THE CENTER FOR FAMILY CHIROPRACITC CARE

601 East Sanborn St
Winona, MN 55987

(507) 474-1530

(Consent to use PHI) Notice of Privacy Practices - Acknowledgement & Consent

Acknowledgement 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 The Center for Family Chiropractic Care 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. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

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.

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

Patient Information:

The Center For Family
Chiropractic Care

Please Print Clearly

Full Name: _____ Nickname: _____

Address: _____ City: _____ State: _____Zip: _____

Date of birth: _____ Social Security #: _____ Gender **M F**

Race: White Black Asian Other _____ Ethnicity: Non-Hispanic Hispanic Preferred Language: _____

Marital Status: _____ Name of Spouse: _____ Number of Children: _____

Home Phone: _____ Cell Phone: _____

Email address: _____

Employer: _____

Emergency Contact _____ Number ( ) _____-_____

How did you hear about The Center For Family Chiropractic Care? _____

Insurance Information
I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are my responsibility and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I understand and agree that unpaid fees for services beyond thirty (30) days may be subject to a 1.5% monthly finance charge (18% annually), with a minimum service charge of $10.00 per month.

_____ Patient/Guardian Initial

Release of Information
I authorize Dr. Eichman and The Center For Family Chiropractic Care P.L.L.C., to release all medical information necessary; to all insurers, their agents or review organizations and the centers for Medicare and Medicaid Services or their agents for processing insurance claims. And to my other health care providers for continuity of care, and continuing care purposes. I also authorize my insurance company or health plan administrator, their agents or review agencies, or third party payers to release all pertinent financial information concerning coverage and payments made under my policy to Dr. Eichman and The Center For Family Chiropractic Care P.L.L.C..

_____ Patient/Guardian Initial

Assignment of Benefits
I hereby direct all payers to release any information regarding any coverage or benefits and to make any payments directly to The Center For Family Chiropractic Care P.L.L.C. I authorize this office to release any information to insurance carriers regarding my treatment to facilitate collection. I agree that all provisions to this Agreement are reasonably necessary for the protection of the rights and interests of The Center For Family Chiropractic Care P.L.L.C. and myself.

_____ Patient/Guardian Initial

Statement of Financial Responsibility
I acknowledge I am responsible for all charges for services provided to me including any amount not paid by my insurance plan(s).

_____ Patient/Guardian Initial

By my signature below and initials above, I acknowledge I have read, understand and agree to the above provisions.
A Photocopy of this Statement of Financial Responsibility shall be considered as effective and valid as the original.

Patient Signature: _____ Date _____

Signature of Parent or Guardian: _____ Date _____

Your Primary Physician _____

Patient Health Questionnaire - PHQ

ACN Group, Inc. Form PHQ-202

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

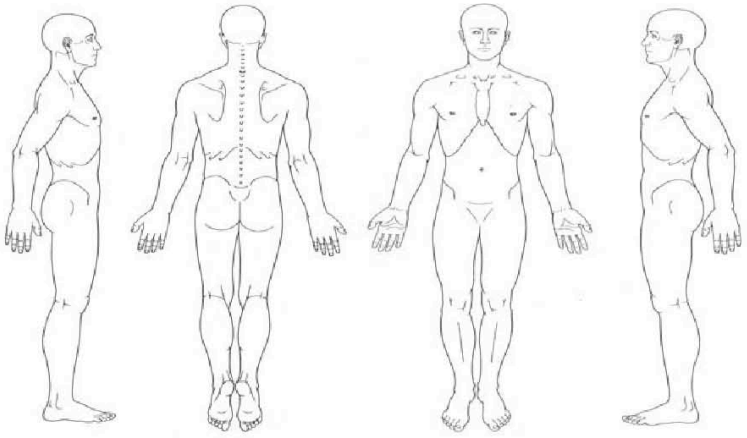
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the <u>past 4 weeks:</u>

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the <u>past 4 weeks</u> how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

① No One
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

10. What is your occupation?

_____

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

Patient Signature _____ **Date** _____

Patient Information

The Center For Family Chiropractic Care

Family History

Indicate if your parents, sisters or brothers have any of these problems:

☐ No family History
☐ Arthritis ☐ Chronic pain Other unlisted: _____
☐ High blood pressure ☐ Cancer
☐ High cholesterol ☐ Heart disease
☐ Diabetes ☐ Depression _____

Causation

How were you injured? _____

Medication, and Surgeries

List all medication types you have taken for your problems related to today's visit.

☐ No medication taken. Pain _____ Anti-inflammatory _____ Other _____

Indicate the types of surgery you have had for or on the areas related to your complaint. _____

☐ No history of surgery for the area of today's problem.

Past Medical History

Please select all past and present medical health problems. ☐ I am in good health and have none of the problems listed below

☐ Diabetes ☐ Lung disease ☐ Stomach problems ☐ Ulcer disease
☐ Kidney disease ☐ Mitral valve prolapse ☐ High cholesterol ☐ Heart problems
☐ Liver problems ☐ Asthma ☐ Bleed easily ☐ Arthritis
☐ Other _____

List all current medications. _____ ☐ No current medications.

List medication allergies. _____ ☐ No medications allergies

List all past surgeries. _____ ☐ No history of surgical procedures.

Social History

Do you drink alcohol?

