WELCOME

Patient #_____

Patient Information

Thank you for choosing our office for your chiropractic needs. Please fill out the information below.
If you have any questions, please feel free to ask. (Please Print)

Name _____ Date_____
Last Middle Initial First

Address_____
Street City State Zip

Sex ☐ Female ☐ Male Age_____ Birthdate_____ E-mail_____
Mo/Day/Year

Home Phone ( )_____ Cell Phone ( )_____ Work ( )_____

Social Security # _____ Driver's License # _____

Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Occupation_____ Patient Employer_____

Employer Address & Phone_____

Spouse Occupation_____ Spouse Employer_____

(If Student or Minor)
Parent's Name, Address & Phone_____

Person to contact in case of emergency_____

Whom may we thank for referring you?_____

Insurance Information

Insurance Company_____

Name of Insured_____ Relationship to Patient_____

Birthdate_____ Social Security #_____ Date Employed_____

Name of Employer_____ Work Phone_____

Symptoms

Please describe your problem and how it began. Date problem began____/____/_____

_____

How bad is your pain? (Circle a number) 0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

How often are your symptoms present?	☐ Intermittently	☐ Occasionally	☐ Frequently	
Describe your current pain/symptoms:	☐ Sharp/stabbing	☐ Throbbing	☐ Aches	
	☐ Dull	☐ Soreness	☐ Weakness	
	☐ Numbness	☐ Shooting	☐ Gripping	
	☐ Burning	☐ Tingling	☐ Other_____	
Since it began, is your problem:	☐ Improving	☐ Getting Worse	☐ No Change	
What makes the problem better?	☐ Nothing	☐ Lying Down	☐ Walking	☐ Standing
	☐ Sitting	☐ Movement	☐ Exercise	☐ Inactivity/Rest
Can you perform your daily activities?	☐ Yes	☐ Yes, with help	☐ Not at all	
Do you exercise?	☐ Yes, almost daily	☐ Yes, occasionally	☐ Not at all	
Describe your job requirements:	☐ Mainly sitting	☐ Light labor	☐ Heavy labor	
Can you perform your work activities?	☐ Yes, all of them	☐ Only some	☐ None at all	
Describe your stress level:	☐ None to mild	☐ Moderate	☐ High	

CONTINUED ON BACK

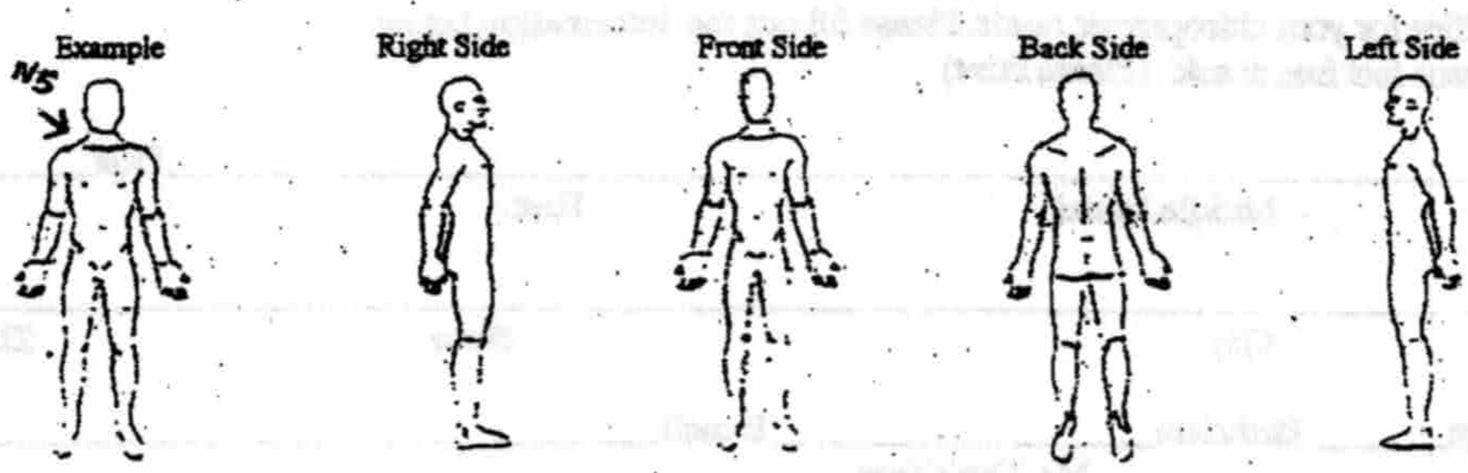
What treatment(s) have you had for this condition in the past? (surgery, medication, injections, therapy, chiropractic) _____

