WEST END
CHIROPRACTIC & WELLNESS

NEW PATIENT ENTRANCE APPLICATION

Welcome! We are honored you chose us to evaluate your condition. So we may file your insurance forms for you, would you please fill out the personal information below? If you need assistance please inform the front desk person. Thank you!

Personal Information:

Patient Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: M or F Marital Status: S M D

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Social Security #: _____ E-mail: _____

Employer Name: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Guardian / Spouse / Family Information:

Name: _____ Relationship: _____

Employer Name: _____ Occupation: _____ Phone #: _____

Children:

Name: _____ Age: _____ Sex: M or F Name: _____ Age: _____ Sex: M or F

Name: _____ Age: _____ Sex: M or F Name: _____ Age: _____ Sex: M or F

Name: _____ Age: _____ Sex: M or F Name: _____ Age: _____ Sex: M or F

Referral Information:

- How did you find out about us _____
- Primary Care Physician (Name & Location) _____

Patient Informed Consent:

I, _____<print name>_____, the undersigned patient, consent to the treatment(s) provided by this clinic. I understand that my condition may necessitate modifications from time to time of the type of treatment(s) rendered and the portions of my body that may need to be examined. I understand and consent to clinic staff providing me with verbal descriptions, when there are changes to my exam(s) and treatment(s), consent to the clinic staff providing said treatment(s) and exam(s) and hereby consent to any similar subsequent treatment(s) or exam(s). If I do not consent, I will immediately inform clinic staff. There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or insurance. I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff.

Patient Signature: _____ **Date:** _____

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CHIROPRACTIC PATIENT HISTORY

So that we may better understand your unique condition, please complete the following information with regard to your current complaint.

Location:

What is the Purpose of Your Visit? _____

What Is Your Primary Complaint? _____

What Caused The Onset? _____ When Did It Start? _____

Does the Complaint Radiate or Travel? If so, Where? _____

Timing and Duration:

✓ Since the onset of your complaint how has it been changing? ☐ Getting Better ☐ Not Changing ☐ Getting Worse

✓ How often do you experience this complaint? ☐ Constantly (100%) ☐ Frequently (75%) ☐ Occasionally (50%) ☐ Intermittently (25%)

✓ Does your complaint worsen? If so, When? ☐ Morning ☐ Midday ☐ Night ☐ Sleep ☐ Work ☐ Other: _____

✓ How much has the complaint interfered with your normal work? (including both work outside the home, and housework)

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

✓ How much would you say this complaint has affected your social activities?

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

Severity:

Use the key below to rate the severity of your pain.

0 = No Pain 1 = Minimal 2 = Very Mild 3 = Mild 4 = Mild to Moderate 5 = Moderate 6 = Moderate to Severe
7 = Mildly Severe 8 = Severe 9 = Very Severe 10 = Excruciating

Please circle where you rate your pain: 1 2 3 4 5 6 7 8 9 10

Quality:

✓ How would you describe the sensation of your complaint?

☐ Sharp pain ☐ Shooting ☐ Numbness ☐ Tingling

☐ Dull Ache ☐ Burning ☐ Throbbing ☐ Other: _____

Modifying Factors:

✓ What makes your complaint feel worse? (list)

_____

Alleviating Factors:

✓ What makes your complaint feel better? (list)

_____

Previous Treatment:

Who have you seen for this condition? ☐ Medical Doctor ☐ Physical Therapist ☐ Chiropractor ☐ Other: _____

Have you had Chiropractic care in the past? ☐ Yes ☐ No If so, When? ___/___/___

Risk Factors:

Do you have a pace maker? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No ☐ Maybe

Do you have any metal implants or devices? ☐ Yes ☐ No

History was obtained from: ☐ Patient ☐ Parent ☐ Guardian ☐ Child ☐ Other: _____

Patient / Guardian Signature: _____ Date: _____

Dr: _____

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Past and General History

To help us better understand your unique condition please complete the information below related to your past and general history.

Past History: (please list any other past health issues or conditions)

Musculosketal Issues_____

Neurological Issues_____

Head, Eyes, Nose Throat Issues_____

Cardiovascular issues_____

Respiratory Issues_____

Bladder or Bowel Issues_____

Skin Issues_____

Autoimmune Conditions_____

Medication History: (please list any medications you are currently taking)

_____

_____

What Other Supplements or Vitamins Are You Taking?

_____

_____

Injury and Surgical History:

What, If Any, Major Injuries Have You Had? When?

_____

_____

Have You Been Hospitalized or had Surgery? If so, when and why?

Patient / Guardian Signature: _____ Date: _____

Dr: _____

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Family and Social History

In an effort to provide you with the best care possible, please take a moment to answer the following questions related to your family history, social history and daily activities.

Family History Information:

Please list any conditions or health issues anyone in your family currently has, or has had in the past below:

_____

_____

_____

_____

Social History:

Please describe your social history below:

Do you use alcohol, caffeine, illicit drugs or tobacco products? _____

Do you exercise, how often? _____

Do you sleep well, how many hours a night? _____

Describe your diet? _____

Describe your job? _____

Daily Activities:

So that we may have an idea as to your daily routine please list a few of your daily activities and your favorite hobbies:

_____

_____

Does Your Current Condition Affect Your Performance in These Activities Or Hobbies?

☐ Yes ☐ No If So How _____

Are there any specific services you are interested in?

Chiropractic ☐	**Acupuncture** ☐	**Exercise Rehab** ☐
Massage ☐	**Cupping** ☐	**Weight Loss/Nutrition** ☐

Patient / Guardian Signature: _____ Date: _____

Dr: _____

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:_____

Patient Name (Please Print):_____

Patient / Guardian Signature:_____ **Date:**_____

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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.

Card Payment Authorization:

I, the undersigned patient, hereby authorize West End Chiropractic and Wellness to initiate debit/credit card charges to my account with the financial institution by me on this form for payment of service(s) and product(s) rendered to me in the amount due.

I understand that the authorization is to remain in effect indefinitely and may be withdrawn by me at any time by request.

I understand that at the end of each month, my balance due will be charged to the debit/credit card listed in my account once all insurance payments have been processed, with the exception of an alternative payment plan.

Last four # of default card: _____ Expiration Date: _____ Visa® MasterCard® Discover® AmericanExpress®

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 / Guardian Signature: _____ **Date:** _____