DR. USE ONLY
HR:_____
BP:____/_____
WEIGHT:_____

File #:_____

Grand Health Chiropractic

Patient Information and History

Date:
Patient Name:
Address: City: State: Zip:
Birthday Age: Social Security:
Male Female Non-binary Pronouns: He/Him She/Her They/Them
Occupation: Employer:
Parent's Name (if a minor):
Single Married Divorced Widowed Separated
Spouse's Name: # of Children: Name(s):
How were you referred to our office?
Race: Ethnicity (circle one): Hispanic or Latino Non-Hispanic or Latino

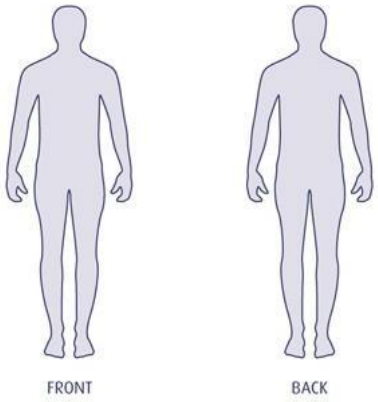
Contact Information

Cell Phone: Cell Phone Carrier:
(Parent's Name & Cell if Minor)
Home Phone:
Work Phone: Ext:
Email:
In case of emergency please contact:
Name: Relationship: Phone #:

Patient Condition

What is your major symptom/problem?
When/How did your symptoms begin?
Have you had this problem before?
Is your condition getting progressively worse? Yes No
Is this problem: Constant Comes and goes
How does it feel: Burning Sharp Shooting Dull Aching Stiff Tingling Throbbing Swelling Other
What makes the condition better?
Worse?
Does it interfere with: Work Sleep Daily Routine Recreation
Painful movements/activities: Sitting Standing Walking Bending Lying down Driving
Rate below the severity of your pain:
(No pain) **0 1 2 3 4 5 6 7 8 9 10** (Severe pain)

Please mark where it hurts →



Health History

Primary Care Physician: Clinic Phone:

Name & Location of Clinic:

What other treatments have you had for this condition? Chiropractic Orthopedic Neurologist
Physical Therapy Medication Surgery

Name of other doctors who have treated you for this condition:

Previous Chiropractic care? No Yes Dates: Local Out of state

Previous Physical Therapy? No Yes Dates: Local Out of state

Date of last Physical Exam: Spinal Exam:

List any Medications you are taking:

Vitamins/Herbs/Minerals:

Females: Are you pregnant: Yes No Beginning of last menstrual cycle:

Check any of the following conditions you have had:

Aids/HIV	Ear Ringing	Neck Pain
Allergies	Epilepsy	Osteoporosis
Anxiety	Headaches	Poor Circulation
Arm/Shoulder Pain	Migraines	Prostate Problems
Arthritis	Heart Disease	Rheumatoid Arthritis
Asthma	Hemorrhoids	Sciatica
Bladder Problems	Herniated Disk	Shingles
Cancer	High Blood Pressure	Sinus Infection
Chronic Fatigue	Insomnia	Stroke
Depression	Irregular Cycle	Thyroid Problems
Diabetes	Kidney Problems	TMJ
Digestion Problems	Leg Pain	Venereal Disease
Earache	Low Back Pain	Vertigo/Dizziness

Stressors		**Exercise**
Smoking	Packs/Day:	None
Alcohol	Drinks/Week:	Moderate
Coffee/Caffeine	Cups/Day:	Daily
High Stress Level	Reason:	Heavy

Have you had any	Description	Date
Auto Accidents		
Surgeries		
Broken Bones		
Falls/Head Injuries		

Family History:

FEMALES ONLY: My signature indicates that, "This is to certify, to the best of my knowledge, that I am not pregnant at this time. I hereby authorize Grand Health Chiropractic and Wellness Center to take X-Rays as necessary to determine the status of my spine. I will assume all responsibility for any effects on a fetus potentially present."

Printed Name: Signature: Date:

I hereby authorize this office and it's doctors to administer care to myself or my child as they deem necessary.

Parent (if minor): Signature: Date:

The Health Care Information Rights of Our Patients and Clients Include:

Your Right to Revoke Consent: You may revoke consent to use or disclose your health information at any time; however, your revocation must be in writing; there are two circumstances under which we will not be able to honor your revocation request: 1) Your health information was released prior to receipt of your request to revoke your consent; and 2) Were you required to give your authorization as a condition for obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Your Right to Limit Uses or Disclosures: You have a right to limit the use or disclosure of your personal health information. To do so you must inform us, in writing, of any health care providers, hospitals, employers, insurers or other individuals or organizations that you do not want us to disclose your health information to. We are not required to agree to your restrictions; however, if we agree with your restrictions, the restriction is binding on us.

Your Right to Receive Confidential Communication Regarding Your Health Information: We normally provide information about your health to you in person at the time you receive services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable, written request if you would like to receive information about your health or the services we provide at a place other than your home or if you would like the information in a different form.

Your Right to Inspect and Copy Your Health Information: You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files; such requests must be in writing. We may refuse your request, and charge you for retrieval and copying costs, only in accordance with Minnesota law.

