GENESIS
CHIROPRACTIC

Genesis Chiropractic
1024 60th Street, Suite 1
Kenosha, Wisconsin 53140

Is this visit due to an auto or workman's comp accident? NO / YES

(If yes, please inform the front desk of this if you haven't already.)

Name: _____Date:_____/_____/_____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____Work Phone: _____ Cell Phone: _____

Would you like text reminders? No/Yes Who is your cell phone carrier?_____

Email Address: _____ Occupation: _____

Date of Birth: _____ Gender: Male / Female Social Security #: _____-_____-_____

Race: American Indian / Asian / Black or African American / Native Islander / White / Decline

Ethnicity: Hispanic-Latino / Non-Hispanic-Latino / Decline Preferred Language:_____

Are you Pregnant? Yes / No Number of Children: _____ Marital Status: _____

Primary Care Physician Name:_____ Clinic Name/Location:_____

Who may we thank for referring you to our office?_____

Have you had x-rays, MRI, or CT scans completed? (if yes) When/Where/Area of body:_____

_____

Do you consume caffeine? No/Yes < 3 Drinks/day 3-6 Drinks/day >6 Drinks/day

Do you consume alcohol? No/Yes Casual Drinker Moderate Drinker Heavy Drinker

Do you smoke? No/Yes Current Smoke (Since :_____) Former Smoker (Quit when_____)

Do you use drugs? No/Yes Recreational (_____) Addiction Former Addict

Do you exercise? No/Yes Daily Weekly Walks Runs Swims

List ALL Allergies (Medications/Food/Environmental) :_____

_____

List ALL Surgeries (DATES INCLUDED):_____

_____

List ALL Medical History conditions:_____

_____

List ALL Medications/Vitamins you are taking (DATE STARTED as well as dosage) If you have a medication list, please provide that instead._____

_____

_____

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Family Health History: Please write down any/all medical histories below that apply to the following family members.

Father: _____ Mother: _____

Brothers: _____Sisters: _____

Son:_____ Daughter:_____

Circle any activities of daily living that are currently affected due to your pain/discomfort

Dressing, Grooming, Walking, Sitting, Standing, Sitting to Standing, In/out of bed, Transfers, Lifting, Climbing Stairs, Housework, Driving, Sleep, Childcare,

Exercises Affected? (list exercise activities)_____ Other:_____

List/Circle all Medical History conditions please read through the full list as it is important to your care and circle NONE if nothing applies.

Constitutional Systems	Unexplained weight loss, night sweats, fatigue, appetite, fever, itch/rash, recent trauma, lumps/bumps/masses, unexplained falls	NONE
Eyes	Visual changes, headaches, eye pain, double vision, blind spots,	NONE
Ears, Nose, Mouth, and Throat (ENT)	Runny nose, frequent nose bleeds, sinus pain, stuffy ears, ear pain, ringing in ears, gingival bleeding, toothache, sore throat, pain with swallowing	NONE
Cardiovascular	Chest pain, shortness of breath, trouble exercising, palpitations, fainting, loss of consciousness, calf pain when walking, high blood pressure, high cholesterol	NONE
Respiratory	Coughing, coughing blood, wheeze, shortness of breath	NONE
Gastrointestinal	Abdominal pain, difficulty swallowing, indigestion, bloating, cramping, nausea/vomiting, diarrhea/constipation, vomiting blood, abnormal stool	NONE
Genitourinary	Incontinence, blood in urine, frequent urination, trouble urinating, menopause	NONE
Musculoskeletal	Pain, stiffness, joint swelling, decreased range of motion, arthritis	NONE
Skin/Breast	Itching, rashes, wounds, tumors, eczema, excessive dryness, Breast: pain, soreness, lumps, or discharge	NONE
Neurological	Any changes in: sight, smelling, hearing, or taste. Seizures, pins and needles, numbness, weakness, poor balance, speech problems, problems with bowel/bladder control	NONE
Psychiatric	Depression, problems sleeping, anxiety, trouble concentrating, lack of energy, mood swings, change in personality	NONE
Endocrine	Hyperthyroid: prefer cold weather, mood swings, sweaty, diarrhea, weight loss. Hypothyroid: prefer hot weather, slow, tired, depressed, thin hair, constipation, dry skin Diabetes: Frequent urination, increased appetite, increased thirst, dizziness, sweating, headache	NONE
Hematological / Lymphatic	Anemia, bruising easily, family history of blood issues, history of blood transfusion	NONE

