

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

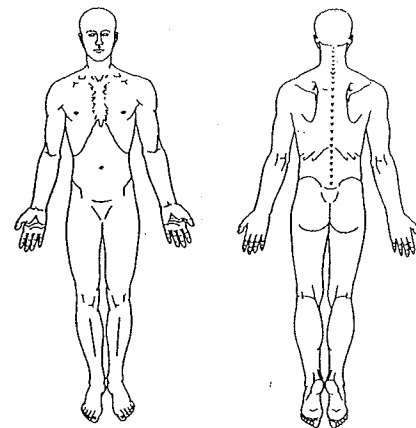
What treatment have you received for your condition? \_\_\_\_\_ Medications \_\_\_\_\_ Surgery \_\_\_\_\_ Physical Therapy  
\_\_\_\_\_ Chiropractic Services \_\_\_\_\_ Other

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 |                              |



<b>Exercise</b>	<b>Work Activity</b>	<b>Habits</b>	<b>Packs/Day</b>	_____
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 \_\_\_\_ / \_\_\_\_

Southridge Chiropractic PC  
425 S 7th St  
Bismarck, North Dakota 58504  
PH: 701-258-8388

**Consent to use PHI**

**Acknowledgment for Consent to Use and Disclosure of Protected Health Information**

**Use and Disclosure of your Protected Health Information**

Your Protected Health Information will be used by Southridge Chiropractic PC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

**Notice of Privacy Practices**

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy.

\_\_\_\_\_ Patient Initials

**Requesting a Restriction on the Use or Disclosure of Your Information**

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

**Notice of Treatment in Open or Common Areas**

Describe and Notify private areas available upon request

**Revocation of Consent**

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

*By my signature below I give my permission to use and disclose my health information.*

\_\_\_\_\_  
Patient or Legally Authorized Individual Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient's Full Name

\_\_\_\_\_  
Time

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

**FINANCIAL POLICY  
SOUTHRIDGE CHIROPRACTIC CLINIC**

Please initial 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, check or credit card.

\_\_\_\_ **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, re-exams, consultation fees, x-rays, acupuncture, covered services (in certain cases), 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 does not pay 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 20 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

# 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)