_____

Have you had x-rays, MRI or other tests for this condition? _____ Which tests and when? _____

Please mark area(s) of injury or discomfort as shown below in the example. Include degree of pain using scale of 1 (discomfort) to 10 (extreme pain).

Numbness.....N
Burning.....B
Pins & Needles...P
Aching.....A
Stabbing.....S



Medical History

Present weight: _____pounds Height _____feet _____inches
Current medications: _____

If you have ever had a listed symptom in the past, please check the "past" box. If you presently have a symptom, please check the "present box". Knowledge of these conditions may influence the type of treatment/therapy you receive.

Condition	Past	Present	Condition	Past	Present	Condition	Past	Present
Neck pain	☐	☐	Muscular incordinations	☐	☐	Swelling, stiffness of joint(s)	☐	☐
Hand pain (R__ L__)	☐	☐	Arthritis	☐	☐	Rheumatoid arthritis	☐	☐
Wrist pain (R__ L__)	☐	☐	Heartburn/indigestion	☐	☐	Angina	☐	☐
Upper back pain	☐	☐	General fatigue	☐	☐	Depression	☐	☐
Lower back pain	☐	☐	Dermatitis/ exzema/ rash	☐	☐	Asthma	☐	☐
Pain in upper leg (R__ L__)	☐	☐	Chronic cough	☐	☐	Emphysema	☐	☐
Pain in lower leg (R__ L__)	☐	☐	Chronic sinusitis	☐	☐	Difficulty in swallowing	☐	☐
Pain in ankle or foot (R__ L__)	☐	☐	Excessive thirst	☐	☐	Diabetes	☐	☐
Headaches	☐	☐	Jaw pain	☐	☐	Tinnitus (ear noises)	☐	☐
Visual disturbances	☐	☐	Dizziness	☐	☐	Bladder infection	☐	☐
Frequent urination	☐	☐	Painful urination	☐	☐	Prostate problems	☐	☐
Kidney stones	☐	☐	Kidney disorders	☐	☐	Loss of bladder control	☐	☐
Constipation/ irregular bowel	☐	☐	Irritable bowel	☐	☐	Colitis	☐	☐
Hepatitis	☐	☐	Heart attack date_____	☐	☐	Aortic aneurysm	☐	☐
Chest pains	☐	☐	High blood pressure	☐	☐	Rapid heart beat	☐	☐
Stroke (date_____)	☐	☐	Loss of appetite	☐	☐	Abnormal weight Gain Loss	☐	☐
Anorexia / Bulimia	☐	☐	Blood disorder	☐	☐	Tumor, explain_____	☐	☐
HIV / AIDS	☐	☐	Epilepsy	☐	☐	Cancer, explain_____	☐	☐
Fainting	☐	☐	Convulsions	☐	☐	Drug or alcohol abuse	☐	☐
Tobacco, frequency_____	☐	☐	Alcohol, frequency_____	☐	☐	Endometriosis	☐	☐
Breast Soreness Lumps	☐	☐	Irregular menstrual flow	☐	☐	Profuse menstrual flow	☐	☐
Birth control, type_____	☐	☐	PMS	☐	☐			

Coffee/ tea/ caffeinated soft drinks: cups/ cans per day_____

If a family member has had any of the following, please mark the appropriate box:

☐	Lung problems	Family member_____	☐	Lupus	Family member_____
☐	Chronic back problems	Family member_____	☐	Diabetes	Family member_____
☐	Chronic headaches	Family member_____	☐	Cancer	Family member_____
☐	Rheumatoid arthritis	Family member_____	☐	Osteoporosis	Family member_____
☐	High blood pressure	Family member_____	☐	Heart problems	Family member_____

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status.

