

# Worker's Comp./Personal Injury Questionnaire

## Patient Information

Date \_\_\_\_\_ Date of Birth \_\_\_\_\_

Patient Name \_\_\_\_\_  
First M Last

What do you prefer to be called? \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Patient SSN# \_\_\_\_\_

Sex ☐ Male ☐ Female Language (If other than English) \_\_\_\_\_

Ethnicity (Mark one) ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (Mark one or more) ☐ American Indian or Alaska Native ☐ Asian ☐ White

☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander

Cell Phone \_\_\_\_\_ Cell Phone Carrier \_\_\_\_\_

Home Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Occupation \_\_\_\_\_

Employer/ School \_\_\_\_\_

Employer/ School Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer/ School Phone \_\_\_\_\_

If Minor, Parent/Legal Guardian's Name \_\_\_\_\_

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Spouse's Name \_\_\_\_\_

Spouse's Cell Phone \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

## Place of Accident

Business Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Case # \_\_\_\_\_ Accident # \_\_\_\_\_

Contact \_\_\_\_\_ Phone \_\_\_\_\_

Additional Information \_\_\_\_\_

## Accident Information

Please give a detailed description of how this accident occurred. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Health Insurance

Do you have a FlexSpending(FSA) or Health Savings HSA) Account? ☐ Y ☐ N

Insurance Company \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Relationship to the patient ☐ Self ☐ Spouse ☐ Child ☐ Other

\* If you selected "self" please stop here and proceed to the next section.

Policy Holder \_\_\_\_\_  
First M Last

Policy Holder's Date of Birth \_\_\_\_\_ Sex ☐ Male ☐ Female

Policy Holder's Address, City, State, Zip \_\_\_\_\_

Policy Holder's Employer \_\_\_\_\_

Employer City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer Phone \_\_\_\_\_

## Secondary Health Insurance

Insurance Company \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Relationship to the patient ☐ Self ☐ Spouse ☐ Child ☐ Other

\* If you selected "self" please stop here and proceed to the next section.

Policy Holder \_\_\_\_\_  
First M Last

Policy Holder's Date of Birth \_\_\_\_\_ Sex ☐ Male ☐ Female

Policy Holder's Address, City, State, Zip \_\_\_\_\_

Policy Holder's Employer \_\_\_\_\_

Employer City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer Phone \_\_\_\_\_

## Insurance Information (for office use only)

Insurance Company \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Case # \_\_\_\_\_ Authorization # \_\_\_\_\_

Claim Adjuster \_\_\_\_\_ Phone \_\_\_\_\_

Additional Information \_\_\_\_\_



## Details Regarding the Accident

Date of Accident \_\_\_\_\_ Time of Accident \_\_\_\_\_ am/ pm

Did you report the accident to your employer? ☐ Yes ☐ No

Did they file an accident report? ☐ Yes ☐ No

Report # \_\_\_\_\_ HR Contact \_\_\_\_\_

Were you admitted to the emergency room? ☐ Yes ☐ No

Hospital Name \_\_\_\_\_

Address \_\_\_\_\_

Treating Doctor \_\_\_\_\_

Explain treatment \_\_\_\_\_

Were any x-rays taken for this accident? ☐ Yes ☐ No

Have you been able to work since the injury? ☐ Yes ☐ No

Were you knocked unconscious? ☐ Yes ☐ No

Other doctors seen for this accident \_\_\_\_\_

Address \_\_\_\_\_

Explain treatment \_\_\_\_\_

Have you had any previous worker's compensation injuries? ☐ Yes ☐ No

If yes, please list date(s) and injuries \_\_\_\_\_

Are you receiving 2/3 pay? ☐ Yes ☐ No

Have you retained an attorney? ☐ Yes ☐ No

Firm Name \_\_\_\_\_

Attorney Name \_\_\_\_\_ Contact \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

## Emergency Contact This must be someone NOT living in your household.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

## Designation of Personal Representative

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

I hereby designate the above named individual as my personal representative who may act on my behalf for the purpose of: Consenting to use and disclosure of my health information, authorizing use and disclosure of my health information, and receiving information that otherwise would be sent me. If I am incapacitated, my personal representative may also sign any form (such as authorization, revocation of authorization, request for access to information and/or billing inquiries), the uses of which are described in privacy policies and procedures. I understand that a person who is identified in my medical record as having medical power of attorney or other legal authority to act on my behalf is additionally recognized as my personal representative. I understand that I have the right to revoke this authorization at any time. Revoking this authorization must be made in writing, signed, and dated.

