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	

The CHIROPRACTIC ADVANTAGE
Move well to live well

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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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Health Intake Form

Patient Name: ____

____
(Address) (City) (State) (Zip)

Email address: ________________________@____________________________ **Age:** ___ **DOB:** ___/___/_____

Home Phone: _____________________ **Cell:** _____________________ **Marital Status** (Circle)**:** M S W D **Preferred method of communication for patient reminders** (Circle)**:** Email / Phone / Text

Gender (Circle)**:** M F **Preferred Language** (circle)**:** English / Spanish / Other: _______________________

Smoking Status (Circle one)**:** Every Day / Occasionally / Never / Former Smoker

Race (Circle one)**:** American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one)**:** Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Occupation: ____________________________ **Employer:** ____

Employer Address (Worker's Comp. only)**:** ____
(Address) (City) (State) (Zip)

Spouse: _______________________ **Occupation:** _______________________ **Employer:** ____________________

Emergency Contact Name: ________________________ **Relationship:** ____________ **Phone:** _________________

Name of Family Medical Doctor and Clinic/Hospital: ____

When doctors work together, it benefits you. May we have your permission to update your medical doctor regarding your care at this office? (Circle one) Yes No

Who may we thank for referring you to our office? ____

Check all insurance coverage that may be applicable: □ Major Medical □ Medicare □ Medicaid □ Auto Accident □ Worker's Compensation □ Medical Savings Account & Flex Plans □ Other: _________________________

Primary Insurance Company: ________________________ **Secondary Insurance Company:** ___________________

History of Present and Past Illness

Purpose of this appointment (Wellness or List Symptoms): ____

Date symptoms appeared or accident occurred: ___/___/____ **Women: Are you pregnant?** □ Yes □ No □ Maybe

What caused your problem? (circle one)**:** Auto Work Other **Describe:** ___________________________________

Have you ever had the same or similar condition? □ Yes □ No **If yes, when and describe:** ___________________

____

Days lost from work: __________ **Date of last physical exam:** __/__/____

List all major illnesses, injuries, falls, auto accidents, surgeries or childbirths, including dates: __________________

____

Have you been treated for any health condition by a physician in the last year? □ Yes □No

If yes, describe: ____

Do you have a congenital condition? □ Yes □No **If yes, describe:** ____

List any allergies (food, medications, hay fever, etc.): ____

Medications, dosages and for what conditions (Include regularly used over the counter medications):____________

____

Do you take nutritional supplements? □ Yes □No **Which ones?** ____

If your health professional offered advanced high-quality supplements, would you consider them? □ Yes □No

If your health professional offered a weight management program, would you consider it? □ Yes □No

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Patient Name: ____________________________ **Date:** ___/___/______

****Indicate if you now have, or have had in the past, any of the following symptoms/conditions:**

Condition	Now	Past	Condition	Now	Past	Condition	Now	Past
Headaches			Excessive Bleeding			Sinus Problems		
Nervousness			Pacemaker			Diabetes		
Tension			Stroke			Indigestion/Heartburn		
Irritability			Ruptures			Joint Pain/Stiffness		
Chest Pains/Tightness			Eating Disorder			Menstrual Difficulties		
Dizziness			Gall Bladder Problems			Weight Loss/Gain		
Shoulder/Neck/Arm Pain			Liver Problems			Depression/Anxiety		
Numbness in Fingers			Pancreas Problems			Loss of Memory		
Numbness in Toes			Loss of Balance			Buzzing in Ears		
Osteoporosis			Osteoarthritis			Circulation Problems		
Difficulty Urinating			Fainting			Seizures/Epilepsy		
Weakness in Extremities			Loss of Smell			Low Blood Pressure		
Breathing Problems			Loss of Taste			High Blood Pressure		
Fatigue			Unusual Bowel Patterns			Heart Disease		
Lights Bother Eyes			Cold Feet/Hands			Cancer		
Ears Ring			Fever			Coughing Blood		
Broken Bones/Fractures			Muscle Spasms			Alcoholism		
Rheumatoid Arthritis			Frequent Colds			HIV Positive		

SOCIAL HISTORY (O=Often, S=Sometimes, N=Never)

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

FAMILY HISTORY (Circle your answers if your relative lives in this area)

Condition	FATHER (Age)___	MOTHER (Age)___	BROTHER(S) (Age)___________	SISTER(S) (Age)___________	SPOUSE (Age)___	CHILDREN (Age)___________
Arthritis						
Asthma/Allergies						
Back or Neck Trouble						
Bursitis						
Cancer						
Diabetes						
Headaches/Migraines						
Heart Trouble/High 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 choose to decline receipt of my clinical summary after every chiropractic visit** (*recommended*)

□ **I certify the information provided is accurate to the best of my knowledge:**

_________________________________ _____________________________________ **Date:** ___/___/_____

Patient Name Printed **Signature of Patient or Legal Guardian**