The Chiropractic Care Center, P.C.
"A pain, injury and wellness center"
18 Lincoln Ave Park View, IA 52748

(563) 285-8434 Fax (563) 285-8453
www.chirocarectr.com

Dear Patient

We welcome you to our family of fine patients who have enhanced their quality of life through chiropractic's natural health methods. Thank you for your confidence in selecting us as your family Doctor of Chiropractic.

Chiropractic has become the largest drugless, healing profession in the world. The reason for this growth is very simple; chiropractic works. Your body has an incredible ability to heal itself when given the opportunity to do so. By relieving interference to your nerve system through specific chiropractic adjustments, your body will function better and begin to heal. The result will be a healthier, pain free, drug free life.

It is important to remember each adjustment builds on the others. This allows for more correction and less likely for the pain to reoccur. Therefore, please follow our recommendations so you can achieve your desired result as quickly as possible. Also every human body is not created equal. So, depending on the severity of your condition, how long you have had the condition, your age, your frequency of care, your overall health, and how well you follow instructions will alter how fast your body heals.

While our friendly environment provides efficient care with minimal waiting, we are always available for private consultations. Just inform us, and this will be arranged. We will be happy to answer any questions concerning your health care. We take pride in ourselves for having many satisfied patients.

As you experience results and gain confidence in our office, please share chiropractic with your family, coworkers and friends, so that they too, can improve their health and quality of life.

Yours in the interest of better health,

Dr. Anita L. Wubbena

The Chiropractic Care Center, pc.
"A pain, injury and wellness center"

18 Lincoln Ave Eldridge, IA 52748
(563)285-8434 Fax (563) 285-8453
Dr Anita L Wubbena

Today's Date ___/___/____

First Name_____ Preferred to be called _____

Last Name _____Date of Birth _____ Age_____

Address _____City_____State _____ Zip Code_____

Social Security number _____ Email address _____

Home Phone #_____ Work Phone #_____

Cell Phone # _____ Cell Phone Carrier_____

Preferred contact method ❑Home Phone ❑Work Phone ❑Cell Phone

Gender (Check one) ❑Male ❑Female ❑Unspecified

Employment Status ❑Employed ❑FT Student ❑PT Student ❑Retired ❑Self-employed ❑Unemployed

Employer:_____

Marital Status (check one) ❑Single ❑Married (Spouses Name _____) ❑Widowed ❑Divorced ❑Other

Race (Check one) ❑White ❑Black/African American ❑Hispanic ❑Other

Ethnicity (check one) ❑Not Hispanic or Latino ❑Hispanic or Latino ❑I choose not to specify

Preferred Language (Check one) ❑English ❑Spanish ❑Other

HEALTH HISTORY

Do you currently smoke tobacco of any kind? ❑Never smoker ❑Current every day smoker ❑Current some day smoker ❑Former smoker

List all **Surgeries**: _____

Current medications, including frequency and dosage if known. (if you have a list, please let us know and we will make a copy)

If there are no current medications, check here: ❑

1)_____ 2)_____

3) _____ 4)_____ _____

List any known allergies you have had to any **medications**. If no allergies are known, check here: ❑

1) _____ 2) _____

Please check all that you have or have had:

❑AIDS	❑Depression	❑Irregular Heart Beat	❑Shortness of Breath
❑Alcoholism	❑Diabetes	❑Kidney Infection	❑Swelling Ankles
❑Allergies	❑Ringing in Ears	❑Kidney Stones	❑Swollen Joints
❑Anemia	❑Digestion Problems	❑Loss of Memory	❑Sinus Infection
❑Arteriosclerosis	❑Dizziness	❑Migraine Headache	❑Sleep Problems/Insomnia
❑Arthritis	❑Frequent Urination	❑Neck Pain/Stiffness	❑Spinal Curvatures/Scoliosis
❑Asthma	❑Headache	❑Nervousness	❑Stroke
❑Back Pain	❑Hemorrhoids	❑Nose Bleeds	❑Thyroid Condition
❑Breast Lump	❑High Blood Pressure	❑Pacemaker	❑Tuberculosis
❑Bronchitis	❑Hot Flashes	❑Polio	❑Ulcers
❑Cancer	❑Loss of Balance	❑Prostate Trouble	❑Varicose Veins
❑Chest Pain	❑Loss of Smell	❑Psychological Problems	❑Other_____
❑Constipation	❑Loss of Taste	❑Sciatica	

