Redenius Chiropractic

Welcome To Our Office!

Today's Date ____/____/____

Patient Title: ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss ❑ Dr.

Name _____ **Preferred Name**_____
First *Middle* *Last*

Address_____

City_____ **State**_____ **Zip Code**_____

Home Phone_____ **Work Phone**_____ **Mobile Phone**_____

Email Address_____

Preferred Contact Method ❑ Home Phone ❑ Work Phone ❑ Mobile Phone

Date of Birth ____/____/____ **Age**_____ **Gender** ❑ Male ❑ Female

Marital Status ❑ Single ❑ Married ❑ Other **Spouse's Name**_____

Emergency Contact_____ **Phone #**_____ **Relationship**_____

Financial Responsibility_____

Referred to our office by_____

Medical Physician Name_____

Employment Status ❑ Employed ❑ Full-Time Student ❑ Part-Time Student ❑ Retired ❑ Other

Occupation _____ **Employer** _____

Health Information

Do you currently take any medications? ❑ Yes ❑ No

	Medication Name	*Frequency*	*Dosage*	*For What Condition?*
1				
2				
3				
4				
5				

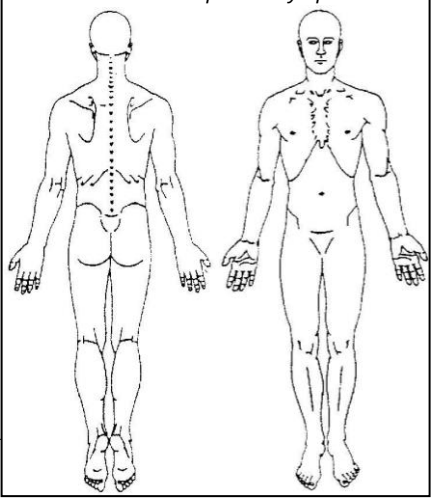
Are you allergic to any medications? ❑ Yes ❑ No

If yes, please list known allergies to medications:_____

Current Problem

Reason for this visit? _____

Mark location of pain or symptoms:



What level of intensity would you rate your pain?
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

Please CIRCLE all that apply:

-Dull -Sharp -Throbbing -Burning -Deep -Aching

-Tingling -Stabbing -Cramping - Numbness -Radiating -Stiffness

What is the frequency of your symptoms?
❑ Constant ❑ Frequent ❑ Occasional ❑ Intermittent

What makes your symptoms worse? _____

What makes your symptoms better? _____

When did the symptoms start?_____

How did you injure yourself?_____

Have you ever experienced this before? ❑ Yes ❑ No _____

How does this affect your personal life? (Hobbies, sports, etc.…) _____

How does this affect your job? (Missed days, inability to lift, stand, sit, etc.…) _____

What home remedies have you tried? _____

Have you been to another doctor for this problem? ❑ Yes ❑ No_____

Have you ever been to a Chiropractor before? ❑ Yes ❑ No_____

Does this affect any of the following tasks? *SELECT the answers that apply to you.*

Bathing/Showering	Hobbies	Playing Sports
Bending Forward	Walking	Preparing Meals
Driving	Eating	Standing
Brushing Teeth	Kneeling	Putting on Pants
Bending to the side Left/Right	Getting In/Out of Bed	Stair Stepping
Twisting	Leaning Back	Putting on Shirt
Cleaning	Going to the Bathroom	Sitting
Carrying Objects	Housework	Putting on Shoes

Past Health History

Have you ever…

Yes	No	
❑	❑	Been Knocked Unconscious? _____
❑	❑	Been in a car accident?_____
❑	❑	Been treated for a spine problem/nerve disorder?_____
❑	❑	Had any significant falls, slips, or injuries?_____
❑	❑	Fractured/broken a bone?_____
❑	❑	Had surgery?_____
❑	❑	Been hospitalized for other than surgery?_____

Do you currently smoke tobacco of any kind? ❑ Yes ❑ Former smoker ❑ Never been a smoker
If yes, how often do you smoke: ❑ Current everyday smoker ❑ Current sometimes smoker # Packs per day____

Do you consume alcohol? ❑ Yes ❑ No # Drinks per week_____

Do you consume caffeine? ❑ Coffee ❑ Soda ❑ Tea ❑ Energy Drinks # Drinks per day_____

Do you exercise? ❑ No ❑ Infrequent ❑ Occasional ❑ Regular ❑ Avoid due to pain

Please mark any you currently have or have had previously:

❑ AIDS	❑ Cramps	❑ Kidney Infection	❑ Sciatica
❑ Alcoholism	❑ Depression	❑ Kidney Stone	❑ Shortness of Breath
❑ Allergies	❑ Diabetes	❑ Loss of Memory	❑ Sinus Infection
❑ Anemia	❑ Digestions Problems	❑ Loss of Balance	❑ Sleep Problems/Insomnia
❑ Arteriosclerosis	❑ Dizziness	❑ Loss of Smell	❑ Spinal Curvatures
❑ Arthritis	❑ Excessive Menstruation	❑ Loss of Taste	❑ Stroke
❑ Asthma	❑ Eye Pain/Difficulties	❑ Migraine Headache	❑ Swelling in Ankles
❑ Back Pain	❑ Fatigue	❑ Neck Pain or Stiffness	❑ Swollen Joints
❑ Breast Lump	❑ Frequent Urination	❑ Nervousness	❑ Thyroid Condition
❑ Bronchitis	❑ Headache	❑ Nosebleeds	❑ Tuberculosis
❑ Bruise Easily	❑ Hemorrhoids	❑ Pacemaker	❑ Ulcers
❑ Cancer	❑ High Blood Pressure	❑ Polio	❑ Varicose Veins
❑ Chest Pain/Conditions	❑ Hot Flashes	❑ Poor Posture	❑ _____
❑ Cold Extremities	❑ Irregular Heart Beat	❑ Prostate Issues	❑ _____
❑ Constipation	❑ Irregular Cycle	❑ Ringing in Ears	❑ _____

Is there a family history of? *(Include Relationship)*

❑ Heart Disease_____
❑ Cancer_____
❑ Stroke_____
❑ Arthritis_____
❑ Diabetes_____
❑ High Blood Pressure_____
❑ Other_____

Women Only
Are you pregnant? ❑ Yes ❑ No ❑ Maybe
Number of Weeks_____
Estimated Due Date_____

The information that I have provided above is accurate to the best of my knowledge and will be used to determine appropriate chiropractic care. _____

Patient Signature

Notice of Privacy Practices (Please ask for a copy if you'd like one.)

Our practice is dedicated to maintaining the privacy of your health information according to the guidelines set forth by federal and state laws. These laws also require us to provide you with notice of privacy practices, and to inform you of your rights and our obligations concerning your health information. The undersigned hereby acknowledge that I have received, reviewed, and understand and agree to the notice of Privacy Practices of Redenius Chiropractic, which describes the practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by Redenius Chiropractic.

Patient's Initials_____

Patient's Rights and Responsibilities (Please ask for a copy if you'd like one.)

Health care involves a partnership between patients, families, and health care providers, each of whom has certain rights and responsibilities. When you are well-informed, participate in treatment decisions, and communicate openly with your doctor and other health professionals, you help make your care as effective as possible. This clinic encourages respect for the personal preferences and values of everyone. The undersigned hereby acknowledges that I have received, reviewed, and understand my rights and responsibilities.

Patient's Initials_____

Statement of Informed Consent

Chiropractic adjustments & Physical Therapy are performed in our office by a skilled Doctor of Chiropractic who has successfully completed advanced educational requirements, national board examinations and state board licensure. As with any healthcare procedure, there are some inherent risks that exist. Whenever possible this risk is minimized to its lowest level. The undersigned hereby consents to evaluation to provide the safest chiropractic care available. The undersigned hereby consents to evaluation and treatment rendered according to the applicable standards of care. It is understood that options exist for treatment and that any/ all treatment have risks and benefits. If the risks and benefits of the proposed treatment are not clear to me, I understand that further information may be requested from the doctor.

Patient's Initials_____

Assignment of Benefits

Assignment of benefits authorizes Redenius Chiropractic & Physical Therapy to file charges directly to your insurance company, saving you time and effort of filing claims yourself. The undersigned hereby authorizes Redenius Chiropractic to submit my insurance claims to my insurance company. By having my signature of file, I need not sign each claim submitted by this office. I understand that I may withdraw my signature at any time. I understand that I may ultimately be responsible for all charges for which my insurance does not pay**. I also understand that as the patient I am responsible for paying the copay/coinsurance/deductible at each time of service.**

Patient's Initials_____

Patient Signature_____ Date_____

Patient Acknowledgement & Receipt of Notice of Privacy Practices Pursuant to HIPAA & Consent for Use of Health Information

The undersigned does hereby acknowledge that he or she has received a copy of Redenius Chiropractic & Physical Therapy Notice of Privacy Practices Pursuant to HIPAA & has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law & Federal Law.