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For the following, please only fill out/circle what applies

NECK PAIN Date Started:_____	Rate Pain 0-1-2-3-4-5-6-7-8-9-10 (Mild) (Moderate) (Severe) Which side? Left/Center/Right	How did pain start? Have you had similar pain before? (When?) Do you have radiating pain? (Where?)
Is the pain… →	Constant 100-75% of time	Frequently 75-50% of time	Intermittent 50-25% of time	Occasional 25-0% of time
Is the pain… →	Sharp	Shooting	Stabbing	Achy	Dull	Throbbing	Tingling	Numb	Burning	Tight
What time of day does your pain feel BEST →	Morning	As the day progresses	Afternoon	Evening	During the night	Stays consistent
What time of day does your pain feel WORSE →	Morning	As the day progresses	Afternoon	Evening	During the night	Stays consistent
What makes the pain feel better? →	Resting	Stretching	Ice	Medication	Chiropractic Care	Other:
What makes the pain feel worse? →	Working	Standing	Twisting	Movement	Walking	Other:

UPPER/ MIDBACK PAIN Date Started:_____	Rate Pain 0-1-2-3-4-5-6-7-8-9-10 (Mild) (Moderate) (Severe) Side Left/Center/Right	How did pain start? Have you had similar pain before? (When?) Do you have radiating pain? (Where?)
Is the pain… →	Constant 100-75% of time	Frequently 75-50% of time	Intermittent 50-25% of time	Occasional 25-0% of time
Is the pain… →	Sharp	Shooting	Stabbing	Achy	Dull	Throbbing	Tingling	Numb	Burning	Tight
What time of day does your pain feel BEST →	Morning	As the day progresses	Afternoon	Evening	During the night	Stays consistent
What time of day does your pain feel WORSE →	Morning	As the day progresses	Afternoon	Evening	During the night	Stays consistent
What makes the pain feel better? →	Resting	Stretching	Ice	Medication	Chiropractic Care	Other:
What makes the pain feel worse? →	Working	Standing	Twisting	Movement	Walking	Other:

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For the following, please only fill out/circle what applies

LOW BACK PAIN Date Started:_____	Rate Pain 0-1-2-3-4-5-6-7-8-9-10 (Mild) (Moderate) (Severe) Which side Left/Center/Right	How did pain start? Have you had similar pain before? (When?) Do you have radiating pain? (Where?)
Is the pain… →	Constant 100-75% of time	Frequently 75-50% of time	Intermittent 50-25% of time	Occasional 25-0% of time
Is the pain… →	Sharp	Shooting	Stabbing	Achy	Dull	Throbbing	Tingling	Numb	Burning	Tight
What time of day does your pain feel BEST →	Morning	As the day progresses	Afternoon	Evening	During the night	Stays consistent
What time of day does your pain feel WORSE →	Morning	As the day progresses	Afternoon	Evening	During the night	Stays consistent
What makes the pain feel better? →	Resting	Stretching	Ice	Medication	Chiropractic Care	Other:
What makes the pain feel worse? →	Working	Standing	Twisting	Movement	Walking	Other:

OTHER: _____ Date Started:_____	Rate Pain 0-1-2-3-4-5-6-7-8-9-10 (Mild) (Moderate) (Severe) Side Left/Center/Right	How did pain start? Have you had similar pain before? (When?) Do you have radiating pain? (Where?)
Is the pain… →	Constant 100-75% of time	Frequently 75-50% of time	Intermittent 50-25% of time	Occasional 25-0% of time
Is the pain… →	Sharp	Shooting	Stabbing	Achy	Dull	Throbbing	Tingling	Numb	Burning	Tight
What time of day does your pain feel BEST →	Morning	As the day progresses	Afternoon	Evening	During the night	Stays consistent
What time of day does your pain feel WORSE →	Morning	As the day progresses	Afternoon	Evening	During the night	Stays consistent
What makes the pain feel better? →	Resting	Stretching	Ice	Medication	Chiropractic Care	Other:
What makes the pain feel worse? →	Working	Standing	Twisting	Movement	Walking	Other:

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PERSONAL INJURY QUESTIONAIRE

Name:_____Date of accident:_____Time:_____A.M./P.M.

