Kiekhoefer Chiropractic
8619 West Point Douglas Rd Suite 110
Cottage Grove, MN 55016

ABOUT THE ADULT PATIENT

Name _____ Today's Date_____ Birthdate _____ Age_____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____Gender ❑ M ❑ F

Significant Other's Name _____ Kid's Names and Ages _____

Your Employer _____ Type of Work _____

e-Mail Address _____ Have you been to a chiropractor before? ▫ No ▫ Yes

Emergency Contact _____ ph # _____

Name of Medical Doctor(s)_____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Kiekhoefer Chiropractic to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient?_____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is: ❑ Cash ❑ Check ❑ Credit Card ❑ Car/Work Ins.

_____ _____

Patient / Parent Signature (This represents a long term authorization for all occasions of service) Date

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

2. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

3. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

4. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

5. Does your condition affect: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving

6. What makes it better?_____

7. What makes it worse? _____

8. What Doctor's have you seen for this?_____

_____

9. Type of treatment:_____

10. Results: _____

NOTES: _____

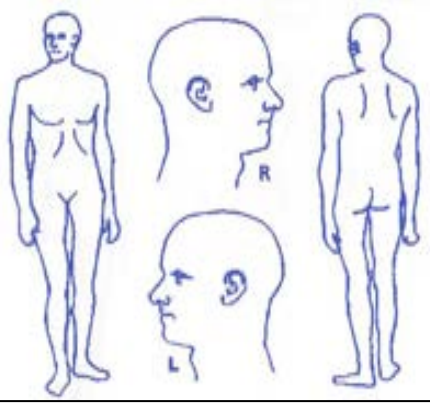
_____

_____

Are you pregnant?

❑ Yes ❑ No

Please mark all areas of concern.



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GENERAL HEALTH HISTORY-ADULT

Patient Name_____ *Mark the conditions that apply to you.*

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Urinary Problems
❑	❑	Migraines	❑	❑	Easy Bruising
❑	❑	Shortness of Breath	❑	❑	Tobacco Use
❑	❑	Allergies / Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Fibromyalgia
❑	❑	Diabetes	❑	❑	Blood Thinner use
❑	❑	Hands or Feet cold	❑	❑	HIV Positive
❑	❑	Muscle aches	❑	❑	Cancer
❑	❑	Trouble Walking	❑	❑	Depression
❑	❑	Leg / Foot Numbness	❑	❑	Alcohol Use
❑	❑	Fainting	❑	❑	___High or ___Low Blood Pressure
❑	❑	Gall Bladder Trouble	❑	❑	Stroke History
❑	❑	Ringing in Ears	❑	❑	High Cholesterol
❑	❑	Ear Problems	❑	❑	TMJ
❑	❑	Sleeping Problems	❑	❑	Digestive Problems
❑	❑	Vision Problems	❑	❑	Pain all Over
❑	❑	Thyroid Problems	❑	❑	Tension / Irritability
❑	❑	Liver Disease	❑	❑	Chest Pains
❑	❑	Kidney Problems	❑	❑	Heart Pacemaker
❑	❑	Light Bothers Eyes	❑	❑	Heart Problems
❑	❑	Other _____			

1. List any medications you are taking:_____
_____
2. Please list all doctors you are currently seeing: _____
_____
3. Has any Doctor or other professional advised you to "Go to a Chiropractor ": ❑ No ❑ Yes, Name_____
_____
_____

PAST HISTORY

4. List any past auto collisions:_____ Was any care received?_____
5. List any past work injuries: _____ Was any care received?_____
6. List any past sport, recreational, or home injuries_____
7. Please describe any past conditions and treatment received: _____
_____
8. Please list any past hospitalizations and surgeries: _____
_____

FAMILY HISTORY

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____
Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____
Is there any other family history you want us to know?_____

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Our Promise to You, Our Valued Patient

We want to assure you that we take the Federal HIPAA (Health Insurance Portability and Accountability Act) laws seriously. These laws were written to protect the confidentiality of your health information. We trust you will never delay treatment in our office because of fear that your personal health information might be unnecessarily disclosed to others outside our office.

Why a Privacy Policy?

