CONFIDENTIAL PATIENT INFORMATION SHEET

Patient _____ Home Telephone_____
first middle last

Address_____ City_____ Zip_____

Email _____ Cell Telephone_____

Date of Birth_____ Age_____ Social Security Number_____

Married__ Single__ Widow(er)__ Divorced___ Number of Children____

Race: American Indian/Alaska Native Black/African American White

Hispanic/Latina Native Hawaiian/Pacific Islaner Asian

Multi-Racial Some other Race Somalian

Preferred Language: English Other:_____

Occupation/Profession_____ Business Phone_____

Patient Spouse

Employer's Name_____ _____

Employer's Address_____ _____

Referred By?_____

Is this related to: work_____ auto_____ other_____

Do you have health and/or accident insurance? Yes_____ No_____

Health Plan_____ Patient ID#_____

Subscribers Name_____ _____

Subscribers ID#_____ _____

Subscribers Group#_____ _____

Subscribers Date of Birth_____ _____

Insurance or financial arrangements can be made at this time.

Copays are due at time of treatment.

Back to Wellness Clinic, 1706 Lor Ray Drive North Mankato, MN 56003
Dehen Chiropractic, Ltd.: Voice(507)388-7744 Email dehenchiro@juno.com
SchugelFamily Chiropractic PA: Voice (507)385-1015 Email mschugel@hickorytech.net

Patient Health Questionnaire - PHQ

ACN Group, Inc. Form PHQ-202

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

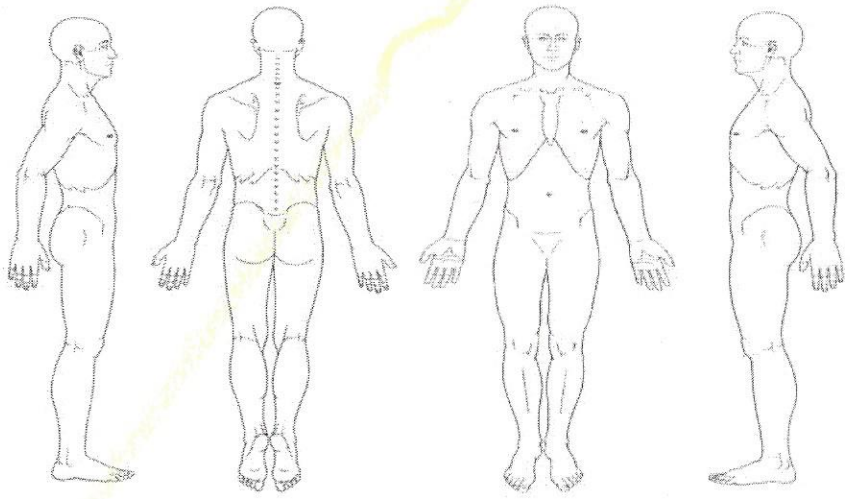
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the <u>past 4 weeks:</u>

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the <u>past 4 weeks</u> how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

① No One
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

10. What is your occupation?

_____

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

Patient Signature _____ **Date** _____

Patient Health Questionnaire - page 2

ChiroCare of Minnesota, Inc.

ChiroCare Use Only rev 1/20/99

Patient Name _____ *Date* _____

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height [ ][ ][ ] (Feet / Inches) Weight [ ][ ][ ] lbs.

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present	
○	○	Headaches
○	○	Neck Pain
○	○	Upper Back Pain
○	○	Mid Back Pain
○	○	Low Back Pain
○	○	Shoulder Pain
○	○	Elbow/Upper Arm Pain
○	○	Wrist Pain
○	○	Hand Pain
○	○	Hip/Upper Leg Pain
○	○	Knee/Lower Leg Pain
○	○	Ankle/Foot Pain
○	○	Jaw Pain
○	○	Joint Swelling/Stiffness
○	○	Arthritis
○	○	Rheumatoid Arthritis
○	○	General Fatigue
○	○	Muscular Incoordination
○	○	Visual Disturbances
○	○	Dizziness