Signature _____ Date_____

Menomonie
CHIROPRACTIC
Center, S.C.

Dr. David Hackbarth, DC
Dr. Joshua Secraw DC

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____ _____

Print Name Signature Date

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____

_____ _____

Signature Date

3120 Schneider Ave. E. Suite 5 Menomonie, WI 54751
Phone 715-232-8858 Fax 715-232-8868

Menomonie
CHIROPRACTIC
Center, S.C.

Dr. David Hackbarth, DC
Dr. Joshua Secraw, DC
Dr. Kristin Wahl, DC

MARKETING AUTHORIZATION

From time to time our practice works with marketing organizations to make you aware of products or services that you may have an interest in purchasing. Your chiropractors and members of the practice staff may need to use your health information, including your name, address, phone number, and your clinical records for the purpose of marketing products and services from Menomonie Chiropractic Center to you. We are specifically requesting authorization to market the follow products and/or services to you…..

Kids wall, referral board, testimonials, birthday cards, patient appreciation day, food drives, Christmas family, Valentine's Day referral, community services, and promotional information.

You may restrict the individuals or organization to which your health care information is released, or revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive you request to revoke your authorization. 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 decided to contest any of your claims.

Information that we use or disclose, based on the authorization you are giving us, may be subject to re-disclosure by the organization listed above, and may no longer be protected by the federal privacy laws.

You have the right to refuse to give us this authorization. If you do not give us the permission, 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 we use to contact you for marketing purposes at any time (164.524). Our practice and staff will receive direct or indirect remuneration from our marketing activities.

This notice is effective as of November 13, 2001. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_____ _____

Patient name printed Date

_____ _____

Patient Signature Authorized Provider Representative

_____ _____

Personal representative Printed Personal Representative Signature

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APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not available a message will be left on your answering machine or with the person answering the phone. Text message may be sent if you desire. By signing this form, you are giving us authorization to contact you with these reminders and information to leave messages on you r answering machine or with individuals at your home or place of employment.

You may restrict the individuals or organization to which your health care information is released, or revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive you request to revoke your authorization. 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 decided to contest any of your claims.

Information that we use or disclose, based on the authorization you are giving us, may be subject to re-disclosure by the organization listed above, and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us the 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 we use to contact you to provide appointment reminders, information about alternatives, or other health related information at any time

This notice is effective as of November 13, 2001. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

Patient name printed	Date
Patient Signature	Authorized Provider Representative
Personal representative Printed	Personal Representative Signature
Cell phone for text reminders	No text or call please sign

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CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law required us to give you a copy of our privacy notice, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

Along with this consent form, your will be given a copy of our privacy notice that describes our privacy policies in detail. You have the right to review that notice before you sign this consent form. We reserve the right to change your privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or my mail.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke any of your authorizations to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive you request to revoke your authorization. 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 decided to contest any of your claims

I have read your consent policy and agree to its terms. I am also acknowledging that I have receive a copy of this consent form and a copy of your privacy notice (Notice of Privacy Practices for Protected Health Information).

Patient name printed	Date
Patient Signature	Authorized Provider Representative
Personal representative Printed	Personal Representative Signature

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WISCONSIN CHIROPRACTIC ASSOCIATION AUTHORIZATION

Your chiropractic and members of the practice staff may need to disclose your name, address, phone number, billing information, and your clinical records to the Wisconsin Chiropractic Association (WCA). This disclosure will be made if we need the WCA's assistance to receive reimbursing your services or, we need the WCA's assistance because the party responsible for reimbursing your services has improperly processed your claim.