The most significant variable that has motivated the Federal government to legally enforce the privacy of health information is the rapid evolution of the use of electronic technology in the administration of health care business. The government has appropriately sought to standardize and protect the electronic exchange of health information. The has challenged us to review not only how your information is used within our computers but also with the internet, phones, fax machines, and any device used to copy or transfer this data. We want to advise you that we have developed policies and procedures for our practice to assure that your personal or health information will be shared only as required and only for the purpose of administering your case. Our office is subject to State and Federal laws regarding the confidentiality of your health information. We will assure our office adherence to those laws and we want you to understand our procedures and your rights as a valued patient. Your health information will be communicated only for the purpose of conducting health care business and obtaining payment for services. Be assured that, without your written permission, your health information will not be used for any other purpose.

How Your Health Information May Be Used to Provide Treatment

Within our office, your health information will be used to provide you the best care and services possible. This may include administrative and clinical procedures designed to optimize scheduling and coordination between you and all office personnel. In addition, we may share this information with referring physicians, clinical pathology laboratories, or other health professionals providing you treatment.

To Obtain Payment

Your health information may be included with an invoice for the purpose of collecting payment for services provided to you in this office. We may do this with insurance forms filed for you by mail or electronically. We will make every effort to work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care in our office. As a result, your health information may be included in the training programs for students, interns, and associates, as well as business and clinical employees. It is also possible that your health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routines process of certifications, licensing, or credentialing activities.

Patient Reminders

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or members of your family. These communications are an important part of our philosophy of partnering with your patients to be sure they receive the best care chiropractic can provide. They may include postcards, newsletters, flyers, and telephone or electronic reminders such as email (unless you tell us that you prefer not to receive reminders).

Public Health and National Security

As permitted or required by State or Federal law, we may disclose your health information to proper authorities for the purpose of law enforcement including, under certain circumstances, if you are a victim of a crime or in order to report a suspected crime.

Family, Friends, and Caregivers

We may share your health information with those you tell use will be assisting you with your home care, treatment, or payment. We will be certain to obtain your permission prior to sharing your information. In the event of an emergency, if you are unable to tell us what you want, we will use our very best judgment when sharing your health information with anyone participating in your care.

Medical Research

Advancing health care knowledge often involves learning from the careful study of health histories of prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements, and approval of an Institutional Review Board.

Authorization to Use or Disclose Health Information

Other than what is stated above or where Federal, State, or local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Patient's Rights

This law is careful to describe that you have the following rights related to your health information. Be assured that our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications
You have the right to request that we communicate with you in a specific way. You may request that we only communicate your health information privately with or without other family members present or through sealed mail communications. We will make all reasonable effort to honor your request.

Inspect and Copy Your Health Information
You have the right to read, review, and copy your health information including your complete chart, x-rays, and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information
You have the right to ask us to update or modify your records if you believe your health information is incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe as completely as possible your reason for the request. Your request may be denied if the health information record in question was not created by our office, is not part of our records, or if the records containing your health information have been requested sealed and/or delivered to any authority for review.

Documentation of Health Information
You have the right to request from us a description of how and where your health information was used by our office for any reason other than for treatment or payment or health care operations. Our documentation procedures will enable us to provide information on your health information usage from April 14, 2003, and forward. Please let us know in writing the time period for which you are interested. We will greatly appreciate you limiting your request to more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of This Notice
You have the right to request and obtain a copy of the Notice of Privacy Practices directly from our office at any time. Just let us know of your request. We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our notice. Patients would be notified of any such changes. You have the right to express concerns or complaints to us or the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express in writing any concerns you may have regarding the privacy of your health information.

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions, please let us know. If not, we would appreciate your acknowledging by signature that you have received, thoroughly reviewed, and understand this policy.

_____ _____
Print Patient Name Date

_____
Patient/Legally Authorized Representative Signature

_____ _____
Print Name of Representative Relationship to Patient

I ACKNOWLEDGE THAT I DO NOT WISH TO OBTAIN A COPY OF THE HIPAA PRIVACY POLICY.

_____
Patient/Legally Authorized Representative Signature

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Financial Policy

Welcome to our office! It is our mission to serve you to the best of our ability. Please read our financial policy, then sign and date it below. Thank you!

