WISCONSIN CHIROPRACTIC CENTER, LLC

5050 West Rawson Avenue
Franklin, WI 53132

(414) 377-8584
(414) 377-8588
info@wichiropracticcenter.com

PATIENT INFORMATION

DATE: _____/_____/_____ SOCIAL SECURITY #_____-_____-_____

PATIENT NAME:_____ SEX: MALE / FEMALE BIRTH DATE: _____/_____/_____

ADDRESS: _____

CITY:_____ STATE:_____ ZIP CODE: _____

HOME PHONE: _____-_____-_____ CELL: _____-_____-_____ E-MAIL: _____

MARITAL STATUS: SINGLE MARRIED SEPARATED DIVORCED JOB STATUS: EMPLOYED UNEMPLOYED STUDENT RETIRED

PATIENT EMPLOYED BY:_____ OCCUPATION: _____

TYPE OF CASE: CASH PERSONAL INSURANCE WORKERS COMPENSATION AUTO ACCIDENT MEDICARE MEDICAID OTHER

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED?:_____ PHONE: _____

REFERRED TO THIS OFFICE BY:_____ **PRIMARY PHYSICIAN'S NAME**: _____

WE FIND PATIENTS RECEIVE THE BEST CARE WHEN THEIR DOCTORS COMMUNICATE TOGETHER.

DO WE HAVE YOUR PERMISSION TO SEND YOUR PRIMARY PHYSICIAN UPDATES ON YOUR CONDITION? YES NO

ABOUT YOUR CURRENT CONDITION

WHAT IS YOUR CURRENT WEIGHT?_____ LBS. HEIGHT: _____FT. _____ IN. AGE_____

PLEASE DESCRIBE YOUR CONDITION: Date Condition Began _____/_____/_____WHAT SIDE IS YOUR PAIN ON: RIGHT LEFT BOTH

HOW DID YOUR PAIN BEGIN: _____

_____

WHAT IS YOUR LEVEL OF PAIN TODAY? (Scale of 1 - 10, 10 being severe): _____ IS THIS CONDITION GETTING WORSE? YES NO

WHAT IS THE NATURE OF YOUR PAIN: CONSTANT INTERMITTENT DULL ACHY SHARP SHOOTING BURNING NUMB TINGLING

WHAT MAKES YOUR PAIN BETTER? _____

WHAT MAKE YOUR PAIN WORSE? _____

IS THIS CONDITION INTERFERING WITH YOUR: WORK SLEEP DAILY ROUTINE PLEASE EXPLAIN: _____

HAVE YOU HAD THIS OR SIMILAR CONDITIONS IN THE PAST? NO YES IF SO, PLEASE EXPLAIN: _____

HAVE YOU BEEN SEEN BY ANOTHER DOCTOR FOR THIS CONDITION? NO YES IF SO, WHERE & WHEN: _____

PLEASE LIST ANY MEDICATIONS YOU ARE TAKING (BOTH PRESCRIPTION AND OVER THE COUNTER):

_____

_____

PLEASE LIST ANY SUPPLEMENTS YOU ARE TAKING: _____

PLEASE LIST ANY MEDICAL CONDITION(S) YOU HAVE OR EVER HAD: _____

PLEASE LIST ANY ALLERGIES: _____

LIST PREVIOUS SURGERIES (with dates): _____

LIST ANY PAST SERIOUS ACCIDENTS (with dates): _____

SOCIAL HISTORY

DO YOU: DRINK ALCOHOL: NO YES IF SO, HOW MUCH PER WEEK? _____ EXERCISE: NO YES IF YES,TYPE: _____

DO YOU: SMOKE: NO YES IF YES, HOW MUCH PER DAY: _____ WEAR SEATBELTS: NO YES

FOR WOMEN: ARE YOU ON BIRTH CONTROL: NO YES IF YES, WHAT TYPE: _____ # OF PAST PREGNANCIES: _____

ARE YOU CURRENTLY PREGNANT: NO YES IF YES, HOW FAR A LONG?_____ ARE YOU NURSING: NO YES

REVIEW OF SYSTEMS (Please put a "C" for current and a "P" for past problems).

___ Headaches
___Numbness / Tingling
___Ringing in Ears / Dizziness
___Loss of Balance
___Chest Pain
___Heart Attacks
___Swollen Ankles
___High/Low Blood Pressure
___Stroke
___Trouble Breathing
___Shortness of Breath
___Asthma
___Allergies/Sinus Pain
___Fatigue
___Night Sweats
___Fever
___Weight Loss
___Cancer
___Kidney/Bladder/Prostate Problems
___Painful Urination
___Liver/Pancreas Problems
___Diabetes
___Constipation/Diarrhea
___Heartburn/Reflux
___Alcoholism/Drug Use
___Ulcer
___Hernia
___Low Back Pain
___Pain Between Shoulders
___Stiff Neck
___TMJ Problems
___Shoulder /Hip Pain
___Depression
___Skin Allergies
___Change in Moles
___Other:_____