## Authorization and Medical Release

I affirm that the above information is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my medical status. I authorize the doctor to treat my condition as he deems appropriate and to grant full disclosure for all previous or concurrent care. I agree to grant full indemnity to Alternative Wellness & Chiropractic and its physicians for complications related to all pre-existing conditions medically diagnosed or otherwise not disclosed.

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Guardian Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_



Name: \_\_\_\_\_

Height: \_\_\_\_\_ B/P: \_\_\_\_\_

Weight: \_\_\_\_\_ Pulse: \_\_\_\_\_

Office Use Only

## I. HEALTH HISTORY

Do you smoke?\* ☐ Y ☐ N ☐ Social ☐ Quit

Current Medication: \* \_\_\_\_\_

☐ I will provide a list of my medications.

Allergies: \* \_\_\_\_\_

Medication Intolerance: \* \_\_\_\_\_

### Personal Disease/Illness

List any past history of disease/illness Month/Year

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### Family Disease/Illness

List any family history of disease/illness Relationship Month/Year

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### Hospitalizations/Surgeries/Injuries

List Past Hospitalizations/Surgeries/Injuries Month/Year

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Primary Physician(s) \_\_\_\_\_

Date of Last Exam \_\_\_\_\_

Date of Last X-ray \_\_\_\_\_

## II. REVIEW OF SYSTEMS

Have you at any time had: (Check all that apply)

### Head and Neck

- ☐ Decreased hearing
- ☐ Ringing in ears
- ☐ Frequent ear infections
- ☐ Dizzy spells
- ☐ Failing vision
- ☐ Double or blurred vision
- ☐ Eye pain
- ☐ Repeated eye infections
- ☐ Recurrent nose bleeds
- ☐ Sinus/throat infections

### Cardiovascular

- ☐ High blood pressure\*
- ☐ Pain (chest, arms or legs)
- ☐ Palpitations
- ☐ Irregular heart beat
- ☐ Swollen ankles
- ☐ Fainting spells

### Digestive

- ☐ Difficulty swallowing
- ☐ Indigestion or heartburn
- ☐ Nausea/vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in bowel movement
- ☐ Black bowel movement

### Neurological/Physc

- ☐ Numbness/Tingling
- ☐ Headache
- ☐ Nervousness
- ☐ Memory Loss
- ☐ Moodiness
- ☐ Difficulty falling asleep
- ☐ Difficulty staying awake
- ☐ Increased irritability
- ☐ Depression/Anxiety

### Endocrine

- ☐ Chronic fatigue
- ☐ Weight gain/Weight Loss (recent)
- ☐ Bruise easily
- ☐ Cold extremities
- ☐ Tremors (shaking of hands)
- ☐ Convulsions
- ☐ Muscle weakness

### Respiratory

- ☐ Hoarseness
- ☐ Persistent cough
- ☐ Blood in spit
- ☐ Shortness of breath

### Skin

- ☐ Rash
- ☐ Hives
- ☐ Moles (cancerous)

### Genitourinary

- ☐ Diabetes\*
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Frequent night time urination
- ☐ Loss of control of urine
- ☐ Sexual dysfunction

### Musculoskeletal

- ☐ Neck pain
- ☐ Joint swelling
- ☐ Mid back pain
- ☐ Low back pain
- ☐ Foot pain
- ☐ Stiff joints

### Other Symptoms

\_\_\_\_\_



### Women Only

Are you pregnant? Y N If Yes, Last Menstrual Period \_\_\_\_\_ Due Date \_\_\_\_\_