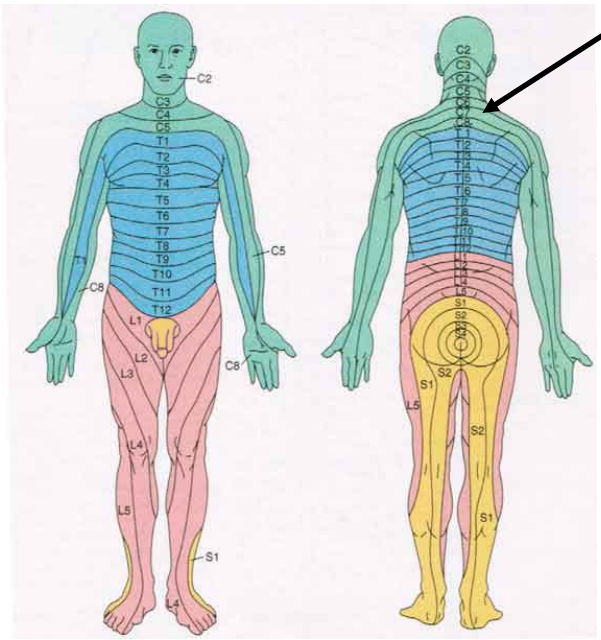
Is there a **family history** of:

	Heart Disease	Arthritis	Cancer	Diabetes	High Blood Pressure	Other _____
Father's Side	❑	❑	❑	❑	❑	❑
Mother's Side	❑	❑	❑	❑	❑	❑

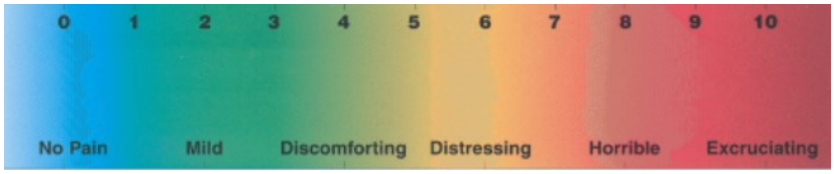
To be performed by clinic staff:

Height:_____ inches Weight: _____pounds BP: _____/_____

Are you having any pain in your neck/upper back or headaches?



Neck & Upper Back (Cervical region)



Do you get Headaches? (circle one) **YES** **NO**

Where are your headaches? _____

How often do you get headaches? _____

How long do they last? _____

Do you take prescription medication for your headaches? YES NO

Do you take over the counter medication for you headaches? YES NO

Does the medication help? YES NO

When did your pain/problem start?_____

How did your problem start?_____

Have you had this or similar conditions in the past? _____

Pains are: ❑Sharp ❑Burning ❑Dull ❑Achy ❑Stiffness ❑Throbbing ❑Numbness ❑Pins & Needles

(please mark areas of discomfort on the diagram)

Frequency of pain? ❑ Constant ❑ Frequent ❑ Intermittent ❑ Occasional

What is the intensity level? (Circle one) 1 2 3 4 5 6 7 8 9 10 (severe/excruciating pain)

Is the pain on the (Circle one) **Right side** **Left side** **Both sides**

Does the pain radiate? _____ **Where**?_____

What makes it **worse**? _____

What makes it **better?**_____

Is condition worse during certain times of the day? _____

How has this condition affected your ability to perform your daily activities? (Please explain)

