Welcome to Ultimate Health Chiropractic

New Patient Information

Name: _____ Date: _____
First *Last* *MI*

I prefer to be addressed as: _____ Birthdate: _____ ○Male ○Female

Address: _____ City: _____State: ___ ZIP:_____

Primary Phone:_____ Other Phone: _____

e-mail:_____ Contact Preferences : ☐ phone ☐ e-mail ☐ text

How did you hear about us?_____

Occupation:_____ Employer: _____

Marital Status: ○Single ○Married ○Divorced ○Widowed ○Partnered

Spouse/Partner Name:_____ Children? ○ Yes ○ No How Many?_____

About Today's Visit

The reason for this visit:_____

Date symptoms began on: _____ Is it getting worse? ○ Yes ○ No

Briefly describe your symptoms_____

How did your symptoms start?_____

Please describe pain: ○Sharp ○ Dull ○ Stiff ○ Ache ○ Numb/Tingling ○ Shooting/Burning

Average pain intensity: no pain ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 worst pain

How often do you experience your symptoms throughout the day?

○ Constant (76% -100%) ○ Frequently (51% -75%) ○ Occasionally (26% - 50%) ○ Intermittently (0%-25%)

How much have your symptoms interfered with your usual daily activities?

○Not at all ○A little bit ○Moderately ○Quite a bit ○Extremely

Have you had similar symptoms in the past? ○Yes ○No If yes, please explain_____

_____

Have you been treated by any other health care professional for your current condition? ○Yes ○No

If yes, whom?_____

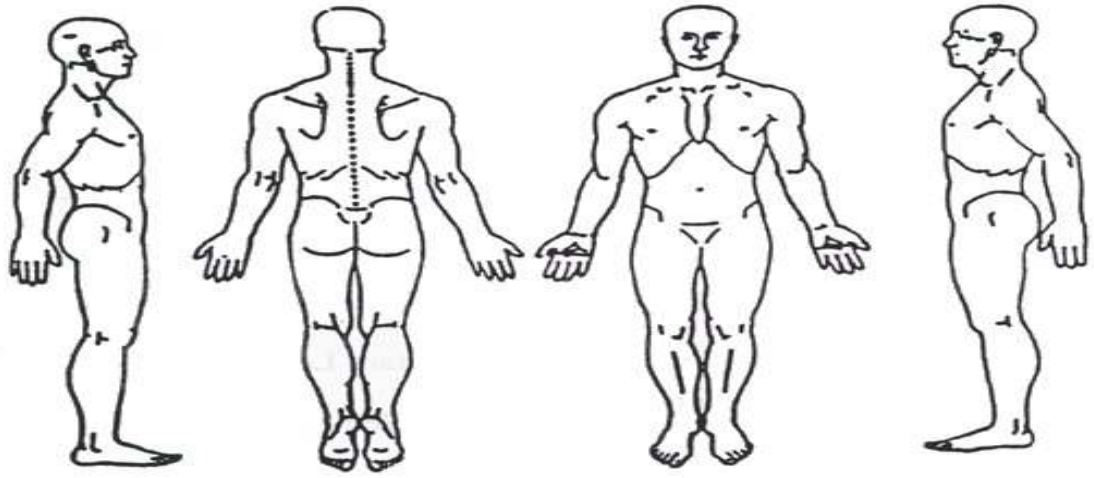
Have you been treated by a chiropractor previously? ○Yes ○No

If yes, whom?_____

Any additional information you would like to include? _____

_____

Please mark the chart below to indicate where you have pain or other symptoms.



Health History

Are you currently taking any medications? ○Yes ○No If yes, please list medications and dosages:

_____

_____

Do you take supplements or vitamins? ○Yes ○No If so, what?_____

Have you had any of the following conditions:

☐ Heart Attack	☐ Stroke	☐ Cong. Heart Defect	☐ Alcohol Abuse
☐ HIV+	☐ Neck Pain	☐ High Blood Pressure	☐ Drug Abuse
☐ AIDS	☐ Headaches	☐ Low Blood Pressure	☐ Shingles
☐ Fainting	☐ Seizures	☐ Epilepsy	☐ Diabetes Type I
☐ Low Back Pain	☐ Emphysema	☐ Glaucoma	☐ Diabetes Type II
☐ Psychiatric Issues	☐ Sinus Problems	☐ Artificial Valves	☐ Cancer
☐ Anemia	☐ Ulcers	☐ Asthma	☐ Arthritis

☐ Other Medical Conditions:_____

Please list any surgeries you have had with dates: _____

_____

Known Allergies (list all) _____

Family Health History: _____

What is your typical exercise routine?_____

Are you on a special diet? ○Yes ○No If so, what is it?_____

Do you smoke? ○Yes ◉No How much?_____ How long?_____

For Women:

Are you pregnant? ○Yes ○No How far along?_____ Nursing? ○Yes ○No

In Case of Emergency

Emergency Contact:_____ Phone:_____

Medical Doctor: _____ Phone:_____

I understand the above information and have accurately completed it to the best of my knowledge. It is my responsibility to inform this office of any changes to the information I have provided.

Signature:_____ Date:_____

Records Release

Ultimate Health Chiropractic is authorized to release any information deemed appropriate concerning my physical condition, including diagnosis and records of treatment or examination, to my insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred.

Signature:_____ Date_____

Thank you for choosing Ultimate Health Chiropractic

Ultimate Health Chiropractic
Notice of Privacy Practices

Ultimate Health Chiropractic is required, by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of your legal duties and privacy practices with respect to your protected health information.

There are certain times that we will disclose your healthcare information. These times include: for purposes of treatment, payment, workers compensation, public health, marketing (includes reminder phone calls and missed appointment phone calls), and change of ownership.

Your Rights:

1. You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Ultimate Health Chiropractic is not required to agree to the restriction that you requested.
2. You have the right to your health information received or communicated through an alternative method or sent to an alternative location.
3. You have the right to inspect and copy your health information.
4. You have a right to request that your health information be amended. However, Ultimate Health Chiropractic is not required to agree to the amendment. If your request has been denied an explanation will be provided along with measures as to how to disagree with your denial.
5. You have a right to receive an accounting of disclosures of your protected health information.
6. You have a right to a paper copy of this notice at any time upon request.

Any changes made to this notice must be presented to you. Our privacy officer is Dr. Chad Koterba and complaints and concerns can be presented to him at 952-541-0148. This paper is a modified version of our HIPAA policies. A full copy can be obtained upon request and is always displayed at the front desk.

I have read, understand, and agree to the HIPAA policies at Ultimate Health Chiropractic.

_____ _____ _____

Patient Signature Date Witness

I am opting not to sign this agreement for the following reason(s):

_____

_____

_____ _____ _____

Patient Signature Date Witness

Financial Agreement
Ultimate Health Chiropractic

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the front desk. This includes insurance copays and/or good faith estimates toward deductibles. If your account is not paid within 90 days from the date of service (or from notification of patient responsibility by insurance) and no financial arrangements have been made, you may be held responsible for legal fees, collection agency fees and any other expenses incurred in collecting your account.

GROUP OR INDIVIDUAL INSURANCE

Your insurance policy is an agreement between *you and your insurance company, not between your insurance company and this chiropractic office.* As a courtesy to our patients, our office will complete any necessary insurance forms at no charge, and file them with your company to help you collect. It is to be understood and agreed that services rendered are charged to you directly and you are personally responsible.

We encourage you to verify your chiropractic benefits directly with your insurance company to understand what services and limits may apply. You are responsible for your copay at the time of service, and we ask that patients with high deductible policies pay toward their visits until the deductible has been met.

"ON THE JOB" INJURY

We are required to treat work-related injuries reported to us under the Minnesota guidelines for Worker's Compensation. This allows for 12 weeks of chiropractic care from the date of injury. If needed we can request 12 additional visits to be used within 12 months.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Injuries as a result of an auto related incident will be submitted to under a personal injury claim. Please provide your claim number and adjuster's contact information so that we can process your claims promptly. If an attorney is handling your case, please notify the front desk as soon as possible. Although you are ultimately responsible for your bill, our office will wait for settlement to be paid as long as you are an active patient. If you suspend or terminate care, any fees for services are due immediately.

PATIENTS WITHOUT INSURANCE

For patients who do not have health insurance, are seeking wellness care (which generally is not covered by insurance) or elect not to use it, we have several cash options. Please ask the front desk to review these with you. We require all cash patients to pay at the time of service. We also require all new patients pay the full amount of their initial visit prior to leaving their first visit.

MEDICARE

We are providers of Medicare. For chiropractors this includes only manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met, and the patient will be required to pay the remaining 20% if it is not covered by a secondary insurance. The subsequent services will be payable at the end of each week or from a monthly statement. Our office will complete the necessary forms and file them with the Medicare provider at no charge.

I HAVE READ AND/OR BEEN EXPLAINED THE ABOVE FINANCIAL POLICY AND AGREE TO ACCEPT THE TERMS AND CONDITIONS.

SIGNED: _____ DATE: _____

WITNESS: _____