ABOUT THE PATIENT

Northern Chiropractic & Wellness Center

Name ______________________ Today's Date__________ Birthdate __________ Age________

Address ______________________ City ______________ State ______ Zip __________

Home Phone ______________ Cell Phone ______________ Work Phone ______________ Gender ☐ M ☐ F

Significant Other's Name ______________________ Kid's Names and Ages ______________________

Your Employer ______________________ Type of Work ______________________

e-Mail Address ______________________ Have you been to a chiropractor before? ☐ No ☐ Yes

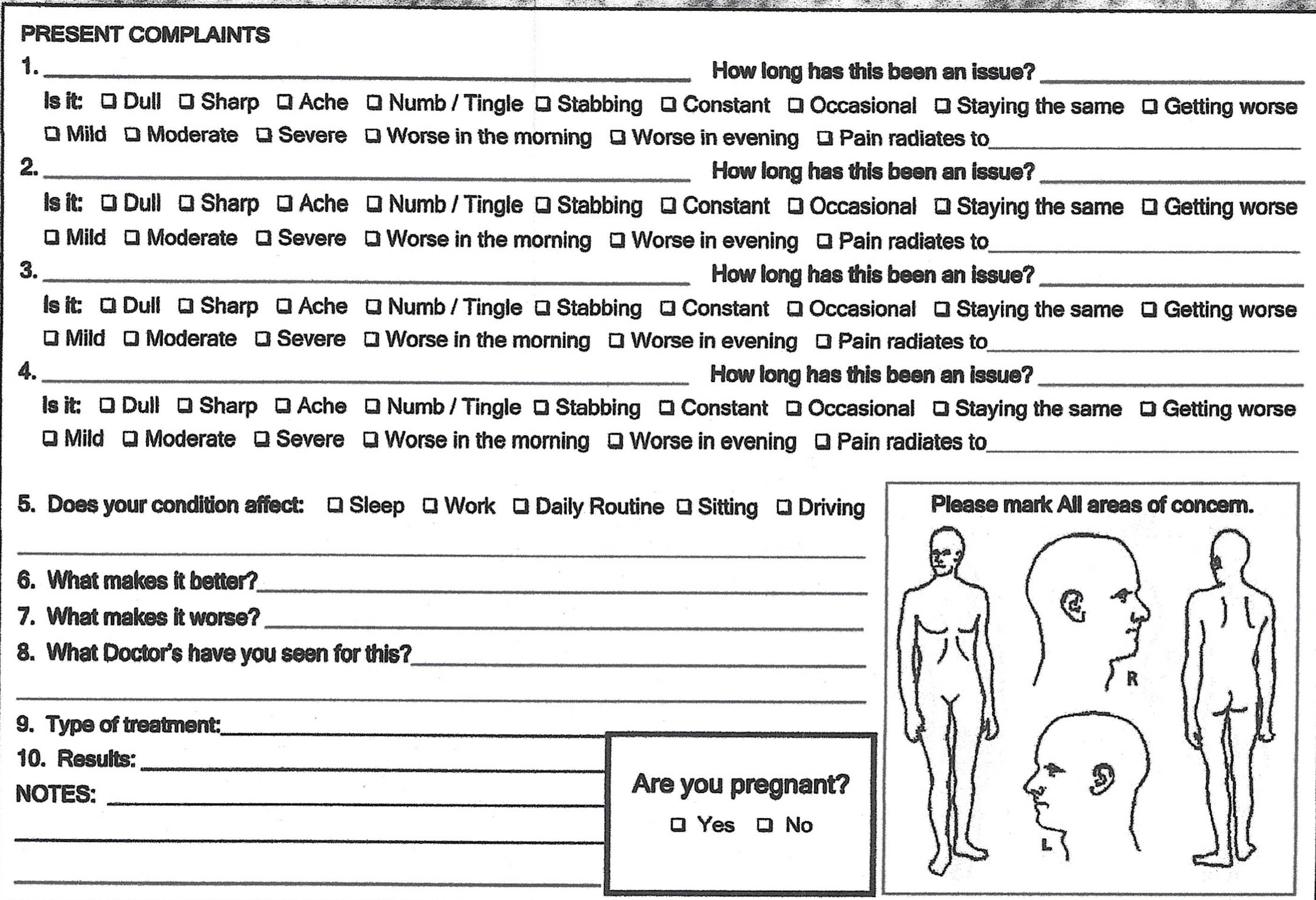
Emergency Contact ______________________ ph # ______________________

