Askeland Chiropractic & Acupuncture P.C.
PATIENT HISTORY

DATE________________

NAME ____ DATE OF BIRTH________________

ADDRESS__________________________CITY____________STATE_____ZIP_________

PHONE (PRIMARY)______________PHONE (W)______________ EMAIL ______________

EMPLOYER__________________________OCCUPATION__________________________

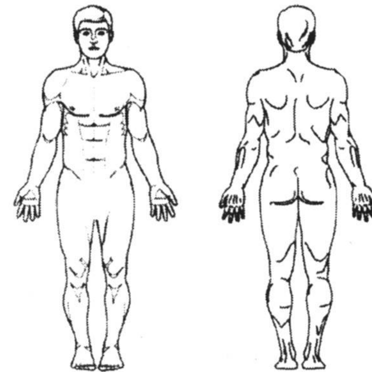
ADDRESS____

SPOUSE NAME____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?____________________

MAIN REASON FOR YOUR VISIT TODAY:

NECK PAIN HEADACHES MID-BACK
LOW BACK ARM SHOULDER LEG
OTHER________________________________



PAIN LEVEL: best 1 2 3 4 5 6 7 8 9 10 worst

(PLEASE MARK PAIN LOCATIONS ON THE DIAGRAM)

DATE OF ONSET:__________ GRADUAL SUDDEN PROGRESSIVE OVER TIME

HOW DID THIS INJURY OCCUR?____

WHAT MAKES YOU FEEL BETTER____________________ ***WORSE?***________________________

HAVE YOU HAD THIS PROBLEM BEFORE?______ ***WHEN?***_________________________________

WHAT DID YOU DO FOR THIS CONDITION BEFORE?____________________________________

Previous Chiropractic Care? Y / N ***Chiropractor's Name:***________________________________

DO YOU HAVE ANY OF THE FOLLOWING?

- ❑ HEADACHES
- ❑ IRRITABILITY
- ❑ CHEST PAIN
- ❑ DEPRESSION
- ❑ DIZZINESS
- ❑ MEMORY LOSS
- ❑ RINGING IN THE EARS
- ❑ DIGESTIVE PROBLEMS
- ❑ LIGHT SENSITIVITY
- ❑ STRESS OR ANXIETY
- ❑ NUMB HANDS OR FEET
- ❑ COLD HANDS OR FEET
- ❑ SHORTNESS OF BREATH
- ❑ DIFFICULTY SLEEPING
- ❑ LOSS OF SMELL OR TASTE

How will you be paying for your first visit services today?

Cash Check Credit Card PI Work Comp

SIGNATURE____

(Please have your insurance card available for us to photocopy)

Askeland Chiropractic & Acupuncture P.C.

Name:________________________________ Date:______________

MAJOR COMPLAINT:____

How long have you had this condition?______________________________ Date of onset:____________

Have you lost workdays? YES / NO If yes, how many?_____________________________

Have you had this or a similar condition before? YES NO If yes, when?___________________________

Was the injury accident related? NO / Auto accident / Work accident If yes, when?_________________

What surgeries have you had? ____

____

List all drugs you now take (prescription and non prescription):_____________________________

____

Name other doctors you have seen for this condition:_______________________________

Do you smoke? Y / N Drink Alcohol? Y / N Drinks per week? ____________

Family History of: Heart Disease Diabetes High Blood Pressure Stroke

Anything else you would like to tell us that would help in determining your case? ____________________

____

What are your health goals?____

How do you expect to achieve these goals?__________________________________

Please mark if you have had any of these symptoms in the last 12 months: **(please check all that apply)**

____Fractured bones
____Auto Accidents
 ___0-1 yrs ago
 ___1-5 yrs ago
 ___5 yrs or more
____Other accidents, falls
____Arthritis
____Diabetes
____Convulsions, epilepsy
____Skin problems
____Cancer
____Frequent colds, flu
____Depressed
____Irritable
____Anemia
____Allergy, sinus
____Under stress
____Eating disorders
____Trouble sleeping
____Trouble concentrating
____Learning disability
____Mood changes

