The CHIROPRACTIC ADVANTAGE
Move well to live well

344 McDonald Street | Oconto, WI 54153 | 920.834.2888 | chiroadvantageoconto@gmail.com

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 Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all 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 obligated to agree to those restrictions only to the extent they coincide with state and federal law.

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. 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.

6. 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.

7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.

8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.

9. This notice is effective on the date stated below.

10. 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. For further information regarding this notice, please contact our office at (920) 834-2888.

_____	_____	___/___/_____
Name of Patient	Signature	Date

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FINANCIAL POLICY

Insurance Patients

Please note that your insurance coverage is a contract between you and your insurance company and that you are ultimately responsible for your bills at The Chiropractic Advantage, LLC.

As a courtesy to our patients, The Chiropractic Advantage will make every effort to verify chiropractic benefits. However; the Federal Healthcare Information Portability & Accountability Act (HIPAA) has restricted The Chiropractic Advantage's ability to verify patient benefits. The Chiropractic Advantage cannot guarantee that your insurance will pay benefits because insurance companies never guarantee payment until they review the claim. Please realize that it is your responsibility to contact your employer or benefits office for details of your coverage.

I understand that I am responsible for all charges not covered by insurance including, but not limited to: all claims denied, unpaid due to deductibles, co-insurance partially paid due to arbitrary determination of usual and customary, un-contracted, re-pricing organizations, and all charges denied from a completed review for medical necessity. I further understand The Chiropractic Advantage will honor all discounts, fee schedules, and network participation pricing as per signed contract. Discounts assigned by organizations or insurances without a signed agreement with The Chiropractic Advantage will become the patient's responsibility. I hereby authorize and assign directly to The Chiropractic Advantage all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

All co-pays, supplies and over the counter items must be paid at the time of service.

I understand that if my health insurance does not include coverage for chiropractic, I will be required to pay at the time of service. I further understand that I have the right to establish a payment plan when costs exceed my ability to pay.

Auto Accidents/Workman's Compensation Injuries: The Chiropractic Advantage will gladly submit your charges to your insurance company(ies), attorney or any other insurance company(ies) involved. However, regardless of any insurance reimbursement or settlement you may or may not receive, all services rendered are charged directly to you, and ultimately, you are responsible for payment.

Medicare Patients: The Chiropractic Advantage accepts Medicare Assignment for chiropractic adjustments. I understand that ***Medicare does not cover x-rays, exams, therapies or supplies.*** The Chiropractic Advantage will submit my claims to Medicare first, then to secondary or supplemental insurance carriers on my behalf. I understand that I am responsible for charges not covered by Medicare and/or secondary/supplemental insurance.

Cash Patients

Please note that you are ultimately responsible for your bills at The Chiropractic Advantage. Payment is always due at the time of service for any and all services and products, unless a Payment Plan Contract is filled out in advance or otherwise agreed upon.

Collection Agency Placement Policy: You are financially responsible for the timely payment of your outstanding bill per our payment policies. Your account will be placed with a collection agency if we have not received any payment within 90-180 days.

NOTICE: If you start care at The Chiropractic Advantage and you stop care for over 12 months, the doctors must complete a re-examination before care is given. An exam fee will be billed for that visit in addition to any other services provided. Accounts past due are subject to a late payment charge of 1.5% per month (18% per annum).

I have read the above policy and understand the terms of payment for The Chiropractic Advantage LLC.

_____ _____

Patient Print Name | Patient Signature

_____ _____

Guardian/Patient Representative Print Name & Relationship | Guardian/Patient Representative Signature

_____

Date

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Informed Consent Form

Your chiropractic physician will use his/her hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or "Spinal Adjustment." As the joints in your spine move, you may experience a "pop" sound as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. The most common complication following spinal manipulation is a temporary ache or stiffness at the site of adjustment. Other possible complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains, dislocations, Bernard-Horner's Syndrome (also known as oculosympathethetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke.

Your chiropractic physician is aware of these complications, and in order to minimize their occurrence he/she will take precautions. These precautions include, but are not limited to, taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell your chiropractic physician prior to taking x-rays.

If you experience soreness, use ice packs on the affected area. Ice therapy consists of the use of ice packs for 20 minutes followed by 40 minutes of rest. This can be repeated as often as needed. Do not apply ice directly to bare skin. Always protect skin with a thin covering such as a shirt or light towel. Cover the ice pack with a thick towel to retain the cold.