Name of Medical Doctor(s)______________________

- I authorize the doctor or her staff to render care as deemed appropriate for me and / or my child.
- I authorize Northern Chiropractic to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient?______________________
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is: ☐ Cash ☐ Check ☐ Credit Card ☐ Car/Work Ins.

______________________________ ______________

Patient / Parent Signature (This represents a long term authorization for all occasions of service) Date



REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. ______________________ How long has this been an issue? ______________
   Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse ☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to______________
2. ______________________ How long has this been an issue? ______________
   Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse ☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to______________
3. ______________________ How long has this been an issue? ______________
   Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse ☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to______________
4. ______________________ How long has this been an issue? ______________
   Is it: ☐ Dull ☐ Sharp ☐ Ache ☐ Numb / Tingle ☐ Stabbing ☐ Constant ☐ Occasional ☐ Staying the same ☐ Getting worse ☐ Mild ☐ Moderate ☐ Severe ☐ Worse in the morning ☐ Worse in evening ☐ Pain radiates to______________
5. Does your condition affect: ☐ Sleep ☐ Work ☐ Daily Routine ☐ Sitting ☐ Driving
   ____
6. What makes it better?______________________
7. What makes it worse? ______________________
8. What Doctor's have you seen for this?______________________
   ____
9. Type of treatment:______________________
10. Results: ______________________

NOTES: ______________________

Are you pregnant?

☐ Yes ☐ No

Please mark All areas of concern.

GENERAL HEALTH HISTORY

Northern Chiropractic & Wellness

Patient Name____ *Mark the conditions that apply to you.*

Past	Present	Condition
☐	☐	Headaches
☐	☐	Migraines
☐	☐	Shortness of Breath
☐	☐	Allergies / Asthma
☐	☐	Medication Side Effects
☐	☐	Diabetes
☐	☐	Hands or Feet cold
☐	☐	Muscle aches
☐	☐	Trouble Walking
☐	☐	Leg / Foot Numbness
☐	☐	Fainting
☐	☐	Gall Bladder Trouble
☐	☐	Ringing in Ears
☐	☐	Ear Problems
☐	☐	Sleeping Problems
☐	☐	Vision Problems
☐	☐	Thyroid Problems
☐	☐	Liver Disease
☐	☐	Kidney Problems
☐	☐	Light Bothers Eyes
☐	☐	Other ________________________________

Past	Present	Condition
☐	☐	Urinary Problems
☐	☐	Easy Bruising
☐	☐	Tobacco Use
☐	☐	Dental Problems
☐	☐	Fibromyalgia
☐	☐	Blood Thinner use
☐	☐	HIV Positive
☐	☐	Cancer
☐	☐	Depression
☐	☐	Alcohol Use
☐	☐	___High or ___Low Blood Pressure
☐	☐	Stroke History
☐	☐	High Cholesterol
☐	☐	TMJ
☐	☐	Digestive Problems
☐	☐	Pain all Over
☐	☐	Tension / Irritability
☐	☐	Chest Pains
☐	☐	Heart Pacemaker
☐	☐	Heart Problems

1. List any medications are you taking:____

____

2. Please list all doctors you are currently seeing: ____

____

3. Has any Doctor or other professional advised you to "Go to a Chiropractor": ☐ No ☐ Yes, Name________________

____

____

PAST HISTORY

4. List any past auto collisions:______________________________ Was any care received?______________
5. List any past work injuries: ______________________________ Was any care received?______________
6. List any past sport, recreational, or home injuries____
7. Please describe any past conditions and treatment received: ____

____

8. Please list any past hospitalizations and surgeries: ____

____

FAMILY HISTORY

Father's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other________________

Mother's side: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Heavy Medication use ☐ Arthritis ☐ Other________________

Is there any other family history you want us to know?____

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosure for the purposes of treatment, payment, or practice parathion will be made only after obtaining your consent:

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records
- In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician's certifications.*

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used or disclosed.