____Neck pain or stiffness R L
____Numbness/tingling, pain in arms, hands, fingers R L
____Jaw pain or clicks (TMJD) R L
____Difficulty in excessive standing, sitting, riding, bending, lifting, twisting
____Shoulder pain R L
____Dizziness
____Ringing in ears R L
____Hearing loss R L
____Blurred or doubled vision
____Upper back pain, stiffness
____Mid back pain, stiffness
____Lower back pain, stiffness
____Pain with cough, sneeze
____Hip pain R L
____Headaches
____Numbness, tingling, pain in buttocks, legs, feet, toes R L

____Foot trouble R L
____Chest pain, asthma
____Heart problems
____Stroke
____High/low blood pressure
____Varicose veins
____Liver trouble
____Gall bladder trouble
____Digestive problems
____Ulcers
____Hemorrhoids
____Prostate problems
____Impotence
____Kidney trouble
____Menstrual problems (PMS)
____Pregnant (**currently**)
____Bed wetting
____Ear Infections
____ AIDS, HIV

<u>**Askeland Chiropractic & Acupuncture P.C.**</u>
Dr. Erik J. Askeland B.S., D.C., F.A.S.A.

Informed Consent and Authorization for Chiropractic Care

Nature and purpose for Chiropractic procedures

The practice of chiropractic includes many standard examination and testing procedures, as well as, therapeutic procedures. These include physical examination, orthopedic and neurological testing, specialized chiropractic examinations, radiological (x-ray) examination and laboratory testing (when clinically indicated). Procedures performed by chiropractors include various physical therapy and rehabilitation procedures, and the procedure unique to the chiropractic profession – the chiropractic adjustment/manipulation.

Chiropractic adjustments are delivered to patients by chiropractors to correct spinal or extremity (ankles, knees, wrists, etc.) joint dysfunction. Within the chiropractic profession these dysfunctions are called *subluxations*. A subluxation is a condition that exists when one or more bones of the spine (called vertebra), or extremities, are misaligned sufficiently to cause lack of motion in these joints, as well as, interference and/or irritation of the nervous system. The primary goal in chiropractic health is the removal of subluxations, and the restoration of normal joint motion and nervous system function.

It is not enough that you understand the benefits of chiropractic care in restoring normal joint motion and nervous system health, you must also be aware of the existence of inherent risks and limitations to chiropractic care. Every type of treatment (medical, chiropractic, or otherwise) carries some form of potential risk associated with it. Risks associated with some forms of chiropractic care include muscular sprain/strain, neurological deficit, osseous fracture and vertebral artery dissection (stroke). While the incidence of injury from chiropractic care is extremely low, and only seldom are the risks great enough to contraindicate care, these facts should be considered in making the decision to receive chiropractic care.

Authorization for Chiropractic Care

I have been informed of the nature and purpose of chiropractic care, the possible consequences of care, and the potential risks of chiropractic care, including the risk that care I receive in this office may not accomplish the desired clinical objective. I have been advised of reasonable alternative treatments, including known risks, consequences, and probable effectiveness of each, and I have been advised of possible consequences if no care is provided. I acknowledge that no guarantees have been provided to me concerning the results of the care I will receive.

I have read the above paragraphs. I understand the information provided has been explained, and any questions I have asked have been explained to my satisfaction.

I knowingly authorize Askeland Chiropractic & Acupuncture P.C., to proceed with chiropractic care and treatment.

Your Signature: ____ Date: ______________

If patient is a minor, signature of parent or guardian _____________________________

Askeland Chiropractic & Acupuncture, P.C.

Office Policies and Patient's Acceptance of Care

At Askeland Chiropractic, we have a responsibility to give you the best care possible. Dr. Askeland has recommended a treatment plan which best outlines the care needed to relieve your pain and achieve your goals.