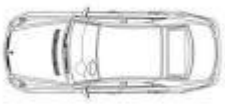
Description of accident:
_____
_____
_____
_____

Driving Role: _____Passenger in the back seat _____Passenger in the front seat
_____Driver of a motorcycle _____Driver with both hands on the wheel
_____Driver with left hand on the wheel _____Driver with right hand on the wheel

Vehicle Status: _____Accelerating _____At a stop light _____Attempting to stop
_____Changing Lanes _____Driving down the road _____Driving in parking lot
_____Moving _____Moving at moderate speed _____Moving in reverse
_____Parked _____Sliding out of control _____Slowing down
_____Speeding _____Spinning out of control (weather related)
_____Stopped _____Turning

Please circle the impact area of the vehicle:

Front *Back*



Lighting Conditions: _____Dawn _____Dusk _____Full Daylight _____Night

Road Conditions: _____Damp _____Dry _____Ice Covered
_____ Nasty _____Snow Covered _____Wet

Visibility: _____Excellent _____Fair _____Good _____Poor

Opposing Vehicle Type: _____Compact Car _____Full Size Car _____Large Pickup Truck
_____Large SUV _____Motorcycle _____Other_____
_____Semi_____Small SUV _____Small Truck

Opposing Vehicle Speed: _____MPH
Your Vehicle Speed: _____MPH

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Headrest Position: _____High _____Low _____Middle _____Unknown

Admitted to the Hospital? _____Yes _____No
If yes when? _____At time of accident _____At a later time
Transportation to hospital? _____Ambulance _____Life Flight
_____Police Car _____Private Transportation

Bracing Status:
_____Was unable to brace for impact w/my hands/feet/knees
_____Was aware that the accident was impending, but unable to brace
_____Was not aware that the accident was impending

Problems:
_____By being thrown from the vehicle
_____Hit the other passenger
_____Hit the console
_____Hit the door
_____Hit the steering wheel
_____Hit the windshield
_____By the seat belt
_____Hit the back of the front seat
_____Hit the dashboard
_____Hit the roof of the car
_____Hit the window

Injury Locations:

_____Back of head	_____Back of neck	_____Chest
_____Fingers on left hand	_____Fingers on right hand	_____Face
_____ Forehead	_____Front of neck	_____Left Arm
_____Left elbow	_____Left hand	_____Left hip
_____Left knee	_____Left leg	_____Left shin
_____Left shoulder	_____Left Wrist	_____Low back
_____Mid back	_____Nose	_____Right Arm
_____Right elbow	_____Right hand	_____Right hip
_____Right knee	_____Right leg	_____Right shin
_____Right shoulder	_____Right wrist	_____Side of head
_____Side of neck	_____Upper back	

Compromised By:

_____Brightness	_____Darkness	_____Fog
_____Rain	_____Snow	_____Traffic

Feelings After the accident:

_____Angry	_____Disoriented	_____Dizzy
_____Nauseous	_____Scared	_____Unconscious
_____Upset	_____Weak	

Patient Signature: _____ **Date:** _____

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HIPPA – ACKNOWLEDGEMENT OF RECEIPT Notice of Privacy Practices

We at Genesis Chiropractic Wellness and Rehabilitation Center are required by law to maintain the privacy of and provide individuals with the attached Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our HIPPA Compliance Officer in person or by our main phone number. If you would like a copy of the Notice, please ask. I hereby acknowledge that I have reviewed the HIPPA notice of Privacy Practice document.

_____ _____
Printed name of patient or patient's representative/parent Date

_____
Signature of patient or patient's representative/parent

Consent to X-ray and Verification of Non-Pregnancy

I hereby state that to the best of my knowledge I am not pregnant and am not actively trying to become pregnant. I also state that pregnancy is neither suspected nor confirmed at this time. I release Genesis Chiropractic Clinic Inc. from any liability and authorize them to complete any radiology examination deemed necessary.