Do not use heat except under the doctor's instruction. Heat may aggravate your injury.

Stay away from heavy lifting or repetitive movements until the doctor indicates you are ready for normal activities. Strenuous athletic activities such as running, lifting weights, impact aerobics, racquetball, tennis, skiing, bowling, etc., should be avoided unless otherwise indicated by your chiropractic physician. Other things to avoid are yard work, lifting heavy objects such as pets, groceries and children, and any other activities that could aggravate or re-injure your condition.

Unless otherwise indicated by your chiropractic physician, you may return to work/school after your appointment.

If a sudden movement causes sharp or severe pain, or if you experience swelling, contact the clinic at (920) 834-2888.

I have read and understand the above information.

DATE: _____

_____
Patient Printed Name

_____
Signature

_____
Signature of Parent or Guardian (if a minor)

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Patient Information

First Name:_____ Middle Name:_____ Last Name:_____
Date:_____ Date of Birth:_____ Age:_____
Sex: ○ Male ○ Female Height:_____ Weight:_____
Preferred Language:_____ Race:_____ Ethnicity:_____
Marital Status:_____ Spouse Name:_____ # of Children:_____
Home #:_____ Cell #:_____ Work #:_____
Address:_____
City:_____ State:_____ Zip:_____
Emergency Contact:_____ Emergency Relation:_____ Emergency Phone:_____
Email:_____

Referral Information

Referred by:_____ Referring Patient:_____ Referring Physician:_____
Advertisement: ○ Yes ○ No Advertisement:_____
Referred Directory: ○ Yes ○ No Referred Directory:_____

Employer Information

Employed:_____ Employer Name:_____
Employer Address:_____
Employer City:_____ Employer State:_____ Employer Zip:_____
Occupation:_____ Work Supervisor:_____ Supervisor #:_____
Work Duties:_____

Insurance Information

Primary Name:_____ Primary Phone #:_____ Primary ID/Policy:_____
Primary Address:_____
Primary City:_____ Primary State:_____ Primary Zip:_____
Primary Group #:_____ Primary Name:_____ Primary DOB:_____
Secondary Name:_____ Secondary Phone #:_____ Secondary ID/Policy:_____
Secondary Address:_____
Secondary City:_____ Secondary State:_____ Secondary Zip:_____
Secondary Group #:_____ Secondary Name:_____ Secondary DOB:_____
Claim #:_____ Claim Contact:_____
Attorney Name:_____ Attorney Phone:_____

Personal Health History

Last Physical Exam:_____ Primary Physician:_____ Physician Phone #:_____
Physician City:_____ Physician State:_____ Physician Zip:_____
Health Conditions:_____
Previous Chiropractic Care: ○ Yes ○ No Date:_____ Conditions Treated:_____
Planning: ○ Yes ○ No
Chance Pregnant: ○ Yes ○ No

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Current Medications and Dosages:_____
Vitamins/Supplements:_____
Allergies (food, medications, seasonal, etc.):_____
Smoking Status: ○ every day ○ occasionally ○ never ○ former smoker

Were you aware that…

Chiropractic is the largest natural healing profession in the world? ○ Yes ○ No
Doctors of chiropractic work with the nervous system? ○ Yes ○ No
The nervous system controls all bodily functions and systems? ○ Yes ○ No
When doctors work together, it benefits you. May we have your permission to update your primary physician regarding your care at this office if needed? ○ Yes ○ No

Complaint Information

Purpose of this appointment (wellness or list symptoms):_____
Condition Origin:_____
Injury Occurred: ○ work ○ automobile ○ third-party ○ other Injury Date:_____
Describe discomfort: _____
Interfere with activities? ○ Yes ○ No Affect sleep? ○ Yes ○ No Frequency:_____
Missed work: ○ Yes ○ No Unable to work from_____until_____
Affected appetite: ○ Yes ○ No Explain:_____
Reduced work: ○ Yes ○ No Explain:_____
Does it worsen? ○ Yes ○ No Explain:_____
Weather affects it: ○ Yes ○ No Explain:_____
Aggravates condition:_____
Improves condition:_____
Received treatment for condition: ○ Yes ○ No Explain:_____
X-Rays taken? ○ Yes ○ No Explain:_____
Pain level rating- scale 1 to 10 (10 being worst) At its best:_____ At its worst:_____ Current level:_____
Experienced same condition before? ○ Yes ○ No Date:_____
Practitioner:_____ Treatment:_____