Are you nursing? Y N Are you planning a pregnancy? Y N

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Breast tenderness associated with cycle | <input type="checkbox"/> Endometriosis                         | <input type="checkbox"/> Night sweats (in menopausal females)      |
| <input type="checkbox"/> Breast fibroids, benign masses          | <input type="checkbox"/> Vaginal discharge, dryness, itchiness | <input type="checkbox"/> Urinary Tract, bladder, kidney infections |
| <input type="checkbox"/> Menstruation Problems                   | <input type="checkbox"/> Thyroid Problems                      | <input type="checkbox"/> Other _____                               |
| <input type="checkbox"/> Uterine fibroids                        | <input type="checkbox"/> Hot flashes                           |  |

### Men Only Do you experience any of the following? (Check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> Prostate problems                        | <input type="checkbox"/> Pain on inside of thighs, legs or heels |
| <input type="checkbox"/> Difficulty with urination, dribbling     | <input type="checkbox"/> Feeling of incomplete bowel evacuation  |
| <input type="checkbox"/> Difficult to start and stop urine stream | <input type="checkbox"/> Decreased sexual function               |
| <input type="checkbox"/> Pain or burning with urination           | <input type="checkbox"/> Other _____                             |
| <input type="checkbox"/> Interruption of stream during urination  |  |

### III. REASONS FOR SEEKING CARE

#### Present Complaints

- \_\_\_\_\_ **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 morning ☐ Worse in evening ☐ Pain radiates to \_\_\_\_\_
- \_\_\_\_\_ **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 morning ☐ Worse in evening ☐ Pain radiates to \_\_\_\_\_
- \_\_\_\_\_ **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 morning ☐ Worse in evening ☐ Pain radiates to \_\_\_\_\_
4. What makes it better? \_\_\_\_\_
5. What makes it worse? \_\_\_\_\_
6. What Doctor's have you seen for this? \_\_\_\_\_
7. Type of treatment: \_\_\_\_\_
8. Results: \_\_\_\_\_

Rate your pain 0 to 10, ten being the worst

Mark ALL areas of pain on figures below

#### Neck Pain

0 1 2 3 4 5 6 7 8 9 10

#### Mid Back Pain

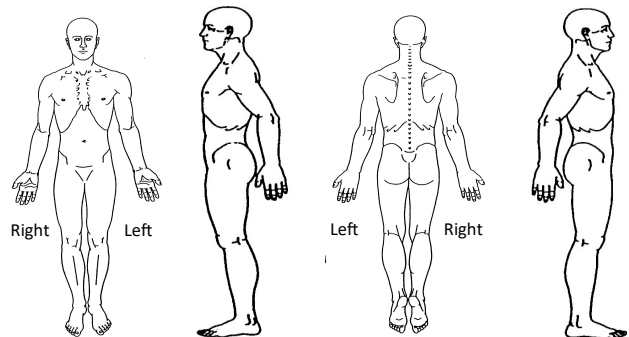
0 1 2 3 4 5 6 7 8 9 10

#### Low Back, Hip Pain

0 1 2 3 4 5 6 7 8 9 10

#### Other Pain \_\_\_\_\_

0 1 2 3 4 5 6 7 8 9 10



### IV. CERTIFICATION

I certify that I have read and understand the above information. I acknowledge that I have answered the above questions correctly and to the best of my ability. I will not hold my chiropractor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

(Office Use Only)

The above health history questionnaire was reviewed by \_\_\_\_\_ (Physician) Date \_\_\_\_\_

# Neck Pain Index

**Please read:** This questionnaire is designed to enable us to understand how much your **neck pain** has affected your ability to manage everyday activities. Please answer each section by checking the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but please **just check the one choice which closely describes your problem *right now***.

## Section 1 PAIN INTENSITY

- ☐ I have no pain at the moment.
- ☐ The pain is mild at the moment.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain is severe but comes and goes.
- ☐ The pain is severe and does not vary much.

