



NEW PATIENT ENTRANCE APPLICATION

Welcome! We are honored you chose us to evaluate your condition. So we may file your insurance forms for you, would you please fill out the personal information below? If you need assistance please inform the front desk person. Thank you!

Personal Information:

Patient Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: M or F _____ Marital Status: S M D _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Social Security #: _____ E-mail: _____

Employer Name: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Insurance Information:

❖ Please complete below and present your insurance card to the front desk.

Name of Insured: _____ Date of Birth: _____

Relationship to Insured: _____

Is This Related To Your Work? Y or N _____ Is This Related To An Auto Accident? Y or N _____

Guardian / Spouse / Family Information:

Name: _____ Relationship: _____

Employer Name: _____ Occupation: _____ Phone #: _____

Children:

Name: _____	Age: _____	Sex: M or F _____	Name: _____	Age: _____	Sex: M or F _____
Name: _____	Age: _____	Sex: M or F _____	Name: _____	Age: _____	Sex: M or F _____
Name: _____	Age: _____	Sex: M or F _____	Name: _____	Age: _____	Sex: M or F _____

Referral Information:

- How did you find out about us? _____
- Who can we thank for your referral? _____

Patient Informed Consent:

I, <print name>, the undersigned patient, consent to the treatment(s) provided by this clinic. I understand that my condition may necessitate modifications from time to time of the type of treatment(s) rendered and the portions of my body that may need to be examined. I understand and consent to clinic staff providing me with verbal descriptions, when there are changes to my exam(s) and treatment(s), consent to the clinic staff providing said treatment(s) and exam(s) and hereby consent to any similar subsequent treatment(s) or exam(s). If I do not consent, I will immediately inform clinic staff. There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or insurance. I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff.

Patient Signature: _____ Date: _____

CHIROPRACTIC AND WELLNESS CENTER OF ALBERTVILLE PEDIATRIC INTAKE FORMS

Child's Name: _____

Mother's Name: _____

Address: _____

Phone: _____ Occupation: _____

Father's Name: _____

Address: _____

Phone: _____ Occupation: _____

Sibling's Name: _____ Age: _____ Sex: _____

Sibling's Name: _____ Age: _____ Sex: _____

Sibling's Name: _____ Age: _____ Sex: _____

Sibling's Name: _____ Age: _____ Sex: _____

Primary Healthcare Provider and/or Clinic: _____

Address: _____

Phone: _____

Your answers to the following questions will help us learn more about your child's health. Please take a few minutes to complete this questionnaire; you may skip any questions you are uncomfortable answering.

1. What is your child's chief complaint today, if any? _____

Check all that apply:

- Neck / Back / Joint pain
- Headaches
- Depression / Anxiety
- Respiratory Problems (asthma, allergies, sinus congestion, etc)
- Digestive Problems (poor appetite, heartburn, constipation, diarrhea, etc.)
- Urinary Problems (difficult or painful urination, kidney stones, etc.)
- Fatigue or low energy
- Female reproductive health
- Male reproductive health
- Stress management
- General Wellness
- Other

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PEDIATRIC INTAKE FORMS

2. Health History

Please list any health problems your child currently has or has had in the past. Please answer to the best of your knowledge.

- Cancer (malignant or metastatic):
- Diabetes (Type I or II)
- Infectious Diseases (hepatitis, HIV, etc)
- Heart, Lungs, or Circulation (asthma, heart murmur, etc)
- Digestive System (poor appetite, heartburn, constipation, diarrhea)
- Psychosocial Health (depression, anxiety, violence toward others or self, etc.)
- Skeleton and Joints (arthritis, back or neck pain)
- Genitourinary System (difficult or painful urination, kidney stones, sexually transmitted diseases, painful menses, etc)
- Nervous System (headaches, dizziness, etc.)
- Eyes, Ears, Nose, & Throat (loss of vision or hearing, ear infections, dental problems)
- Skin (rashes, sores, moles that have changed, etc)
- Chronic Immune System Deficiencies (colds, sinusitis, bronchitis, etc.)
- Other

Family Health History:

Do / did any members of your immediate family have any serious health conditions?

