MINNESOTA CHIROPRACTIC AND REHABILITATION (763) 390-1323
1025 EVERGREEN LANE, PLYMOUTH, MN 55441 FAX:(763) 390-0826

Please Print all Answers

New Patient Information

Name _____ Age _____ Sex _____ Date _____

Address _____ City _____ Zip _____

Phone _____ Work _____ Cell _____

Best time to Call _____ Which # _____ E-mail _____

Social Security # _____ Birthdate _____ Family Doctor _____

☐ Married ☐ Single ☐ Sep ☐ Divorced ☐ Widowed Spouse's Name _____

Employer _____ Spouse's Employer _____

Employer Address _____ Spouse's Birthdate _____

Employer Phone _____ Spouse's Social Security _____

Parent's Employer If Patient Is Minor / Child _____

Parents Social Security # If Patient Is Child _____

Emergency: Who Do We Call? _____ Relationship _____

Name of Relative or Friend Not Living with You Phone

Does your Employer provide Health Fairs, Wellness Support or Ergonomic Training (circle all that apply) to its employees?_____

HEALTH INSURANCE INFORMATION

Name of Insurance Company _____ Group Number _____

Name of Insured (Policy Holder) _____ Policy Number _____

Insured Birthdate _____

ACCIDENT INSURANCE INFORMATION

Name of YOUR Auto Insurance Company _____

Agent Name _____ Adjuster's Name _____

Accident Claim Number _____ Phone Number _____

Name of LIABLE Insurance Company _____ Adjuster's Name _____

Claim Number _____ Phone Number _____

Attorney Name _____ Phone Number _____

WORK OR INJURY INSURANCE INFORMATION

Employer or Responsible Party _____

Contact Person _____ Phone Number _____

Please provide the receptionist with your driver's license & insurance card to be photocopied for your permanent medical record.

Welcome to MINNESOTA CHIROPRACTIC AND REHABILITATION (MCR). We offer chiropractic, physical therapy, rehabilitation, acupuncture, massage therapy and nutritional counseling. We will strive to help restore or improve your health but there are no guarantees or promises of improvement or complete recovery. Patients are encouraged to leave valuables at home or with an accompanying family member or friend. MCR shall not be liable for the loss of or damage to any personal property including, but not limited to money, credit cards, clothing, jewelry, glasses/contacts, dental devices, hearing aids, furs, documents or any other items. Your signature on this document fully authorizes our staff & doctors to perform any examinations, diagnostic tests &/or treatment as we may consider medically necessary & to release all information pertinent to your health, insurance or benefits to any & all applicable parties on your behalf. Our office and staff are committed to providing all patients regardless of race, color, national origin, age, sex, disability or religious or political beliefs quality health care services delivered with dignity and concern. Office hours allow our patients convenience to schedule appointments before & after work as well as during lunch. If you must miss an appointment please notify us. Without notice, we reserve the right to charge a missed appointment fee that you must pay before you are seen or treated again. We are available to immediately see new patients, in most cases the same day. As a courtesy for you, we may call you on the telephone when an appointment is missed and/or you have not been in for a while. If you do not wish for us to call you or mail you reminder cards please let us know in writing for your file.

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SYMPTOM SURVEY

What is your chief problem or symptoms? _____
What caused the problem or symptoms to occur? _____
When did the problem or symptoms begin? _____
Have you seen another doctor for this problem? □ No, If yes, who _____
What tests/procedures have been performed? □ X-Ray □ MRI □ Surgery □ Hospitalization □ _____
Have you had this problem or symptoms in the past? □ No, If yes, explain _____
Have you tried any other treatments for this? □ No, If yes, explain _____
Is the problem or symptoms getting worse? □ No, If yes, explain _____

√ ALL OF THE ITEMS THAT APPLY TO YOU NOW AND IN THE PAST:

□ Arthritis / Gout	□ Depression/Anxiety	□ Pregnancy	□ Seasonal Allergies	□ Headaches
□ Eye Pain–Strain	□ Dizziness	□ Seizures	□ Ringing in Ears	□ Blurred Vision
□ Jaw Pain	□ Bleeding Gums	□ Neck Pain / Spasms	□ Chronic Fatigue	□ Heart Disease
□ Gall Stones	□ Swallowing Difficulty	□ Thyroid Problems	□ Chest Pain	□ Chest Congestion
□ Anemia	□ Hypertension	□ Stroke	□ Kidney Stones	□ Pancreatitis
□ Shortness of Breath	□ Irregular Heart Beat	□ HIV / AIDS	□ Asthma/Bronchitis	□ Mid-Back Pain
□ Shoulder/Elbow Pain	□ Wrist or Hand Pain	□ Low Back Pain	□ Hip/Knee/Leg Pain	□ Foot or Ankle Pain
□ Abdominal Pain	□ Diabetes	□ Groin or Rectal Pain	□ Female Disorders	□ Urinary Problems
□ Skin Problems	□ Broken Bones	□ Digestive Problems	□ Nausea – Vomiting	□ Irregular Bowels

PATIENT & FAMILY HISTORY

What is your occupation? _____ ☐ Full Time ☐ Part Time
What is your employment status? ☐ Working ☐ Sick Leave ☐ Unemployed ☐Retired
☐ Temp Disability ☐ Perm Disability Last Day of Work _____
Do you use tobacco? ☐ No ☐Yes Explain: _____
Do you consume alcohol? ☐ No ☐Yes Explain: _____
Do you have a history of substance abuse? ☐ No ☐Yes Explain: _____
List all past surgeries _____
List all drug allergies _____
List all current and past medications / drugs
Drug Name: _____ _____
_____ _____
_____ _____

List all physicians you have seen in the past 5 years?
Name _____ For What? _____
_____ _____
_____ _____
_____ _____

Family History

Father	□ Living	Age: _____	□ Deceased – Cause of Death	_____
Mother	□ Living	Age: _____	□ Deceased – Cause of Death	_____
Brother	□ Living	Age: _____	□ Deceased – Cause of Death	_____
Brother	□ Living	Age: _____	□ Deceased – Cause of Death	_____
Sister	□ Living	Age: _____	□ Deceased – Cause of Death	_____
Sister	□ Living	Age: _____	□ Deceased – Cause of Death	_____

□ Other problem(s) not listed _____

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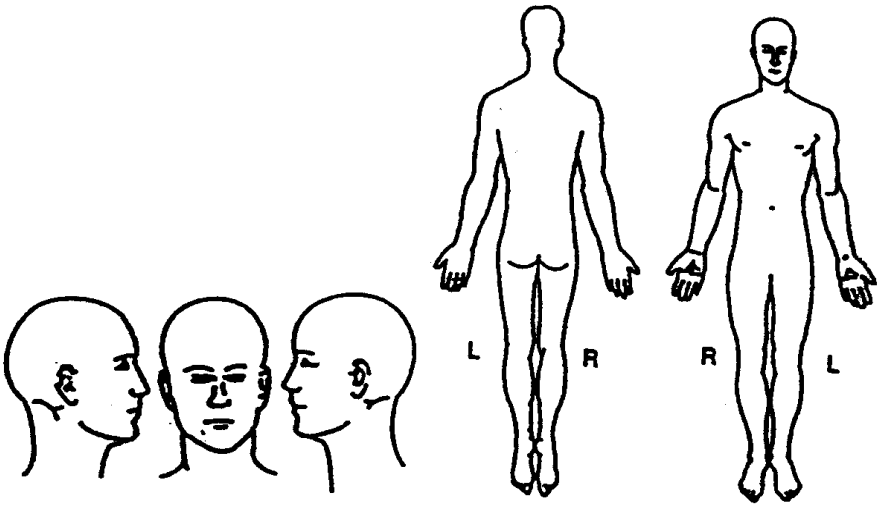
PAIN DRAWING

Circle location(s) of your symptoms on body drawing. Outline using the symbols for the type of sensation.

Pain	: : : : : : : : :
Numbness	+ + + + + +
Burning	/ / / / / / / / / /
Ache	X X X X X X

Describe your pain (check all that apply):

- □ Constant
- □ Intermittent
- □ Recurring
- □ Stabbing
- □ Dull Ache
- □ Sharp
- □ Deep Ache
- □ Throbbing
- □ Tingling
- □ While Resting
- □ Daily
- □ During Exercise
- □ Nightly
- □ _____



Onset of Pain:

- □ Sudden
- □ Gradual

On a scale of 1 to 10 how would you rate your pain level? _____ (1 = Mild, 10 = Intense)

