Welcome to Fosston Chiropractic Clinic, P.A.

www.fosstonchiro.com

Chiropractic *Acupuncture* *Sport and Spinal Rehabilitation*

Thank you for choosing us for your chiropractic care. Please complete this form. If you have any questions or concerns, please ask for assistance. We will be happy to help you.

Please Print

Name: ____

First MI Last

Date: ____/____/____ Birth date: ____/____/________

SS# ____-____-____ Sex: Male/Female

Address: ____

City: _________________________ State: ____ Zip: ________

Home Phone: ______________ Work Phone: ______________

Email: ____

May we contact you by email? ☐ Yes ☐ No

Are you: ☐ Minor ☐ Married ☐ Widowed

☐ Single ☐ Divorced ☐ Separated

What name do you preferred to be called? __________________

Employer: ____

Occupation: ____

Person to Contact in the event of Emergency: _______________

Phone # of Contact: ___________________________________

Who is your Medical Doctor? ____________________________

Who referred you to our clinic? __________________________

What do you desire from your chiropractic care?

☐ Pain Relief Only

☐ Correction of your problem

☐ Wellness Care and Preventative Care

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name ________________ **Date** ________________

1. Describe your symptoms ________________

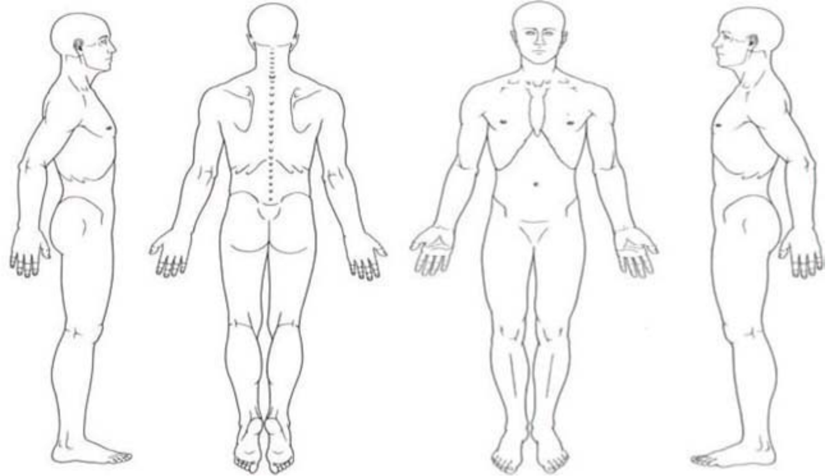
a. When did your symptoms start? ________________

b. How did your symptoms begin? ________________

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

① No One
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. What treatment did you receive and when? ________________

b. What tests have you had for your symptoms and when were they performed?

① Xrays date: ________ ③ CT Scan date: ________
② MRI date: ________ ④ Other date: ________

9. Have you had similar symptoms in the past?

① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

10. What is your occupation?

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

____

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

Patient Signature ________________ **Date** ________________

Patient Health Questionnaire - page 2

ACN Group, Inc PHQ-102

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name ______________________ **Date** ______________

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height [ ][ ][ ] (Feet, Inches) Weight [ ][ ][ ] lbs.

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present	Condition
○	○	Headaches
○	○	Neck Pain
○	○	Upper Back Pain
○	○	Mid Back Pain
○	○	Low Back Pain
○	○	Shoulder Pain
○	○	Elbow/Upper Arm Pain
○	○	Wrist Pain
○	○	Hand Pain
○	○	Hip/Upper Leg Pain
○	○	Knee/Lower Leg Pain
○	○	Ankle/Foot Pain
○	○	Jaw Pain
○	○	Joint Swelling/Stiffness
○	○	Arthritis
○	○	Rheumatoid Arthritis
○	○	General Fatigue
○	○	Muscular Incoordination
○	○	Visual Disturbances
○	○	Dizziness

Past	Present	Condition
○	○	High Blood Pressure
○	○	Heart Attack
○	○	Chest Pains
○	○	Stroke
○	○	Angina
○	○	Kidney Stones
○	○	Kidney Disorders
○	○	Bladder Infection
○	○	Painful Urination
○	○	Loss of Bladder Control
○	○	Prostate Problems
○	○	Abnormal Weight Gain/Loss
○	○	Loss of Appetite
○	○	Abdominal Pain
○	○	Ulcer
○	○	Hepatitis
○	○	Liver/Gall Bladder Disorder
○	○	Cancer
○	○	Tumor
○	○	Asthma
○	○	Chronic Sinusitis

