

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 Islander 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

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name _____ Date _____

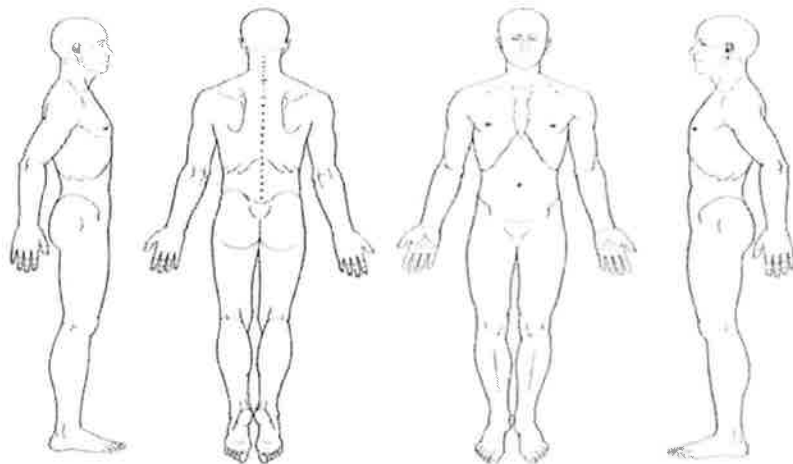
1. Describe your symptoms

a. When did your symptoms start?

b. How did your symptoms begin?

2. How often do you experience your symptoms? Indicate where you have pain or other 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)



3. What describes the nature of your symptoms?

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

4. How are your symptoms changing?

- ① Getting Better
- ② Not Changing
- ③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None 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 past 4 weeks 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 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: _____
- ② MRI date: _____
- ③ CT Scan 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 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 _____



• DEHEN CHIROPRACTIC, LTD

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:

- | | |
|---|--|
| <input type="checkbox"/> vital signs | <input type="checkbox"/> palpation |
| <input type="checkbox"/> range of motion testing | <input type="checkbox"/> orthopedic testing |
| <input type="checkbox"/> muscle strength testing | <input type="checkbox"/> basic neurological exam |
| <input type="checkbox"/> spinal manipulative therapy | <input type="checkbox"/> mechanical traction/flexion distraction |
| <input type="checkbox"/> low level laser therapy | <input type="checkbox"/> ultrasound |
| <input type="checkbox"/> nutritional therapy | <input type="checkbox"/> rehabilitation/core strengthening |
| <input type="checkbox"/> 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: _____



• DEHEN CHIROPRACTIC, LTD

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

Cell#: _____ E-mail: _____

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.

Back to Wellness Clinic

Non-Covered Services: Financial Disclosure Form

**Back to Wellness Clinic
Dehen Chiropractic, Ltd.
1706 Lor Ray Drive North Mankato MN 56003
(507)388-7744**

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 **not** be eligible for reimbursement through your plan's chiropractic benefit, and therefore will likely be your financial responsibility **should you elect to receive them**, 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): \$20.40 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