_____

Is this condition getting progressively worse? _____

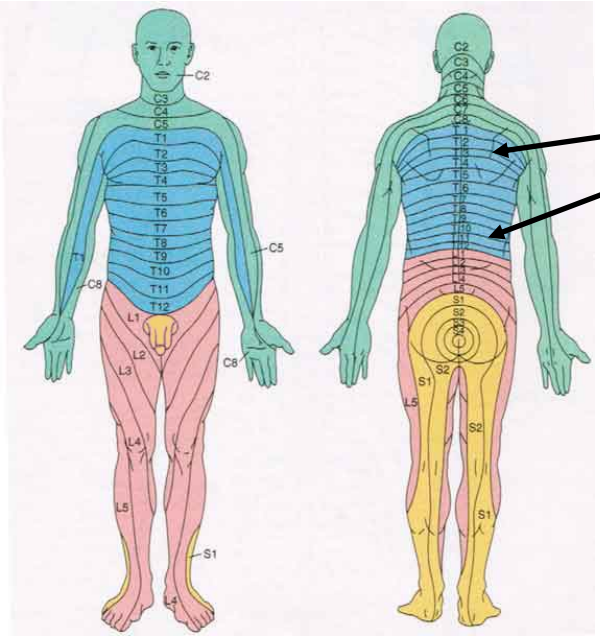
Other Doctors seen for this condition? _____

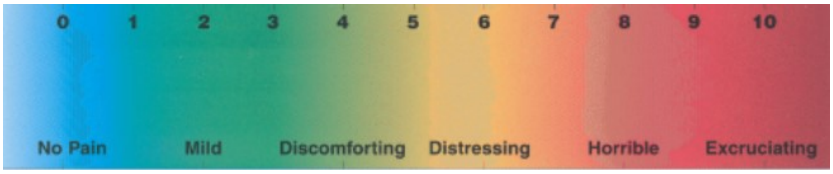
Any home remedies or pain medications? _____

Have you ever been to a Chiropractor before for this problem?_____

How long ago? _____

Are you having pain in your midback region?





When did your pain/problem start?_____

How did your problem start?_____

Have you had this or similar conditions in the past? _____

Pains are: ❑Sharp ❑Burning ❑Dull ❑Achy ❑Stiffness ❑Throbbing ❑Numbness ❑Pins & Needles

(please mark areas of discomfort on the diagram)

Frequency of pain? ❑ Constant ❑ Frequent ❑ Intermittent ❑ Occasional

What is the intensity level? (Circle one) 1 2 3 4 5 6 7 8 9 10 (severe/excruciating pain)

Is the pain on the (Circle one) **right side** **left side** **both sides**

Does the pain radiate? _____ **Where**?_____

What makes it **worse**? _____

What makes it **better?**_____

Is condition worse during certain times of the day? _____

How has this condition affected your ability to perform your daily activities? (Please explain)

_____

Is this condition getting progressively worse? _____

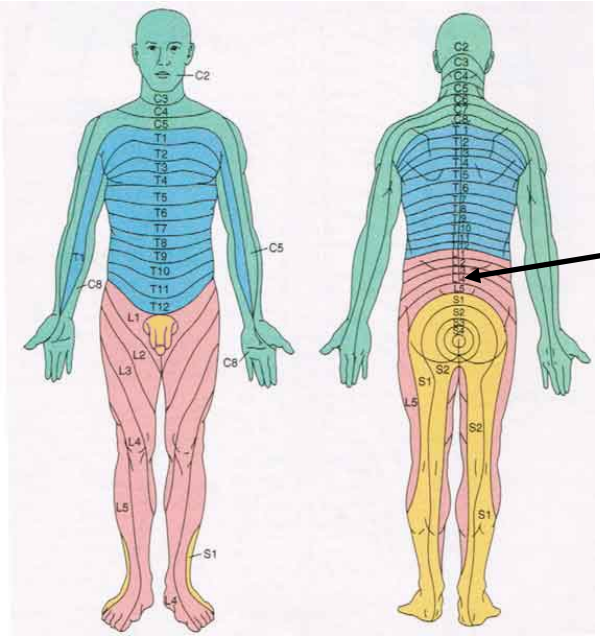
Other Doctors seen for this condition? _____

Any home remedies or pain medications? _____

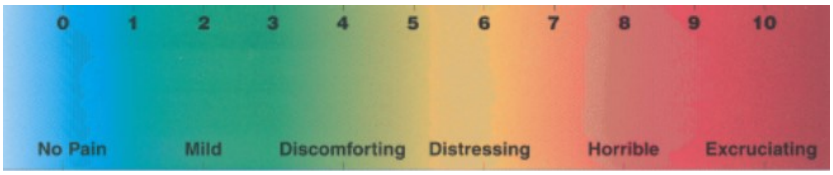
Have you ever been to a Chiropractor before for this problem?_____

How long ago? _____

Are you having any pain in the lower back?