- No
- Yes -- if so, please describe your relation to this individual and their condition

3. Pregnancy:

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PEDIATRIC INTAKE FORMS

Please check any areas that applied to the patient's mother during her pregnancy:

- | | | |
|--|---|---|
| <input type="checkbox"/> Complications | <input type="checkbox"/> Vitamins / Minerals | <input type="checkbox"/> Toxic Exposures |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Diagnosed Illnesses | <input type="checkbox"/> Allergic Reactions |
| <input type="checkbox"/> Recreational Drugs | <input type="checkbox"/> Hospitalization | <input type="checkbox"/> Mental Trauma |
| <input type="checkbox"/> Smoking | <input type="checkbox"/> Immunization | <input type="checkbox"/> Physical Injury |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Prenatal Classes |
| <input type="checkbox"/> Caffeine: Cola | <input type="checkbox"/> Premature Contractions | <input type="checkbox"/> Chiropractic Care |
| <input type="checkbox"/> Caffeine: Tea | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Prenatal Care |
| <input type="checkbox"/> Caffeine: Coffee | <input type="checkbox"/> Other Pain | <input type="checkbox"/> Carried to Full Term |
| <input type="checkbox"/> Caffeine: Chocolate | <input type="checkbox"/> Excessive Weight Loss | <input type="checkbox"/> Attitude - Happy |
| <input type="checkbox"/> Caffeine: Other | <input type="checkbox"/> Excessive Weight Gain | <input type="checkbox"/> Attitude - Depressed |

4. Labor and Delivery

- | | |
|--|---|
| <input type="checkbox"/> Greater than 12 hours | <input type="checkbox"/> Caesarian Section |
| <input type="checkbox"/> Complications | <input type="checkbox"/> Hospital |
| <input type="checkbox"/> Fetal Monitor Used | <input type="checkbox"/> Home Birth |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Premature Delivery |
| <input type="checkbox"/> Forceps Used | <input type="checkbox"/> Vacuum Extraction |
| <input type="checkbox"/> Other | |

5. Perinatal History - If known, please indicate

The duration of the pregnancy was _____ weeks.
The apgar score at birth was _____.
The apgar score at five minutes was _____.
The length at birth was _____.
The birth weight was _____.

Please check any problems the patient had at birth:

- | | |
|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Breathing | <input type="checkbox"/> Nursing |
| <input type="checkbox"/> Coloring | <input type="checkbox"/> Sleeping |
| <input type="checkbox"/> Crying | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Choking | |
| <input type="checkbox"/> Other | |

Please check if any item (s) applied to the patient at birth:

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Medication | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Artificial Feeding | <input type="checkbox"/> Erythromycin |
| <input type="checkbox"/> Vitamin K | <input type="checkbox"/> Circumcision |
| <input type="checkbox"/> Other | |

Please list your child's allergies: _____

CHIROPRACTIC AND WELLNESS CENTER OF ALBERTVILLE PEDIATRIC INTAKE FORMS

Please list any surgeries your child has had in the past, and the date of the surgery if known:

Please list any traumas or injuries:

Please list current medications:

6. Nutrition

Please check if the patient has received any of the following items:

- | | |
|---|---|
| <input type="checkbox"/> Breast Milk | <input type="checkbox"/> Sweets |
| <input type="checkbox"/> Commercial Formula | <input type="checkbox"/> Juice: Fruit |
| <input type="checkbox"/> Cow's Milk | <input type="checkbox"/> Juice: Vegetable |
| <input type="checkbox"/> Goat's Milk | <input type="checkbox"/> Vitamins |
| <input type="checkbox"/> Solid Foods | <input type="checkbox"/> Medications |
| <input type="checkbox"/> Other | |

7. Immunizations

Please list any immunizations the patient has received along with the date it was received and any reactions observed:

Note foreign travel (countries and dates):



CHIROPRACTIC & WELLNESS CENTER OF ALBERTVILLE

OFFICE POLICY

The following is a summary of our clinic policies. We believe that a clear definition will allow us both to concentrate on the most important issue; regaining and maintaining your health. We are happy to answer any questions you have regarding your account.