## Section 2 PERSONAL CARE (washing, dressing, etc.)

- ☐ I can look after myself without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but I manage most of my personal care.
- ☐ I need some help in most aspects of self-care.
- ☐ I do not get dressed, I wash with difficulty and I stay in bed.

## Section 3 LIFTING

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example, on a table.
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights, if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

## Section 4 READING

- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I cannot read as much as I want because of moderate pain in my neck.
- ☐ I cannot read as much as I want because of severe pain in my neck.
- ☐ I cannot read at all.

## Section 5 HEADACHE

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

## Section 6 CONCENTRATION

- ☐ I can concentrate fully, when I want with no difficulty.
- ☐ I can concentrate fully, when I want with slight difficulty.
- ☐ I have a fair degree of difficulty concentrating when I want to.
- ☐ I have a lot of difficulty concentrating when I want to.
- ☐ I have a great deal of difficulty concentrating when I want to.
- ☐ I cannot concentrate at all.

## Section 7 WORK

- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work but no more.
- ☐ I can do most of my usual work but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I cannot do any work at all.

## Section 8 DRIVING

- ☐ I can drive my car without neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I cannot drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive my car at all because of severe pain in my neck.
- ☐ I cannot drive at all.

## Section 9 SLEEPING

- ☐ I have no trouble sleeping.
- ☐ My sleeping is slightly disturbed. (less than 1 hour sleepless)
- ☐ My sleep is mildly disturbed. (1-2 hours sleepless)
- ☐ My sleep is moderately disturbed. (2-3 hours sleepless)
- ☐ My sleep is greatly disturbed. (3-5 hours sleepless)
- ☐ My sleep is completely disturbed. (5-7 hours sleepless)

## Section 10 RECREATION

- ☐ I am able to engage in all recreational activities with no pain in my neck at all.
- ☐ I am able to engage in all recreational activities with some pain in my neck.
- ☐ I am able to engage in most but not all recreational activities because of my neck pain.
- ☐ I am able to engage in a few of my usual recreational activities because of pain in my neck.
- ☐ I can hardly do any recreational activities because of pain in my neck.
- ☐ I cannot do any recreational activities at all.

Signature \_\_\_\_\_

Date \_\_\_\_\_ File # \_\_\_\_\_ Disability Index Score: \_\_\_\_\_ Improvement \_\_\_\_\_ %  
Oswestry Disability Index



# Low Back Disability Index

**Please read:** This questionnaire is designed to enable us to understand how much your **low back pain** has affected your ability to manage everyday activities. Please answer each section by checking the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but please **just check the one choice which closely describes your problem *right now***.

## Section 1 Pain Intensity

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is severe.
- ☐ The pain is severe and does not vary much.

## Section 2 Personal Care (washing, dressing, ect.)

- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increase the pain, but I manage not to change my way of doing it.
- ☐ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain, I am unable to do some washing and dressing without help.
- ☐ Because of the pain, I am unable to do any of my washing and dressing without help.

## Section 3 Lifting

- ☐ I can lift weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights at the most.

## Section 4 Walking

- ☐ I have no pain on walking.
- ☐ I have some pain on walking but it does not increase with distance.
- ☐ I can not walk more than one mile without increasing pain.
- ☐ I can not walk more than ½ mile without increasing pain.
- ☐ I can not walk more than ¼ mile without increasing pain.
- ☐ I can not walk at all with out increasing pain.

## Section 5 Sitting

- ☐ I can sit in a chair as long as I like without pain.
- ☐ I can sit only in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than ½ hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain.

## Section 6 Standing

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain on standing, but it does not increase with time.
- ☐ I can not stand for longer than one hour without increasing pain.
- ☐ I can not stand longer than ½ hour without increasing pain.
- ☐ I can not stand longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain immediately.

## Section 7 Sleeping

- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Because of my pain, my normal nights sleep is reduced by less than ¼.
- ☐ Because of my pain, my normal nights sleep is reduced by less than ½.
- ☐ Because of my pain, my normal nights sleep is reduced by less than ¾.
- ☐ Pain prevents me from sleeping at all.