What if anything gives you relief? _____

IF YOUR PROBLEM OR SYMPTOMS ARE DUE TO AN ACCIDENT OR INJURY PLEASE COMPLETE BELOW

□ **AUTO ACCIDENT** Date _____ Time ____ [am] [pm] Location_____

Were You	□ Driver	□ Passenger
	□ Unconscious	□ Treated in E.R.
	□ Wearing a Seat Belt	□ YES □ NO
	□ Transported by Ambulance	□ YES □ NO
Vehicle Damage	□ Minimal – Moderate	□ Severe - Totaled
	Was the vehicle towed away?	□ YES □ NO
Police Report	□ None	□ Yes with Police Dept_____
Activities	□ No restrictions	□ Missed ____ days of work or school
	□ I felt fine before the accident	

□ **WORK RELATED** or Other Injury Date _____ Time ____ [am] [pm] Location _____

Describe injury and how it happened:

_____

_____

_____

Accident Reported to _____ on _____(date)

- □ No restrictions □ Missed ____ days of work or school
- □ I felt fine before the injury

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HEALTH CARE PRIVACY NOTICE – INFORMED CONSENT – ASSIGNMENT OF BENEFITS – AUTHORIZATION & LIEN

This office is committed to providing patients with quality health care services delivered with dignity and concern. Fulfilling this commitment requires the efforts of the doctors, therapists, staff and patient working together as a team to obtain the maximum results. Patient satisfaction is a vital interest to Minnesota Chiropractic and Rehabilitation (MCR) and its staff. MCR is required by law to abide by the terms of this Health Care Privacy Notice as well as other applicable federal and state laws governing privacy practices in health care. MCR may change and/or modify the terms of this Notice at anytime without additional notice to you except to publicly post at MCR and/or make available to patients any updated notices. Photocopy of this Notice is available to you upon request. The term Provider refers to doctors and/or licensed professionals at MCR. MCR & our staff are committed to maintaining the privacy of your protected health information (PHI). PHI is information about you, including demographic information that may identify you and that may be related to your present, future and past physical or mental health or condition and the care and treatment you receive from our practice. This Notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read this Notice and direct questions, misunderstandings or concern to the Compliance Officer of MCR. MCR may use & disclose your PHI for health care delivery purposes. Your PHI may be used and/or disclosed without your written authorization by the doctors and staff of MCR for the purposes of your care and treatment; paying your health care bills; and to support the operations of this practice. Your doctor and the staff will take all reasonable measures to maintain the confidentiality of your PHI. The Privacy Rule allows you the right to review and receive copies of your health care records as it relates to your health care. The request must in writing, allowing your provider 30 days to respond. Your provider may deny your request if it will cause harm to you or to another person. Your provider may charge a copy fee, which will be in compliance with State law. Your provider will comply with any reasonable request to have confidential communication by alternative means or at an alternative location if not doing so endangers you. You may request to have an amendment placed in your record if you disagree with anything in your record. This does not mean that anything will be removed or changed and the provider has the right to respond with a rebuttal statement if he/she feels it is necessary. You may revoke authorization, in writing, at any time, except in the event that the provider has acted as indicated in the doctor's Authorization Notice. You have the right to file a written complaint with our Compliance Officer if you believe that any of your privacy rights have been violated. You can obtain a complaint form from the Compliance Officer and/or the Office of the Civil Rights. All complaints must be filed within 180 days of when you knew or should have known that the violation occurred. The Privacy Law prohibits MCR from taking any retaliatory actions against anyone who files a complaint. A more detailed, updated & comprehensive Health Care Privacy Notice is available for your review at MCR. I understand that MCR, its doctors & staff are accepting my case based on examination findings & believe the outlined treatment should produce change and/or improvement. However as with any diagnostic test, procedure, examination or doctors care a guarantee of improvement or complete recovery cannot be made and it is even possible that no change will occur. I further understand that in the practice of medicine, chiropractic, massage therapy & physical therapy there are some risks including but not limited to fractures, disk injuries, strokes, dislocations, sprains-strains, drug interactions & reactions and/or other injuries or side effects which cannot be pre-determined. I do not expect the doctor/provider to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor/provider to exercise judgment during the course of the procedure(s) which the doctor/provider feels at the time is in my best interest. In addition, because psycho-social, spiritual, and cultural values affect a patient's response to care, patients are allowed to express and follow spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of treatment. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office, You may choose to opt-out of any marketing or fundraising communications at any time. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them. Patients have the right to refuse treatment, but must be aware of the probable consequences of refusing treatment and/or failing to cooperate with the prescribed treatment. Should you refuse and/or fail to comply with prescribed treatment your provider will discuss specific consequences with you. Therefore I give my full consent to the doctor/provider to render treatment on me or the minor for whom I am legally responsible by a health care provider. I, the assignee, being the patient or legal guardian for said minor listed below, do hereby irrevocably authorize, direct, assign and give a full lien to the office named above and listed below, hereinafter referred to as "MCR" against any & all insurance benefits, proceeds of any settlement, judgment or verdict which may be paid to the undersigned as a result of the injuries or illness for which I have been treated by MCR. I, the assignee further authorizes any and all insurance company, attorney and any & all third party payer to pay directly to MCR all sums of money due them for any & all services rendered to me or minor by whom I am responsible for by reason of accident, illness and by any & all reason of any other bills that are due or may become due, and to withhold such sums from any health & accident, workers compensation and or including all insurance or third party benefits. Assignee agrees that MCR & staff may deliver medical records, consultations, depositions and/or court appearances which must be paid in full in advance and authorizes MCR to release any information pertinent to said health care to any insurance company, adjuster, attorney or legal service bureau to facilitate collections under the terms of this document. Assignee grants MCR a full power of attorney to endorse &/or sign my name on any & all checks for payment of any indebtedness owed this office & assignee.

