Patient Health Record

River Falls Chiropractic

PERSONAL INFORMATION:

Name:_____ Age:_____ Today's Date:_____

Address:_____ City/State/Zip: _____

Home Phone #: (__)____-_____ Work Phone #: (__)____-_____ Cell Phone #: (__)____-_____

Email Address:_____ Male_____ Female_____ DOB:_____

Occupation: _____ Employer Name: _____

☐Married ☐Widowed ☐Single ☐Divorced

Number of Children and Ages:_____

Height:_____ Weight: _____

Non-smoker: _____ Smoker: _____ Packs per day:_____

YOUR HEALTH:

*Please place an "X" on the scale above marking where you believe your level of health and wellness is at this time. Place a circle (o) on the diagram indicating where you would **like** your health and wellness to be.*

YOUR HEALTH PROFILE:

What brings you into our office? Please briefly describe your chief concern, including the impact it has had on your life. If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the "General History" page.

Current Health Concerns: _____

_____

Rate Severity: _____ **Type of pain:** _____

(1 = mild; 10 = worst imaginable)

When did this start? _____

How often do you have these symptoms? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100% of the day

Did problem begin with an injury? _____

Since the problem started, it is: ____TheSame ____Getting Better ____Getting Worse

What makes the problem worse? _____

_____

What, if anything, makes it feel better? _____

_____

Does this interfere with your: _____Work _____Leisure _____Sleep _____Sports _____Other:

_____

Have you seen other doctors for this condition? ___Chiropractor ___ Medical Doctor ___Other

Name: _____

Date: _____What was diagnosis? _____

Name: _____

Date: _____What was diagnosis? _____

General History:

List all medications and supplements you are taking and why:
(Prescription and non-prescription)

_____
_____
_____

Have you had any surgeries or hospitalizations? (Please include all surgeries)

_____
_____
_____

What are your occupational duties? _____

Have you ever had any work-related injuries? _____

Have you ever had any slips, falls or auto accidents? _____

_____

Please check if current and circle if in past all symptoms you have ever had, even if they do not seem related to your current problem:

☐ Headaches	☐ Pins and needles in legs	☐ Fainting	☐ Neck pain
☐ Pins and needles in arms	☐ Loss of smell	☐ Back Pain	☐ Loss of balance
☐ Dizziness	☐ Anxiety	☐ Ringing in ears	☐ Nervousness
☐ Numbness in fingers	☐ Numbness in toes	☐ Loss of taste	☐ Stomach Upset
☐ Fatigue	☐ Depression	☐ Irritability	☐ Tension

☐ Sleeping problems	☐ Stiff Neck	☐ Cold Hands	☐ Cold Feet
☐ Diarrhea	☐ Constipation	☐ Fever	☐ Hot Flashes
☐ Cold Sweats	☐ Lights bother eyes	☐ Urinary Problem	☐ Heartburn
☐ Mood Swings	☐ Menstrual Pain	☐ Menstrual Irregularity	☐ Ulcers

Please check (✓) all medical conditions that a parent or sibling has had:

☐ Arthritis	☐ Asthma	☐ Cancer	☐ Diabetes
☐ Genetic Disorder	☐ Heart Disease	☐ Mental illness	☐ Osteoporosis
☐ Stroke	☐ Thyroid Disorder	☐ Neurological Disorders (Parkinsons, Paralysis)	

On a scale of 1-10 describe your psychological/emotional stress levels:
(1 = none/ 10 = extreme)
Occupational: _____

Personal: _____

On a scale of 1-10, (1 being very poor and 10 being excellent) describe your:

Eating Habits: _____Exercise Habits:_____ Sleep: _____ General Health: _____ Mind-set:_____

YOUR GOALS: At our office we concern ourselves with YOUR health and YOUR wellness goals. Please list your goals for your health and wellness in the spaces provided.

Physical Goals:	Nutritional/ Biochemical Goals:
_____	_____
_____	_____
_____	_____

Have you ever:

Purchased Organic Food: ☐ Yes ☐ No

Belonged to a health club: ☐ Yes ☐ No

Consumed vitamins or supplements: ☐ Yes ☐ No

If there is a need for dietary changes, would you like our recommendations? ☐ Yes ☐ No

If there is a need for specific exercises, would you like our recommendations? ☐ Yes ☐ No

If there is a need for support in the stress reduction area, would you like our recommendations? ☐ Yes ☐ No

Payment

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered 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. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider 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 the Doctor's Office 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 the Doctor's Office will be credited to my account on receipt.