## Section 8 Social Life

- ☐ My social life is normal and gives my no pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, ect.
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

## Section 9 Traveling

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling but none of my usual forms of travel make it any worse.
- ☐ I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain while traveling which compels me to seek alternate forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents me from all forms of travel except that dome lying down.

## Section 10 Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall it is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow.
- ☐ My pain is neither getting better nor getting worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Signature \_\_\_\_\_

Patient Name:

**We would like to take a moment to welcome you to our clinic and assure you that you will receive the very best of care available for your condition. The following are our clinic financial policies please familiarize yourself with our policies, please initial each section. If you have any questions, please contact the front desk. Thank You.**

#### **Covered/Non-Covered Services**

I understand that the services rendered and/or supplies/aides given to me may not be considered eligible for benefits (eg. Services and/or supplies/aides may be determined to be not medically necessary, non-covered or investigational) by my health insurance company. I understand that my health insurance coverage has certain restrictions and limitations, such as authorization requirements, and non-covered services and/or supplies/aides. Since I have chosen to obtain the services and/or supplies/aides, I agree to be financially responsible for any and all related charges, if they are not covered by my insurance.

Your treatment plan makes it necessary to utilize not only Chiropractic Care codes, but to also utilize what is best described as Physical Rehabilitation codes. Policy benefits for both areas of care vary greatly by insurance policy and we cannot be aware of each person's specific policy benefits. To provide our best level of care, we provide a treatment plan that is specific for you and not based on your insurance policy benefits. Your specific policy benefits will determine what your patient responsibility will be. Our clinic will not quote insurance benefits; therefore, you are encouraged to contact your health plan. **It is ultimately your responsibility to check with your insurance to understand the contract and coverage.**

**New Patient Promo:** New patients are eligible for a Consultation, Exam, and X-rays, if needed for \$\_\_\_\_\_. Which is paid in full due at time of service. This promo **does not** include a chiropractic adjustment. Promo excludes Medicare and Medicaid.

**Illinois Medicaid:** This office **does not** accept Illinois Medicaid. I agree that I do not receive Illinois Medicaid health coverage. Initials\_\_\_\_\_

\_\_\_\_ **PLEASE INITIAL AFTER READING**

#### **Billing and Payments**

You, the patient or legal guardian, are responsible for all claims made to your insurance. Billing is a courtesy service which we provide to our patients at no extra charge. This clinic will provide any necessary reports or required information to aid in insurance reimbursement of services. In the event of the insurance plan's denial of benefits or claim payments, the patient is responsible for the total balance due to the provider. If the insurance carrier requires the patient to send in more information regarding his/her claim and the patient fails to return the required information to the carrier, the patient will be billed for the entire balance on the claim, as the insurance company requires the provider to do.

All co-pays and known co-insurance amounts are due at the time of service.

In the event you do not have health insurance coverage, we do offer a Time of Service reduction of our fee schedule. This reduced fee must be paid at time of service in order to receive the reduction.

Patient statements mailed out bi-monthly for previous months billing and payment activities. Payments on your account are due by the last day of the month in which the statement was sent. Patients are given 90 days to make payments on account before sent to pre-collections. If at any time a payment cannot be made, please call our clinic to set up a payment plan or inform the clinic of your situation as you may qualify for deferred payments.

All accounts with patient portion balance showing no patient payment activity will be charged a 1.5% monthly late payment fee, for each month no payment is made on the account.

All outstanding unpaid patient account balances over \$100 will result in the inability for the patient to schedule future appointments, until the patient portion of the account is paid, or payment arrangements are made.

\_\_\_\_ **PLEASE INITIAL AFTER READING**

Patient Name:

### Assignment of Benefits

By signing this form you are authorizing payment of medical benefits will be made directly to this clinic. If your insurance carrier sends payment to you for services incurred in this clinic, you agree to send or bring those payments to this clinic upon receipt. However if you pay for your visits in full the assignment will not be reported by this provider and any payment will be send directly to you.

