

# 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 \_\_\_\_\_

**PEDIATRIC HISTORY FORM**

**Date:** \_\_\_\_\_

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

**Parent(s) Name(s):** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Age** \_\_\_\_\_

**Birth Weight:** \_\_\_\_\_ **Current Weight** \_\_\_\_\_

**Birth Length:** \_\_\_\_\_ **Current Length** \_\_\_\_\_

**Type of birth:** Normal vaginal \_\_\_\_\_ Forceps \_\_\_\_\_ Breech \_\_\_\_\_ C-section \_\_\_\_\_  
Home \_\_\_\_\_ Birthing Center \_\_\_\_\_ Hospital \_\_\_\_\_

**Problems during pregnancy:** \_\_\_\_\_

**Problems during delivery:** \_\_\_\_\_

**APGAR SCORES:** \_\_\_\_\_

**Was there presence at birth of:** Jaundice (yellow) \_\_\_\_\_  
Cyanosis (blue) \_\_\_\_\_

**Congenital anomalies/defects:** \_\_\_\_\_

**Infant feeding:** Breastfed \_\_\_\_\_ Bottle \_\_\_\_\_ Formula \_\_\_\_\_

**# of hours sleep per night** \_\_\_\_\_

**Obstetrician/midwife** \_\_\_\_\_  
Name Located at

**Pediatrician/family MD:** \_\_\_\_\_  
Name Located at

**Date of last visit to MD:** \_\_\_\_\_ **Purpose:** \_\_\_\_\_

**List of Medications currently given to child** \_\_\_\_\_

**Purpose of this appointment** \_\_\_\_\_

Has this child ever been treated on an emergency basis? \_\_\_\_\_

Date: \_\_\_\_\_

Pregnancy history: \_\_\_\_\_

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

Delivery/birth history: \_\_\_\_\_

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

Developmental history: At what age did the child:

_____ Respond to sound	_____ Crawl
_____ Follow an object with eyes	_____ Stand
_____ Hold head up	_____ Walk alone
_____ Sit alone	

Childhood diseases: \_\_\_\_\_ Chicken pox                      \_\_\_\_\_ Rubella  
    \_\_\_\_\_ Mumps                                      \_\_\_\_\_ Rubeola  
    \_\_\_\_\_ Measles                                      \_\_\_\_\_ Whooping cough  
 Other \_\_\_\_\_

Has the child ever suffered from:

__ Dizziness	__ Bakaches	__ Heart trouble	__ Chronic earaches
__ Diabetes	__ Fainting	__ Hypertension	__ Colds/flu
__ Arthritis	__ Headaches	__ Asthma	__ Allergies
__ Neuritis	__ Digestive disorders	__ Sinus trouble	__ Constipation
__ Anemia	__ Rheumatic Fever	__ Orthopedic problems	__ Diarrhea
__ Poor appetite	__ Hyperactivity	__ Paralysis	__ Behavioral problems
__ Bed wetting	__ Convulsions	__ Broken bones	__ Muscle jerking
__ Arm problems	__ Walking problems	__ Leg problems	__ Ruptures/hernias
__ Neck problems			

Doctors Notes:

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

## Infant Functional Form

Child's name: \_\_\_\_\_

Today's date: \_\_\_\_\_

Please check all that apply to your child.

- \_\_\_\_\_ 1. Has your child been more irritable/less consolable?
- \_\_\_\_\_ 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 nursing or taking a bottle?
- \_\_\_\_\_ 9. Has your child had a developmental milestone and then lost it? (i.e. able to roll over and now no longer can do so?)
- \_\_\_\_\_ 10. Has your child shown unwarranted emotions such as fear?
- \_\_\_\_\_ 11. Has your child shown a new physical issue (i.e. sucking their thumb or blanket for comfort)?
- \_\_\_\_\_ 12. Has a normal daily activity shown change (i.e. cries now when put in carseat)?
- \_\_\_\_\_ 13. Have any normal play patterns changed?
- \_\_\_\_\_ 14. Have you noticed any changes in relationships with grandparents/daycare providers?

\_\_\_\_\_ Score