Patient Information Form/Update

Patient Information:

Name____DOB_________________

Parent's name if patient is under 18____

Address______________________________City__________State____Zip+4________________

Phone Number: Home_____________________________Work___________________________

Cell______________________________

Preferred Language____

Race __American Indian __Asian __African American __Hispanic or Latino __Native Hawaiian

__White __Multiracial __Other

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
_ _ _ Depression
_ _ _ Numbness
_ _ _ Sweats

Muscle/Joint
_ _ _Arthritis
_ _ _Bursitis
_ _ _Low back pain
_ _ _ Mid back pain
_ _ _ Neck pain

Respiratory
_ _ _ Chest pain
_ _ _ Chronic cough
_ _ _ Difficult breathing
_ _ _Wheezing

O F C Pain or Numbness
_ _ _ Shoulders
_ _ _ Arms
_ _ _ Elbows
_ _ _ Hands
_ _ _ Hips
_ _ _ Legs
_ _ _ Knees
_ _ _ Feet
_ _ _ Painful tailbone
_ _ _ Poor posture
_ _ _ Sciatica
_ _ _ Spinal curvature

Gastro-Intestinal
_ _ _Belching or gas
_ _ _Colitis
_ _ _ Constipation
_ _ _ Diarrhea
_ _ _ Bloated abdomen
_ _ _ Gall bladder trouble
_ _ _ Hemorrhoids
_ _ _ Jaundice
_ _ _ Liver trouble
_ _ _ Nausea
_ _ _ Pain over stomach
_ _ _ Poor appetite
_ _ _ Ulcers

O F C Cardio-vascular
_ _ _ High blood pressure
_ _ _ Abnormal heartbeat
_ _ _ Swelling of ankles

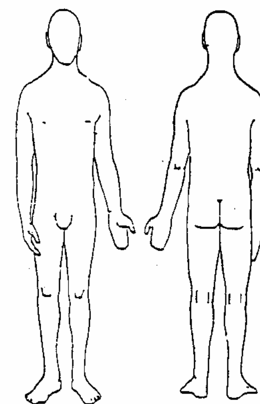
Eye, Ear, Nose & Throat
_ _ _Asthma
_ _ _Loss of hearing
_ _ _Earache
_ _ _ Sore throat
_ _ _ Enlarged glands
_ _ _ Nasal obstruction
_ _ _ Nose bleeds
_ _ _ Sinus infection
_ _ _ Sore throat
_ _ _ Enlarged glands

Skin
_ _ _Bruise easily
_ _ _Dryness
_ _ _Hives or allergy
_ _ _Itching
_ _ _Skin eruptions (rash)

Genito-Urinary
_ _ _Prostate trouble
_ _ _Bed-wetting
_ _ _Blood in the urine
_ _ _Frequent urination
_ _ _Kidney infection
_ _ _Painful urination

O F C Women Only
_ _ _ 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_________



Please indicate where you are having pain

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

__AIDS
__Alcoholism
__Anemia
__Cancer
__Diabetes
__Eczema
__Edema
__Emphysema
__Epilepsy
__Gout
__Heart disease
__Multiple Sclerosis
__Pace maker
__Pneumonia
__Polio
__Rheumatic fever
__Stroke
__Tuberculosis

Reason for today's visit (Describe)

____

____

____

Minser Chiropractic Clinic, 203 Park Ave S, Suite 101, St. Cloud, MN 56301, 320-253-5650

How long have you had this condition?____ Is it getting worse? Yes__ No__

What seemed to be the initial cause____

Grade your pain (0 is no pain, 10 is the worst pain): _______Presently ________At its worst ________At its best

Describe your pain (circle those that apply): sharp dull achy shooting tingling burning stabbing stinging pulling pinching

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

____

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

____

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

____

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

____

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	__	__	__	__	Sleep	__	__	__	__	Sugar	__	__	__	__
Tobacco	__	__	__	__	Exercise	__	__	__	__	Water	__	__	__	__

____

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

____

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.

Relationship **Past and Present Health Problems**

____

____

____

____

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
Address: 203 Park Avenue South, Suite 101
St. Cloud, MN 56301

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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

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

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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

Pediatric Functional Form

Child's name:____

Today's date:____

Please check all those that apply to your child.

_______1. Has your child been more irritable?

_______2. Has your child had difficulty sleeping?

_______3. Has your child's sleeping pattern changed?

_______4. Has your child's digestion pattern changed (i.e. constipation/diarrhea)

_______5. Has your child's intake of food been less or more?

_______6. Has your child needed more parental attention/affection?

_______7. Has your child been more distant/less affectionate?

_______8. Has your child had trouble with learning or retaining information?

_______9. Has your child's attention or focus been shortened?

_______10. Has your child's balance or coordination been altered?

_______11. Have you noticed any changes in speech patterns?

_______12. Have you noticed any changes in breathing patterns?

_______13. Have you noticed any visional changes such as squinting?

_______14. Have you noticed a change in "playing" patterns?

_______15. Have you noticed any aggression/violence/acting out?

_______16. Have you noticed any changes in relationships with grandparents/daycare providers/teachers?

_______Score