Heiden Chiropractic Inc.
DBA, Independence Chiro and Trempealeau Chiro
11378 Chase St. Trempealeau WI 54661

Patient Name: _____ Today's Date: ___/___/___

Phone_____ Email _____

Address _____

Date of Birth: _____ Height _____ Weight _____

Would you like appointment reminders? YES NO

Marital Status: ☐ Married ☐ Separated ☐ Widowed ☐ Single

If you are under 18 years of age, who are your legal parents or guardian?

Name _____ Date of Birth: ___/___/___ Phone: (____) _____

Who do you normally live with? ☐ Mother and Father ☐ Father ☐ Mother ☐ Legal Guardian ☐ None of these

Who should we contact in the event of an emergency? _____

Relationship of emergency contact to patient: _____ Phone (____) _____

How did you learn about us? _____

Describe your condition, symptoms, or the purpose of this appointment:

_____

_____

When did your symptoms start? _____

Additional Information Related to the Condition:

Describe your pain: ☐ Burning ☐ Sharp ☐ Dull ☐ Ache

What caused it?

_____

What aggravates it? Bending Coughing Daily Routine Driving Getting up Lifting Sitting Sleeping Standing Looking up/down Walking Work Exercise Movement Household Chores

What relieves it? Ice Heat Stretching Medication Rest Activity Analgesics Massage Adjustments

Has the Patient ever had the same or similar condition or symptoms previous to this most recent occurrence? ☐ Yes ☐ No

When? ___/___/___

Have you been seen elsewhere for this condition this year? Yes No

Please list any surgeries _____ When? _____

_____ When? _____

_____ When? _____

_____ When? _____

Serious illnesses or conditions? _____ When? _____

Have you been treated for any health condition by a physician in the last year? ☐ YES ☐ NO

How much caffeine do you consume? _____ How much water do you drink? _____

How much alcohol do you consume? _____

What medications or supplements are you taking?

_____

_____

_____

Do you have any Allergies?

_____

Do you have a PACEMAKER? ☐ Yes ☐ No

Have you ever suffered from:

☐ Dizziness	☐ Arthritis	☐ Digestive Disorders
☐ Backaches	☐ Headaches	☐ Extremity Pain
☐ Heart Trouble	☐ Numbness	☐ Sinus Trouble
☐ Diabetes	☐ Asthma	☐ Anemia
☐ Hernia	☐ Heart Attack	☐ Cancer
☐ STROKE		

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? ☐ YES ☐ NO ☐ UNCERTAIN

Do you have health insurance? ☐ YES ☐ NO ☐ Not Sure Company: _____

Full Name of **Policy Holder**: _____ **Policy Holder's** Date of Birth ___/___/____

Health insurance Id: _____ Group number: _____

I agree to pay my estimated patient responsibility and further understand that the estimated responsibility is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual responsibility as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorney s who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance companies, attorneys, or other payers.

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: _____ Date: ___/___/____

Heiden Chiropractic
11378 Chase St
Trempealeau, WI 54661
p 608.534.6090
trempealeaufamilychiro.com

Patient Name: _____

Authorizations and Releases

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services.

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their 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. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
5. Patients have the right to file a formal complaint with our privacy official about any suspected violations.
6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Initial _____

Consent to Professional Treatment

The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. The patient may refuse treatment at any time.

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. 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 As a part of the analysis, examination, and treatment, you are consenting to the following procedures: palpation, orthopedic testing, postural analysis, hot/cold therapy, vital signs, basic neurological testing, spinal manipulative therapy, range of motion testing, muscle strength testing, EMS, Ultrasound, and X-rays.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. 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 responsibility to inform me.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during your history and during examination. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. This is the same rate of stroke determined in studies for people getting their hair washed at a salon, looking behind you while driving. Here at Trempealeau and Independence Family Chiropractic we offer light force neck adjustments using an instrument when you have increased risk factors to stroke or other conditions.

Initial _____

Consent to Perform and Interpret X-rays
The patient consents to the performance of x-rays as deemed necessary by the attending physician of this office. The patient acknowledges that certain risks are associated with x-rays. The patient, hereby states that they have no known limitations that would forbid the taking of x-rays such as pregnancy.
The patient further agrees that this office may seek outside interpretation of patient x-rays by a qualified professional not employed by this office. The patient agrees to any additional fees associated with this service and assigns benefits to be paid directly to that professional by your third-party payor.
Initial _____

Assignment of Benefits and Release of Records
The patient hereby assigns benefits to be paid directly to this provider by all of their third party payors. This assignment is irrevocable. Failure to fulfill this obligation will be considered a breach of contract between the patient and this office.
The patient authorizes this office to release any information required by a third party payor necessary for reimbursement of charges incurred.

Initial _____

Financial Obligation and Appointment Policy

I hereby accept full financial responsibility for services rendered by this practice. I accept full responsibility for any fees incurred, regardless of insurance coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. It is my responsibility to notify this practice of any changes in my health care coverage.

Signature of Patient or Guardian (if a minor) _____ Date _____

Patient: _____

For Work Comp or Auto Injury Only

Were you injured at work? YES NO

if yes please provide a copy of the incident report and the following info:

Employer Name:_____

Employer Phone:_____ Ext. _____ Fax:_____

Were you in a Car Accident? YES NO

If yes please provide a copy of your auto insurance card and accident report if available.