

## Patient Information Form/Update

Patient Information:

Name \_\_\_\_\_ DOB \_\_\_\_\_

Parent's name if patient is under 18 \_\_\_\_\_

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

Phone Number: Home \_\_\_\_\_ Work \_\_\_\_\_

Cell \_\_\_\_\_

E-mail address \_\_\_\_\_

Patient's SSN \_\_\_\_\_

Name of Insured \_\_\_\_\_ DOB \_\_\_\_\_

Insured's SSN \_\_\_\_\_

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

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. If payment is not received in 30 days after being billed by this office, a \$3.00 re-billing fee is added every 30 days. Thank you.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Confidential Health Questionnaire

**All information will be kept strictly confidential. Your response will help determine if chiropractic treatment will benefit you.**

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Today's date \_\_\_\_\_ SSN \_\_\_\_\_

*Please check the degree of all conditions which you have or have had. We need your complete health report before we can be responsible for your case.*

**O = occasional, F = frequent, C = constant**

**O F C General**

- Allergy
- Dizziness
- Fainting
- Fatigue
- Fever
- Headache
- Loss of weight
- Loss of sleep
- Nervousness
- Depression
- Numbness
- Sweats

**O F C Pain or Numbness**

- Shoulders
- Arms
- Elbows
- Hands
- Hips
- Legs
- Knees
- Feet
- Painful tailbone
- Poor posture
- Sciatica
- Spinal curvature
- Swollen joints
- Ear noise

**O F C Cardio-vascular**

- High blood pressure
- Low blood pressure
- Pain over heart
- Rapid heartbeat
- Slow heartbeat
- Swelling of ankles

**O F C Skin**

- Boils
- Bruise easily
- Dryness
- Hives or allergy
- Itching
- Skin eruptions (rash)
- Varicose Veins

**Eye, Ear, Nose & Throat**

- Asthma
- Colds
- Deafness
- Earache
- Ear discharge
- Sore throat
- Enlarged glands
- Enlarged thyroid
- Far sightedness
- Hay fever
- Horaseness
- Nasal obstruction
- Near sightedness
- Nose bleeds
- Sinus Infection
- Corrective eyewear

**Genito-Urinary**

- Prostate trouble
- Bed-wetting
- Blood in the urine
- Frequent urination
- Kidney infection
- Painful Urination

**Muscle/Joint**

- Arthritis
- Bursitis
- Foot trouble
- Hernia
- Low back pain
- Mid back pain
- Neck pain

**Gastro-Intestinal**

- Belching or gas
- Colitis
- Colon trouble
- Constipation
- Diarrhea
- Bloating abdomen
- Gall bladder trouble
- Hemorrhoids
- Jaundice
- Liver trouble
- Nausea
- Pain over stomach
- Poor appetite
- Vomiting
- Ulcers

**Respiratory**

- Chest pain
- Chronic cough
- Difficult breathing
- Wheezing

**Women only**

- Congested breasts
- Excess menstrual flow
- Hot flashes
- Irregular cycle
- Lumps in breast
- Menopause
- Painful menstruation
- Abnormal vaginal discharge

**Are you pregnant?** No\_\_ Yes\_\_

If yes, how long \_\_\_\_\_ months

Number of children \_\_\_\_\_

*Check any of the following conditions you currently have or have had*

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> AIDS             | <input type="checkbox"/> Edema         | <input type="checkbox"/> Rheumatic fever    | <input type="checkbox"/> Eczema           |
| <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Emphysema     | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Anemia           | <input type="checkbox"/> Epilepsy      | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Goiter        | <input type="checkbox"/> Pacemaker          | <input type="checkbox"/> Diabetes         |
| <input type="checkbox"/> Cancer           | <input type="checkbox"/> Gout          | <input type="checkbox"/> Polio              | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Chicken Pox      | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Measles          |

Reason for today's visit (Describe)

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How long have you had this condition? \_\_\_\_\_ Is it getting worse? Yes \_\_\_ No \_\_\_

Does it bother your: Work \_\_\_ Sleep \_\_\_ Other \_\_\_\_\_

What seemed to be the initial cause \_\_\_\_\_

Have you seen a chiropractor before? Yes \_\_\_ (If yes, how long ago?) For what reason:  
No \_\_\_

