SOUTHSIDE CHIROPRACTIC, PA
5536 Chicago Ave S, Minneapolis, MN 55417
Phone: (612)-827-0657 Fax: (612)-827-3102

NEW PATIENT PAPERWORK

Today's Date: _____/_____/_____

Name:_____ Preferred Name:_____ Date of Birth:_____ Age:_____

Home Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ E-mail:_____☐ Subscribe to Weekly Emails

Occupation:_____ Employer:_____

Emergency Contact:_____ Relationship:_____ Phone:_____

Preferred Pronoun:
☐ He ☐ She ☐ They ☐ Other_____

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Non-binary ☐ Other
Sex: ☐ Male ☐ Female ☐ Intersex

How did you hear about our office?
☐ Walk-In/Health Insurance ☐Internet ☐Community Event ☐Referral_____

Billing Responsibility

Preferred Billing Method ☐ Mailed Paper Statements ☐ Electronic Email Statements ☐ Both

How would you like to be billed for this visit? ☐ Self ☐Insurance ☐Other _____

Primary Insurance:_____ Secondary Insurance:_____

Current Complaints

PRIMARY Complaint:_____ Onset:_____

A) Is it: ☐Improving ☐Worsening ☐Staying the Same
B) Is it: ☐Mild ☐Moderate ☐Severe **Rated:** best 1 2 3 4 5 6 7 8 9 10 worst
C) What worsens it: ☐General Activity ☐Moving Wrong ☐Bending ☐Lifting ☐Walking ☐Sports
☐Getting up from a chair ☐Using a computer/desk work ☐Other:_____
D) What makes it better: ☐Rest ☐General Activity ☐Ice ☐Heat ☐OTC Meds ☐Rx Meds
☐Massage ☐Chiropractic ☐Other:_____
E) Is it worse in the: ☐AM ☐PM ☐As the day goes on ☐Off and on ☐Steady
F) Is the symptom: ☐ Dull/Achy ☐Tight/Stiff ☐ Sharp/Stabbing ☐ Numb/Tingly ☐Shooting ☐Burning ☐Cramping

SECONDARY Complaint:_____ Onset:_____

A) Is it: ☐Improving ☐Worsening ☐Staying the Same
B) Is it: ☐Mild ☐Moderate ☐Severe **Rated:** best 1 2 3 4 5 6 7 8 9 10 worst
C) What worsens it: ☐General Activity ☐Moving Wrong ☐Bending ☐Lifting ☐Walking ☐Sports
☐Getting up from a chair ☐Using a computer/desk work ☐Other:_____
D) What makes it better: ☐Rest ☐General Activity ☐Ice ☐Heat ☐OTC Meds ☐Rx Meds
☐Massage ☐Chiropractic ☐Other:_____
E) Is it worse in the: ☐AM ☐PM ☐As the day goes on ☐Off and on ☐Steady
F) Is the symptom: ☐ Dull/Achy ☐Tight/Stiff ☐ Sharp/Stabbing ☐ Numb/Tingly ☐Shooting ☐Burning ☐Cramping

Health History

Are you currently taking any prescription medications? ☐Yes ☐No If yes, please list them below:

_____

_____

Are you currently taking any over-the-counter medications/vitamins? ☐ Yes ☐No If yes, please list them below:

_____

_____

Have you ever had any of the following illnesses/medical conditions?

☐Alcohol/Drug Abuse	☐Chemotherapy	☐Heart Murmur	☐Osteoporosis
☐Anemia	☐Congenital Heart Defect	☐Heart Surgery/Pacemaker	☐Psychiatric Problems
☐Arthritis	☐Diabetes	☐Hepatitis	☐Rheumatic Fever
☐Artificial Bones/Joints	☐Emphysema	☐High Blood Pressure	☐Rheumatoid Arthritis
☐Artificial Valves	☐Epilepsy	☐HIV+AIDS	☐Severe/Frequent Headaches
☐Asthma	☐Fainting/Seizures	☐IBS/IBD	☐Shingles
☐Blood/Lymph Disorder	☐Frequent Neck Pain	☐Kidney Problems	☐Sinus Problems
☐Breathing Problems	☐Glaucoma	☐Lower Back Problems	☐Tuberculosis
☐Cancer	☐Heart Attack/Stroke	☐Mitral Valve Prolapse	☐Ulcers/Colitis

If you have or have had any other serious illnesses/medical conditions, please list them:_____

_____

Please list anything that you may be allergic to:_____

List any surgeries or medical procedures:

Date:_____ Procedure:_____ Date:_____ Procedure:_____

Date:_____ Procedure:_____ Date:_____Procedure:_____

Please list any past serious accidents with dates:_____

Please select one: ☐I have never smoked ☐Former smoker ☐Current smoker (How much: _____ pack per day/week)

Please select one: ☐I don't drink alcohol ☐Rarely drink ☐Social drinker ☐Heavy drinker (_____oz. per day/week)

Have you ever had chiropractic care? ☐Yes ☐No If yes, date of last treatment_____ By whom:_____

IF APPLICABLE: *I hereby declare that to the best of my knowledge* ☐***I am pregnant*** ☐***I am not pregnant. Due Date:***_____
If there is a chance that I may be pregnant, I will inform the doctor prior to my examination.

