BACK IN ACTION
CHIROPRACTIC CENTER, LLC
500 Main Ave, Suite A, De Pere, WI 54115
920-336-9355

Please fill out this form as completely and accurately as possible.

PERSONAL DATA

Today's Date: _____
Name_____ Age _____ Date of Birth _____
Parents' name (if you are under 18) _____
Home Address_____ City _____ State_____ Zip _____
Home Phone (_____) _____ Business Phone (_____) _____
Cell Phone (_____) _____ E-Mail Address_____
Social Security Number: _____ Emergency Contact:_____ Phone #:_____
Preferred Method of Contact: Home phone Cell Phone Work Phone Email Text message Do Not Contact
Please Indicate your Race: American Indian or Alaska Native Asian Caucasian African American
Native Hawaiian or other Pacific Island Other: _____ Choose Not to Specify
Please Indicate your Ethnicity: Hispanic or Latino Not Hispanic or Latino Choose Not to Specify
Occupation_____ Employer _____
Marital Status ❑ S ❑ M ❑ D ❑ W Spouse/Partner's Name:_____
Names and ages of children _____
Whom may we thank for referring you to our office? _____

Is this due to: auto accident work injury personal injury
Do you have Insurance? Y N Company _____ ID # _____
Group # _____ Primary Holder _____ DOB _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare my necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account, however, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if Back in Action Chiropractic Center extends credit to me and I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable unless prior arrangements are made. I hereby authorize Back IN Action Chiropractic Center, LLC, and whomever he may designate as his assistants, to administer treatment as he deems necessary and I also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above is true and correct.

Patient's (Parent or Guardian's) Signature _____ Date _____

For Women:

Are You Pregnant? Y N Date of Last Menstrual Period _____

Patient Signature: _____

Personal Medical History (Circle any relevant to your medical history)

Cancer	Muscular Dystrophy	Rheumatic Fever	Digestive disorders	Tuberculosis
Polio	Multiple Sclerosis	Scarlet Fever	Sinus Trouble	Concussion
Diabetes	Nervousness	Numbness	Heart Trouble	Hepatitis
Asthma	Venereal Disease	High Cholesterol	High Blood Pressure	HIV
Convulsions	Backaches	Dizziness	Hepatitis C	

REASON FOR SEEKING CHIROPRACTIC CARE

Your Present Complaint _____

Briefly Describe Your Symptoms _____

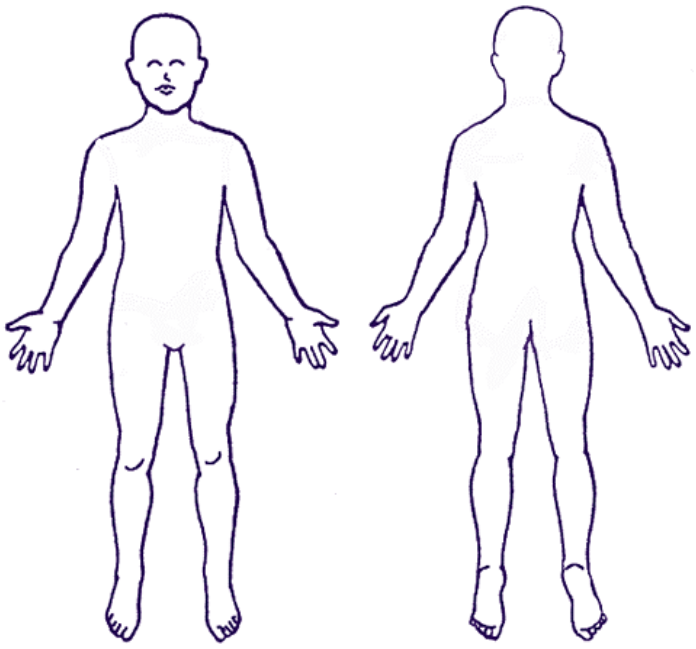
Are these concerns affecting your quality of life? (Please circle only those applicable to you)

Work Y N	Driving Y N	Sleep Y N
School Y N	Walking Y N	Sitting Y N
Exercise/sports Y N	Eating Y N	Other Y N

PAIN DRAWING

Using the letters below, mark the areas on your body where you feel the described sensation. Include all affected areas.

