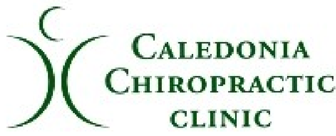

Welcome

Thank you for choosing Caledonia Chiropractic Clinic.
If you have any questions or concerns, do not hesitate to ask for assistance, we will be happy to help.

Patient Information:

Name: ____DOB:_______________
FIRST MIDDLE LAST

Address: ____ Apt#:_______________

City: ________________________________State: ____________Zip: _______________

Home Phone#: _____________________ Work/Cell Phone#: __________________________

How did you hear about our office? ____

SS#: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Email Address: ______________________________

Marital Status: □ single □ married □ divorced □ separated □ widowed

Employer: _____________________________ Occupation: __________________________

Employer Address: ______________________________ Phone Number: _________________

City: ____________________________ State: ___________ Zip code: ________________

Spouse/Parents Name: ____

Emergency Contact: ____________________________ Phone#: ______________________

Is this injury due to an automobile accident? □ YES □ NO
Is this injury due to a work related incident? □ YES □ NO

Do you have insurance? □ YES (if yes, please fill out the information below) □ NO

Policy Holders Name: ______________________________ Date of Birth: ________________
Relationship to patient: □ spouse □ parent/guardian □ other: ____________________________

Policy Holder SS#: __ __ __ - __ __ - __ __ __ __ Policy Holder Employer: ________________________

Insurance Company Name: ____

Policy/ID #: _______________________________ Group #: ___________________________
(Please have your Drivers License and insurance cards available for the patient coordinator to make a copy of)

Primary Care Physician: ______________________________ Phone#: _________________
May we contact them about your condition? □ Yes □ No Date last seen: _________________
Have you seen anyone else about your condition? □ Yes □ No
If yes, who? ____
Do you smoke? □ Yes □ No If yes, how many cigarettes a day: ________________
Are you pregnant? □ No □ Yes my due date is: _________________
Last Menstrual Cycle: ___________________

I have provided correct information in the questionnaire to the best of my knowledge.

Signed: ____Date: ____________________

AUTHORIZATION TO EXAMINE, X-RAY AND RENDER CARE:

I hereby authorize the examination and rendering of care. I also authorize the taking of x-ray film of my body.

Initials: _______________

INFORMED CONSENT FOR CHIROPRACTIC CARE

I understand that, we with any health care procedure, there are certain inherent risks, which may arise during the course of treatment. I do not expect the doctor to be able to anticipate all possible risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based on the facts known then, and are in my best interest.

Upon my initial visit with the doctor, I will take the opportunity to discuss with the doctor the nature, purpose and risks associated with chiropractic adjustments as well as other recommend procedure and have all my questions answered to my satisfaction. I also understand that results are not guaranteed.

I have read, or have had read to me, the above explanation of risks associated with chiropractic adjustments and related treatment. By signing below, I state that I have weighed the risks involved in undergoing care and have decided that it is in my best interest to undergo the chiropractic care recommended. Having discussed and been informed of the possible risks, I hereby give my consent to care. I intend this consent form to cover the entire course of treatment for my present and future conditions for which I may seek care.

Initials: _______________

I have provided correct information in the questionnaire to the best of my knowledge and will provide the doctor with any updated information as it arises.

I agree to take responsibility in my health and work with Caledonia Chiropractic Care Center to optimize my recovery.

Initials: _______________

INSURANCE AND BILLING ARRANGEMENTS

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that Caledonia Chiropractic Clinic 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 the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment.

I understand and agree that it is my sole responsibility to inform Caledonia Chiropractic Clinic of ***any*** changes in my insurance carrier as soon as such information is provided to me or if my insurance has been suspended or canceled.

If credit is necessary, such arrangements must be made prior to services performed. Payment is due within 30 days of treatment or the sale of a product. A 1% per month (12% per year) late payment will be assessed on any unpaid balance remaining after 30 days.

I have been informed of the same day discount option and I understand full payment for this discount is within three calendar days. I understand that if full payment is not made within three calendar days, I will be charged the normal clinic fees.

If it becomes necessary to use a collection agency for my account, I am responsible for the charges incurred by the clinic.

