PATIENT INFORMATION

PATIENT NAME

Last Name _____ First Name _____ Middle _____

Gender: M F Date of Birth ____ / ____ / ____ Age _____ SS# _____

Home Address _____ Marital Status _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____

Employer Name _____ Phone _____

Employer Address _____

City _____ State _____ Zip _____

SPOUSE, GUARDIAN, EMERGENCY CONTACT

Last Name _____ First Name _____ Middle _____

Phone Number _____

Date of Birth ____ / ____ / ____

HOW DID YOU HEAR ABOUT THE OFFICE

Referral Source _____

HIPAA REQUIRED INFORMATION		
ETHNICITY (circle one)	Hispanic or Latino	Not Hispanic or Latino
RACE (circle one)	American Indian African American White	Asian Native Hawaiian Other Race
Preferred Method of Contact (circle one)	Phone	Email

MY CERTIFICATION

I certify that the above information is correct and I request services.

x _____ _____

Signature of patient or person acting on patient's behalf Date

MY PRIVACY

I have received a copy of the **Notice of Privacy Practices.** I understand that 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 among the healthcare providers who may be directly and indirectly involved in providing my treatment; Obtain payment from third-party payors; Conduct normal healthcare operations such as quality assessments and accreditation.

x _____ _____

Signature of patient or person acting on patient's behalf Date

Patient Health Questionnaire - PHQ

Form PHQ-202

rev 7/18/05

Patient Name _____ ***Date*** _____

1. Describe your symptoms _____

_____

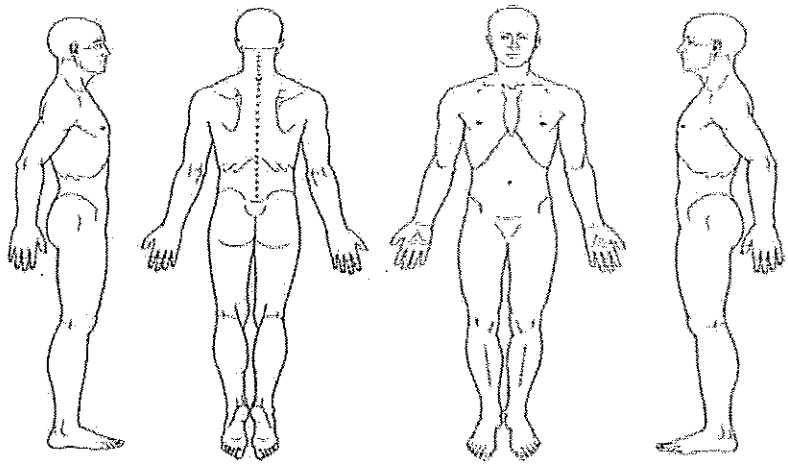
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

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)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb 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 ⓪ 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:* _____ ③ CT Scan *date:* _____
② MRI *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*** _____

PAST MEDICAL HISTORY

(circle if past or present history)

Eyes/Ears	Cardiovascular	Respiratory	GU	Neuro	Endocrine
Blindness	Aneurysm	Asthma	Hernia	Epilepsy	Goiter
Cataracts	Angina	Bronchitis	Incontinence	Seizures	Hyperlipidemia
Glaucoma	Atherosclerosis	COPD	Kidney stones	Migraines	Hypothyroidism
Glasses/Contacts	DVT	Pneumonia	UTI	TIA	Thyroid disease
Hearing aids	Dysrhythmia				Type 1 Diabetes
Deafness	High cholesterol	GI	Musculoskeletal	Psych	Type 2 Diabetes
	Hypertension	Abdominal pain	Rheumatoid arthritis	Bipolar	
Nose/Sinus	Heart Attack	Cirrhosis	Osteoarthritis	Depression	Other
Allergies	Stroke	GERD	Gout	Anxiety	Abnormal weight loss/gain
Sinus infection	Other heart disease	Gallbladder disease	Osteoporosis/-penia		Anemia
		Hepatitis	Injury, Fractures		Arnold-Chiari Malformation
		Ulcer			Cancer
					Lupus

Medications

Allergies

Family History (Major diseases including cancer, diabetes, heart disease, bone/joint diseases for parents, grandparents, siblings)

List any surgeries or hospitalizations you have had complete with the month and year for each:

Smoking (circle one) Current Every Day Smoker Current Some Day Smoker Former Smoker Never Smoker

For women: Are you pregnant? ___ Yes ___ No **If pregnant, how many weeks?** _____

Primary care physician: _____ **Location:** _____

May we update them on your condition? _____Yes _____No

Height_____ **Weight**_____ **Blood Pressure**_____

Patient's name (print): _____**Date:**_____

Patient's signature:_____

CONSENT TO TREATMENT

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment.

There are some risks that may be associated with treatment, in particular you should note:

a. 'While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following treatment;

b. There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal or soft tissue manipulation or treatment.

c. There have been reported cases of injury to a vertebral artery following osseous spinal manipulation. Vertebral artery injuries have been known to cause a stroke, sometimes with serious neurological impairment, and may, on rare occasion, result in paralysis or death. The possibility of such injuries resulting from cervical spine manipulation is extremely remote;

Osseous and soft tissue manipulation has been the subject of government reports and multi-disciplinary studies conducted over many years and have demonstrated it to be highly effective treatment of spinal conditions including general pain and loss of mobility, headaches and other related symptoms. Musculoskeletal care contributes to your overall well being. ***The risk of injuries or complications from treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.***

I acknowledge I have discussed the following with my healthcare provider:

a. The condition that the treatment is to address;

b. The nature of the treatment;

c. The risks and benefits of that treatment; and d.

Any alternatives to that treatment.

I have had the opportunity to ask questions and receive answers regarding the treatment.

I consent to the treatments offered or recommended to me by my healthcare provider, including osseous and soft tissue manipulation. I intend this consent to apply to all my present and future care with Nicole Graue, DC.

Name:_____ Witness Name:_____

Date: _____

Horizon Chiropractic
4925 E 26th St, Sioux Falls, SD 57110
605-371-8646
Fax: 605-332-6616

PATIENT FINANCIAL RESPONSIBILITY

This office will provide insurance billing services for you, if you so desire, as a courtesy. **Remember that you are ultimately responsible for any charges incurred in this office. It is your legal responsibility to pay any deductible amount, co-insurance, and or any other balances not paid by your insurance carrier. Your signature on this document indicates that you agree to pay for any outstanding charges incurred in this office.**

Patients who do not have health insurance:

Since we will not need to pay staff to bill and follow up with insurance companies, we pass the savings on to you. We offer EVERYONE our Time of Service rates when their accounts are paid in full on each visit. Our fee schedule is available upon request.

Patients with a deductible have two options:

1. You can pay our regular fee schedule and we will bill insurance for you. This notifies the insurance company that your deductible should be reduced by what you pay on each visit. If and when the deductible is met, your plan will most likely switch to a co-pay status.
2. You can pay our Time of Service fees, which are significantly less than our regular fees. However YOU will then be responsible for submitting all services you have paid for to your insurance for reimbursement. We will not be billing on your behalf.

We will strive to work out feasible payment options for anyone who is in need of care. Unless other prior written agreements have been made, any outstanding balance more than 60 days old is considered delinquent. A re-billing fee of 1.5% (based on the outstanding balance, per month) will also be added to all accounts that fit this criterion. Office policy dictates that delinquent accounts may be referred to a collection agency for collection which may include possible blemishes on your credit record. If this happens, an administrative collection fee of $100 (minimum) may be added to your account to cover our costs and you specifically authorize us to run your credit report.

ERISA Authorization

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

I authorize payment of insurance benefits directly to Horizon Chiropractic, Inc. I also authorize the doctor to release all information necessary to communicate with personal physicians, other healthcare providers, collection agencies, and payers to secure the payment of benefits or inform them of concurrent treatment. By signing below I indicate that I have read, understand, and agree with the terms on this page.

_____ _____

Signature of responsible party (Parent of Legal Guardian) Date