PATIENT'S NAME (PLEASE PRINT):	RELATIONSHIP TO PATIENT:
SIGNATURE:	DATE:

Regarding: Chiropractic Adjustments, modalities, and therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per two million adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Northern Chiropractic and Wellness have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor(s). After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

Patient or authorized person's signature ______________________ Date ____________

Parent or Guardian Print name: ______________________________

PAYMENT AGREEMENT /USE OF INSURANCE AUTHORIZATION

I hereby authorize the Doctors of Northern Chiropractic and Wellness to work with my condition through the use of adjustments to my spine, as he/she deems appropriate. I clearly understand and agree that all services rendered by me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. Northern Chiropractic and Wellness will not be held responsible for any preexisting medically diagnosed conditions nor for any medical diagnosis. I

also understand that if I suspend or terminate my care, any fees for professional services rendered by me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to Northern Chiropractic and Wellness, LLC for services rendered. I understand and agree that health and accident

insurance policies are an arrangement between an insurance carrier and myself. I understand that Northern Chiropractic and Wellness will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to Northern Chiropractic and Wellness, LLC will be credited to my account upon receipt. I therefore understand that any bills that are not paid for by insurance I am financially responsible for.

Signature:	Date:
Guardian or Spouse Authorizing Care's Signature:	Date:

NORTHERN
Chiropractic and Wellness

NO SHOW/MISSED APPOINTMENT POLICY

We, at Northern Chiropractic and Wellness, understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice). You can cancel appointments by calling the following number: 651-797-3756, or by email at northernchirowellnessmn@gmail.com.

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit **on time.** For your convenience, we have a text message appointment reminder option. Please let our front desk know if you would like this feature activated on your account.

We want to thank you all for all your support and love being able to serve you. Due to our growing business, we will no longer be able to accommodate "walk-ins". Please call or stop by the front desk to make your next appointment (s).

PLEASE REVIEW THE FOLLOWING POLICY:

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, as of January 1, 2023, Northern Chiropractic and Wellness reserves the right to charge a fee of $25.00 for all missed appointments ("no shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour advance notice. "No Show" fees will be added to your account. This fee is not covered by insurance.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

I have read and understand No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify Northern Chiropractic and Wellness appropriately if I have difficulty keeping my scheduled appointments.

______________________ Patient Name	__________ Date of Birth	__________ Date
______________________ Patient Signature or Parent/Guardian if minor		______________ Relationship to Patient
______________________ Staff Signature	______________ Date	

PATIENT FINANCIAL RESPONSIBILITY & AUTHORIZATION FORM

Thank you for choosing **Northern Chiropractic and Wellness** for your medical needs. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.
- Copays are due at the time of service.
- Coinsurance, deductibles and non-covered items are due 30 days from receipt of billing.

By my signature below, I hereby authorize assignment of financial benefits directly to **Northern Chiropractic and Wellness** and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.

Patient Acknowledgement and Authorization

- We respect patient confidentiality and only release personal health information about you in accordance with the State and federal law. The attached notice describes our policies related to the use of the records of your care and how you may get access to this information. Please review this policy carefully.

By my signature below, I acknowledge that I have received and read the privacy notice provided by **Northern Chiropractic and Wellness**. I hereby authorize **Northern Chiropractic and Wellness** to release medical and other information acquired in the course of my examination and/or treatment to the necessary insurance companies, third party payors, and/or other physicians or healthcare entities required to participate in my care.

Patient Name ________________________________

Patient/Guardian Signature ________________________

Date ____________________