_____ _____

Signature Date

_____ _____

Guardian or Spouse's Signature Authorizing Care Date

Who should receive bills for payment on your account? (Circle one)

Patient Spouse Parent Worker's Comp Auto Insurance Medicare Health Insurance

Informed consent and acceptance

PATIENT NAME: _____

To the patient: Please read this entire document prior to signing it. 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.

Chiropractic has only one goal, remove subluxation to allow your nerve system to function properly. Improved nerve function may lead to improved health, function, and quality of life.

1. Subluxation can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's INNATE ABILITY to maintain maximum health.
2. An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation.
3. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease.

We do not treat any disease or condition. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you see the services of a health care provider who specializes in that area.

The Nature of the chiropractic adjustment.

The primary treatment I use as a Doctor of Chiropractic is the chiropractic adjustment also known as a chiropractic manipulative therapy. I will use that procedure to treat you. I may use my 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 knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

x chiropractic adjustments	**x** palpation	**x** vital signs
x range of motion testing	**x** orthopedic testing	**x** basic neurological testing
x muscle strength testing	**x** postural analysis	**x** EMS
x radiographic studies	**x** hot/cold therapy	

-Please circle any treatments you decline at this time-

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic adjustments and therapy. These complications may include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations. Some types of adjustments have been associated with injuries leading to or contributing to serious complications. Some patients will feel some stiffness and soreness following the first few days of treatment. I 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 RESPONSBILITY TO INFORM ME.

The probability of those risks occurring.

Complications with spinal adjustments are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-Ray. The incidences of complications are exceedingly rare and are estimated to occur between 1 in 1,000,000 to 1 in 5,000,000 (associated risks from taking ibuprofen are 3 in 1,000). The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers
- Hospitalization/Surgery

If you choose to use one of the above noted “other treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary care provider.

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.

I, _____ have read and fully understand the above statements.
Any 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.

Patient’s Signature_____ Date_____

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 disclosures for the purposes of treatment, payment or practice operations 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), revised 9/22/2013, 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 and or disclosed.

Patient Name (Print):_____

Relationship to Patient (*if under age 18*):_____

Signature:_____Date:_____

River Falls Chiropractic

Todd Frisch, D.C. Amy Hietala, D.C. Heidi Webb, D.C.

215 North 2nd Street, Ste 201, River Falls, WI 54022 * Phone: 715-425-6665 Fax: 715-425-6677

Financial Disclaimer

Dear Patient,

Welcome to **River Falls Chiropractic**! We are pleased that you have chosen our clinic to address your healthcare needs. We would like to take a few minutes to explain what you can expect from your insurance company as well as what we in turn expect from you.

Your benefit under your insurance plan for chiropractic care may not cover all of your visits to our office. You are financially responsible for co-payments, co-insurance and deductibles for covered services. Services exceeding benefit limits or considered maintenance or preventative are not reimbursable by your plan. You are also financially responsible for all non-covered services. Please feel free to discuss any questions with our accounts department.

If your doctor feels that care will not be a covered expense based on the type of care you are receiving, it may be in your best interest to discuss one of the several financial plans we have available.

- If at anytime there is a change in your insurance benefits it is **YOUR RESPONSIBILITY TO NOTIFY THE FRONT DESK. WE CAN NOT BE RESPONSIBLE FOR BACK BILLING IN THESE SITUATIONS.**
- Please understand that any benefit quoted to you by this office is **NOT A GUARANTEE** that your insurance co. will make payment on your claims.
- **YOUR CO-PAY, CO-INSURANCE, AND OR DEDUCTIBLE IS DUE AT THE TIME OF YOUR VISIT.** We welcome payments in advance by **cash, check, Visa, MasterCard, American Express, and debit cards.**

Also note: If you are filing your claims through AUTO INSURANCE or WORKMAN'S COMPENSATION, the insurance may not settle in your favor or your case may be denied, at which point you will be responsible to pay your balance.