A=Ache
B=Burning
N=Numbness
P=Pins & Needles
S=Stabbing
SH=Sharp
T=Throbbing
ST=Stiffness
D=Dull



Patient Signature _____

CHIROPRACTIC CLINICAL OBJECTIVE

Physical, emotional and chemical STRESSES, common to our contemporary lifestyles, can result in misalignment of the spinal column causing damage to the nerve system. The result is a condition called Vertebral Subluxation. The Chiropractic exam/evaluation is specifically designed to detect Vertebral Subluxations in all phases of their progression.

Many common symptoms and conditions are caused by the interference and stress on the nerve system. Please place a (X) on conditions that you are currently suffering from and a (O) on any conditions you have had in the past.

__Arthritis
__Back Curvature
__Mental / Emotional Disorders
__Diabetes
__Swollen or Painful Joints
__Convulsions / Epilepsy
__Skin Problems
__Bruise easily
__Cancer
__Allergies
__Frequent Colds
__Upper Back Pain / Stiffness
__Excessive Gas
__Constipation / Diarrhea
__Prostate Problems
__Impotence
__Kidney Problems
__Frequent Urination
__Menstrual Problems / PMS
__Menopausal problems

__Headache
__Migraine Headache
__Neck Pain R/L
__Shoulder Pain R/L
__Numbness or Tingling in arms, or hands R/L
__Carpal Tunnel Syndrome R/L
__Dizziness
__Ringing in Ears
__Hearing Loss
__Loss of Balance
__Digestive Problems
__Depression
__Attention Disorder
__Anxiety Disorder
__Eating Disorder
__Trouble concentrating
__Loss of memory
__Ear Infection
__Learning Disability

__Asthma
__Chest Pain
__Difficult Breathing
__Heart Problems
__Heart Attack
__Stroke

__High / Low Blood Pressure
__Varicose Veins
__Liver Trouble
__Gall Bladder Trouble
__Mid Back Pain / Stiffness
__Pain with cough, or strain
__Hip Pain
__Low Back Pain / Stiffness
__Sciatica
__Numbness or Tingling in legs or feet R/L
__Muscle Tightness
__Trouble sleeping

HEALTH, WELLNESS, AND CHIROPRACTIC CARE

The primary system in the body, which coordinates health, is the CENTRAL NERVE SYSTEM. The vertebrae, the bones of the spinal column, surround and protect the delicate NERVE SYSTEM. Chiropractors are specialists trained in "early detection" of injury to the SPINE AND NERVE SYSTEM.

The information below will help us to see the types of PHYSICAL, EMOTIONAL and CHEMICAL stressors you have been subjected to and ***how they may relate to your present spinal, nerve and health status.***

CURRENT PHYSICAL STRESS

Please describe your usual work position and how long you maintain it during the day. For example, do you work at a computer, talk on the phone or stand at a machine for most of the day?

_____

Does your job require regular airline travel and hotel stays? ❑Y ❑N If yes, how often? _____
How long is your daily commute? _____ How many hours do you typically work in a week? _____
How many hours per week do you watch T.V.? ____ Are you sitting or lying on a couch? _____
Please describe your exercise/sports program including type and frequency:

_____

_____

How many hours of sleep do you typically get each night? _____ Do you sleep well? ❑Y ❑N
Do you ever sleep on your stomach? ❑Y ❑N How old is your mattress? _____
Do you wear orthotics (foot supports) or a heel lift? ❑Y ❑N If yes, for how many years? _____
Do you use a cervical pillow? ❑Y ❑N

PAST PHYSICAL TRAUMAS

Did you have any **significant childhood injuries**? (Fractures, stitches, falls, sports-related, etc.) Please list dates, injury and treatment: _____

_____

Have you had any **significant adult injuries**? (Fractures, falls, stitches, sports-related, etc.) Please list dates, injury and treatment: _____