Past	Present	
○	○	High Blood Pressure
○	○	Heart Attack
○	○	Chest Pains
○	○	Stroke
○	○	Angina
○	○	Kidney Stones
○	○	Kidney Disorders
○	○	Bladder Infection
○	○	Painful Urination
○	○	Loss of Bladder Control
○	○	Prostate Problems
○	○	Abnormal Weight Gain/Loss
○	○	Loss of Appetite
○	○	Abdominal Pain
○	○	Ulcer
○	○	Hepatitis
○	○	Liver/Gall Bladder Disorder
○	○	Cancer
○	○	Tumor
○	○	Asthma
○	○	Chronic Sinusitis

Past	Present	
○	○	Diabetes
○	○	Excessive Thirst
○	○	Frequent Urination
○	○	Smoking/Use Tobacco Products
○	○	Drug/Alcohol Dependence
○	○	Allergies
○	○	Depression
○	○	Systemic Lupus
○	○	Epilepsy
○	○	Dermatitis/Eczema/Rash
○	○	HIV/AIDS

Females Only

○	○	Birth Control Pills
○	○	Hormonal Replacement
○	○	Pregnancy
○	○	

Other Health Problems/Issues

○	○
○	○
○	○

Indicate if an immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○ _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____

_____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

Patient Signature _____ *Date* _____

Doctor's Additional Comments

_____

_____

_____

Doctors Signature _____ *Date* _____

• Dehen Chiropractic, LTD
• Schugel Family Chiropractic, PA

Back to Wellness Clinic Informed Consent

Dear Patient,

The purpose of this form is to inform you, not alarm you. It is important that you understand the information contained in this document. Please ask questions before you sign, if there is anything that is unclear.

Examination and Treatment

We may use a variety of examination procedures and therapies in your care. As a part of the examination and treatment, you are consenting to the following procedures:

___vital signs
___range of motion testing
___muscle strength testing
___spinal manipulative therapy
___low level laser therapy
___nutritional therapy
___palpation
___orthopedic testing
___basic neurological exam
___mechanical traction/flexion distraction
___ultrasound
___rehabilitation/core strengthening
___Other (please explain)_____

The nature of the chiropractic manipulative therapy (CMT).

The primary treatment we use as a Doctors of Chiropractic is chiropractic manipulative therapy (CMT). We will use that procedure to treat you. We may use our 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 own knuckles. You may also feel a sense of movement.

The material risks inherent in CMT.

As with any healthcare procedure, there are certain complications which may arise during CMT. We 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.

Chiropractic is a safe and comfortable form of health care for most people. If a potential risk is identified, you will be informed and offered either treatment or a referral to the appropriate health care specialist for evaluation and care.

Soreness: It is not uncommon to experience some localized soreness following a manipulation. This type of soreness is usually minor and occurs most often following the initial few visits. It is similar to the soreness you may experience after exercise.

Rib Fracture: Fractures caused from CMT are extremely rare, so rare that an actual number of incidences per CMT have never been determined. Patients suffering from

bone weakening conditions like osteoporosis are in a higher risk category. Alternative forms of CMT are utilized for this type of patient.

TIA/Stroke: According to the literature, possible neurological complications can arise in 1 per 1-8 million office visits or 1 per 2-5.85 million CMTs. Alternative CMT is utilized when necessary to minimize any potential risks.

Ruptured/Herniated Disc: There have been some reports of herniated or ruptured discs caused by CMT. The literature states the risk of this is 1 per 5 million CMTs, so even more rare than strokes. Alternative CMT methods are often utilized to minimize the risk and help the patient recover from serious disc-related pain.

Other complications include but are not limited to: dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and at that physical therapy or burns.

Other treatment options include:

- **Medication**: Self-administered, over-the-counter medications or prescription drugs, can help to relieve pain and swelling. Caution should be used as the danger of side effects is well documented.
- **Hospitalization**: Well documented as expensive and dangerous.
- **Surgery**: Always a possibility, when necessary, but well documented in the scientific literature as expensive, dangerous and often ineffective.

If you chose to use one of the above noted "other treatment" options, you should be aware that there are also risks and benefits with each of those 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.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read or have had read to me the above explanation of the CMT and related treatment. I have discussed it with Dr. Dehen/Schugel 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.

Patient Name (please print):_____

Patient Signature:_____ Date:_____

BACK TO WELLNESS CLINIC

• DEHEN CHIROPRACTIC, LTD
• SCHUGEL FAMILY CHIROPRACTIC, PA

ASSIGNMENT OF BENEFITS

I hereby authorize payment of medical benefits to **BACK TO WELLNESS CLINIC** for the services described.