INSURANCE BENEFITS – CREDIT POLICIES – PAYMENT TERMS & CONDITIONS

As a courtesy, Minnesota Chiropractic and Rehabilitation (MCR) will obtain a verification of applicable insurance benefits as they are quoted to us but some third party payers misquote benefits, coverage and liability. MCR is not responsible for what a third party payer and/or representative may tell us. Any contractual, written, verbal or other obligations or arrangements between you and an attorney, insurance company, liable or third party payer are between you and said person. I understand that my insurance is an arrangement between myself and my insurance company, NOT between MCR and my insurance company. I request that MCR prepare the customary forms at no charge so that I may obtain insurance benefits. I understand that I am responsible for charges on all service(s) and/or product(s) which may exceed the maximum allowable and/or when a third party and/or insurance carrier does not reimburse this facility enough to meet our cost of service. A service charge is computed by a 'periodic rate' of 1 ½ % per month-18% per annum and is added to all balances owed 60+ days. Any balance past due 90 days or more may be submitted to an attorney and/or agency for legal collection for which I agree to be 100% responsible for all monthly service charges, interest, costs related too but not limited to all collection related expenses, attorney fees, court & filing fees. Returned checks, debit & credit charges made payable to this facility for insufficient funds, stop payments or other reasons of non-payment will be assessed a $30.00 charge. No cancellation fee will be assessed for appointment cancellations made 24 hours prior to the scheduled appointment time. Cancellations made within 24 hours of the scheduled appointment time or missed appointments may be assessed a missed appointment fee of $50.00.

PATIENT CONSENT & SIGNATURE

By my signature below I acknowledge that I have read or have had read to me and have received a photocopy upon my request of this document including the Health Care Privacy Notice, Facility terms & conditions, Financial Policy and Informed Consent and fully understand and have had all of my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valid as an original.

Print Name of Patient

X

Signature (if minor, parent must sign) Date

MINNESOTA CHIROPRACTIC AND REHABILITATION

FINANCIAL POLICY

Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. Regardless of your coverage, we will suggest the chiropractic care we think you need. We ask that you read and understand our policy as it applies to your particular situation.

PATIENTS WITHOUT INSURANCE We request that 100% of the first visit be paid at the time of the visit. A non discriminatory "Time of Service Discount" is offered to anyone who pays for services the day they are rendered. The "TOS" is only offered on the day the service is rendered. This discount does not apply to orthopedic supports, orthotics, physical therapy equipment rentals or purchases, vitamins, supplements, ointments, acupuncture treatments, weight loss programs, psychological counseling services and massage therapy. We are happy to accept your check, cash, FSA or HSA, Master Card, Visa, Discover, or American Express.

GROUP OR INDIVIDUAL INSURANCE Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers Chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. When possible, we will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you collect. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles or co-pays.

SECONDARY/SUPLEMENTAL INSURANCE Please inform us of any secondary/supplementary insurance you may have. We will assist you if you need help in filing.