_____

_____

Have you had any **automobile accidents or work-related injuries**?
Date:_____ driver/front passenger/rear passenger Seatbelt? Y N Airbag discharged? Y N
Injuries: _____ Care received: _____
Date:_____ driver/front passenger/rear passenger Seatbelt? Y N Airbag discharged? Y N
Injuries: _____ Care received: _____

Describe any **surgeries** you've had & dates _____

Have You Been Treated By a Physician for any Health Conditions in the Last Year? Y N

Describe Condition _____ Date of last physical exam _____

EMOTIONAL STRESS

Please indicate if you have experienced any of the emotional stresses below:

Childhood trauma	❑Y ❑N	Loss of loved one	❑Y ❑N	Abuse	❑Y ❑N
Work or school	❑Y ❑N	Divorce/separation	❑Y ❑N	Financial	❑Y ❑N
Lifestyle change	❑Y ❑N	Parents' divorce	❑Y ❑N	Illness	❑Y ❑N

CHEMICAL STRESS

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g., food allergies, drug reactions, exposure to chemicals in the air, etc.)
The following will reveal exposures you may have had.
Please Indicate your **Smoking Status**: Non-smoker Former Smoker Smoker, how many per day?___
Were you **vaccinated?** ❑Y ❑N If yes, did you have a **reaction**? ❑Y ❑N
Have you been **exposed to** any of the following on a regular basis, past or present?
❑ Toxic chemicals ❑Radiation ❑Second hand smoke ❑Chemotherapy ❑Drug therapy ❑other
If yes, please explain:_____
Do you have any **food or medication allergies**? ❑Y ❑N **If yes, please list:**
_____
How many **fast food meals** do you eat per week? _____
How many **alcoholic beverages** do you drink per week? _____
How many glasses of **water** do you drink per day? _____
How many **caffeinated beverages** (coffee, tea, soda) do you drink per day? _____
Are you currently on **prescription** or **over-the counter medication?** ❑N ❑Y **Please list, indicating dose & frequency**_____
_____
Please list any **nutritional supplements** you are taking: _____
_____
How do you rate your **physical health**? ❑Excellent ❑Good ❑Fair ❑Poor

QUALITY OF LIFE

How do you rate your **emotional/mental health**? ❑Excellent ❑Good ❑Fair ❑Poor
How do you rate your overall **"quality of life"**? ❑Excellent ❑Good ❑Fair ❑Poor

EXPECTATIONS

I would like to have the following benefits from ***Chiropractic Care***: (Check all that apply)
_ Relief of a symptom or problem
_ Relief and prevention of a symptom or problem
_ Healthier spine and nerve system
_ Optimal health on all levels
What are your top three health goals?
1. _____
2. _____
3. _____
I hereby certify that the information provided is true and accurate.
Patient Signature: _____ _____ Date: _____

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 a copy of our privacy notice, please understand that we have, and always will, respect the privacy of your health and personal 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 our 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.

Along with this consent form, you will be given a copy of our privacy notice that describes our privacy policies in detail. You have the right to review that notice before you sign this consent form. 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.

Your right to limit uses or disclosures

You may revoke any of your authorizations 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 your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this consent and a copy of your privacy notice (Notice of Privacy Practices for Protected Health Information).

_____ _____

Printed Name Date Authorized Provider Representative

_____ _____

Signature Date

Appointment reminders and health care information authorization

Your chiropractor and members of the practice staff may need to use your name, address, phone, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may interest 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.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at your office address. 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. In addition, 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 your claims.

Information that we use or disclose based on the authorization you are giving to 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 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).

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.

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 the authorization.

_____ _____

Patient name printed Date

_____ _____

Patient signature Authorized provider representitive

Informed Consent For Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. It is important that each patient understand both the objective and the method that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. **Health** is the state of optimal physical, mental and social well- being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called vertebral **subluxation.** This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic. Due to possible subluxation and/ or under the doctor's recommendations, **x-rays** may be necessary to assist with patient care.

