



INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

By any standard, a chiropractic adjustment is a conservative and very safe procedure. However, we would like to notify you that there is a very remote possibility for injury from a chiropractic adjustment.

According to a study by the Rand Corporation, a serious adverse reaction from a neck adjustment occurs once in 1 million manipulations. In contrast, the Journal of the American Medical Association found more than 2 million Americans became seriously ill each year from reactions to currently prescribed drugs. 106,000 of those people die from the side effects.

I understand that there are risks to any treatment that I have. I also understand that my doctor has given me a treatment plan that best suits my condition and I will use that information to make my own decision on whether or not to have the recommended treatment.

I understand the remote possibility of an injury (i.e.: rib fracture, etc.) from a chiropractic treatment and elect to receive the recommended treatment.

Patient Signature

Date



**3803 Silver Lake Road Unit 100 St Anthony MN, 55421
Phone: 612-789-1700•Fax: 612-788-9011**

Proof of Notice Provided

I have read HealthWise Family Chiropractic's Notice of Privacy Practices, which explains how my health information may be used and disclosed, as well as, how I can get access to this information. I understand I may request a copy of this information at any time.

Patient's Name: _____
(please print)

Signature: _____ Date: _____

PAYMENT POLICY

If your insurance policy provides for chiropractic services, this is our payment plan.

LIMITED ASSIGNMENT: We will submit a bill for services to your insurance company and wait for payment directly from them. This can take anywhere from 30 to 90 days. If you have a deductible, **you will be responsible** for any amount that you have not met to date. We will send you a statement at the beginning of the month that will include the portion you owe. Any unpaid balances are due on the 15th of the month. **Copays are due at time of service or a \$10.00 surcharge will be added.**

If you require services that are not covered by your insurance company, you will be expected to pay for those services. (Prices are available before the service is performed.) If you require an appointment after hours, there is a \$50.00 emergency charge that is not covered by your insurance company. Payment is expected at the time of service.

Please note that your insurance coverage is a contract between you and your insurance company and that you are ultimately responsible for your bills at HealthWise Family Chiropractic. It is therefore important that **you** contact your insurance company to know your specific chiropractic benefits.

Any charges not paid are considered delinquent. Delinquent charges will be assessed an interest rate of 1.5% monthly. In the event that an account becomes delinquent in excess of three months, collective action will take place. A fee of \$20.00 will be charged for any returned checks.

NO SHOW POLICY

We expect a phone call if you are unable to keep your appointment. If we do not hear from you by the time of your appointment, you will be charged a fee of \$50.00 for the missed appointment.

Thank you for your consideration and understanding. We hope that this explanation will answer your questions and clarify our policy. Feel free to ask us any questions regarding the above payment policy.

I have read the above payment policy and understand the terms of payment for this office.

Patient or Guardian Signature

Date

Insurance Information:

Insurance Company: _____ Insurance Phone: _____

Insurance Address: _____

City: _____ State: _____ Zip Code: _____

Patient Name: _____ ID #: _____

Group # _____ Policy Holder's Name: _____

Policy Holders Birthdate: _____ Policy Holder's SS#: _____

Policy Holder's Employer: _____

Insurance Verification:

As the insurance company tells us upon verification, this is only an **estimation** of benefits not a guarantee of benefits. Benefits will be paid in accordance with insurance plan when a claim is received. We recommend each patient contact their insurance company to verify their own benefits. **We provide insurance billing as a service to our patients.** Please notify us immediately if there are any changes to your insurance plan to avoid unnecessary charges to your account.

I consent to and authorize that payment of benefits for healthcare-related services be made to HealthWise-Family Chiropractic, PA. This consent specifically authorizes HealthWise Family Chiropractic, PA, to release protected healthcare information to insurers and governmental agencies and their agents for billing and determination of benefits purposes. Additionally, I assign any benefits payable for physician services to the physician or organization furnishing these services. I understand that I may be responsible for costs not covered by an insurer or third party payer.

Print Patient Name: _____

Signature: _____ **Date:** _____

HealthWise Family Chiropractic, P.A.
Auto Accident Intake

Name: _____ Date: _____

Address: _____

City: _____ State/Zip: _____

Phone: _____ Birthdate: _____ Age: _____

Cell Phone: _____ Email: _____

Marital Status: S M D W Number of Children _____

How did you hear about us? _____

Date of Accident _____ Time _____ AM PM

Your insurance company _____

Agent Name and Phone # _____

Policy # _____ Claim # _____

Collision Description:

Were you the: Driver Front Passenger Rear Passenger Pedestrian

How many people were in your vehicle during the accident? _____

Names of occupants: _____

Speed you were traveling? _____ Other vehicle? _____

Your description of the accident: _____

Were the police contacted? Yes No

From which city were the police from? _____

Was a report filed? Yes No

If yes, do you have a copy of the police report? Yes No

Was a traffic violation issued? Yes No

If yes, to whom? _____

Did an ambulance respond? Yes No

Accident Site:

Road/Street Name _____

City/State _____

Nearest intersection, road/street _____

Driving conditions: Wet Dry Icy Snow Other _____

Road visibility: Good Fair Poor

Which direction were you headed? _____

Vehicle:

Describe the vehicle you were in (year, make, model):

Describe all other vehicles involved in collision (year(s), make(s), and model(s)):

Were you wearing a seatbelt? Yes No

Was the vehicle equipped with airbags? Yes No

If yes, did it/they inflate properly? Yes No

Did your seat have a headrest? Yes No

If yes, what was the position of the headrest? Low Mid-position High

Were your eyeglasses, dentures, hat, etc. jarred off by the force of impact?

Yes No If yes, describe: _____

Do you have an estimate of property damage? Yes No

If yes, how much? _____

Impact:

Was the impact from: Front Rear Left Right Roll-over

At the time of the impact were you:

Looking straight ahead? Yes No

Looking to the left? Yes No

Looking to the right? Yes No

Looking down? Yes No

Looking up? Yes No

Were both hands on the steering wheel? Yes No

If no, which hand was on the wheel? Left Right

Was your foot on the brake? Yes No

If yes, which foot was on the brake? Left Right

Were you (please circle one): Surprised by the impact Braced for the impact

Patient condition:

Were you unconscious immediately after the accident? Yes No

If yes, for how long? _____

Please describe how you felt immediately after the accident:

Treatment:

Did you go to the hospital? Yes No
When did you go to the hospital? Immediately Next day 2 days+

How did you get to the hospital? Ambulance Private transportation

Name of Hospital: _____

Name of Doctor: _____

Diagnosis: _____

Treatment received: _____

X-rays/Imaging: _____

Symptoms/Injuries:

Circle all symptoms/injuries you felt immediately following the accident. Place an X next to those symptoms you are still currently experiencing.

- | | | |
|-----------------------|----------------------------|----------------------------|
| ___ ankle/foot pain | ___ arm/shoulder stiffness | ___ cold hands/feet |
| ___ knee pain | ___ diarrhea | ___ numbness in hands |
| ___ leg pain | ___ constipation | ___ fatigue |
| ___ head/jaw pain | ___ stomach upset | ___ shortness of breath |
| ___ hip pain | ___ fainting | ___ ears ringing |
| ___ neck pain | ___ headaches | ___ loss of taste or smell |
| ___ low back pain | ___ memory loss | ___ foot numbness/tingling |
| ___ upper back pain | ___ loss of balance | ___ visual difficulty |
| ___ mid-back pain | ___ dizziness | ___ poor concentration |
| ___ shoulder pain | ___ fever | ___ leg numbness |
| ___ sleeping problems | ___ nausea | ___ leg tingling |

Did any part of your body strike anything in the vehicle? Yes No
If yes, explain _____

Did the seatbelt cause any bruising? Yes No
If yes, describe: _____

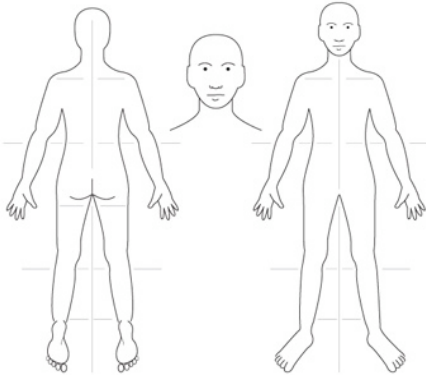
Did you (or) do you have any visible signs of injury? Yes No
If yes, describe: _____

Have the injuries due to the accident changed your ability to work? Yes No

What do your job duties consist of?: _____

How much time of work have you missed? _____

Mark an X on the picture where you continue to have pain, numbness or tingling since the accident.



Rate the severity of your pain on a scale from 1 (little or no pain) to 10 (severe pain): at it's worst _____ at it's best _____

Description of pain (circle all that apply):

- | | | | |
|--------|-----------|-----------|-------------|
| Sharp | Dull | Throbbing | Numbness |
| Aching | Shooting | Burning | Tingling |
| Cramps | Stiffness | Swelling | Other _____ |

How often do you have this pain? _____

Are your symptoms worse in: AM PM No Pattern

Since your problem began, is the pain: Increasing Decreasing About the same

Does your pain interfere with: (circle all that apply)

- | | | | |
|------|---------------|------------|------------------|
| Work | Daily Routine | Recreation | Other Activities |
|------|---------------|------------|------------------|

If yes, please explain: _____

Difficulty sleeping: That night 2+nights Every night since accident

Are there any movements that are painful to perform? (circle all that apply)

- | | | | | | |
|---------|----------|---------|---------|------------|-------|
| Sitting | Standing | Walking | Bending | Lying Down | Other |
|---------|----------|---------|---------|------------|-------|

Current Health History:

Have you been treated for any other health condition in the last year? Yes No

If Yes, please explain: _____

Are you pregnant? Yes No Beginning of last menstrual period? _____

Medications you are currently taking: _____

When was your last physical exam? _____

Have you had any X-rays taken in the past year? Yes No

Which clinic/area of your body? _____

Dietary Habits:

Caffeine (type/use) _____ Fruits/Veggies (servings/day) _____

Alcohol(type & drinks/week) _____ Cigarettes(pack/day) _____

Vitamins/Supplements: _____

Past Health History:

Have you had previous chiropractic care? Yes No

Clinic name/date last visit _____

Please circle if you have had or presently have any of the following conditions:

- | | | | | |
|-----------|------------|---------------------|---------------------|-------------------|
| Anemia | Bronchitis | Digestive Disorders | Hepatitis | Rheumatic Fever |
| Angina | Cancer | Dizziness | High Blood Pressure | Sinus Trouble |
| Arthritis | Concussion | Epilepsy | Multiple Sclerosis | Stroke |
| Asthma | Diabetes | Heart Disease | Numbness | Thyroid Disorders |
| Other | _____ | | | |

Please list any prior surgeries or hospitalizations you have had:

Health and Medical Release Information:

I, _____, give permission to Dr. Blomberg, her staff, associates, and employees of the HealthWise Family Chiropractic, to share private and medical information with my medical doctor, _____, as well as his staff, employees, and associates. Also, my medical doctor, as well as his or her staff, employees, and associates have permission to share personal and medical information with Dr. Blomberg and her staff.

Signature: _____ **Date:** _____

Medical Doctor Information:

Clinic Name: _____ Phone: _____

Doctor's Name: _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature _____ Date: _____

Print Name: _____ Relationship to patient _____