CHIROPRACTIC REGISTRATION AND HISTORY

PATIENT INFORMATION

PATIENT NAME:_____ DATE:_____
ADDRESS:_____
_____
PHONE: HOME: _____ CELL: _____ WORK: _____
GENDER: _____MALE _____FEMALE DOB:____/____/_____ AGE:_____ E-MAIL:_____
HEIGHT:_____ WEIGHT:_____
SINGLE:_____ MARRIED:_____ DIVORCED:_____ WIDOWED:_____ OTHER:_____
PATIENT SS #:_____
RACE:_____ ETHNICITY:_____ PREFERRED LANGUAGE:_____
SMOKING: NEVER SMOKED:_____FORMER SMOKER:_____ YEAR QUIT:_____ CURRENT SOME DAY SMOKER:_____
CURRENT EVERY DAY SMOKER: _____ FREQUENCY:_____
PLACE OF WORK:_____JOB TITLE:_____
ARE YOU CURRENTLY PREGNANT: _____ YES _____ NO DUE DATE:_____
EMERGENCY CONTACT: _____ RELATIONSHIP: _____
EMERGENCY CONTACT PHONE: _____

INSURANCE

WHO IS RESPONSIBLE FOR THIS ACCOUNT?_____
RELATIONSHIP TO PATIENT: _____ INSURANCE CO.: _____
PRIMARY INSURED'S NAME: _____ DOB: _____

ACCIDENT INFORMATION

IS CONDITION DUE TO AN ACCIDENT? _____YES _____NO DATE OF ACCIDENT: _____
TYPE OF ACCIDENT: _____AUTO _____WORK _____HOME _____OTHER
WHO HAVE YOU MADE A REPORT OF YOUR ACCIDENT? _____AUTO INSURANCE _____EMPLOYER _____ WORK COMP
_____OTHER CONTACT PERSON:_____ PHONE:_____

FAMILY HISTORY

PLEASE LIST IF YOU OR ANYONE IN YOUR IMMEDIATE FAMILY HAS HAD:
DIABETES: _____YES _____NO _____ MATERNAL _____ PATERNAL TYPE: _____
WHO: _____
STROKE: _____ YES _____ NO _____ MATERNAL _____PATERNAL WHO: _____
HEART ATTACK: _____ YES _____ NO _____ MATERNAL _____ PATERNAL WHO: _____
CANCER: _____ YES _____ NO _____ MATERNAL _____ PATERNAL TYPE: _____
WHO: _____

ALLERGIES AND MEDICATIONS

PLEASE LIST ANY MEDICATIONS THAT YOU ARE CURRENTLY TAKING: _____
PLEASE LIST ANY ALLERGIES THAT YOU HAVE: _____
_____

PLEASE CHECK IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:
AIDS/HIV _____ Alcoholism _____ Anorexia _____ Appendicitis _____ Arthritis _____ Bleeding Disorders _____ Cancer _____
Chemical Dependency _____ Chicken Pox _____ Diabetes _____ Epilepsy _____ Fractures _____ Gout _____ Heart Disease _____
Hepatitis _____ Hernia _____ Herniated Disk _____ High Blood Pressure _____ High Cholesterol _____ Kidney Disease _____
Migraine Headaches _____ Multiple Sclerosis _____ Osteoporosis _____ Pacemaker _____ Parkinson's Disease _____ Polio _____
Pinched Nerve _____ Prosthesis _____ Psychiatric Care _____ Rheumatoid Arthritis _____ Stroke _____ Suicide Attempt _____
Thyroid Problems _____ Tuberculosis _____ Tumors _____ Ulcers _____ Whooping Cough _____ Other _____

-OVER-

PATIENT CONDITION

CURRENT PROBLEM OR REASON FOR CHIROPRACTIC CARE:

_____

_____

WHEN DID YOUR SYMPTOMS FIRST BEGIN: _____ **IS IT :** _____BETTER _____WORSE _____SAME

WHAT IS THE SEVERITY OF YOUR PAIN: (0 = NO PAIN, 10 = WORST PAIN)_____

TYPE OF PAIN: _____SHARP _____DULL _____THROBBING _____NUMBNESS _____ACHING _____SHOOTING
_____BURNING _____TINGLING _____CRAMPING _____STIFFNESS _____SWELLING _____OTHER

HOW OFTEN DO YOU HAVE THIS PAIN? _____

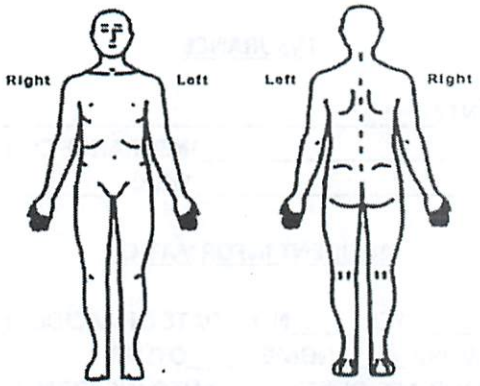
IS IT CONSTANT OR DOES IT COME AND GO? _____