"ON THE JOB" INJURY (Worker's Compensation) If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within 3 months, or if you suspend or terminate care, any fees and services are due immediately.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS Please present your auto insurance card, your health insurance card, and tell us if you have retained an attorney. Minnesota is a no fault state and as a result 100% of your care will usually be reimbursed by your automobile insurance carrier. In the event that your benefits are denied or "cut off" and you have retained an attorney, we will wait for settlement of your claim for up to six months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately. Patients are fully responsible for all money owed this office and such payment is not contingent on any settlement, claim, judgment, or verdict by which they may eventually recover said fee and it is also regardless of any attorney liens or pending settlement(s). If a third party payer fails to pay said balance in full within the six month period, the patient must pay the balance in full. Assignee is fully responsible for all money owed this facility for any and all treatment, products & services rendered to the patient or minor shown below.

-OVER-

MEDICARE We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%. All other services we provide are NON-COVERED. These services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare at no charge.

MEDICAL SAVINGS ACCOUNTS/FLEX PLANS/HEALTH SAVINGS ACCOUNT Please inform us if you have a medical savings account, sometimes known as a 'flex plan' or health savings account. We will be happy to provide you with a statement of your charges for reimbursement.

CANCELLATION POLICY No cancellation fee will be assessed for appointment cancellations made 24 hours prior to the scheduled appointment time. Cancellations made within 24 hours of the scheduled appointment time or missed appointments may be assessed a missed appointment fee of $50.00.

INSURANCE FORMS/PAYMENT If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request for more information regarding your care, please bring it in to us as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake, or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office, may come to you instead of our office. If you should receive a check in the mail, please contact us to see if it does represent payment of your bill here.

SERVICE CHARGE A service charge is computed by a 'periodic rate' of 1 ½ % per month-18% per annum and is added to all balances owed 60+ days. Any balance past due 90 days or more may be submitted to an attorney and/or agency for legal collection for which I agree to be 100% responsible for all monthly service charges, interest, costs related too but not limited to all collection related expenses, attorney fees, court & filing fees. Returned checks, debit & credit charges made payable to this facility for insufficient funds, stop payments or other reasons of non-payment will be assessed a $30.00 charge.

SPECIAL PAYMENT INSTRUCTIONS

☐ We have verified your benefits and while your insurance company did not guarantee payment, they stated that you have a $_____deductible, $_____of which has been met. Additionally, your insurance will pay _____% of covered charges, leaving _____% of each visit due by you.

☐ You agree to pay a "Time of Service Discount" of $_____ for each treatment date.

☐ You are required to pay a $_____co-pay at the time of service.

I have read and understand the Financial Policy of Minnesota Chiropractic and Rehabilitation (MCR). I understand that my insurance is an arrangement between myself and my insurance company, NOT between MCR and my insurance company. I request that MCR prepare the customary forms at no charge so that I may obtain insurance benefits. I understand that I am responsible for charges on all service(s) and/or product(s) which may exceed the maximum allowable and/or when a third party and/or insurance carrier does not reimburse this facility enough to meet our cost of service. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctors at MCR that fees will be due and payable immediately.

_____ _____

Patient's signature (or guardian if patient is a minor) Date

MINNESOTA CHIROPRACTIC AND REHABILITATION

Authorization to release medical records to:
Minnesota Chiropractic and Rehabilitation

PATIENT INFORMATION:
Name (print): _____ Prior Name if any:_____
Address: _____ City:_____ State:_____ Zip:_____
Phone Number:_____
Date of Birth: _____ Social Security Number: _____

I authorize the following facility/provider to release my health information upon this request:

INFORMATION TO BE RELEASED FROM:
Name of facility or provider: _____
Address:_____ City:_____ State:_____ Zip:_____
Phone number:_____ Fax:_____

HEALTH INFORMATION TO BE RELEASED:

____ The most recent 2 years of pertinent information (chart notes, radiology reports, laboratory reports and special tests.)
____ Hospital Records
____ X-ray/Radiology Films
____ All Medical Records
____ Specific Information (please specify):

PURPOSE FOR WHICH THE DISCOLSURE IS BEING MADE:

____ Continuation of Care

PATIENT AUTHORIZATION/MY RIGHTS:
I understand that authorizing the release of this information is voluntary. I may revoke this authorization in writing. I understand that any release of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosures of my health information, I may contact Minnesota Chiropractic and Rehabilitation. I understand that Minnesota Chiropractic and Rehabilitation will not condition my treatment, payment, enrollment, or eligibility for benefits on whether I sign the authorization.

Signature: _____ Date: _____

This authorization will expire 90 days from the date signed