Review of Systems (indicate if you now have, or have had in the past, any of the following)

Headaches	○ Now ○ Past	Excessive Bleeding	○ Now ○ Past	Sinus Problems	○ Now ○ Past
Nervousness	○ Now ○ Past	Pacemaker	○ Now ○ Past	Diabetes	○ Now ○ Past
Tension	○ Now ○ Past	Stroke	○ Now ○ Past	Indigestion/Heartburn	○ Now ○ Past
Irritability	○ Now ○ Past	Ruptures	○ Now ○ Past	Joint Pain/Stiffness	○ Now ○ Past
Chest Pain/Tightness	○ Now ○ Past	Eating Disorder	○ Now ○ Past	Menstrual Difficulties	○ Now ○ Past
Dizziness	○ Now ○ Past	Gall Bladder Problems	○ Now ○ Past	Weight Loss/Gain	○ Now ○ Past
Shoulder/Neck/Arm Pain	○ Now ○ Past	Liver Problems	○ Now ○ Past	Depression/Anxiety	○ Now ○ Past
Numbness in Fingers	○ Now ○ Past	Pancreas Problems	○ Now ○ Past	Loss of Memory	○ Now ○ Past
Numbness in Toes	○ Now ○ Past	Loss of Balance	○ Now ○ Past	Buzzing in Ears	○ Now ○ Past
Osteoporosis	○ Now ○ Past	Osteoarthritis	○ Now ○ Past	Circulation Problems	○ Now ○ Past
Difficulty Urinating	○ Now ○ Past	Fainting	○ Now ○ Past	Seizures/Epilepsy	○ Now ○ Past
Weakness in Extremities	○ Now ○ Past	Loss of Smell	○ Now ○ Past	Low Blood Pressure	○ Now ○ Past

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		Loss of Taste	○ Now ○ Past	High Blood Pressure	○ Now ○ Past
Breathing Problems	○ Now ○ Past				
Fatigue	○ Now ○ Past	Unusual Bowel Patterns	○ Now ○ Past	Heart Disease	○ Now ○ Past
Light Bothers Eyes	○ Now ○ Past	Cold Hands/Feet	○ Now ○ Past	Cancer	○ Now ○ Past
Ears Ring	○ Now ○ Past	Fever	○ Now ○ Past	Coughing Blood	○ Now ○ Past
Broken Bones/Fractures	○ Now ○ Past	Muscle Spasms	○ Now ○ Past	Alcoholism	○ Now ○ Past
Rheumatoid Arthritis	○ Now ○ Past	Frequent Colds	○ Now ○ Past	HIV Positive	○ Now ○ Past
Sprain/Strain	○ Now ○ Past	Hospitalization	○ Now ○ Past	Surgery	○ Now ○ Past
Auto Accident	○ Now ○ Past	Struck Unconscious	○ Now ○ Past	Concussion	○ Now ○ Past

Social History (indicate how frequently you experience or utilize the following:)

Key: O = often, S = sometimes, N = never

Vigorous Exercise	○ O ○ S ○ N	Financial Pressure	○ O ○ S ○ N	Tobacco Use	○ O ○ S ○ N
Moderate Exercise	○ O ○ S ○ N	Alcohol Use	○ O ○ S ○ N	Caffeine	○ O ○ S ○ N
Family Pressure	○ O ○ S ○ N	Drug Use	○ O ○ S ○ N	Other Stress	○ O ○ S ○ N

Family Health History (indicate if any of your family members have/have had any of the following:)

	Father (age____)	Mother (age____)	Grandparent(s) (age____)	Sibling(s) (age____)	Spouse (age____)	Children (age____)
Arthritis						
Asthma/Allergies						
Back or Neck Trouble						
Bursitis						
Cancer						
Diabetes						
Headaches/Migraines						
Heart Trouble						
High/Low Blood Pressure						
Insomnia						
Kidney or Liver Trouble						
Depression/Anxiety						
Arm/Leg Pain, Numbness or Tingling						
Scoliosis						
Genetic Condition						

**If any listed family members are deceased, please list their age at death and cause:_____

I certify that I am the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of changes incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I am responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Signature of Patient or Guardian:_____ Date:_____