other complications are also generally described as rare.

Initial _____

Consent to Perform and Interpret X-rays

The patient consents to the performance of x-rays as deemed necessary by the attending physician of this office. The patient acknowledges that certain risks are associated with x-rays. The patient, hereby states that they have no known limitations that would forbid the taking of x-rays.

The patient further agrees that this office may seek outside interpretation of patient x-rays by a qualified professional not employed by this office. The patient agrees to any additional fees associated with this service and assigns benefits to be paid directly to that professional by your third-party payor.

Initial _____

Assignment of Benefits and Release of Records

The patient hereby assigns benefits to be paid directly to this provider by all of their third party payors. This assignment is irrevocable. Failure to fulfill this obligation will be considered a breach of contract between the patient and this office.

The patient authorizes this office to release any information required by a third party payor necessary for reimbursement of charges incurred.

I hereby authorize this practice to release any medical or other information required by third party payors, including government agencies, insurance carriers, or any other entities necessary to determine insurance benefits or benefits payable for related services and supplies provided to me by the practice.

Initial _____

Financial Obligation and Appointment Policy

I hereby accept full financial responsibility for services rendered by this practice. I accept full responsibility for any fees incurred, regardless of insurance coverage. I understand that my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I further understand that I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. Should the account be referred to an attorney or collection agency for collection, I shall pay all fees, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. It is my responsibility to notify this practice of any changes in my health care coverage.

This office reserves the right to charge a $20 fee for missed appointments or appointments canceled without notification of at least 1 hour. Payment in full is required for all services at the time of visit, unless alternative arrangements have been agreed to in advance.

Signature of Patient or Guardian (if a minor) _____ Date _____

Patient: _____