Your Right to Amend Your Health Information: You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. Amendment requests must be in writing and give us reason to support the change you are asking us to make; however, the clinic is not obligated to comply with your request if it is judged to be unreasonable.

Your Right to Receive an Accounting of the Disclosures We Have Made of Your Records: You have the right to submit a written request for an accounting of the disclosures we have made of your health information for the last six years before the date of your request. By law, such accounting requests will include all disclosures made except for those that: 1) Are required for your treatment, to obtain payment for your services or to operate our practice; 2) Were made to you; 3) We are required or permitted to make without our consent or authorization; 4) Were disclosed with your written consent; 5) Were necessary to maintain a facility directory of individuals involved with your care; 6) Were disclosed for national security or intelligence purpose; 7) Were made to correctional or law enforcement officers; or 8) Were made prior to April 14, 2003.

We will provide the first accounting within any 12-month period without charge. Retrieval and copying fees complying with Minnesota law may be charged for any additional accounting requests during the same 12-month period. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

Your Right to Obtain a Paper Copy of This Notice: You may request a copy of this notice at any time.

Your Right to Complain: You may complain to us if you feel that we have violated your privacy rights. We respect your right to do so and will not take any action against you if you do file a complaint. For further information about our privacy policies and practices, to express a concern or to file a complaint, please contact the Compliance/Privacy Officer at:

Grand Health Chiropractic and Wellness Center
Trisha Augustine, DC
1048 Selby Ave
St. Paul, MN 55104
651-228-9000

CONSENT/AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

OUR PRIVACY PLEDGE: Grand Health Chiropractic is concerned with and committed to the protection of our patients' privacy and ensuring the confidentiality of personal health information entrusted to us.

Ways in which the clinic may use or disclose your health care information include, but are not limited to:

- Another provider or facility for the purpose of diagnosis, assessment or treatment of your health condition.
- Another party, such as insurance carrier, HMO or employer for the purpose of receiving payment for services rendered to you.
- The use of that information within our practice for quality control or other operational purposes.
- The use of that information to contact you by telephone, mail or e-mail with appointment reminders, information about the clinic, treatment alternatives or other health-related information that may be of interest to you.

Along with this consent form, you will be given a copy of our privacy notice that describes our privacy policies in detail. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. The current notice, including the effective date, will be posted in the clinic and will be given to you when you come in for treatment.

Your Right to Limit Uses or Disclosures: You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions; however, if we agree with your restrictions, the restriction is binding on us.

Your Right to Revoke Your Authorization: You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

YOU HAVE A RIGHT TO REFUSE CONSENT FOR DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION. WITHOUT YOUR CONSENT, HOWEVER, GRAND HEALTH CHIROPRACTIC WILL NOT BE ABLE TO SUBMIT CLAIMS TO INSURANCE CARRIERS OR OTHER THIRD PARTY PAYERS AND MAY NOT ACCEPT YOU AS A PATIENT/CLIENT.

Initial Here

[ ] I acknowledge receipt of Grand Health Chiropractic's Notice of Privacy Practices

By signing below, I give consent to Grand Health Chiropractic clinicians or staff to disclose my personal health information.

Printed Name: Signature: Date:

Parent/Guardian (if minor): Date:

PROFESSIONAL FEE SCHEDULE

INITIAL VISIT AND STANDARD VISITS	
Consultation	No Charge
Examination (complexity/time based)	$60 - $140
X-rays (per view)	$60
Adjustment (# of regions)	$60 - $75
Extremity Adjustment	$60
Application of Ice/Hot Pack	$35
Therapies (per unit)	$40 - $49

USUAL AND CUSTOMARY PHYSICAL THERAPY FEES			
Consultation	No Charge	Electronic Muscle Stimulation (per unit)	$35
Evaluation	$160	Ultrasound (per unit)	$40
Re-Evaluation	$85	Therapeutic Exercises (per unit)	$70
Hot/Cold Packs	$35	Neuromuscular Re-Education (per unit)	$70
Traction	$40	Manual Therapy Techniques (per unit)	$52
		Therapeutic Activities (per unit)	$58

Our experience has shown that it is wise to have an understanding with our patients as to our office policies and fees. This form has been prepared for your convenience and information. We offer several methods of payment for your needs. This information will enable us to better serve you and help to avoid misunderstandings in the future. Our main concern is your health and well-being, and we will do our best to help you in any way we can. A detailed outline of service charges can be provided upon request.

PLAN 1: GROUP INSURANCE

If you have insurance which covers physical therapy, we will bill your insurance directly. Please present your card on your first visit. Until we have the completed necessary information to verify coverage, you will be required to pay for your care. This includes any deductible or co-pay at the time of your service. In the event the insurance check should come to you, you are expected to bring the check in to us. Remember, insurance companies do not guarantee payment. Please know that we will bill the insurance company for all the services provided including but not limited to extremity adjustment, traction, neurological re-education, and soft tissue therapies. If you have questions regarding any of your billing please ask.

