



425 S. 7th Street
Bismarck, ND 58504
Phone: 701-258-8388
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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 CONFIDENTIAL 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? _____

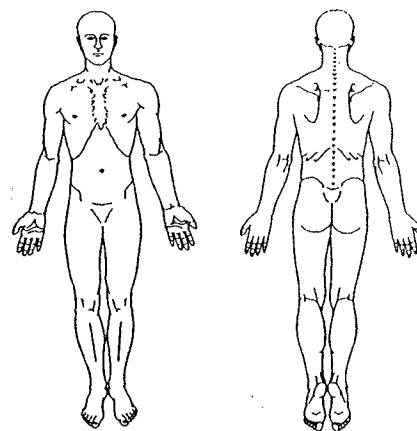
Date of Last: Physical exam _____ Spinal X-ray _____ Blood Test _____
Spinal Exam _____ Chest X-ray _____ Urine Test _____
Dental Exam _____ MRI, CT-Scan, Bone Scan _____

Circle any of the following if you have had:

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

Exercise	Work Activity	Habits	Packs/Day	_____
None		Smoking	Drinks/Week	_____
Moderate		Alcohol	Cups/ Day	_____
Daily	Sitting	Coffee/Caffeine Drinks	Reason	_____
Heavy	Standing	High Stress Level		
	Light Labor			
	Heavy Labor			

-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) F= Father M= Mother B= Brother 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: _____

=====

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 THE 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