WHAT TREATMENT HAVE YOU ALREADY RECEIVED FOR YOUR CONDITION: _____

NAME AND ADDRESS OF OTHER DOCTOR(S) WHO HAVE TREATED YOU FOR YOUR CONDITION: _____

_____

PLEASE "X" WHERE YOUR SYMPTOMS ARE:



PREVIOUS INJURIES/SURGERIES

FALLS:
DATE: _____ **DESCRIPTION:** _____

HEAD INJURIES:
DATE: _____ **DESCRIPTION:** _____

BROKEN BONES:
DATE: _____ **DESCRIPTION:** _____

DISLOCATIONS:
DATE: _____ **DESCRIPTION:** _____

SURGERIES:
DATE: _____ **DESCRIPTION:** _____

SIGNATURE: _____ DATE: _____

NOTES:

_____

_____

_____

_____

_____

_____

The revised Oswestry Disability Index (for back pain/dysfunction)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer ONE box in EVERY section that applies to you NOT the general population.

SECTION 1-PAIN INTENSITY
___ The pain comes and goes and is very mild.
___ The pain is mild and does not vary much.
___ The pain is comes and goes and is moderate.
___ The pain comes and goes and is very severe.
___ The pain is severe and does not vary much.

SECTION 2-PERSONAL CARE
___ I would not have to change my way of washing or dressing to avoid pain.
___ I do not normally change my way of washing or dressing even though it causes some pain.
___ Washing and dressing increases the pain, but I manage not to change my way of doing it.
___ Because of the pain, I am unable to do some washing and dressing without help.
___ Because of the pain, I am unable to do any washing and dressing without help.

SECTION 3-LIFTING
___ I can lift heavy weights without extra pain.
___ I can lift heavy weights, but it causes extra pain.
___ Pain prevents me from lifting heavy weights off the floor, but I manage if they are on a chair or table.
___ Pain prevents me from lifting heavy weights off the floor.
___ I can only lift very light weights at the most.

SECTION 4-WALKING
___ I have no pain walking.
___ I have some pain walking, but does not increase with distance.
___ I cannot walk more than one mile without increasing pain.
___ I cannot walk more than ½ mile without increasing pain.
___ I cannot walk more than ¼ mile without increasing pain.
___ I cannot walk at all without increasing pain.

SECTION 5-SITTING
___ I can sit in any chair as long as I like.
___ I can only sit in my favorite chair as long as I like.
___ Pain prevents me from sitting more than one hour.
___ Pain prevents me from sitting more than ½ hour.
___ Pain prevents me from sitting more than 10 min.
___ I avoid sitting because it increases pain right away.

SECTION 6-STANDING
___ I can stand as long as I want without pain.
___ I have some pain standing, but it does not increase with time.
___ I cannot stand for longer than one hour without increasing pain.
___ I cannot stand for longer than ½ hour without increasing pain.
___ I cannot stand for longer than 10 min. without increasing pain.
___ I avoid standing because it increases the pain right away.

SECTION 7-SLEEPING
___ I get no pain in bed.
___ I get pain in bed, but it does not prevent me from Sleeping well.
___ Because of pain, my normal night's sleep is reduced By less than ¼.
___ Because of pain, my normal night's sleep is reduced By less than ½.
___ Because of pain, my normal night's sleep is reduced By ¾.
___ Pain prevents me from sleeping at all.

SECTION 8-TRAVELING
___ I have no pain while traveling.
___ I have some pain while traveling, but usual travel Doesn't make it any worse.
___ I have extra pain while traveling, but it does not Prevent me to seek alternative methods of travel.
___ I have extra pain while traveling, which compels me To seek alternative forms of travel.
___ Pain restricts all forms of travel except that done Lying down.
___ Pain prevents all forms of traveling.

SECTION 9-SOCIAL LIFE
___ My social life is normal and gives me no pain.
___ My social life is normal, but increases the degree of Pain.
___ Pain has no significant effect on my social life apart From limiting my more energetic interests.
___ Pain has restricted my social life and I do not go out Very often.
___ Pain has restricted my social life to my home.

SECTION 10-CHANGING DEGREE OF PAIN
___ The pain is rapidly getting better.
___ The pain fluctuates, but is definitely getting better.
___ The pain seems to be getting better, but Improvement is slow at present.
___ The pain is neither getting better nor worse.
___ The pain is gradually worsening.
___ The pain is rapidly worsening.

SIGNATURE:_____ DATE:_____

General Pain Index Questionaire

We would like to know how much your pain presently prevents you from doing what you would normally do. Regarding each category, please indicate the overall impact your present pain has on your life, not just when the pain is at its worst.

Please circle the number which best describes how your typical level of pain affects these six categories of activities.