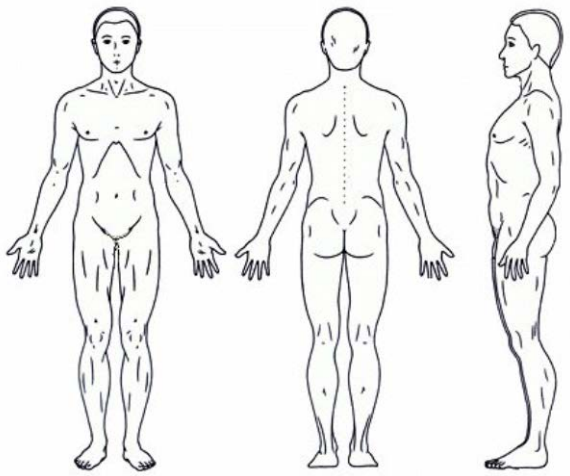
FAMILY HISTORY

FATHER: IS HE LIVING? ____YES _____ NO CAUSE OF DEATH: _____

MOTHER: IS SHE LIVING?_____YES _____NO CAUSE OF DEATH: _____

BROTHERS/SISTERS: HOW MANY?_____ SIGNIFICANT FAMILY HEALTH PROBLEMS: _____

PAIN DIAGRAM – PLEASE MARK AREA(S) OF INJURY OR DISCOMFORT BELOW:



CERTIFICATION, PRIVACY, ASSIGNMENT AND CONSENT TO TREAT

I, the undersigned certify that the above information is correct and I request services. I certify that I have been given, read and understand the following forms and policies: HIPPA Patient Privacy Notice, Patient Financial Responsibility and Informed Consent for Chiropractic Treatment. I have read them fully and have been offered the opportunity to have my questions answered prior to treatment. I understand I have certain rights to privacy regarding my protected health information and I understand how my information may be used at this facility. I assign my insurance benefits directly to Wisconsin Chiropractic Center, LLC and understand that I am financially responsible for all charges whether or not paid by insurance. I understand the risks to chiropractic care as they have been explained to me and authorize and consent to treatment.

_____ _____ _____

Patient or Responsible Party Signature Relationship to Patient Date

WISCONSIN CHIROPRACTIC CENTER, LLC

5050 West Rawson Avenue, Franklin, WI 53132
Phone: (414) 377-8584 Fax: (414) 377-8588
E-Mail: doctor@wichiropracticcenter.com
www.wichiropracticcenter.com

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

Wisconsin Chiropractic Center, LLC:

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

Sign only after you understand and agree to the above.

_____
Printed name of Patient

x_____ _____
Signature of Patient Date

x_____ _____
Signature of Representative Date
(if patient is a minor or is handicapped)

x_____ _____
Witness to Patient's Signature Date

WISCONSIN CHIROPRACTIC CENTER, LLC

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 effect 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.

_____	_____	_____
Name of Patient	Signature	Date

For further information regarding this notice, please contact our Doctor at (414) 377-8584.

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PATIENT FINANCIAL RESPONSIBILITY

This office will provide insurance billing services for you, if you so desire, as a courtesy. **Remember that you are ultimately responsible for any charges incurred in this office. It is your legal responsibility to pay any deductible amount, co-insurance, and or any other balances not paid by your insurance carrier. Your signature on this document indicates that you agree to pay for any outstanding charges incurred in this office.**

Patients who do not have health insurance:

Since we will not need to pay staff to bill and follow up with insurance companies, we pass the savings on to you. We offer EVERYONE our Time of Service rates when their accounts are paid in full on each visit. A written copy of our fee schedule is available upon request.

Patients with a deductible have two options:

1. You can pay our regular fee schedule and we will bill insurance for you. This notifies the insurance company that your deductible should be reduced by what you pay on each visit. If and when the deductible is met, your plan will most likely switch to a co-pay status.
2. You can pay our Time of Service fees, which are significantly less than our regular fees. However YOU will then be responsible for submitting all services you have paid for to your insurance for reimbursement. We will not be billing on your behalf.

We will strive to work out feasible payment options for anyone who is in need of care. Unless other prior written agreements have been made, any outstanding balance more than 60 days old is considered delinquent. A re-billing fee of 1% (based on the outstanding balance, per month) will also be added to all accounts that fit this criterion. Office policy dictates that delinquent accounts may be referred to a third party collection agency for collection, which may include possible blemishes on your credit record. If this happens, an administrative collection fee of $100 (minimum) may be added to your account to cover our costs and you specifically authorize us to run your credit report.

If your insurance denies payment for any reason, we will offer you our time of service discount (our lowest fee schedule) for any outstanding charges that are paid in full within 15 days of notice.

I authorize payment of insurance benefits directly to Wisconsin Chiropractic Center, LLC. I also authorize the doctor to release all information necessary to communicate with personal physicians, other healthcare providers, collection agencies, and payers to secure the payment of benefits or inform them of concurrent treatment. By signing below I indicate that I have read, understand, and agree with the terms on this page.

_____ _____

Signature of responsible party (Parent or Legal Guardian) Date