Lower Back (Lumbar region)



When did your pain/problem start?_____

How did your problem start?_____

Have you had this or similar conditions in the past? _____

Pains are: ❑Sharp ❑Burning ❑Dull ❑Achy ❑Stiffness ❑Throbbing ❑Numbness ❑Pins & Needles

(**please mark areas of discomfort on the diagram)**

Frequency of pain? ❑ Constant ❑ Frequent ❑ Intermittent ❑ Occasional

What is the intensity level? (Circle one) 1 2 3 4 5 6 7 8 9 10 (severe/excruciating pain)

Is the pain on the (Circle one) **Right side** **Left side** **Both sides**

Does the pain radiate? _____ **Where**?_____

What makes it **worse**? _____

What makes it **better?**_____

Is condition worse during certain times of the day? _____

How has this condition affected your ability to perform your daily activities? (Please explain)

_____

Is this condition getting progressively worse? _____

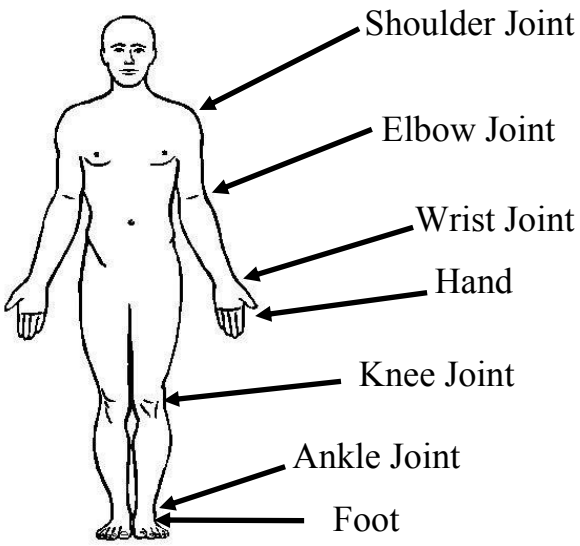
Other Doctors seen for this condition? _____

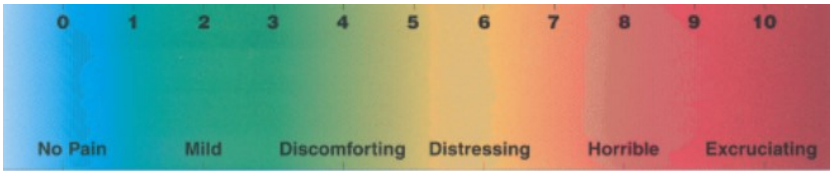
Any home remedies or pain medications? _____

Have you ever been to a Chiropractor before for this problem?_____

How long ago? _____

Are you having any pain in your extremities?





When did your pain/problem start?_____

How did your problem start?_____

Have you had this or similar conditions in the past? _____

Pains are: ❑Sharp ❑Burning ❑Dull ❑Achy ❑Stiffness ❑Throbbing ❑Numbness ❑Pins & Needles

(please mark areas of discomfort on the diagram)

Frequency of pain? ❑ Constant ❑ Frequent ❑ Intermittent ❑ Occasional

What is the intensity level? (Circle one) 1 2 3 4 5 6 7 8 9 10 (severe/excruciating pain)

Is the pain on the (Circle one) **right side** **left side** **both sides**

Does the pain radiate? _____ **Where**?_____

What makes it **worse**? _____

What makes it **better?**_____

Is condition worse during certain times of the day? _____

How has this condition affected your ability to perform your daily activities? (Please explain)

