GREEN BAY CHIROPRACTIC CLINIC
MAUREEN O'CONNOR, D.C.
515 S. MILITARY AVE
GREEN BAY, WI 54303

## 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:_____
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: _____

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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 the past 2 weeks, how often have you Been bothered by any of the following problems? | Not At All | Several Days | More than Half the days | Nearly Every Day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed or hopeless | 0 | 1 | 2 | 3 |

**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?** _____

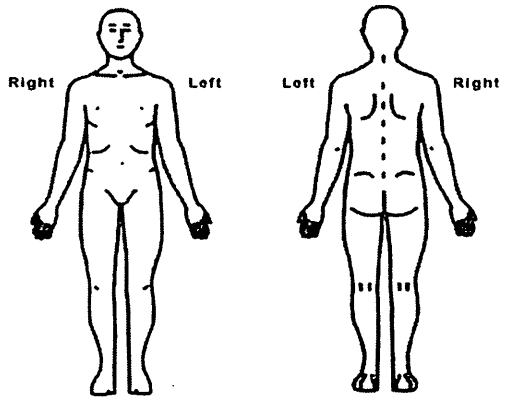
**IS IT CONSTANT OR DOES IT COME AND GO?** _____

**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:**_____
**Patient's Name:** _____
**Signature of Parent or Guardian (If a minor):** _____

**NOTES:**

_____

_____

_____

_____

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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 check **ONLY ONE** line per each section that applies to you, NOT the general population.
**This information will be collected once every 30 days to assess your treatment plan.**

**SECTION 1- PAIN INTENSITY**
_____ The pain comes and goes and is very mild.
_____ The pain is mild and does not vary much.
_____ The pain comes and goes and is moderate.
_____ The pain is moderate and does not vary much.
_____ 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.
_____ Washing and dressing increases the pain and I find it necessary 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 dressing without help.

**SECTION 3- LIFTING**
_____ I can lift heavy items without extra pain.
_____ I can lift heavy items, but it causes extra pain.
_____ Pain prevents me from lifting heavy items off the floor, but I manage if they are on a chair or table.
_____ Pain prevents me from lifting heavy items off the floor.
_____ Pain prevents me from lifting heavy items, but I can manage light to medium items if they are conveniently positioned.
_____ I can only lift very light items 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 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 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 compel 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 when absolutely necessary.
_____ 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 m social life to my home.
_____ I have hardly have any social life BECAUSE of the pain.

**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:** _____
**Printed Name:** _____
**Signature of Parent or Guardian (If a minor):** _____

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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 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 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, getting dressed, driving

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:** _____

**Printed Name:** _____

**Signature of Parent or Guardian (If a minor):** _____

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## 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 greatly 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, such as, but not limited to:

Deductibles
Co-insurance
Copays (Collected at time of service)
Non-covered services

We do accept assignment of your in-network insurance, but it is **your responsibility** to pay any copays and/or deductibles 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 and MEDICARE REPLACEMENT POLICIES:** We do accept assignment from Medicare and most replacement policies. We will submit your claim and Medicare will pay 83% of the allowable charges, only your adjustment. Unfortunately, most Medicare services in chiropractic offices are NON-COVERED services, including an exam on the first visit that is required in order to assess treatment. Hopefully, in the future, U.S. Congress will make changes to include Chiropractic services like all other doctors, until then, it is your responsibility for any remaining balances at the time of service including, but not limited to:

Exam
Deductible
Co-Insurance (after deductible is met for Medicare policies)
Co-Pay (for Medicare Replacement policies)
Therapies
Roller
X-Rays

Unpaid balances over 30 days are subject to late payment fees.*

**MEDICAL ASSISTANCE:** The patient is responsible for the current copay prices associated with the following services:

Adjustment
Exam
X-rays

Unfortunately, the following services are considered NON-COVERED services by Medical Assistance. However, it has been found time and again for non-covered therapies to be very beneficial in your treatment and shortening the duration. Please see front desk for current charges of non-covered services. These include:

Roller
Therapies- including Interferential, Ultrasound, and Cold Laser

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 100% your responsibility. Unpaid balances over 30 days are subject to late payment fees.*

**CASH PATIENTS:** Cash prices are due at the time of service. We are required to perform an exam on the first visit to assess a treatment plan for you. Please see front desk for current prices for service offered including:

Adjustment
Exam
X-rays
Therapy
Roller

**PERSONAL INJURY OR AUTOMOBILE ACCIDENT**: Please present your auto insurance forms as soon as possible including claim number and adjustor contact 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 or bill a "responsible party". We will therefore process your claim either with your auto insurance med-pay (full coverage) or with your personal health insurance.
If you do not carry med-pay or personal health insurance, our current cash prices will be due at the time services are rendered.

**WORKER'S COMPENSATION:** Many Worker's Compensation plans will pay for chiropractic care. However, if your claim is denied, you are personally responsible for services rendered that were performed in good faith. 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:** We will make every attempt to bill you, however, accounts over 90 days failing to honor agreed payment plan 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

Services at our office have been performed in good faith to help treat your injury. We greatly appreciate your help in keeping the cost of services down by paying any outstanding bills in a timely manner.

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:**_____
**Patient's Name:** _____
**Signature of Parent or Guardian (If a minor):**_____

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# INFORMED CONSENT TO TREAT

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 used as a Doctor of Chiropractic is spinal manipulative therapy; that procedure will be used to treat you. With manipulative therapy, hands or a mechanical instrument will be used 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 / Therapies

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

| | | |
|---|---|---|
| Spinal manipulative therapy | Palpation | Basic neurological testing |
| Range of motion testing | Orthopedic testing | Muscle strength testing |
| Postural analysis | Vital Signs | Radiographic Studies (X-Ray) |
| Cold Laser | Ultrasound | Interferrential Therapy |
| Disc Decompression | Hot/Cold Therapy | |

## The Material Risks Inherent in Chiropractic Adjustment and Therapies

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, 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 day of treatment. Every reasonable effort during the examination will be made to screen for contraindications to care; however, if you have an underlying condition, it is your responsibility to inform the doctor. For any therapies performed, such as, Interferrential Therapy, Ultrasound and Cold Laser, there may be contraindications which could cause exacerbation or harm, especially with certain symptoms or illnesses, such as but not limited to:

| | | |
|---|---|---|
| **Pacemaker** | **Open Wounds** | **Active Cancer** |
| **Heart conditions** | **Pregnancy** | **Balance issues** |
| **Current cold/ Flu** | **Certain Medications** | **Other illnesses or Symptoms** |
| **Any implants or devices** | | |

Some of these do not mean you cannot have the treatment, but please **ALERT** your doctor and they will assess the risks of the therapy vs. the rewards of the treatment.

**The Probability of Those Risks Occurring**

Fractures are rare occurrences and generally result from some underlying weakness of the bone which is checked during the history, examination and possibly with 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 Associated to Remaining Untreated**

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility and increasing pain. 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 and therapies. If I have any questions, I have discussed my concerns and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatments and procedures, and have decided that it is in my best interest to undergo the treatment(s) recommended. I hold harmless Green Bay Chiropractic Clinic, it's doctors, and any of its therapy attendees and realize that they are not held responsible if injury or harm may arise from any treatment and/or therapies. Having been informed of the risks, I hereby give my consent to the treatment(s) and/or therapies that may be performed during my course of treatment.

**Signature:**_____ **Date:**_____
**Patient's Name:** _____
**Signature of Parent or Guardian (If a minor):** _____

**X-rays**:
Females: Please initial that you are **NOT** pregnant. _____

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## CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

**OUR PRIVACY PLEDGE:** We are very concerned with protecting your 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 payments of your services. We may need to use your health information within our practice for quality control or other operation 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 are in for treatment. 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 received your request to revoke 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, billing, 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 or voicemail. 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.

**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:** _____

**Patient's Name:** _____

**Signature of Parent or Guardian (If a minor):** _____