Acknowledgements:

- **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and is only released on my behalf for seeking reimbursement from any involved third parties.**
- **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care.**
- **I acknowledge that any insurance I may have is an agreement between the carrier and me, and that I am responsible for the payment of any covered or non-covered services I receive at this office.**
- **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern.**

Signature:_____

Print Name:_____

Date:_____

READ AND SIGN

IF YOU HAVE INSURANCE COVERAGE:

Please be advised that the information provided by your insurance company is not a guarantee of payment, only an estimate of what might be covered under your policy at the time of inquiry. Verification of coverage does not guarantee benefits. We determine actual coverage and payment when we receive a claim. **By signing below you confirm that you understand that YOU ARE 100% RESPONSIBLE FOR YOUR ACCOUNT BALANCE AS DETERMINED BY YOUR INSURANCE.**

By signing below you confirm you understand that:

- It is your responsibility to inform us of any change to your insurance policy so that your coverage can be re-verified.
- Not all services are a covered benefit with all insurance plans.
- It is your responsibility to be aware of what service(s) is being provided to you and if it is a covered benefit under your insurance.
- You are responsible for any non-covered charges not payable by your insurance policy.
- We will send all required claim forms and documentation to ensure your claims are processed in a timely manner.
- Final determination of benefits available is determined when the claim is sent to your insurance company and we receive an explanation of benefits from them.
- After all co-pays, contracted plan reductions, and insurance payment credits are applied to your account, any remaining portion will be your responsibility.
- If you are a **MEDICARE PATIENT,** please be advised that Medicare **ONLY COVERS** Spinal Adjustments in a chiropractic office. All services outside of the spinal adjustment in our office will be your financial responsibility.

Signature:_____ **Date:**_____

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, please do not hesitate to ask us. **WE ARE HERE TO HELP YOU.**

INFORMED CONSENT:

I hereby give my consent to the performance of diagnostic tests and procedures, and chiropractic treatment or management of my condition(s). Chiropractic treatment or management of conditions almost always includes the chiropractic adjustment. Like most health care procedures, the chiropractic adjustment carries with it some risks. Unlike many such procedures, the serious risks associated with the chiropractic adjustment are extremely rare. The following are the known risks:

- **Temporary soreness, or increased symptoms or pain;** it is not uncommon for patients to experience temporary soreness, increased symptoms, or pain after the first few treatments.
- **Dizziness, nausea, flushing;** these symptoms are relatively rare, please inform your chiropractor if you experience these symptoms during or after your visit.
- **Fractures;** some underlying conditions that weaken bones, like osteoporosis, may be susceptible to fracture. Please notify your chiropractor if you have been diagnosed with a bone weakening disease or condition. Your treatment will be modified accordingly.
- **Disc herniation or prolapse;** spinal disc conditions such as bulges or herniation may worsen even with chiropractic care. Please notify your chiropractor if symptoms change or worsen.
- **Stroke;** according to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care. There is an extremely rare type of stroke associated with both chiropractic and primary care medical visits but they appear to be coincidental to the care.

I understand that the practice of chiropractic, like the practice of all healing arts, is not an exact science, and I acknowledge that no guarantee can be given as to the results or outcome of my care.

I have read or had read to me this informed consent document. I have discussed or been given the opportunity to discuss any questions or concerns with my chiropractor and have had these answered to my satisfaction prior to signing this document. I have made my decision voluntarily and freely.

Signature:_____ Date:_____

Witness:_____ Date:_____

Doctor Signature:_____ Date:_____

Signature of Translator/Interpreter:_____ Date:_____

PLEASE READ & SIGN BACK PAGE

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PRIVACY NOTICE

This notice describes how health information about you may be used and disclosed and how you can access this information. Please review it carefully. The privacy of your health information is important to us. **We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. We are required to follow the privacy practices that are described in this Notice. You may request a copy of this notice at any time.**

Uses & Disclosures of Health Information

We may use and disclose health information about you for treatment, payment and healthcare operations. For example –
Treatment: We may use or disclose your health information to another healthcare provider who is providing treatment to you.
Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family & Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare in our office, or with payment for your healthcare, with your written or verbal agreement.

We will not use your health information for marketing communications. We may use or disclose your health information when we are required to do so by law. We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

PATIENT RIGHTS

You have the right to look at or obtain copies of your health information, with limited exceptions. If you have an extensive file, we will charge you a reasonable cost-based fee for expenses such as copies and staff time.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to any additional restrictions, however if we agree to do so, we will abide by our agreement (except in case of emergency).

Amendment: You have the right to request that we amend your health information (your request must be in writing, and must explain why the information should be amended). We may deny this request under certain circumstances.

QUESTIONS/COMPLAINTS:

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information, etc. you have the right to inform us.

I have received and reviewed this notice.

Signature: _____

Print Name: _____

Date: _____