I understand that a 24 hour notice is required for cancellations of an appointment and should I fail to do such, a ***$35 missed appointment fee*** may be charged to my account. This fee must be paid prior to any additional treatment.

I have read and agree to the above.
I understand and authorize the billing arrangements as stated above.

Initials: _______________

Personal Injury and Workmen's Compensation Claims:

I understand that I will notify the front office staff when I schedule my appointment that my medical condition involves a Personal Injury or Workmen's Compensation case and will bring all the necessary documentation at that time. Should I fail to do such or change the nature of my claim after my initial visit, a ***$35 clerical fee*** will be charged to my account. This fee must be paid prior to any additional treatment.

I have read and agree to the above.

I understand and authorize the billing arrangements as stated above.

Initials: _______________

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE INFORMATION CONTAINED IN THIS AGREEMENT

____
Printed Name of Patient

____ ________________________
Signature of Patient or Representative **Date**

____ ________________________
Witness to Patient's Signature **Date**

Dr. Timothy Schneider, Caledonia Chiropractic Clinic, 5401 Douglas Ave. Suite A, Racine, WI 53402

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Here are some examples of how we might have to use or disclose your health care information:

1) Your chiropractor or a staff member may have to disclose your health information including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.
2) Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are potentially responsible for the payment of your services.
3) Your chiropractor and members of the staff may need to use your health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run his/her practice.
4) Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

   You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

   You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

Permitted uses and disclosures without your consent or authorization

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

1) We are permitted to use or disclose your health information to the extent that we are required to do so by applicable federal or state laws.
2) We are permitted to use or disclose your health information to a public health authority for a wide range of public health activities when the public health authority is authorized to collect or receive your health information under state or federal law.
3) We are permitted to use or disclose your health information to an appropriate government authority if we reasonably believe you are the victim of abuse, neglect or domestic violence.
4) We are permitted to use or disclose your health information for state and federal health oversight activities of the health care system and government benefit programs.
5) We are permitted to use or disclose your health information in response to a court order or, in response to a subpoena, discovery request, or other lawful purpose.
6) We are permitted to use or disclose your health information to a law enforcement official as required by laws that require us to report certain types of wounds or physical injuries or, to

comply with court orders, a grand jury subpoena, or administrative requests authorized by the law.

7) We are permitted to use or disclose your health information to an appropriate law enforcement authority if the disclosure is necessary to prevent or lesson a serious and imminent threat to the health or safety of a person or the public.
8) We are permitted to use or disclose your health information to a correctional institution if we provide health care services to you as an inmate.
9) We are permitted to use or disclose your health information if we provide health care services to you in an emergency.
10) We are permitted to use or disclose your health information if we provide care to you that is related to a work place injury to the extent necessary to comply with Wisconsin's worker's compensation laws.

Other than the circumstances described in the preceding examples, any other use or disclosure of your health information will only be made with your written authorization.

Your right to revoke your authorization

You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

1) If we have already released your health information before we receive your request to revoke your authorization.
2) If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Your right to limit uses or disclosures

If there are health care providers, hospitals, employers, insurers or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

Your right to receive confidential communication regarding your health information

We normally provide information about your health to you in person at the time you receive chiropractic services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home or, if you would like the information in a different form. To help us respond to your needs, please make any request in writing.

Your right to inspect and copy your health information

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to inspect and/or copy your health information to be in writing. We may refuse your request if the information is for use in a civil, criminal, or administrative action or proceeding

which is anticipated to occur in a time frame reasonable proximate to your request. There may be a cost associated with your request if we must copy information for you.

Your right to amend your health information

You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

Your right to receive an accounting of the disclosures we have made of your records

You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except

1. those disclosures required for your treatment, to obtain payment for your services, or to run our practice.
2. those disclosures made to you.
3. those disclosures we are permitted to make without your consent or authorization as described above.
4. those disclosures made based on an authorization you signed.
5. those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved with your care.
6. those disclosures for national security or intelligence purposes.
7. those disclosures made to correctional officers or law enforcement officers.
8. those disclosures that were made prior to the effective date of the HIPAA privacy law.

We will provide the first accounting within any 12-month period without charge. There is a fee for any additional requests during the next 12 months. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

Your right to obtain a paper copy of this notice

If you have agreed to receive privacy notices by e-mail, you may request a paper copy of this notice at any time.