Payment Policy:

- **Auto Accident and Workers Compensation:** If the incident is properly documented and the necessary forms and liens are signed, you are not required to pay for services on the day they are rendered and we will make efforts to file your services with your insurance provider for you. You are still responsible for all charges on your account. **Any balance billed from our office deemed 'patient responsibility' exceeding 90 days past due will be assessed a 10.00% interest charge.**
- **For patients with insurance:** Chiropractic and Wellness Center of Albertville will file your insurance claim for you, and will attempt to verify coverage of services to be performed. We will review this information with you and explain what services (if any) are not covered that you will be responsible for. You are responsible for the balance on your account for any professional services rendered if your insurance denies coverage. **Any balance billed from our office deemed 'Patient Responsibility' exceeding 90 days past due will be assessed a 10.00% interest charge.** Payment plans are available, but you must contact our office to setup these plans. Additional Notes about insurance coverage:
 - **Copays are due at the time of service.**
 - **You may be responsible for a Deductible Amount.** This amount is deemed 'patient responsibility'. Our office will bill you for this amount following our offices receipt of an 'Explanation Of Benefits' (aka EOB) from your insurance company.
 - **You may be responsible for a Coinsurance Amount.** (aka % Responsibility) Our office will bill you for this amount following our offices receipt of an Explanation Of Benefits (aka EOB) from your insurance company.
 - **You may choose to make payments in advance of receiving a bill for any amount considered patient responsibility.**
- **For patients without insurance:** You have the option of paying in full on the date of service, paying in advance for your services or receiving a bill from our office. Discounts apply for payment in advance and payment made on the same day. You are responsible for the balance on your account for any services rendered. **Any balance billed from our office deemed 'Patient Responsibility' exceeding 90 days past due will be assessed a 10.00% interest charge.**

Appointment Cancellation:

In order for us to better serve our growing number of patients, we ask that you call if you will be late or unable to keep your scheduled appointment.

Emergency / After Hours Calls:

In case of an emergency you may contact our office any time for an appointment and our office has a doctor on call 24 hours. Should you require treatment during a non-treating time additional charges may apply.

Massage Policies:

- **Cancellation Policy:** If you cannot make your appointment we ask that you please contact our office 24 hours in advance to cancel. If your appointment is not cancelled 24 hours in advance it will be considered a 'No Show' and you will be subject to our 'No Show Policy.'
- **No Show Policy:** If you fail to cancel your appointment according to the cancellation policy you are considered a 'No Show' and will be unable to schedule your next appointment without providing payment in advance. **If you fail to redeem this appointment time or fail to cancel according to the 'Cancellation Policy' you will surrender your payment for this appointment.**
- **Refusal of Service Policy:** We reserve the right to refuse to provide services to any person at anytime. Should you be denied service you will be reimbursed for any unused services that have been paid in advance.

By signing below I acknowledge having received and read the above 'Office Policy.' I hereby agree to the terms and conditions outlined above.

Patient Name (Please Print): _____

Patient / Guardian Signature: _____ Date: _____



CHIROPRACTIC & WELLNESS CENTER OF ALBERTVILLE

SUMMARY OF NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT AND CONSENT

FOR PHI RELEASE

Privacy Policy:

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA) and specifically its Privacy Rule, I have certain rights to privacy regarding my Protected Health Information (PHI). I understand that my PHI can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers that may be involved in my treatment directly or indirectly.
- Obtain payment or reimbursement from health coverage programs or others.
- Conduct normal healthcare business operations including routine aspects of operating a health related practice or business.

Acknowledgement and Consent:

I have received, read and understand the Notice of Privacy Practices containing a more complete description of the creation, uses and disclosures of my PHI. I understand that the Chiropractic and Wellness Center of Albertville has the right to change its Notice of Privacy Practices from time to time and that I may contact the Privacy Officer for Chiropractic and Wellness Center of Albertville at or through the address listed below to obtain a current copy of the Notice of Privacy Practices.

I also understand that I may request in writing that you restrict how my PHI is used or disclosed to carry out treatment, payment or healthcare operations. However, I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I further agree that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Privacy Officer Contact Information:

The privacy officer for Chiropractic and Wellness Center of Albertville may be contacted by mail by writing: Attn: Privacy Officer, PO Box 251, Albertville, MN 55301.

Office Use Only:

The following is practice documentation of our good faith effort to obtain acknowledgement of the above. Patient's acknowledgement of this notice could not be obtained due to the following situation:

- Patient Refused to Sign.
- Communication Barrier Prohibited Obtaining Acknowledgement.
- Emergency Circumstances
- Other: _____

Signature of Practice: _____

Date: _____

Patient Name (Please Print): _____

Patient / Guardian Signature: _____ Date: _____