Past	Present	Condition
○	○	Diabetes
○	○	Excessive Thirst
○	○	Frequent Urination
○	○	Smoking/Use Tobacco Products
○	○	Drug/Alcohol Dependence
○	○	Allergies
○	○	Depression
○	○	Systemic Lupus
○	○	Epilepsy
○	○	Dermatitis/Eczema/Rash
○	○	HIV/AIDS

Females Only

Past	Present	Condition
○	○	Birth Control Pills
○	○	Hormonal Replacement
○	○	Pregnancy
○	○	

Other Health Problems/Issues

Past	Present	Condition
○	○	
○	○	
○	○	

Indicate if an immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○ ______________

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

______________ ______________ ______________

______________ ______________ ______________

List all the surgical procedures you have had and times you have been hospitalized:

______________ ______________ ______________

______________ ______________ ______________

Patient Signature ______________________ **Date** ______________

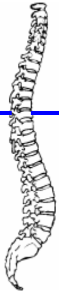
Doctor's Additional Comments

____

____

____

Doctors Signature ______________________ **Date** ______________



Fosston Chiropractic Clinic, P.A. Gabe Wiener, D.C.

104 North Johnson Avenue
Fosston, MN 56542
(218) 435-6186

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own 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. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. 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.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

____

Name of Patient (Print please)

____

Signature of Patient Date

Fosston Chiropractic Clinic, P.A.
Financial Policy

We do not base your treatment program on your insurance coverage and neither should you. Your schedule of care is based on your unique situation. Our goal is to correct your problem in the shortest amount of time and the most cost effective manner.

<u>Your insurance policy is a contract between you and your insurance company.</u>
We accept most insurance. We are a participating provider for BCBS of MN, Medica, HealthPartners, MNCare, UCare, Medicare, Medical Assistance

Co-pays and non-covered services are due at the time the service is rendered.

☐ Cash – We accept cash, checks, or credit cards. Payment is due at the time of service.

☐ Group Insurance – We will gladly file your claims for you and bill your insurance company for all services that are rendered on the day of service. Remember that your insurance is a contract between you and your insurance company, any amount that your insurance does not pay is your responsibility.

☐ MNCare/UCare – Under this plan, only adjustments and spinal x-rays are covered services. You are responsible for exams, therapies, supports, supplements and extremity adjustments.

☐ Medical Assistance – Under this plan, only adjustments and spinal x-rays are covered services with a maximum of 24 visits a year and not to exceed 6 visits/month. Prior authorization for extra visits may be necessary. You are responsible for exams, therapies, supports, supplements and extremity adjustments.

☐ Medicare – After the $100 deductible has been met, Medicare pays 80% of spinal adjustments only, with a maximum of 24 visits/year. We will bill your supplement insurance once Medicare has paid. Most supplements only pay for Medicare covered services. You are responsible for any services not paid by Medicare or your supplement. You are responsible for exams, therapies, supports, supplements and extremity adjustments.

☐ Automobile Accidents/Personal Injury – Under the MN No-Fault Law, your insurance company is required to pay for your care. Please provide us with a claim number and the appropriate billing information and notify us if you have retained an attorney.

☐ Worker's Compensation – You must notify your employer and file a Report of injury with your employer before treatment is rendered at our office. Please notify us if you have retained an attorney. Work Comp. will not allow you to see more than one health care provider at a time.

I have read and understand the above policy. I understand that I am personally responsible for payment of all services rendered to me. I understand that my insurance policy is a contract between me and my insurance company. I consent to an examination, any needed x-rays, and treatment. I authorize Fosston Chiropractic Clinic, P.A. to hereby assign all benefits paid, as a result of claims submitted on my behalf, to Fosston Chiropractic Clinic, P.A.

We have never turned a patient away from our clinic because of their financial situation, but we have turned people away for not making their health a priority!

______________________________ ____________________
Patient's Signature Date