\_\_\_\_ PLEASE INITIAL AFTER READING

### Reminders/Missed Appointments

With the exception of emergencies, it is vital that you keep all your appointments. Reminder cards and text messages are available to help you save the date and time of your appointments.

Our patient's, team and doctor's time is valuable, and we wish to provide every patient with an excellent experience. When you do not show up for a scheduled appointment, it creates an unused appointment slot that could have been used for another patient. Please provide us the courtesy of a **24 hour cancellation** or change notice if you are unable to keep your appointment time.

On your third no-show occurrence, there will be a **\$25 charge** to your account. After three consecutive no-show occurrences, the clinic may elect to terminate our relationship with you.

\_\_\_\_ PLEASE INITIAL AFTER READING

### Statement of Privacy

We use and disclose the information we collect from you only as allowed by Health Insurance Portability and Accountability Act and Iowa State. This includes issues relating to your treatment, payment, and care operations. Your personal health information will never be otherwise given to anyone without your written consent. You may give written authorization for us to disclose your information to anyone you choose, for any purpose. Our clinic and systems are secure from unauthorized access and our team is trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients. We will only request personal information needed to provide our standard of quality chiropractic or massage care, implement payment activates, conduct normal business operations, and comply with the law. This includes name, address, phone numbers, SSN, employment date, medical history, health records, etc. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We may use and/or disclose your information to communicate reminders about your appointments including text messaging, voicemail messages, and mailings. You have a right to request copies of your healthcare information; all requests must be in writing. We may charge for copies in the amounts allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the US Dept of Health and Human Services. We thank you for being a patient at our clinic.

\_\_\_\_ PLEASE INITIAL AFTER READING

### Release of Information

If we bill your insurance company, and you insurance company requires medical reports or records to document your treatment or progress, your signature below authorizes this clinic to release the medical information necessary to process your claim.

If you pay at the Time of Service and insurance is not billed by our clinic, then your signature below verifies that our clinic will not bill insurance for any services rendered and in turn your health insurance company will not be able to request medical records for services rendered.

\_\_\_\_ PLEASE INITIAL AFTER READING

### Pregnancy Release

I certify that I am not pregnant at this time, and I agree to indemnify Alternative Wellness & Chiropractic Center for any medical complications which may result from radiographic studies performed on myself or unborn fetus.

\_\_\_\_ PLEASE INITIAL AFTER READING



Patient Name: \_\_\_\_\_

### Terms of Acceptance

When a patient seeks chiropractic care, it is essential for both patient and clinic to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method used to attain it. This will prevent any confusion or disappointment. An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Vertebral Subluxation is a misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential. We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the service of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding the treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. The doctor and/or his staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care provider, or are not related to the spinal structural conditions diagnosed at this clinic.

**\_\_\_\_ PLEASE INITIAL AFTER READING**

### Informed Consent to Chiropractic Treatment

As with any healthcare procedure there are certain complications which may arise during chiropractic manipulation and therapy. Doctors of Chiropractic are required to obtain your informed consent before starting treatment. In particular you should note:

- 1.) Some patients may experience some stiffness or soreness following the first few days of treatment.
- 2.) Some types of manipulation have been associated with stroke; strokes from chiropractic adjustments are very rare. I am aware that nerve or brain damage including stroke is reported to occur once in one to ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same change as a normal dose of aspirin or Tylenol causing death.
- 3.) I will make every effort to screen for any contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.
- 4.) Other complications may include fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. When osteoporosis, degenerative disc or other abnormality is detected, this clinic will proceed with extra caution.

The probabilities of these complications are rare and generally result from some underlying weakness of the bone or tissue which Dr. Womboldt checks for during the history, examination, and x-ray (when warranted).

I acknowledge I have had the opportunity to discuss the associated risks as well as the nature and purpose of treatment with my chiropractor.

I authorize and agree to allow the doctor and his designated staff to work with my case, my spine and the spine of the charge I represent through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal bio-mechanical and neurological function.

I intend this consent to apply to all my present and future chiropractic care.

**Patient Printed Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

**Doctor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_