WEST END
CHIROPRACTIC & WELLNESS

1660 Hwy 100 South Suite 146
St. Louis Park, MN 55416
(952)-500-8477

Patient Information

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (Home/Cell/Work): _____ Email: _____

Sex: ☐ M ☐ F Date of Birth (xx/xx/xxxx): _____ Marital Status: ☐ S ☐ M ☐ D

Reason for Visit (Goals):

_____

Referral Information

How did you hear about us? _____

Current Health Information

Weight: _____ Height: _____ Body Fat %: _____

Current Dietary and training Regimen:

_____

What kind of diet/workout program has worked best for you in the past: _____

_____

Average Daily Diet

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Health Conditions

Has the patient been diagnosed with or treated for any of the following diseases in the past (Circle if yes)

Heart Disease	Yes	Cancer	Yes
High Blood Pressure	Yes	Diabetes	Yes
High Cholesterol	Yes	Asthma	Yes
Kidney Disease	Yes	Liver Disease	Yes
Bleeding Disorder	Yes	Autoimmune Disorder	Yes
Headaches/Back Pain	Yes		

Other: _____

Any current or past injuries? Explain: _____

Food Allergies: _____

Current Medications or Supplements: _____

Lifestyle

Does the patient currently:	(Circle if Yes)	How much?	How often?
Exercise regularly	Yes	_____	_____
Drink alcohol	Yes	_____	_____
Use recreational drugs	Yes	_____	_____
Smoke/Chew tobacco	Yes	_____	_____
Experience secondhand smoke	Yes	_____	_____
Drink caffeine	Yes	_____	_____
Travel regularly outside the US	Yes	_____	_____

Please list a few of the patient's daily activities and favorite hobbies: _____

_____

Please list a few of the patient's favorite health foods: _____

_____

Are you aware of what eating clean is and what it means? _____

What do you need most in a nutrition and wellness consultant? _____

_____

Why are you ready for change NOW? _____

SUMMARY OF NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT AND CONSENT
FOR PHI RELEASE

Privacy Policy:

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA) and specifically its Privacy Rule, I have certain rights to privacy regarding my Protected Health Information (PHI). I understand that my PHI can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers that may be involved in my treatment directly or indirectly.
- Obtain payment or reimbursement from health coverage programs or others.
- Conduct normal healthcare business operations including routine aspects of operating a health related practice or business.

Acknowledgement and Consent:

I have received, read and understand the Notice of Privacy Practices containing a more complete description of the creation, uses and disclosures of my PHI. I understand that West End Chiropractic has the right to change its Notice of Privacy Practices from time to time and that I may contact the Privacy Officer for West End Chiropractic at or through the address listed below to obtain a current copy of the Notice of Privacy Practices.

I also understand that I may request in writing that you restrict how my PHI is used or disclosed to carry out treatment, payment or healthcare operations. However, I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I further agree that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Privacy Officer Contact Information:

The privacy officer for West End Chiropractic may be contacted by mail by writing: Attn: 1660 Hwy 100 S, Ste 146 St. Louis Park, MN 55416.

Office Use Only:

The following is practice documentation of our good faith effort to obtain acknowledgement of the above. Patient's acknowledgement of this notice could not be obtained due to the following situation:

- ☐ Patient Refused to Sign.
- ☐ Communication Barrier Prohibited Obtaining Acknowledgement.
- ☐ Emergency Circumstances
- ☐ Other: _____

Signature of Practice: _____ Date: _____

WEST END
CHIROPRACTIC & WELLNESS

OFFICE POLICY

The following is a summary of our clinic policies. We believe that a clear definition will allow us both to concentrate on the most important issue; regaining and maintaining your health. We are happy to answer any questions you have regarding your account.

Payment Policy:

- **Auto Accident and Workers Compensation:** If the incident is properly documented and the necessary forms and liens are signed, you are not required to pay for services on the day they are rendered and we will make efforts to file your services with your insurance provider for you. You are still responsible for all charges on your account. Any balance billed from our office deemed 'patient responsibility' exceeding 90 days past due will be assessed a 10.00% interest charge.

- **For patients with insurance:** West End Chiropractic will file your insurance claim for you, and will attempt to verify coverage of services to be performed. We will review this information with you and explain what services (if any) are not covered that you will be responsible for. You are responsible for the balance on your account for any professional services rendered if your insurance denies coverage. Any balance billed from our office deemed 'Patient Responsibility' exceeding 90 days past due will be assessed a 10.00% interest charge. Payment plans are available, but you must contact our office to setup these plans. Additional Notes about insurance coverage:

    - Copays are due at the time of service.
    - You may be responsible for a Deductible Amount. This amount is deemed 'patient responsibility'. Our office will bill you for this amount following our offices receipt of an 'Explanation Of Benefits' (aka EOB) from your insurance company.
    - You may be responsible for a Coinsurance Amount. (aka % Responsibility) Our office will bill you for this amount following our offices receipt of an Explanation Of Benefits (aka EOB) from your insurance company.
    - You may choose to make payments in advance of receiving a bill for any amount considered patient responsibility.

- **For patients without insurance:** You have the option of paying in full on the date of service, paying in advance for your services or receiving a bill from our office. Discounts apply for payment in advance and payment made on the same day. You are responsible for the balance on your account for any services rendered. Any balance billed from our office deemed 'Patient Responsibility' exceeding 90 days past due will be assessed a 10.00% interest charge.

Appointment Cancelation:

In order for us to better serve our growing number of patients, we ask that you please call if you will be late or unable to keep your scheduled appointment.

Massage Policies:

- **Cancelation Policy**: If you cannot make your appointment we ask that you please contact our office 24 hours in advance to cancel. If your appointment is not cancelled 24 hours in advance it will be considered a 'No Show' and you will be subject to our 'No Show Policy.'
- **No Show Policy**: If you fail to cancel your appointment according to the cancelation policy you are considered a 'No Show' and will be unable to schedule your next appointment without providing payment in advance. If you fail to redeem this appointment time or fail to cancel according to the 'Cancelation Policy' you will surrender your payment for this appointment.
- **Refusal of Service Policy**: We reserve the right to refuse to provide services to any person at any time. Should you be denied service you will be reimbursed for any unused services that have been paid in advance.

By signing below I acknowledge having received and read the above 'Office Policy.' I hereby agree to the terms and conditions outlined above.

Patient Name (Please Print): _____

Patient Signature: _____ **Date:** _____