☐ Never ☐ Occasionally ☐ Socially ☐ Frequently (more than 3 days per week)

Do you smoke? ☐ Yes ☐ No Have you ever smoked? ☐ Yes ☐ No
Do you use tobacco? ☐ Yes ☐ No Have you ever used tobacco? ☐ Yes ☐ No

Have you had substance abuse treatment? ☐ Yes ☐ No
Have you ever used illegal drugs? ☐ Yes ☐ No

Are you working? ☐ Yes ☐ No

What is your education level? _____ Degree: _____

Symptoms and Activities of Daily Living

Please check all activities/situations that make your symptoms worse.

☐ Standing ☐ Bending ☐ Emotional stress ☐ Menstruating ☐ Sitting
☐ Sleeping ☐ Walking ☐ Sexual activity ☐ Touching over the affected area
☐ Moving from a sitting to standing position
Other _____

Has your problem decreased or prevented your ability to exercise or work? ☐ Yes ☐ No

Patient Signature: _____ Date: _____

Patient Information

The Center For Family Chiropractic Care

Review of Systems

Do you have any ill feelings? ☐ No symptoms ☐ Decreased activity level ☐ Fever ☐ Chills ☐ Fatigue ☐ Night Sweats ☐ Loss of appetite ☐ Weight loss ☐ Weight gain ☐ Loss of energy ☐ Uncontrolled sweating	Do you have any mental Health problems? ☐ No symptoms ☐ Depression ☐ Disturbed sleep ☐ Suicidal thoughts ☐ Anxiety ☐ Nervousness ☐ Irritability	Do you have any problems urinating? ☐ No symptoms ☐ Frequent urination ☐ Urgency ☐ Trouble stopping or starting stream ☐ Erectile dysfunction ☐ Nocturia ☐ Burning with urination ☐ Losing control/incontinence ☐ bowel dysfunction ☐ Sexual Dysfunction ☐ Hesitancy
Do you have trouble with your vision? ☐ No symptoms ☐ Blurred vision ☐ Double vision ☐ Vision Loss ☐ Eye pain ☐ Work glasses/contacts	Do you have any symptoms of heart trouble? ☐ No symptoms ☐ Chest pain ☐ Palpitations ☐ Fainting ☐ Shortness of breath ☐ Ankle swelling	Do you have breathing problems? ☐ No symptoms ☐ Coughing ☐ Wheezing ☐ Shortness of breath
Do you have stomach problems? ☐ No symptoms ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Loss of bowel control	Do you have muscle or joint problems? ☐ No symptoms ☐ Joint pain ☐ Joint weakness ☐ Muscle weakness	Do you have and skin problems? ☐ No symptoms ☐ Rash ☐ Itching ☐ Dryness ☐ Lesions ☐ Open wound/infection ☐ Hair/nail changes
Do you have any immunity problems? ☐ No symptoms ☐ Enlarged lymph nodes ☐ Hives ☐ Hay fever ☐ Persistent infections	Do you have any endocrine problems? ☐ No symptoms ☐ Diabetes ☐ Thyroid disorder	Do you have any neurological problems? ☐ No symptoms ☐ Seizures ☐ Abnormal sensory feelings in extremity ☐ Loss of memory
Do you have bruising or bleeding problems? ☐ No symptoms ☐ History of anemia ☐ Abnormal bleeding ☐ Bruising ☐ Heat intolerance ☐ Cold Intolerance	Do you have an allergy to any medications? ☐ Yes ☐ No Please list: _____ _____	

Please list any other information you feel your doctor may need to know on the back of this page.

Patient Signature: _____ Date: _____

INFORMED CONSENT

Patient Name _____

The Center For Family Chiropractic Care, P.L.L.C.
601 East Sanborn St
Winona, MN 55987

The primary treatment used by doctors of chiropractic is the spinal manipulation, often called a spinal adjustment.

The nature of the chiropractic adjustment:

I will use my 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 or sense movement.

The material risks inherent in the chiropractic adjustment:

As with any healthcare procedure, there are certain complications, which may arise during chiropractic manipulation. Those complications include: fractures, muscle strains, sore muscles, stroke, or stiffness.

The probability of those risks occurring:

Fractures are rare, and usually associated with an underlying weakness of the bone, which is checked for during your initial history, examination, and x-ray. Stroke has been the subject of much debate, with one prominent authority saying that there is at most a one in a million chance of such an outcome. Again, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other risks listed above are also generally described as "rare".

The availability and nature of other treatments options:

Other treatments options for your condition may include:
Self-administered, over-the-counter analgesics and rest
Medical care with prescription drugs such as anti-inflammatories, muscle relaxants and pain killers
Hospitalization with traction
Surgery

The material risks inherent in such options include:

Side effects from analgesics, and covering up the condition leading to re-injury or aggravation of the injury
Prescription pain killers can lead to dependence and even addiction
Hospitalization can lead to exposure to communicable disease, and can be very expensive
Surgery can lead to adverse reactions to anesthesia, and surgery is an invasive procedure
All these risks can be discussed with your chiropractor or medical doctor

The risk and dangers attendant to remaining untreated:

Remaining untreated allows for the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult to treat.

Authorization for care:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and my self. Furthermore, I understand and agree that all services rendered to me, or my legal dependants are my responsibility, except where an insurance contract between The Center For Family Chiropractic Care, P.L.L.C. and my insurance company supersedes my responsibility.

Do not sign until you have read and understand the above.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment, and the authorization for care. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment that is recommended. Having been informed to the risks, I herby give my consent to that treatment.

Date _____ _____
Print Name

_____
Signature

[ ] Dr. Jude Eichman, D.C.
[ ] Dr. Jennifer Eichman, D.C.

Dr._____, D.C.
Dr. Signature