Subluxations are corrected and/or reduced by an **adjustment.** An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non- chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks, and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____ _____

Print Name Signature Date

Consent to evaluate and adjust a minor child:

I,_____ being the parent or legal guardian of _____ have read and fully understand the above informed consent and hereby grant permission for my child to receive chiropractic care.

_____ _____

Signature Date

Important Insurance Information

Today most insurance policies do cover chiropractic care. We will be happy to file your primary insurance claim for you and do everything we can to assure you receive proper reimbursements; however, we cannot take responsibility for what your health insurance will or will not cover.

It is important that you understand that health and accident insurance policies are an arrangement between an insurance carrier and you, the patient, their insured. Of course, Back In Action Chiropractic Center will prepare any necessary reports and forms to assist you in making collection from your insurance company. Furthermore, any amount authorized to be paid directly to Back In Action Chiropractic Center will be credited to your account on receipt.

However, you must clearly understand and agree that all services rendered to you are charged directly to you and that you are personally responsible for payment. In order to facilitate the correct and rapid processing of your insurance claim we suggest you do the following:

1. Call your insurance company or agent to determine exactly what coverage you have. Ask what deductible, if any, applies to your policy. Then ask how much of your claim your insurance company will pay.
2. If this is an auto accident or work related injury please obtain insurance claim forms, if needed, from your agent/insurance company or work, fill in the required information and bring them to our office. Be sure to write down all information concerning any injury (auto, work related, slipping, etc.)
3. When you bring your insurance forms to our office, please ask one of our staff to double check them. This will help avoid unnecessary errors and give you a chance to ask any questions that you may have regarding your claims.
4. If your policy has a deductible feature, then we suggest you pay this amount at the outset of your care. We also require that you keep your account current on at least a monthly basis. Any reimbursement from payments received from your insurance company will promptly be credited to your account.
5. Some of today's insurance policies don't provide the type of coverage that you may desire and larger patient payments will be required. If this is a hardship, ask your doctor about the Back In Action Chiropractic Center patient payment plan. This will allow you to get the help that you need and pay for it at your own pace.
6. If you are an auto accident or on the job injury victim, we suggest you discuss your coverage with your HR office or insurance company. They may have suggestions that will help you in this regard.
7. You will be asked to authorize Back In Action Chiropractic Center to furnish information regarding your case directly to your insurance company and to assign all benefits as a result of the claim. This will expedite its handling.
8. It's a good idea to know your own insurance coverage. However, if you have questions, feel free to ask. Our staff is experienced in insurance claims handling and will be glad to help in any way they can.

Assignment of Insurance Benefits:

I hereby authorize payment to be made directly to Back In Action Chiropractic Center, of all benefits which may be due and payable under insurance coverage for the above named patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to Back In Action Chiropractic.

Authorization To Release Medical Record Information:

Back In Action Chiropractic Center is hereby authorized to disclose all or any part of the medical records on the above named patient to such insurance companies, Organizations, or agencies as may be responsible for payment of services rendered by Back In Action Chiropractic Center. This authorization I give with full knowledge that such disclosure may contain information of a confidential nature and may result in a denial of insurance coverage for services rendered by said Back In Action Chiropractic Center.

New Patient Care Services

We require 25% of the first visit charges due on the first day of service. The balance of these charges may be made in payments over the next 4 weeks, unless we bill your insurance for payment. Properly documented Worker's Compensation and auto accident claims are not required to pay at this time if appropriate forms and liens are signed.

Established Patient Care Services

Patients under care are required to make regular payments on all copayments/co-insurance, or deductibles, except for properly documented Worker's Compensation or auto accident claims. Payments need to be paid in advance or when services are rendered, depending on your arrangements. We do charge ten percent interest on all account balances over 90 days. We do not send statements unless requested.

The undersigned certifies that he/she has read and understands each of the above paragraphs and is the patient or responsible party with the power to execute this document and accept these terms.

Signature of Witness:_____ Signature of Patient or Responsible Party:_____