By signing this form you are giving us authorization to send the WCA this information. You are also giving the WCA authorization to re-disclose your information to the party responsible for the payment of your services, the WCA's legal counsel, and state or federal agencies that may be asked to intercede on your behalf.

You may restrict the individuals or organization to which your health care information is released, or revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive you request to revoke your authorization

Information that we use or disclose, based on the authorization you are giving us, may be subject to re-disclosure by the organization listed above, and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us the 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 may send to the WCA at anytime (164.524).

This notice is effective as of November 13, 2001. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

Patient name printed	Date
Patient Signature	Authorized Provider Representative
Personal representative Printed	Personal Representative Signature

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MENOMONIE CHIROPRACTIC CENTER

CONSENT TO TREATMENT WITHOUT X-RAYS

I hereby request and authorize **Menomonie Chiropractic Center** to render treatment to me without x-rays.

I agree to hold **Menomonie Chiropractic Center** harmless and release them from any claim for damages resulting from such treatment.

PATIENT SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____

PARENT/GUARDIAN SIGNATURE:
_____
(Applies only if patient is under the age of 18)

Menomonie Chiropractic Center
Clinic Policies

1. ☐ **CASH:**

Payment is due at the time of service. A 10% cash discount will be given on all non-insurance accounts that pay their account in full at the time of service. If payment in full cannot be made and you choose to make payments on your account, no discount will be given. Financial arrangements should be made with billing personnel or your doctor.

2. ☐ **INSURANCE**

As a courtesy to our patients, our clinic will bill your insurance company for you. Please remember, an insurance contract is between the patient and the patient's insurance company; therefore, it is the responsibility of the patient to keep the account current. ***All co-payments and/or deductibles must be paid at the time of service.***

3. ☐ **PERSONAL INJURY:**

Patients involved in LITIGATION (law suits) are, as others, responsible for their services here at the clinic. ***Payment is due at the time of service, unless (1) an attorney is involved in the case and a doctor's lien has been executed, and/or (2) an insurance company is making consistent payments on your account, in which case a waiver must be signed to inform the insurance company that payments should be sent directly to our office.*** Although a doctor's lien waives patient's payments until their case is settled, we recommend that all patients make consistent payments on their accounts, in the event a settlement is not made. Interest will be applied at 1.5% on accounts in which monthly payments are not being made.

4. ☐ **WORKER'S COMPENSATION:**

Payment is due at the time of service until injury is declared a work injury by the employer and their insurance carrier. All payments will be reimbursed as soon as the injury is declared worker's compensation.

5. ☐ **MEDICARE:**

As a courtesy to you, our patient, our clinic will bill Medicare for you. Medicare does not pay for your examination or your x-rays, but they do require you have an examination and x-rays before you are treated by the doctor. If you refuse to accept these procedures, Medicare will not pay for your treatments. Medicare also does not cover "Maintenance" type care. Therefore, if your treatment extends over 12 visits, without a new injury, we are forced to require you to pay cash at the time of your visit. If Medicare or your supplemental insurance should cover more than 12 visits, our clinic will reimburse you for the payments that you have made. If you do not have a supplemental insurance carrier, we require that you pay your co-payments at the time of service. If you do have a supplemental insurance, our office would be happy to bill them for you, after we have received your Medicare payment. ***Any non-covered services by Medicare or supplemental insurance will be your responsibility.***

6. ☐ ***If payment is not received within 30 days, a 1.5 % interest rate will be applied to ALL accounts with a cash balance. Any collection fees on delinquent accounts will be added to the patient's bill.***

7. ☐ It is understood and agreed the amount paid to the doctor for x-rays is for analysis only, and the x-ray will remain the property of this office, being on file where they may be seen at any time and remain a permanent part of your records. Copies may be obtained for a reasonable copy charge.

Payment arrangement: $_____ **per** _____

My signature is an acknowledgement that I have read the policies above and agree to abide by them.

Patient Signature_____ **Date:**__/__/__

Guardian Signature_____ **Date:**__/__/__