Our duties

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms the change will apply for all of your health information in our files.

Re-disclosure

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

Your right to complain

You may complain to us or to the Secretary of Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be sent to us at the address listed below.

To contact us

If you would like further information about our privacy policies and practices please contact:

Caledonia Chiropractic Clinic, S.C.

5401 Douglas Avenue, Suite A

Racine, Wisconsin 53402

(262) 681-8829

This notice is effective as of ___________________. This notice will expire seven years after the date upon which the record was created. By signing below, I acknowledge that I have received a copy of this notice.

___________________________	_______________________________
Patient Name Printed	Date
__________________________	___________________________________
Patient Signature	Authorized Provider Representative
__________________________	______________________________
Personal Representative Printed	Personal Representative Signature

____

Description of personal representative's authority to act for the patient.

PATIENT HEALTH QUESTIONNAIRE – PHQ

ACN Group, Inc. – Form PHQ – 202

Patient Name____Date____________________

1. Describe your symptoms____

____

a. When did your symptoms start?________________b. How did your symptoms begin?_____________

Indicate where you have pain or other symptoms

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)

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:** None Unbearable

A. Indicate the average intensity of your symptoms ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

B. How much has pain interfered with your normal work (including both work outside of home, 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 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 ⑤Poor

8. **Who have you seen for your symptoms:** ① No one ② Medical Doctor ③ Other Chiropractor ④ Physical Therapist ⑤ Other

A. What treatment did you receive and when?____

B. What test have you had for your symptoms and when were they preformed? ① X-rays date_________ ② MRI date____________ ③ CT Scan 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 No one ② Medical Doctor ③ Other Chiropractor ④ Physical Therapist

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 ② Self Employed ④ Unemployed ⑤ Off Work Part Time ⑥ Other

Patient Signature____**Date**____________________

ACN Use Only rev 4/23/99

PATIENT HEALTH QUESTIONNAIRE – PAGE 2

Patient Name____ Date____________________

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height? Weight lbs.

For each of the conditions listed below, place a check in the past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the present column.

Past	Present		Past	Present		Past	Present	
○	○	Headache	○	○	High Blood Pressure	○	○	Diabetes
○	○	Neck Pain	○	○	Heart Attack	○	○	Excessive Thirst
○	○	Upper Back Pain	○	○	Chest Pain	○	○	Frequent Urination
○	○	Mid Back Pain	○	○	Stroke	○	○	Smoking/use Tobacco
○	○	Low Back Pain	○	○	Angina	○	○	Drug/Alcohol Dependence
○	○	Shoulder Pain	○	○	Kidney Stones	○	○	Allergies
○	○	Elbow/Upper Arm Pain	○	○	Bladder Infection	○	○	Depression
○	○	Wrist Pain	○	○	Painful Urination	○	○	Systemic Lupus
○	○	Hand Pain	○	○	Loss of Bladder Control	○	○	Epilepsy
○	○	Hip/Upper Leg Pain	○	○	Prostate Problems	○	○	Dermatitis/Eczema/Rash
○	○	Knee/Lower Leg Pain	○	○	Abnormal Weight Gain/loss	○	○	HIV/AIDS
○	○	Ankle/Foot pain	○	○	Loss of Appetite			**Females only**
○	○	Jaw Pain	○	○	Abdominal Pain	○	○	Birth Control Pills
○	○	Joint Swelling/Stiffness	○	○	Ulcer	○	○	Hormonal Replacement
○	○	Arthritis	○	○	Hepatitis	○	○	Pregnancy
○	○	Rheumatoid Arthritis	○	○	Liver/Gall Bladder Disorder	○	○	**Other Health Problems**
○	○	General Fatigue	○	○	Cancer	○	○	**Issues**
○	○	Muscular In coordination	○	○	Tumor	○	○	
○	○	Visual Disturbances	○	○	Asthma	○	○	
○	○	Dizziness	○	○	Chronic Sinusitis	○	○	

Indicate if an immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○__________________

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

List all the surgical procedures you have had and times you have been hospitalized:

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

Patient Signature____**Date**____________________

Doctor's Additional Comments

____

____

Doctors Signature____**Date**____________________