_____

Is this condition getting progressively worse? _____

Other Doctors seen for this condition? _____

Any home remedies or pain medications? _____

Have you ever been to a Chiropractor before for this problem?_____

How long ago? _____

EVERYDAY ACTIVITIES ASSESSMENT

Patient Name _____Date _____

FUNCTIONAL ACTIVITIES:

As a result of your condition, Please indicate how long you could perform the functional activities described below:

Sit Continuously: ___hr ___min Drive Continuously: ___hr ___min

Stand Continuously: ___hr ___min Walk Continuously: ___hr ___min

PERSONAL ACTIVITIES: As a result of your condition, do you have any difficulty with the following activities

Dressing	❑Yes	❑No	❑Partial	❑ Does Not Apply
Bathing/Showering	❑Yes	❑No	❑Partial	❑ Does Not Apply
Wash/Dry Hair	❑Yes	❑No	❑Partial	❑ Does Not Apply
Going to the toilet	❑Yes	❑No	❑Partial	❑ Does Not Apply
Desk/Computer Work	❑Yes	❑No	❑Partial	❑ Does Not Apply
Vacuuming/Sweeping	❑Yes	❑No	❑Partial	❑ Does Not Apply
Making Bed	❑Yes	❑No	❑Partial	❑ Does Not Apply
Ironing	❑Yes	❑No	❑Partial	❑ Does Not Apply
Preparing Meals	❑Yes	❑No	❑Partial	❑ Does Not Apply
Taking out Garbage	❑Yes	❑No	❑Partial	❑ Does Not Apply
Window Washing	❑Yes	❑No	❑Partial	❑ Does Not Apply
Carrying Heavy Purse	❑Yes	❑No	❑Partial	❑ Does Not Apply
Gardening	❑Yes	❑No	❑Partial	❑ Does Not Apply
Mowing Lawn/Yard Work	❑Yes	❑No	❑Partial	❑ Does Not Apply
Wash/Wax Vehicle	❑Yes	❑No	❑Partial	❑ Does Not Apply
Kneeling/Squatting	❑Yes	❑No	❑Partial	❑ Does Not Apply
Climbing Stairs	❑Yes	❑No	❑Partial	❑ Does Not Apply
Sex	❑Yes	❑No	❑Partial	❑ Does Not Apply
Child Care	❑Yes	❑No	❑Partial	❑ Does Not Apply
Reading	❑Yes	❑No	❑Partial	❑ Does Not Apply
Laundry	❑Yes	❑No	❑Partial	❑ Does Not Apply
Load/Unload Dishwasher	❑Yes	❑No	❑Partial	❑ Does Not Apply
Shoveling Snow	❑Yes	❑No	❑Partial	❑ Does Not Apply
Heavy Briefcase/Laptop	❑Yes	❑No	❑Partial	❑ Does Not Apply
Sitting for long periods	❑Yes	❑No	❑Partial	❑ Does Not Apply

WORK ACTIVITIES:

As a result of your condition, check all the following activities in which you experience difficulty.

❑ Lifting from the floor ❑ Lifting from the waist ❑ Twisting ❑Pushing ❑Pulling

Other: _____

RECREATIONAL ACTIVITIES:

List some of the hobbies or recreational activities you enjoy but can no longer perform/enjoy because of your condition.

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AUTHORIZATION FOR TREATMENT

I, the undersigned, a patient in this office hereby authorize Dr. Wubbena and whomever may be designated as assistants to administer such treatment as is necessary, and to perform the following adjustments and such additional therapy or procedures as are considered therapeutically necessary on the basis of findings during the course of said treatment.

I herby certify that I have read and fully understand the above authorization for chiropractic treatments, the reason why the above named treatment is considered necessary, its advantages and possible complication, if any, as well as possible alternative modes of treatment, which will be explained to me by Dr. Anita L. Wubbena.

I also certify that no guarantee or assurance has been made as to the results that maybe obtained.