It is necessary for our office to have a copy of your insurance card(s) in your file. It is your responsibility to notify our office of any changes in your insurance carrier(s). We will verify your insurance coverage. However, insurance companies do make errors in reporting the coverage and benefits. They also have a disclaimer and state "this is not a guarantee of payment until we actually receive a claim". We will file your claims with your insurance. However, it must be understood that your insurance contract is between you (the patient) and your insurance company.
You are responsible for any amount not paid by your insurance company.

Our office does not guarantee your insurance company will pay your claims. If you fail to respond to the insurance company's request, you will be responsible for the full amount.

Copays are due on the same date of service. If this office needs to bill you for unpaid copays, you will be assessed an additional $5.00 billing fee per monthly statement.

Medicare Patients

Chiropractic Non-Covered Services	Reason Medicare May Not Pay	Estimated Cost
1. Chiropractic examinations	Items 1-5 are non-covered services and items under Medicare when delivered and/or ordered by a Doctor of Chiropractic	1. $40-$80
2. Chiropractic x-rays		2. $60-$120
3. Chiropractic extra-spinal adjustments		3. $30
4. Therapy, such as ultrasound, electric stim., intersegmental traction, and rehab		4. $20-$30
5. Nutritional supplements, ice packs, pillows, and BioFreeze		5. $1-$100
6. Spinal manipulation	6. Medicare may construe your spinal manipulation to be maintenance care	6. $45-$80

Delinquent accounts will be turned over to our Collection Agency.

I have read the above policies and agree I am responsible for any amount not covered by my insurance company.

_____
PRINT PATIENT NAME

_____
DATE

_____
PATIENT SIGNATURE OR LEGAL GUARDIAN SIGNATURE

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Patient/Insurance Information Update

Patient Information

Last_____ First Name _____ MI_____
Date of Birth _____
Address _____
City _____ State _____ Zip Code _____
Home Phone _____ Cell Phone_____
Email Address: _____

If a Minor

Name of Person Responsible for Payment _____
Cell Phone Number of Person Responsible _____
Email Address of Person Responsible _____

Primary Insurance Information

Primary Insurance Company Name_____ ID#_____ Group _____
Policy Holder's Name _____ Policy Holder's Date of Birth _____
Relationship to Patient _____

Secondary Insurance Information

Secondary Insurance Company Name_____ ID#_____ Group _____
Policy Holder's Name _____ Policy Holder's Date of Birth _____
Relationship to Patient _____

Assignment & Release

I hereby authorize payment of benefits be made directly to Kiekhoefer Chiropractic for services rendered to myself and/or dependents**. I understand that I am responsible for any charges not paid by insurance.** I authorize the release of any medical & billing information to my insurance company and the billing party named on behalf of me and/or my dependents.
Copays are due on the same date of service. If this office needs to bill you for unpaid copays, you will be assessed an additional $5.00 billing fee per monthly statement.

Patient Signature_____ Date _____

Medicare Authorization: For Medicare Patients only

Chiropractic non-covered services:	Reason Medicare may not pay:	Estimated cost:
1) Chiropractic Examinations	Items 1-5 are non-covered services and items under Medicare when delivered and/or ordered by a Doctor of Chiropractic	1) $40.00 to $80.00
2) Chiropractic X-Rays		2) $60.00 to $120.00
3) Chiropractic Extra-spinal Adjustments		3) $30.00
4) Therapy such as ultrasound, electric stim., Intersegmental traction and rehab		4) $30.00 to $50.00
5) Nutritional Supplements, ice packs, pillows, and BioFreeze		5) $1.00 to $100.00
6) Spinal Manipulation	6) Medicare may construe your spinal manipulation to be maintenance care	6) $48.00 to $72.00

I request that payment of authorized Medicare Benefits be made on my behalf to Kiekhoefer Chiropractic for any services furnished by this office. I authorize any holder of medical information about me to release to Medicare & its agents any information needed to determine these benefits or the benefits payable for related services. I understand my acceptance requests that payment be made & authorizes release of medical information necessary to pay the claim. If other health insurance is indicated on the approved claim form or electronically submitted claims, my acceptance authorizes releasing the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and I am responsible only for the deductible, coinsurance, and non-covered services of this charge.

Medicare Patient Signature _____ Date _____