1. FAMILY/AT HOME RESPONSIBILITIES such as Yard work, chores around the house, driving the kids to school-

0 1 2 3 4 5 6 7 8 9 10
Completely able to function — Completely unable to function

2. RECREATION including hobbies, sports and/or other activities-

0 1 2 3 4 5 6 7 8 9 10
Completely able to function — Completely unable to function

3. SOCIAL ACTIVITIES including parties, theater, concerts, dining-out and attending social functions-

0 1 2 3 4 5 6 7 8 9 10
Completely able to function — Completely unable to function

4. EMPLOYMENT including volunteer work and homemaking tasks-

0 1 2 3 4 5 6 7 8 9 10
Completely able to function — Completely unable to function

5. SELF-CARE such as taking a shower/bath, driving or getting dressed

0 1 2 3 4 5 6 7 8 9 10
Completely able to function — Completely unable to function

6. LIFE-SUPPORT ACTIVITIES such as eating and sleeping

0 1 2 3 4 5 6 7 8 9 10
Completely able to function — Completely unable to function

SIGNATURE:_____ DATE:_____

GREEN BAY CHIROPRACTIC CLINIC
BILLING POLICIES

GROUP OR INDIVIDUAL INSURANCE: Your insurance is an agreement between **you** and **your insurance company**, not between your insurance company and this chiropractic office. It is your responsibility to **verify coverage** with **your insurance company** for services rendered at this office. Insurances and plans vary in their coverage and we do not have details of each individual insurance plan available.

As a courtesy to our patients, our office will complete any necessary primary and secondary insurance forms and file them with your insurance company to help with collection. It is understood and agreed that services rendered are charges to you directly, and you are personally responsible for any charges above and beyond what the insurance carrier pays.

We do accept assignment of your insurance, but it is **your responsibility** to pay any copays and/or deductibles at the time of service. Copays are due at the time of service. Any above and beyond payment is due within 30 days of service, and are subject to late payment fees.*

MEDICARE: We do accept assignment from Medicare. We will submit your claim and Medicare will pay 83% of the allowable charges. It is your responsibility for any remaining balances including deductible, therapy, and exam charges. Unpaid balances over 30 days are subject to late payment fees.*

MEDICAL ASSISTANCE: The patient is responsible for the following copays: $2.00 per adjustment, $2.00 per x-ray. Therapy including Interferential, Ultrasound, and Cold Laser are not covered by Medical Assistance. These therapies can be very helpful and can be included at a cost of $21 per therapy. Although you are ultimately responsible for your entire bill, our office will file your claims for you. If your coverage is terminated or lapsed, charges are your 100% responsibility. Unpaid balances over 30 days are subject to late payment fees.*

PERSONAL INJURY OR AUTOMOBILE ACCIDENT: Please present your auto insurance forms as soon as possible including claim number and adjustor information. If an attorney is handling your case, please notify us right away. **We do not accept third party payers**, meaning we will **not** wait for payment until your case is settled. We will therefore process your claim either with your auto insurance med-pay (full coverage) or with your personal health insurance.

WORKER'S COMPENSATION: Worker's compensation pays in full for chiropractic care. However, if your claim is denied as a worker's compensation case, you are responsible for services rendered. Unpaid balances over 30 days are subject to late payment fees if denied by Worker's Compensation. *

MISSED OR CANCELLED APPOINTMENTS: We understand that some cancellations are unavoidable, but they are very costly to our office. We reserve the right to charge $10.00 per visit to your account if not notified within 24 hours prior to your appointment.

COLLECTIONS: Accounts over 90 days failing to honor agreed payment will be sent to collections. Any unpaid balances must be paid in full before any more appointments will be made. Failure to comply will result in dismissal from our office.

AUTHORIZATION TO PAY

I have read the above billing policy and understand my responsibility of payment for professional services rendered in good faith. I authorize my insurance company, relevant to this claim, to pay directly Green Bay Chiropractic Clinic. I also authorize the release of any information pertinent to my case to any insurance company, adjustor, or attorney involved in this case.

"A 1% per month (12% per year) late payment fee will be assessed on any unpaid balance remaining after 30 days." (Section 138.05(3). Wis. Stats.)

SIGNATURE: _____ **DATE:**_____

GREEN BAY CHIROPRACTIC CLINIC
CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

OUR PRIVACY PLEDGE: We are very concerned with protecting you privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health care information. • We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition. • We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services. • We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

YOUR RIGHT TO LIMIT USES OR DISCLOSURES: You have the right to request that we do not disclose your health information to specific individuals, companies or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

YOUR RIGHT TO REVOKE YOUR AUTHORIZATION: You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

APPOINTMENT REMINDERS AUTHORIZATION: Your chiropractor and members of the practice staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care. You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives or other health related information at any time (164.524).

I have read your consent policy and agree to its terms. I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this notice.

SIGNATURE:_____ DATE:_____

INFORMED CONSENT TO TREAT

Patient Name: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy; I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following possible procedures:

Spinal manipulative therapy	Palpation	Basic neurological testing
Range of motion testing	Orthopedic testing	Cold Laser
Muscle strength testing	Postural analysis	Disc decompression
Ultrasound	Hot/cold therapy	Vital signs
Radiographic studies		

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatments" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Maureen O'Connor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated:_____ **Dated:**_____

_____ _____

Patient's name **Doctor's Name**

_____ _____

Signature **Signature**

_____

Signature of Parent or Guardian (if a minor)