By signing this statement, you acknowledge you understand the services you are receiving may not be covered by your health plan, and in that situation, you would be 100% responsible for all charges incurred.

_____ _____

Signature Date

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Non-Covered Services: Financial Disclosure Form

Chiropractic services typically covered by health insurance policies include:

- Chiropractic adjustment for acute clinical conditions
- Limited treatment of symptom flare-ups or exacerbations.

Services that we expect to **NOT** be eligible for reimbursement through your plan's chiropractic benefit, and therefore will likely be your financial responsibility are outlined below. Your financial responsibility is limited to services received during the treatment dates below.

Treatment plan start date: 01/01/2024 Treatment plan end date: 12 /31 /2024

Non-covered Services and Cost Per Visit*	
• Exam(s) (MEDICARE/MEDICARE Replacement)	$55-75
• Maintenance Care Spinal Adjustments	$55
• X-Ray(s) to detect subluxation	$145
• Durable Medical Equipment (Braces, Orthotics, Ice Pack)	Depends on Product
• Decompression Therapy	$75-150

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 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:_____

Maintenance Care Disclaimer Form

This brief handout defines the two phases of chiropractic care and explains which is covered through your health insurance. The "Maintenance" care phase is NOT covered through your health insurance. Any financial responsibility you may have for choosing to receive care in your maintenance phase will be reviewed with you by your chiropractor prior to receiving care.

When is chiropractic care covered by my health insurance?
Chiropractic care is covered by your health insurance plan if it for acute (short-term) care such as a recent injury, or for a condition where treatment offers lasting benefit or curative value

Is there a certain amount of treatment that is covered?
For most plans, the amount or length of treatment that is covered by insurance is not necessarily defined by the number of visits or types of treatment. Rather, the treatment is covered as long as it demonstrates significant, lasting, or progressive improvement to your condition.

When is chiropractic care NOT covered by my insurance plan?
Chiropractic care is NOT covered by your health insurance plan when you reach a certain point in treatment where chronic symptoms remain stable or where you no longer show progress in reducing these chronic symptoms through chiropractic care. At this point, you have reached what is called "maintenance" care.

How will I know if I have reached the end of covered care?
Your chiropractic provider will let you know when you have reached the point of "maintenance" care and will discuss further care options.

What happens when I am determined to have reached the end of covered treatment but I still want to have regular chiropractic adjustments?
You may continue maintenance treatment, but you must pay for it out of pocket. If you choose to receive chiropractic care beyond acute care, it is a self-pay service where you would be responsible for payment.

How will I know what maintenance care will cost me?
Prior to receiving maintenance care, your provider will have you sign a Financial Disclosure Form, letting you know in advance the cost of the elected services.

Is it possible to move from maintenance care back to chiropractic care covered by my insurance plan?
If you sustain a future incident or injury, your chiropractic care would meet the criteria for acute care and would be covered by your health plan, until that condition has reached a plateau level and does not provide any more lasting, curative value.

Who should I contact with questions?
Please contact your health plan's customer service department for any specific questions regarding your benefit coverage.

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:_____

MISSED APPOINTMENT POLICY

Out of respect and consideration for our practice members, we kindly ask you to honor your scheduled appointment time. Please note that appointment space is limited daily and both of our doctors have waiting lists.

We understand unanticipated events occasionally occur. In our desire to be effective and fair to all of our clients' time, we ask you give a minimum 24 hour advance notice when cancelling an appointment. This allows the opportunity for someone else to schedule and utilize your valuable appointment space.

We are happy to excuse one missed chiropractic appointment with no penalty. If there is a second missed appointment, you will be charged a $45 cancellation fee which is applied to your account. Insurance will not be billed for these charges. Cancellation fees are the responsibility of the patient and must be paid in full before the next visit.

Missed Clinical Nutrition appointments will be billed at $60 for every 15 minutes scheduled. For missed massage appointments, patients will be billed at $40 for an hour.

I have read and understand the River Falls Chiropractic Appointment Cancellation Policy. I am aware that I will be charged for the missed appointment, and I agree to these terms.

I, _____, have received a copy of The Cancellation Policy.

_____ _____

Signature of Patient Date