Date_____Signature_____

Signature of parent or guardian (if minor)_____

Date_____Witness_____

Cancellations/ No Show of your Appointment Policy

- When you do not show up for a scheduled appointment, it creates an unused appointment slot that could have been used for another patient. It is very important that you call within 24 hours in advance to cancel your appointment.
- If for any reason you need to cancel an appointment, please notify our office as a soon as possible.
- On your second no-show occurrence, there will be a $25 charge to your account.

After three consecutive no-show occurrences, the practice may elect to terminate our relationship with you.

Date_____Signature_____

FINANCIAL POLICY

In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies:

Our clinic has established a single fee schedule that applies to all patients for each service provided. You may be entitled to a network or contractual discount under the following circumstances:

- If we are a participating provider in your health plan
- If you are covered by a State or Federal program with a mandated fee schedule.
- If you are a member of ChiroHealth USA, or any other Discount Medical Plan Organization we may join. Patients who are uninsured, underinsured (limited benefits for chiropractic care), may join ChiroHealth USA in our office and will be entitled to network discounts similar to our insured patients. Membership is $49.00 a year and covers you and your dependents. Ask our staff for information.
- Patients who meet state and federal poverty guidelines or other special circumstances outlined in our "Hardship Policy" may be offered a discount for a period of time as determined by the clinic. Verification will be required.

Our office is willing to work with you in any way possible to make your experience with us pleasant.

Please indicate if you would like our office to submit claims to your insurance company.

_____Yes _____No

Please indicate below your preference for payment.

_____ I wish to pay my co-pay/co-insurance in full at the time of service and have insurance submitted.

_____ I wish to pay my balance after receiving my monthly statement.

_____ I wish to pay in full at the time of service and have no insurance submitted for non-covered services.

_____ I wish to set up a Payment Arrangement to fit my budget.

_____ I would like to join ChiroHealth USA (For more information, please contact the front desk)

_____ Charges to be billed to another responsible party. (automobile accident, worker's compensation, or other party other than yourself)

I fully understand that I am directly and fully responsible for all bills, for services rendered. In the event I fail to pay in a timely manner, I realize I will also be responsible for all legal fees, including court and attorney costs incurred by The Chiropractic Care Center P.C. to recoup fees for services rendered.

Responsible Party (print) _____

Date _____Signature _____

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OFFICE POLICY REGARDING INSURANCE

Please indicate if you would like our office to submit claims to your insurance company.

_____Yes _____No

Insurance Company Name_____

Address_____

Phone # _____

Insured's Name_____ Member ID#_____

Insured's Date of Birth _____ Insured's Employer _____

1) Our office does NOT guarantee that your insurance will pay. We will make every attempt, at the beginning of your health care, to receive verification of your policy and what it covers. We will file your claim, however, it must be completely understood that the contract is between you and your insurance company. If for some reason, your insurance claim is denied, you are responsible for the full amount of your bill, or any amount not paid by your insurance company.

2) Many plans tell their insured that they will be covered up to a certain percentage (i.e. 70%, 80% that the insurance plan will cover) this is only what each plan finds to be "usual and customary" excluding yearly maximums, deductibles, allowed charges or limitations. Services which are considered maintenance or supportive are typically not covered by insurance companies.

3) Your wellness is our top priority. Based on your health history, exam, and diagnostic studies, we will design care specifically for you. They are not based on insurance benefits or flex plan contribution limits. Many insurance benefits are for catastrophic coverage only and altering your care based on coverage limitations can predispose you to a relapse or reduce your chances of reaching a complete recovery. Chiropractic care is typically very affordable and planning ahead will allow you to prioritize your health and maximize your benefits.

4) *If this injury is due to an auto accident or work related, please notify the receptionist.

If you understand the above, and agree with the office policy, please sign your name below and we shall accept your insurance assignment. All claims filed will be marked "benefits assigned".

This office is not a participating provider for every insurance company and or policy. Please know that in the event we are not in Network with your insurance company we will notify you as soon as possible. We will continue to file claims on your behalf, however, we will not accept assignment and all insurance payments will be mailed directly to you.

Date_____ Print Name _____

Signature_____

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A Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected heath 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 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.**

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 HIPPA 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 _____