I give my permission to the doctors to submit insurance benefit claim forms in my name and on the behalf of myself, my spouse and/or my minor children.

I realize that I am responsible for and agree to pay any charges not covered by my insurance. This includes unmet deductibles and non-covered services. (see reverse side) ***Copays and cash plans are due at the time of service.***

If I allow my account to become delinquent and it is referred to a collection agency, I am **solely** responsible for any outstanding balances and **all** reasonable collection costs and attorneys fees.

Special arrangements can be made, but must be mutually agreed to *in advance.* Please contact the staff at any time if you have any difficulties. We will do everything possible to find a way to provide the health care services you need.

My signature indicates my authorization of this activity.

_____ _____ _____

Name (printed) Signature Date

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of the **BACK TO WELLNESS CLINIC**.

I understand that the Notice describes the uses and disclosures of my protected health information by **BACK TO WELLNESS CLINIC** informs me of my rights with respect to my protected health information.

_____ _____ _____

Name (printed) Signature Date

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.

1706 LOR RAY DRIVE NORTH MANKATO, MN 56003 • PH: 507-388-7744 • FAX: 507-388-8001 • WWW.BACKTOWELLNESSCLINIC.COM

Non-Covered Services: Financial Disclosure Form

Back to Wellness Clinic
Dehen Chiropractic, Ltd.
Schugel Family Chiropractic, P.A.
1706 Lor Ray Drive North Mankato MN 56003
(507)388-7744/ (507)385-1015

As your Doctor of Chiropractic, I want to provide you with the best care possible. While your policy covers some chiropractic services, there may be others that I feel would help the treatment of your condition and maintenance of good health, but are not covered by your health insurance coverage. If you agree to receive these services, and they are later determined to not be eligible for reimbursement through your health plan policy, your signature on this form signifies your agreement to pay for them in full. **While you may choose to not obtain these services**, I want to reassure you that I will only recommend care that I believe will benefit your health.

Chiropractic services typically covered by health insurance policies include:

- Chiropractic manipulations to treat a clinical condition
- Treatment that has the potential to significantly improve a clinical condition
- Limited treatment of symptom flare-ups or exacerbations where a permanent condition exists.

Services that we expect to <u>not</u> be eligible for reimbursement through your plan's chiropractic benefit, and therefore will likely be your financial responsibility <u>**should you elect to receive them**</u>, are outlined below

Possible Non-Covered Service(s)	Cost Per Visit*	
New Pt Exam(s): 99201-$64.23, 99202-$108.12,99203-$155.04	$64.23-155.04	
Est. Pt Exam(s): 99211-$30.60, 99212-$64.26, 99213-$122.40	$30.60-122.40	
Spinal Manipulation: 98940-$40.80, 98941-$57.12, 98942-$68.34 Extremity: 98943-$38.76	$40.80-68.34	
Therapies/Modalities Manual Therapy (Graston): $48 Laser Therapy: $25.50 Ultrasound: $18.36 Taping(neuromuscular reeducation): $48.96 Therapeutic Exercises: $45.90	$18.36-48.96	
Durable Medical Equipment (**Circle All Applicable Products**) Braces Orthotics Cervical Pillow Ice Pack Nutritional supplements Biofreeze	AS Marked (see front desk)	
Other:		
Other:		

*Patient's billed amount may not exceed the provider's usual and customary amount

I believe these services will not be eligible for reimbursement through your health plan because (check one):

- ☐ They are maintenance or elective care rather than treatment to improve a clinical condition
- ☐ They are excluded from your chiropractic coverage, even when related to treatment to improve a clinical condition

Provider/Authorized Healthcare Representative Signature: _____ **Date:**_____

I acknowledge that I am signing this statement voluntarily, and that it is not being signed after the services have already been provided. I have had ample opportunity to ask questions about my liability, and other covered treatment alternatives, and the provider/staff has answered them to my satisfaction. **I understand that I have the right to refuse this care and that by signing this form, I will be fully responsible for the total billed charge(s) related to non covered services.**

Patient's Name: _____

Patient's Signature: _____ Date: _____

A copy of this signed form must be provided to the patient upon request