By _____ Date _____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State Law:

By _____ Date _____
Signature of Parent/ Guardian

Pregnancy Waiver for Films

I hereby acknowledge that Dr. Jeff Redenius or any other provider of Redenius Chiropractic & Physical Therapy has informed me prior to having Radiographic Films of the advisability of risk & the probable consequences of receiving such procedures during pregnancy. I have stated on my own volition that I am not pregnant at this time & do hereby release & hold harmless from any legal action or responsibility caused by the use of this procedure.

By _____ Date _____
Signature of Patient or Authorized Representative

If Patient is Under the age of 18

I the parent/guardian allow my child that is a minor under the age of 18 to be seen at Redenius Chiropractic & Physical Therapy PLC for care. Without my supervision.

By_____ Date_____
Signature of Parent/Guardian

INFORMED CONSENT FOR TREATMENT

Redenius Chiropractic & Physical Therapy

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physiotherapy, physical medicine, physical therapy procedures, etc. on me by the Doctor of Chiropractic named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. Those complications include but are not limited to fractures, disc injuries, dislocations, muscle strain, Horner's Syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

I give consent to use text message typically for appointment reminders.

Sign only after you understand and agree to the above.

Printed name of patient _____ Date_____

*Signature of Patient*_____ *Date*_____

Signature of Representative _____ *Date*_____

(If patient is a minor or is handicapped)

Note: The patient needs to sign this form **before** treatment begins.

Family Name: _____ Done By_____

DOB: _____ Date:_____ Email:_____

Chiropractic & Physical Therapy Payment Policy

Thank you for choosing Redenius Chiropractic & Physical Therapy as your chiropractic and physical therapy provider! We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans. If you are not insured by a plan, we do business with, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. As a courtesy, we have verified your insurance coverage. Please note that Chiropractic & Physical Therapy benefits can be different than other health care benefits. Although these benefits were quoted based on your individual contract with your insurance company, the information obtained does not guarantee payment. If you have any doubts as to the correctness of the following information, we urge you to contact your insurance company directly. We are not responsible for any incorrect information received from your insurance company. Please contact your insurance company with any questions you may have regarding your coverage.

Your deductible is _____ and _____is remaining.

Your portion is _____co-pay and/or_____co-insurance per visit.

Your policy has a visit limit of: _____. Other limitations and exclusions are as follows:

_____

ne of service.
nd deductibles

Payment is required on each visit. We accept cash, check or credit card. We will charge a $25.00 fee for all returned checks. **Initial appropriate line that matches your benefits**.

_____I have a deductible to meet; therefore, I will pay $45.75 at each visit towards my deductible and will be billed for the additional amount applied to my deductible as determined by my insurance company.

____I have a deductible to meet but because my insurance posts and pay the amount as determined by Medicaid.

____I have **Medicaid,** there I will wait until insurance posts and pay the amount as determined by Medicaid.

____I have co-insurance; therefore, I will pay $10 at each visit towards my coinsurance and will be billed for the additional co-insurance amount as determined by my insurance company.

____I have copay; therefore, I will pay my copay amount at each visit.

____I have copay, followed by co-insurance; therefore, I will pay my copay amount at each visit and will be billed for my co-insurance amount as determined by my insurance company. (Continued on page 2)

Done By_____

_____I authorize Redenius Chiropractic & Physical Therapy to keep my credit card on file and to **charge** it for my per visit amount at each **date of service**. (Please hand card to front desk attendant.)

____I authorize Redenius Chiropractic & Physical Therapy to keep my credit card on file and **charge** it for the balance due on my account on the **30th of the month**. (Please hand card to front desk attendant.)

____I authorize Redenius Chiropractic & Physical Therapy to send me my statement through **ePay** (email or text), instead of it being sent through the mail.

3. Non-covered services. Please be aware that some and perhaps all the services you receive may be non-covered or not considered reasonable or necessary by the insurer and therefore are your responsibility.

4. Proof of Insurance. All patients must complete their patient information form. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may request your medical records from us and by signing below, you authorize us to release these records to your insurance company. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 15 days to pay your account in full. Please contact our billing department to set up a payment plan if you are unable to pay your balance in full. Be aware that if a balance remains unpaid, we may refer your account to a collection agency and you, and your immediate family members may be discharged from this practice.

8. Missed appointments. Our policy is to charge a $25.00 fee for missed appointments not cancelled within 24 hours of your scheduled appointment. These charges will be your responsibility and billed directly to you. If you have cancelled or missed three appointments without providing 24-hour notice, we will no longer pre-schedule your appointments.

Redenius Chiropractic & Physical Therapy is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**