Are you under the care of a physician? Yes \_\_\_ (if yes, for what?)  
No \_\_\_

Have you been hospitalized in the last 5 years? Yes \_\_\_ For major surgery? Yes \_\_\_ For serious injury? Yes \_\_\_  
No \_\_\_ No \_\_\_ No \_\_\_

Have you had any mental or emotional disorders? Yes \_\_\_ Are you currently taking any medication? Yes \_\_\_ (please list)  
No \_\_\_ No \_\_\_

Do you wear: Heel lifts \_\_\_ Sole lifts \_\_\_ Inner soles \_\_\_ Arch supports \_\_\_ Negative heels \_\_\_ Platform shoes \_\_\_

Habits	None	Light	Mod	Heavy		None	Light	Mod	Heavy		None	Light	Mod	Heavy
Alcohol	___	___	___	___	Drugs	___	___	___	___	Soft Drinks	___	___	___	___
Coffee	___	___	___	___	Exercise	___	___	___	___	Water	___	___	___	___
Tobacco	___	___	___	___	Sleep	___	___	___	___	Sugar	___	___	___	___

Have you ever:	Yes	No		Yes	No	
Had a broken bone?.....	___	___		Used a cane, crutch or other support?.....	___	___
Been hospitalized?.....	___	___		Been struck unconscious?.....	___	___
Had strains or sprains?.....	___	___		Been hospitalized for other than surgery?.....	___	___
Do you:				Have any drug allergy?.....	___	___
Take minerals, herbs, or vitamins?.....	___	___				

When did you last have:	Never	0-6 Months	6-18 Months	Longer
Spinal x-ray.....	___	___	___	___
Spinal examination.....	___	___	___	___
Physical examination.....	___	___	___	___

Please list any other health conditions you have been treated for, or surgery you have had: \_\_\_\_\_

Family health info: Some health conditions are the result of hereditary spinal weaknesses. Info about your immediate family, brothers, sisters, parents, and grandparents, will give us a better understanding of your total health picture.

<b>Relationship</b>	<b>Past and Present Health Problems</b>
_____	_____
_____	_____
_____	_____

I authorize the release of any medical information necessary to process insurance claims. The payment should be paid to the treating physician/doctor at Minser Chiropractic Clinic. Please sign here \_\_\_\_\_

Summary: (Doctor's use)

**Minser Chiropractic Clinic**  
**NOTICE OF PRIVACY PRACTICES**

Our practice is dedicated, and we are required by applicable federal and state laws, to maintain the privacy of your health information. These laws also require us to provide you with this Notice of our privacy practices, and to inform you of your rights, and our obligations, concerning your health information. We are required to follow the privacy practices described below while this Notice is in effect. This Notice is effective as of 4-10-2003, and will remain in effect until we replace it.

**CHANGES TO NOTICE**

We reserve the right to change this Notice and the privacy practices described below at any time in accordance with applicable law. Prior to making significant changes to our privacy practices, we will alter this Notice to reflect the changes, and make the revised Notice available to you on request. Any changes we make to our privacy practices and/or this Notice may be applicable to health information created or received by us prior to the date of the changes.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

**PERMITTED USES AND DISCLOSURES OF HEALTH INFORMATION:**

- A. **TREATMENT, PAYMENT and HEALTHCARE OPERATIONS:** You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for treatment, payment, and healthcare operations. Examples of these activities are as follows:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, and other business operations.

- B. **AUTHORIZATIONS:** You may specifically authorize us to use your health information for any purpose or to disclose your health information to anyone, by submitting such an authorization in writing. Upon receiving an authorization from you in writing we may use or disclose your health information in accordance with that authorization. You may revoke an authorization at any time by notifying us in writing. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those permitted by this Notice.
- C. **DISCLOSURES TO FAMILY AND PERSONAL RELATIVES:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. Such disclosures will be made to any of your personal representatives appropriately authorized to have access and control of your health information. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare only if authorized to do so. In the event of your incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.
- D. **MARKETING:** We will not use your health information for marketing communications without your written authorization
- E. **USES AND DISCLOSURES REQUIRED BY LAW:** We may use or disclose your health information when we are required to do so by law, including for public health reasons (e.g., disease reporting). In some instances, and in accordance with applicable law, we may be required to disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.
- F. **PATIENT AND THIRD PARTY PROTECTION:** Only as permitted by law, we may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
- G. **LAW ENFORCEMENT/NATIONAL SECURITY:** Under certain circumstances we may disclose health information relating to members of the Armed Forces to military authorities. Under certain circumstances we may also disclose health information relating to inmates or patients to correctional institutions or law enforcement personnel having lawful custody of those individuals. We may disclose health information in response to judicial proceedings and law enforcement inquiries as permitted by law and to authorized federal officials health information required for lawful intelligence, counterintelligence,