PLAN 2: HEALTH CARE MADE AFFORDABLE (HCMA)/CASH

For those patients who qualify, we offer discounted cash agreements on a monthly block basis. Please ask for details separate to this professional fee schedule. Fees are to be paid at the time services are rendered, unless special arrangements have been made in advance. Discontinuing care before completing the agreed upon corrective or wellness care plan will cause your plan to be prorated at our regular rates for all visits from the beginning of care.

PLAN 3: AUTO/PERSONAL INJURY

You need to report the accident and present your auto insurance card to us on your first visit. Payment will be required until your coverage can be verified. We will bill the insurance company directly.

Insurance verification and authorization is not a guarantee of payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee. I understand that I may be responsible for any balance that is not paid by insurance. I authorize the Clinic to release any information regarding my treatment to any insurance company in effort to receive reimbursement for services provided. I authorize the use of this signature on all insurance submissions.

I have read and understand all of the options available to me.

Signature: Parent (if minor): Date:

Financial Responsibility Agreement

Please take a few minutes to read the following financial responsibility statements upheld by our clinic. This form is used to prevent any misunderstanding and to provide our patients with a clear understanding of our billing procedures. If you have any questions, please let us know ***prior*** *to signing the agreement.*

Responsible Party Clearly Defined

Payment in full is due on the date of service, unless you have active insurance with benefits remaining that are applicable to the procedures being performed. Our office extends a line of credit for the full amount of the procedure to allow processing time for your health insurance claims. It is understood that the clinic will diagnose treatment based on your health and not your insurance coverage. You are financially responsible for all charges whether or not paid by insurance.

Discontinuation of Treatment

If you choose to prematurely discontinue treatment before the agreement is completed, the chiropractic visits will be charged our normal fee schedule for chiropractic.

Claim Processing & Payment Terms and Conditions

All balances remaining open at 60 days are due in full, regardless of pending insurance claims. We will file your insurance claim in order to help you achieve your maximum allowable benefits, but we cannot extend credit beyond 60 days. If you believe that you will need longer than 60 days to pay your charges, please speak to your Doctor or contact our Billing Dept. If the insurance company pays our office after you've paid the balance due, we will issue a refund check to the responsible party and mail it to the address listed on the account.

Additional Interest, Charges, and Fees

Monthly charges may also include a $3.00 Statement fee. If a check is returned due to insufficient funds or otherwise, a $30.00 returned check fee will be added to the account and interest charges may apply.

Collection Activity and Additional Charges

Patient accounts with balances open at 90 days may be subject to more aggressive collection efforts and turned over to a collection agency or an attorney's office. Accounts that are turned over for third party collections will accrue a finance charge which is consistent with the maximum allowable by law and all charges incurred in the recovery of the delinquent account will be added to the patient's balance. These charges include, but are not limited to, collection fees, reasonable attorneys' fees whether litigation is commenced or not, transaction fees, NSF fees, other legal fees, and court costs. These recovery costs may increase a patient's balance by as much as 50%.

I have read, understood, and agree to the provisions of the Grand Health Chiropractic Financial Responsibility Agreement

Signature: Date:

INFORMED CONSENT WAIVER & AUTHORIZATION TO TREAT

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

> ***Adjustment****:* An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments of the spine and joints of the body.
> ***Health****:* A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.
> ***Vertebral Subluxation****:* A subluxation is a complex of functional and/or structural and/or pathological articular changes that compromise neural integrity and may influence organ system function and general health.

We obtain the necessary clinical information to establish an accurate impression of the person's health status by utilizing diagnostic and treatment procedures that are supported by the best available evidence, clinical experience or consensus-driven guidelines and are in accordance with legal standards of care. We do not offer advice regarding treatment prescribed by others. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we follow cooperative patient management with referral to communication and collaboration with other health care providers to ultimately benefit the patient.

Practice Objective
Our office recognizes and places particular attention on the adjustment, correction and prevention of the subluxation complex by facilitating neurological and biomechanical integrity in the preservation and restoration of your health and wellness.

The material risks inherent in chiropractic adjustments
As with any healthcare procedure, there are certain complications which may arise during chiropractic adjustments and therapy. These complications include but are not limited to: costovertebral strains and separations, fractures, muscle strain, cervical myelopathy, and although rare, various vascular injuries. Some patients will feel stiffness and soreness following the first few days of treatment. We will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us.

Informed Consent and Authorization
I, the undersigned, have been informed by the participating treating doctor of Chiropractic (D.C.) that he/she is/are a licensed chiropractor, and having been informed by such Doctor as to the benefits and potential risks of chiropractic and radiological treatment, hereby consent to such treatment. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I, therefore, accept chiropractic care on this basis.

This document is binding and the parties hereto intend this Informed Consent Waiver and Authorization to Treat to be binding and insure the benefit of their respective principals, heirs, executors, administrators, successors, and assigns; includes any and all my successors and/or heirs. I further state that should complication arise from such agreed treatment with treating Doctor of Chiropractic that such individual and myself will be the only parties to engage in any and all recourse should that need arise foregoing any and all others.

Signature: Parent (if minor): Date: