SOUTHRIDGE CHIROPRACTIC CLINIC

425 S. 7th Street
Bismarck, ND 58504
Phone: 701-258-8388
Toll Free: 1-800-458-8388
Fax: 701-258-8788

Dr. Chad Kahl
Dr. Jamie Kahl
Dr. Rusty Kjos
Dr. Kelly Gartner
Dr. Kent Maier
Dr. Angela Ness
Dr. Sheri Ten Broek

Welcome,

Thank you for choosing Southridge Chiropractic Clinic.

Please complete the following paperwork:

- **Patient Confidential Information & Patient Condition:** Please fill out the both front and back of each of these pages. Include the names and dosages of all medications you are currently taking.
- **Notice of Privacy Practices**: This protects your rights as a patient. Print, sign and date in designated areas.
- **Financial Policy:** Depending on what type of insurance you have please read the corresponding section and initial along the side showing that you understand. Sign the bottom of the page.

If you are filling this paperwork out for your child or a minor, please print their name for the patient and sign your name as the guardian/representative.

If you have any questions please call us at 701-258-8388.

Reminder, please bring your **photo ID** and **insurance card** with you to your appointment!

Thank you,

The Southridge Chiropractic Clinic Team

## PATIENT CONFIDENTAL INFORMATION

Patient Name _____ _____ _____
First Middle Last

Social Security # _____ _____ Male _____ Female Birthdate ____/____/____ Age _____

Address _____ City _____ State _____ Zip _____-_____

Home Phone _____ Cell Phone _____ Email _____

Circle One: Minor Single Married Divorced Widowed Separated

Race (circle one): African American American Indian Asian Caucasian/White Decline Other_____

Ethnicity (circle one): Hispanic Non-Hispanic Decline

If over the age of 13 are you a smoker? (circle one): Never Former Current Every Day Current Some Day

Preferred Language (circle one): English Spanish Other_____

Patient or Parent's Employer _____ Work Phone _____

Employer's Address _____ City _____ State ____ Zip _____

Spouse or Parent's name _____ Employer _____ Cell phone _____

Who referred you to our Clinic? _____(Example-Name, Phone Book, Internet)

Is this an accident? _____Yes _____No Auto (date) _____ Work Injury (date) _____

Have you contacted an attorney? _____Yes _____No If so, name of attorney _____

Emergency Contact Information _____ Home Phone _____
Someone NOT living with you

Relationship _____ Cell Phone _____

Responsible Party for this account _____Relationship to patient _____

Address _____ Phone _____ Cell _____

Birthdate _____ Social Security _____ Employer _____

Is this person a patient already at our clinic _____ Yes _____ No

## INSURANCE INFORMATION

Insurance Name _____ Name of Policy Holder _____

Policy Number _____ Group Number _____ Policy Holder Birthdate ___/___/___

**Are you covered by another Insurance besides the one above? _____ YES _____ NO If so please fill out the following:

Insurance Name _____ Name of Policy Holder _____

Policy Number _____ Group Number _____ Policy Holder Birthdate ___/___/___

**-CONTINUED ON BACK PAGE-**

## ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage (health, accident or Worker's compensation coverage) and assign directly to *SOUTHRIDGE CHIROPRACTIC PC* all insurance benefits, if any, otherwise I am responsible for services rendered. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, my insurance carrier or other medical entity. A copy of this authorization will be sent to my insurance company or other entity if requested. The original authorization will be kept on file by the organization. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I understand I am financially responsible for all charges and the bill whether it is paid by the insurance or if the claims submitted are denied. I authorize the use of my signature on all insurance submissions. The above-named clinic/ or doctors associated with this clinic may use my health care information and may disclose such information to my insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end if I give written notice otherwise this will be in effect indefinitely.

Please sign here stating that you have read the above paragraph and accept the terms above:

Print _____ Sign _____ Date ___/___/_____

Signature of Patient, Guardian or Personal Representative

Clinical summaries will show the treating physician, vitals, medications and allergies that are listed in your file. If you would like this at each visit please provide your email. If not, please check the box below and sign. Thank you!

☐ **I choose to decline receipt of my clinical summary after every visit (These summaries are often blank because of the nature and frequency of chiropractic care.)**

Patient Signature: _____ Date:_____

## CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize the Doctors at Southridge Chiropractic Clinic and whomever they may designate as their assistants to administer chiropractic care as deemed necessary to my _____

Relationship of child

_____

Name of child

Date:_____

Signed:_____

Name: _____ **PATIENT CONDITION**

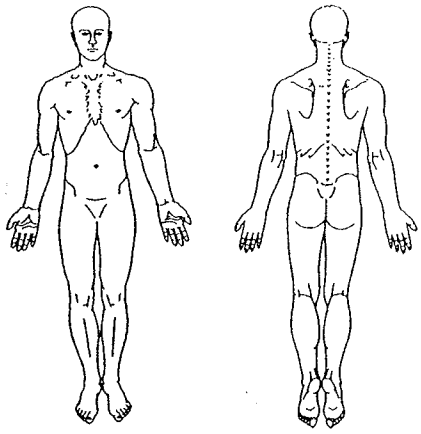
Date_____ Height _____ Weight _____

Reason for visit _____

When did your symptoms appear? _____

Was there an accident or injury? If so, when?_____

Is this condition getting worse _____Yes _____ No _____ Staying the Same



Mark an X on the picture where you have pain, numbness or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ____Sharp ____Dull ____Throbbing ____Numbness ____Aching ____Shooting
____Burning ____Tingling ____Cramps ____Stiffness ____Swelling ____Other

How often do you have this pain? _____

Is it constant or does it come or go? _____ Does it interfere with your ____ Sleep ____ Daily Routine
____ Work ____ Recreation

Activities or movements that are painful to perform ____ Sitting ____ Standing ____Walking
____ Bending ____ Lying Down

What treatment have you received for your condition? ____ Medications ____Surgery ____Physical Therapy
____ Chiropractic Services ____ Other

Name of other doctor(s) who have treated you for your condition? _____

Date of Last: Physical exam _____ Spinal X-ray _____ Blood Test _____
Spinal Exam _____ Chest X-ray _____ Urine Test _____
Dental Exam _____ MRI, CT-Scan, Bone Scan _____

**Circle any of the following if you have had:**

AIDS/HIV
Alcoholism
Allergy Shots
Anemia
Anorexia
Appendicitis
Arthritis
Asthma
Bleeding Disorders
Breast Lump
Bronchitis
Bulimia
Cancer
Cataracts
Chemical Dependency
Chicken Pox
Diabetes
Emphysema
Epilepsy
Fractures
Glaucoma
Goiter
Gonorrhea
Gout
Heart Disease
Hepatitis
Hernia
Herniated Disk
Herpes
High Blood Pressure
Kidney Disease
Liver Disease
Measles
Migraine Headaches
Miscarriage
Mononucleosis
Multiple Sclerosis
Mumps
Osteoporosis
Pacemaker
Parkinson's Disease
Pinched Nerve
Pneumonia
Polio
Prostate Problems
Prosthesis
Psychiatric Care
Rheumatoid Arthritis
Rheumatic Fever
Scarlet Fever
Sexually Transmitted Disease
Stroke
Suicide Attempt
Thyroid Problems
Tonsillitis
Tuberculosis
Tumors, Growths
Typhoid Fever
Ulcers
Vaginal Infections
Whooping Cough
Other _____
_____

**Exercise**
None
Moderate
Daily
Heavy

**Work Activity**
Sitting
Standing
Light Labor
Heavy Labor

**Habits**
Smoking — Packs/Day _____
Alcohol — Drinks/Week _____
Coffee/Caffeine Drinks — Cups/ Day _____
High Stress Level — Reason _____

***-Continued on Back-***

Are you pregnant? _____YES _____ NO Due Date _____

| Injuries/Surgeries you have had | Description | Date |
|---|---|---|
| Falls | | |
| Head Injuries | | |
| Broken Bones | | |
| Dislocations | | |
| Surgeries | | |
| Motor Vehicle Accidents | | |
| Work Injuries | | |

**Are you currently taking any medications?** ☐ **I'm not taking any medications.**

(If so, please include regularly used over the counter medications)

| Medication Name | Dosage and Frequency (i.e. 5mg once a day, etc.) |
|---|---|
| | |
| | |
| | |
| | |

**Do you have any medication allergies?** ☐ **I have no known drug allergies.**

| Medication Name | Reaction | Onset Date | Additional Comments |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Do you have any Family History of the following:**

| | | | | | |
|---|---|---|---|---|---|
| Cancer | F | M | B | S | Key (Immediate family members only)<br>F= Father<br>M= Mother<br>B= Brother<br>S= Sister |
| Alcoholism | F | M | B | S | |
| Diabetes | F | M | B | S | |
| Heart Disease | F | M | B | S | |
| High blood pressure | F | M | B | S | |
| Other (please specify): | | | | | |

*For office use only:* BP____/_____

Notice of Privacy Practices Acknowledgement
Initial Uses Authorization Form
**Southridge Chiropractic PC**

Effective: April 14, 2003
Updated: September 23, 2013

By signing this form, you acknowledge that you were presented with a copy of the Notice of Privacy Practices of Southridge Chiropractic PC. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. The most current Notice of Privacy Practices will be placed on display in the office at all times. You may obtain additional copies of our most current notice by requesting it from our privacy official, (privacy official).

Southridge Chiropractic PC also uses protected health information for the following reasons: (you may opt out of this authorization). Special initial authorization is required and attached. Marketing; internal referral board, testimonials, pictures on bulletin board, or information unrelated to healthcare and other marketing materials. _____ (please initial if approve)

If you have any questions regarding this notice or our health information privacy policies, please contact: (privacy official)at: Southridge Chiropractic PC ,
425 S. 7th St., Bismarck, ND 58504 , 701-258-8388
Hours Available: A message may be left for our privacy official any time the clinic is open and your call will be returned within 7 business days.

Your Email address: _____ (you may receive PHI through email)

Print Patient Name: _____

Signature Patient/Personal Representative: _____

Relationship of Personal Representative: _____

Date of Signature: _____

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Staff complete only if NO signature is obtained, If it is not possible to obtain the patient's acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

- □ Patient refused to sign this acknowledgement even though the patient was asked to do so and the patient was given the Notice of Privacy Practices
- □ Other: _____

Staff Signature: _____ date: _____

# FINANCIAL POLICY
# SOUTHRIDGE CHIROPRACTIC CLINIC

Please initial the correct line:

_____ **CASH** – I am aware that I am totally responsible for all health care bills incurred on my account. I will pay them each visit with cash or check. I can use a credit card also but, I do understand that I will not receive the cash discount then.

_____ **MEDICARE** – I understand that this office is participating provider for Medicare. It will bill and receive payment from Medicare for covered services as long as a spinal problem exists and is demonstrated by exam or x-ray. Only spinal adjustments are covered and extremities (wrist, elbow, knee, ankle or feet) are NOT covered by Medicare. An initial exam is mandatory prior to receiving care. Non-covered services include exam and consultation fees, x-rays, acupuncture, covered services, and unapproved services not covered by my insurance.

_____ **INSURANCE** - I understand that my insurance policy is a contract between my company and me. This office, as a courtesy to me, will submit claims in a timely manner, respond to any written request from my insurance company, and allow up to 30 days for them to pay their portion of my bill. If this payment is not received within 30 days of service, I understand it is my responsibility to contact my insurance company to see why payment has not been issued. I am totally responsible for the balance at that time. It is also my responsibility to request pre-authorization from my insurance company for treatment, according to my policy.

_____ **WORKER'S COMPENSATION** – I am aware that this office will bill my worker's compensation insurance for my work related injury. I will submit any correspondence received from my insurance company to this office. If my company denies liability for any reason, I understand that I am personally responsible for all health care bills accrued at this office.

_____ **PERSONAL INJURY** – I understand that this office will bill my personal injury insurance company for treatment related to my injury. I am also aware that if this insurance company terminates or denies my health care bills that I, personally, am responsible for those bills. At that time, this office will submit claims to my general health insurance company if I have such a policy.

_____ **MEDICAID** - I understand that this office will bill the medical assistance program for covered services which include 12 spinal manipulations of the spine. This program does not cover any other areas but the spine. I am aware that non-covered services such as physiotherapy, vitamins, acupuncture, massage, supplies and supports are my responsibility of these at the time of service. I am aware that if this program does not cover my services for any reason that I, myself am responsible.

**I UNDERSTAND THAT THERE IS A TIME FRAME TO FILE ALL INSURANCE CLAIMS. IT IS MY RESPONSIBILITY TO CONTACT THIS OFFICE WITH ANY NEW OR CHANGING INFORMATION ON MY INSURANCE POLICY. IF I DO NOT CONTACT OR GIVE THIE CORRECT INFORMATION TO THIS OFFICE, IT IS MY RESPONSIBILITY FOR THE BILL IN FULL.**

**I UNDERSTAND THAT ANY SUPPLIES, SUPPORTS OR NUTRITIONAL SUPPLEMENTS MUST BE PAID FOR AT THE TIME OF PURCHASE REGARDLESS OF THE INSURANCE INDICATED ABOVE.**

**I HAVE READ THE ABOVE AND UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF MY ACCOUNT ACCORDING TO THE ABOVE INDICATED POLICY THAT I HAVE INITIALED.**

| PRINT NAME | PATIENT'S SIGNATURE | DATE |
|---|---|---|

# INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Medical doctors, chiropractic doctors, osteopaths, and physical therapists that perform manipulation are required by law to obtain your informed consent before starting treatment. The following is Southridge Chiropractic PC's informed consent for treatment. We intend this consent form to cover the entire course of treatment for your present condition and for any conditions for which you seek treatment at this clinic.

## The nature of the chiropractic adjustment.

The primary treatment we use as Doctors of Chiropractic is spinal manipulative therapy. We will use that procedure to treat you. We may use our hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement. Various ancillary procedures, such as cold packs, electrical muscles stimulation, ultrasound, massage, acupuncture, Graston, traction as well as exercise instruction may also be used.

## The material risks inherent in chiropractic adjustment.

Unlike many such procedures, the serious risks associated with the chiropractic adjustment are extremely rare. Following are the known risks:

**Temporary soreness or increased symptoms or pain.** It is not uncommon for patients to experience temporary soreness or increased symptoms or pain after the first few treatments.

**Dizziness, nausea, flushing.** These symptoms are relatively rare. It is important to notify the chiropractor if you experience these symptoms during or after your care.

**Fractures.** When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening disease or condition. If your chiropractor detects any such condition while you are under care, you will be informed and your treatment plan will be modified to minimize risk of fracture.

**Disc herniation or prolapse.** Spinal disc conditions like bulges or herniations may worsen even with chiropractic care. It is important to notify your chiropractor if symptoms change or worsen.

**Stroke.** Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. 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. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. Once in a million is about the same chance as getting hit by lightning.

**Other risks** associated with chiropractic treatment include rare burns from physiotherapy devices that produce heat.

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 outcomes of my care.

I have read or have had read to me the above explanation of treatment here at Southridge Chiropractic Clinic. Any questions I have regarding these procedures have been answered to my satisfaction ***prior to my signing this consent form.*** I have made my decision voluntarily and freely. By signing below I have been informed of the risks and give my consent to that treatment.

Date: _____ Print Name: _____ Signature: _____
Patient — Patient or Guardian

Signature: _____
Witness (for office staff only)