and other national security activities.

- H. **APPOINTMENT REMINDERS:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

**PATIENT RIGHTS:**

- A. **ACCESS TO RECORDS:** Upon submission of a written request to us, you have the right to review or receive copies of your health information, with limited exceptions. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may request that we provide copies in a format other than photocopies and we will use the format you request if it is readily available. We will charge you a reasonable cost-based fee relating to the production of such copies. If you request copies, we will charge you \$0.75 for each page, a fee of no more than \$10 for the labor of copying the records, and postage if you want the copies mailed to you. (Note: We will not charge you any fees for retrieving or handling the information or for processing the request.) The per page dollar amount does not apply to copies of x-rays, for which we will not charge you more than the actual cost of reproducing the x-rays. If you request an alternative format, we will charge a reasonable cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice if you are interested in receiving a summary of your information instead of copies. If you request copies in connection with your application for social security benefits, we will not charge you any fee.
- B. **ACCOUNTING OF CERTAIN DISCLOSURES:** Upon written request, you have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and other activities authorized by you for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
- C. **RESTRICTIONS AND ALTERNATIVE COMMUNICATIONS:** You have the right to request that we place additional restrictions on our use or disclosure of your health information for treatment, payment and healthcare operation purposes. Depending on the circumstances of your request we may, or may not agree to those restrictions. If we do agree to your requested restrictions we must abide by those restrictions, except in emergency treatment scenarios. You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (e.g., your place of business rather than your home). Such requests must be made in writing, must specify the alternative means or location, and must provide satisfactory explanation how payments will be handled under the alternative means or location you request.
- D. **AMENDMENTS TO RECORDS:** You have the right to request that we amend your health information. Such requests must be made in writing, and must explain why the information should be amended. We may deny your request under certain circumstances.
- E. **ELECTRONIC NOTICES:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

**QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made or any decisions we make regarding the use, disclosure, or access to your health information you may complain to us using the contact information listed below. You also may submit a written complaint to the US Department of Health and Human Services. We will provide you with the address to file such a complaint upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the US Department of Health and Human Services.

Please direct any of your questions or complaints to:

Contact: Mary Beth Minser, D.C.; Tammy Fimrite, D.C.; Lacie Mockros, D.C.  
Telephone: (320) 253-5650  
Fax: (320) 253-9222  
e-mail: [minserchiro@charterinternet.com](mailto:minserchiro@charterinternet.com)  
Address: 203 Park Avenue South, Suite 101  
St. Cloud, MN 56301

**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

I, \_\_\_\_\_ (Patient's name), acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Minser Chiropractic Clinic, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received, or maintained by the Practice.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

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**FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO PATIENT**

This Practice has made a good-faith effort to obtain an acknowledgement of \_\_\_\_\_ (patient's name)'s receipt of our Notice of Privacy Practices. In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply)

- Patient Unavailable
- Patient Physically Unable
- Patient Unwilling

In an effort to obtain the patient's acknowledgement, the Practice has attempted to provide patient with a Notice of Privacy Practices in the following manner (check all that apply):

- Personally                       Mail                       Phone Follow-Up

Other: \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name of Physician

Minser Chiropractic Clinic  
Name of Practice

**CONSENT TO TREATMENT OF MINOR CHILD**

I hereby authorize Dr. Mary Beth Minser, Dr. Tammy Fimrite, or Dr. Lacie Mockros and whom they may designate as their assistants to administer treatment as they so deem necessary to \_\_\_\_\_ dated at Minser Chiropractic Clinic this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_

\_\_\_\_\_  
Parent or Guardian Signature