In order to make progress during your treatment, it is necessary for you to keep each appointment. Each visit builds on the one before, and it is important not to lose the spinal correction towards which we have been working. Therefore, if you have to cancel an appointment, it is imperative that you reschedule to make up for the missed appointment.

APPOINTMENTS:

Office Hours:	Monday, Wednesday and Thursday	8:00 a.m. – 12:00 p.m. & 3:00 p.m. – 5:30 p.m.
	Tuesday and Friday	8:00 a.m. – 12:00 p.m.

Please be on time for all appointments, as this time is specifically set aside for you. If you arrive late for your appointed time we cannot work you in between the other scheduled appointments, since in fairness to all, we must allow scheduled patients to receive care during their appointed times.

Call if you are going to be late. If you must cancel or move your appointment, please do so **24 hours in advance.** Please try to make up all missed appointments within the same week to continue the course of care necessary for your treatment.

We reserve the right to charge for missed appointments not notified 24 hours in advance.
"NO SHOW" APPOINTMENTS ARE SUBJECT TO A $55 MISSED APPOINTMENT FEE.
This bill will be mailed to your home and immediate payment is expected.

PAYMENTS:

ALL PAYMENTS ARE EXPECTED AT THE TIME OF SERVICE.

*** This includes deductible, co-insurance, co-pays, supplements, etc. ***

*** We also offer self payment options for those who choose not to use insurance for treatment. ***

INSURANCE:

VERIFICATION OF COVERAGE IS NOT A GUARANTEE OF PAYMENT FOR SERVICES RENDERED.

***** Patients are responsible for knowing their own insurance benefits for care.*****

After verification of your coverage, we will submit claims directly to your insurance company for services rendered. You are responsible for all uncovered services at the time of visit.

Your insurance is an agreement between you and your insurance company. There is NO direct relationship between our office and your insurance company. The type of plan chosen by you, and/or your employer, determines your insurance benefits. Benefits are not determined by our office. As such, we have no say in the terms of your contract, the methods of reimbursement, or determination of your insurance benefits.
Our office gives an insurance company 90 days from an incurred charge to pay their portion. If for any reason your insurance company does not pay within 90 days, then the balance becomes your responsibility and is due and payable at that time.

Therefore, this office does not promise that your insurance company will pay the charges, and will not enter into a dispute with the insurance company over reimbursement. If your carrier denies payment, then you are personally responsible for payment.

GUARANTEES:

We do not guarantee that we can prevent or cure any illness, injury, or disease. In this office we find and remove spinal subluxation so that your nervous system will function optimally, and so that your spine does not degenerate prematurely.

I have read and agree to the above listed terms set forth by Askeland Chiropractic and Acupuncture, P.C.

Signed: (Patient) ____ Date: ______________________

Askeland Chiropractic & Acupuncture P.C.

HIPAA RELEASE OF INFORMATION AUTHORIZATION FORM

NAME OF PATIENT: ______________________________________
DATE OF BIRTH: __________________

At my request, I authorize Askeland Chiropractic & Acupuncture to disclose Protected Health Information to the following person(s):

____
Relationship to Patient: ________________________________

____
Relationship to Patient: ________________________________

____
Relationship to Patient: ________________________________

I authorize the following Protected Health Information to be released **(check which option(s) apply)**:

- o All Information Requested
- o All Claims Information
- o Explanation of Benefits Information
- o All Payment Information

I understand that I may revoke this authorization at any time by giving notice ***in writing*** *to Askeland Chiropractic & Acupuncture.*

Patient Signature: ____
Date: ___________________________

Askeland Chiropractic & Acupuncture P.C.

HIPAA Patient Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created to provide a standard of certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information about treatment, payment or health care operations, in order to provide health care that is in your best interest. **Your Personal Health Information (PHI) will never be given to any entity besides what is required for your treatment, payment and health care operations.**

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as radiologists that only interact with physicians and not patients), and may have to disclose personal health information for purpose of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: ______________________ Parent/Legal Guardian: ___________________

Signature: _______________________ Signature: ______________________________

Date: ___/___/___ Date:___/___/___