_____ _____
Printed name of patient or patient's representative/parent Date

_____
Signature of patient or patient's representative/parent

Communication Method Disclosure and Consent

Genesis Chiropractic Clinic Inc communicates with its patient population in a variety of ways. We use information the patient or the patient's representative/parent provides, including landline phone, cell phone, text messaging, email, fax and U.S. mail. By providing your cell phone number during the registration process, you: 1. Consent and agree to receive telephone calls, text messages and other communications. These calls may be in regard to services received at Genesis Chiropractic Clinic Inc and your financial obligations related to those services. I understand this consent applies to all current and future medical service accounts for which I am the Guarantor. 2. Understand you may be charged for such calls, messages, or other communications by your wireless carrier. 3. I understand it is my responsibility to inform Genesis Chiropractic Clinic Inc if I choose to withdraw this permission. I can withdraw this consent at any time by contacting Genesis Chiropractic Clinic Inc. I have read, fully understand, and agree to the above:

_____ _____
Printed name of patient or patient's representative/parent Date

_____
Signature of patient or patient's representative/parent

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INFORMED CONSENT

Terms of Acceptance

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. Chiropractic has only one goal; to identify and correct subluxations. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

1. Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral/extremity subluxation. Our chiropractic method of correction is by specific adjustments of the spine and extremities

2. Health: A state of optimal physical, mental and social well-being, not merely the absence of infirmity.

3. Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

4. Extremity Subluxation: A misalignment of an extremity causing edema, fixation and or joint irregularity. The aim of extremity adjusting is to assess the extremity, do an analysis, and then develop a treatment for the extremity.

We may diagnose any condition or disease that comes into our office in addition to the vertebral and extremity subluxations. It is our goal to refer a patient to their health care practitioner, or in urgent matters, to the closest emergency room if we feel their health, or our diagnosis, warrants the referral. We do not treat diseases or conditions in our office beyond the spine or extremities, however, other diseases may improve with chiropractic care. In doing so, it's important to work with you, the patient, on reaching your optimal health. Our only practice objective is to serve you the patient. We are here for your health!

Chiropractic care, while rare and unlikely, has risk factors. Most are self-limiting but rare serious risk factors include fracture, exacerbation of a disc herniation, and stroke.

Privacy and Sharing of Information

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we require you to read and sign this consent form stating that you understand and agree with how your records will be used.

1. The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

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5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.

X-Ray Release

This is to certify that practitioners at Genesis Chiropractic have my permission to perform an X-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child and, if applicable, will inform Genesis Chiropractic if I am or might be pregnant. If I am pregnant, I consent to receive an x-ray once it is safe to do so.
I hereby authorize any medical facility to release my previous films/images and reports to Genesis Chiropractic for comparative purposes. In addition, I authorize Meier Family Chiropractic to release my films/images to any other facility for comparative purposes or to a radiologist for review of my films/images.

Consent to Care for Minor

If applicable, I authorize providers at Genesis Chiropractic to administer care necessary to my son/daughter.

Insurance & Financial Responsibility

I understand that health and accident insurance policies are an arrangement between an insurance carrier and me. I understand that Genesis Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Genesis Chiropractic will be credited to my account on receipt. Your insurance company will only pay for services that they determine are medically necessary. I understand that some or all services provided for me might not be covered by my contract benefits.
I understand that all services rendered to me are charged directly to me and I am personally responsible for payment. I understand that if I suspend or terminate my care, any fees for services rendered to me will be immediately due and payable.
I understand that cancellations must be communicated prior to my appointment. A no call/no show will result in a fee except in the event of an emergency. I understand that a no call/no show fee will be collected at the time of my missed appointment.

I have read and fully understand the above statements. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

_____ _____
Printed name of patient or patient's representative/parent Date

_____
Signature of patient or patient's representative/parent

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FEES AND PAYMENTS

Payment in full is due at the time services are rendered. We urge patients to be familiar with their chiropractic insurance benefits prior to appointment. Our office staff calls and verifies your insurance benefits if you need to be informed. Co pays and deductibles are due at time of service or your appointment may be rescheduled. If payment arrangements need to be made, please speak with our office staff to make payment arrangements. Billing your insurance company does not ensure payment, in cases of partial payment OR denial (unless stated otherwise by your insurance carrier) you are responsible for the remaining balance. You are responsible to inform our office of any changes to your insurance policy prior to your visit at our facility, not doing so can result in timely filing, in which the unpaid claim will become your responsibility

AUTHORIZED CONSENT FORM

I, _____ authorize the following people to accompany and discuss any and all chiropractic treatment at Genesis Chiropractic Wellness and Rehabilitation Center, INC. This includes any information pertaining to medical treatment, diagnosis, prognosis, and calling and scheduling/canceling appointments.

1. _____ Relationship to Patient _____
   Phone #_____

2. _____ Relationship to Patient _____
   Phone #_____

3. _____ Relationship to Patient _____
   Phone #_____

_____ _____
Printed name of patient or patient's representative/parent Date

_____
Signature of patient or patient's representative/parent

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INSURANCE BENEFIT VERIFICATION FORM

I REQUEST THAT MY INSURANCE INFORMATION AND BENEFITS BE RELEASED TO GENESIS CHIROPRACTIC CLINIC INC. I understand that my signature requests payment information and benefits be made accessible throughout the duration of my care at this facility.
The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

_____ _____
Printed name of patient or patient's representative/parent Date

_____
Signature of patient or patient's representative/parent

_____ _____
Signature of staff Date

ASSIGNMENT OF BENEFITS

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical benefits, to include major medical benefits to which entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical/auto plan, to issue payment check(s) directly to GENESIS CHIROPRACTIC CLINIC, INC. For medical services rendered to myself and/or dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize GENESIS CHIROPRACTIC CLINIC, INC. to (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.
I have requested medical services from GENESIS CHIROPRACTIC CLINIC, INC. on behalf of myself and/or my dependents, and understand by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.
I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____
Patient/Responsible Party Signature Date

_____ _____
Witness Date

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ATTORNEY LIEN

I hereby authorize Genesis Chiropractic Clinic, Inc. to furnish my attorney and/or my third party insurance company with a full report of my examination, diagnosis, treatment, prognosis, and any other medical information in regards to my personal injury case.

I further authorize and direct my attorney to pay directly to Genesis Chiropractic Clinic, Inc. such sums as may be due and owing for medical services rendered to me by reason of this accident. All charges are to be paid at 100% of itemized costs.

I fully understand that I am directly and personally responsible Genesis Chiropractic Clinic, Inc. for all medical bills for services rendered and that this agreement is made solely for said clinics protection and consideration of said clinics delayed payments. I further understand that such payment is not contingent on any settlement, judgment or verdict that I may eventually recover and that payment of the account is due and payable upon demand. I further agree and understand that if I do not recover on my case, I am personally responsible for paying the doctor and will also be held responsible for paying Genesis Chiropractic Clinic, Inc. and will also be held responsible for any attorneys fees, collection agency costs, interest at 12% annum, court costs and any other expense incurred in order to collect the amount owed to Genesis Chiropractic Clinic, Inc.

*_____ _____
Patient/Responsible Party Signature Date

The undersigned being the adjuster or record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to pay for the medical services rendered in regards to the above-named patient said payment shall be mailed directly to Genesis Chiropractic Clinic, Inc. at 1024 60th Street Kenosha WI 53140.

*_____ _____
Adjusters Signature Date

Please sign, date and return one copy to Genesis Chiropractic Clinic, Inc. as soon as possible. Please retain one copy for your records.

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AUTO INSURANCE LIEN

I hereby authorize Genesis Chiropractic Clinic, Inc. to furnish my auto insurance company and/or my third party auto insurance company with a full report of my examination, diagnosis, treatment, prognosis, and any other medical information in regards to my personal injury case.

I further authorize and direct insurance company to pay directly to Genesis Chiropractic Clinic, Inc. such sums as may be due and owing for medical services rendered to me by reason of this accident. All charges are to be paid at 100% of itemized costs.

I fully understand that I am directly and personally responsible Genesis Chiropractic Clinic, Inc. for all medical bills for services rendered and that this agreement is made solely for said clinics protection and consideration of said clinics delayed payments. I further understand that such payment is not contingent on any settlement, judgment or verdict that I may eventually recover and that payment of the account is due and payable upon demand. I further agree and understand that if I do not recover on my case, I am personally responsible for paying the doctor and will also be held responsible for paying Genesis Chiropractic Clinic, Inc. and will also be held responsible for any attorneys fees, collection agency costs, interest at 12% annum, court costs and any other expense incurred in order to collect the amount owed to Genesis Chiropractic Clinic, Inc.

*_____ _____
Patient/Responsible Party Signature Date

The undersigned being the adjuster or record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to pay for the medical services rendered in regards to the above-named patient said payment shall be mailed directly to Genesis Chiropractic Clinic, Inc. at 1024 60th Street Kenosha WI 53140.

*_____ _____
Adjusters Signature Date

Please sign, date and return one copy to Genesis Chiropractic Clinic, Inc. as soon as possible. Please retain one copy for your records.