New Patient Information

Name: ___________________________ Address:____

City: ___________________________ State: ______ Zip Code: ___________ Email:__________________________________

Home/Cell Phone: ______________________ Work Phone: _____________________Date of Birth:_________________

Referred By:_____________________________

Please read thoroughly, initial at each section and sign at the bottom. Thank You.

Guarantee of Payment

_________ I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of this health care facility.

Information about Possible Risk of Chiropractic Treatment

_________ You have the right, as a patient, to be informed about your condition and the recommended integrative and complementary procedure to be used so that you make an informed decision whether or not to undergo the procedure after knowing the risks and hazard involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

Doctors of chiropractic, Medical Doctors and Physical Therapists using manual therapy treatment for patients with headaches and cervical spine (neck) complaints are required to explain that there have been rare cases of injury to a vertebral artery as a result of treatment. Such an injury has been known to cause a stroke, sometimes with serious neurological damage. The rare chance of this happening is estimated to be approximately from 1 to 400,000 treatments to 1 per 10 million treatments. Appropriate tests will be performed to help identify if you may be susceptible to this type of injury; you will be notified if that is the case. If you have any questions about this, please do not hesitate to speak with your practitioner.

As with any health care procedure, complications may arise during treatment. These complications include soreness, muscle or ligament sprain/strain, dislocation, fractures, disc injuries or physiotherapy burns. These are extremely rare occurrences.

Consent for Treatment

_________ I authorize the performance of diagnostic tests, procedures and treatment deemed necessary by personnel involved in my care.

Authorization to Treat a Minor (under the age of 18)

_________I hereby request and authorize my doctor at this clinic to perform diagnostic tests and render chiropractic adjustment and other treatment to my minor son/daughter. This authorization also extends to include radiographic examination at the doctor's discretion. As of this date, I have legal right to select and authorize health care services for the minor child named above. Under the terms and conditions of my divorce (if applicable), separation or other authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify Kramer Chiropractic Clinic P.A.

____

Signature of Patient or Responsible Party Date Relationship to Patient

Assignment of Insurance Proceeds

If you have insurance, please sign this assignment of benefits agreement. By agreeing to this assignment, we will direct your insurance company to make any payments for your chiropractic, physiotherapy, physical rehabilitation, x-rays, diagnostic testing or any other reimbursable treatment or evaluations you receive to our clinic directly.

In exchange for services and supplies rendered, I do assign to Kramer Chiropractic Clinic, P.A. any insurance proceeds, including accident and health insurance benefits and bodily injury claim awards up to the amount of any unpaid balance on my account. In giving this assignment, I acknowledge that I will be responsible for the amount of any unpaid balance with interest as allowed by law.

Signature ___________________________________ Date ___________________

Records Release Authorization

You, Kramer Chiropractic Clinic, P.A. are authorized to release any information contained in my file to any insurance company, attorney, adjuster or member of my office staff, including any contracted billing services representing the clinic, in order to process any claim for reimbursement of charges incurred for supplies furnished to me or services rendered to me by you or another member of the clinic. I further authorize phone contact with the above listed third parties, should phone contact be required for the purpose of obtaining payment for charges outstanding.

Signature ___________________________________ Date ___________________

Patient Acknowledgement of Receipt of the Notice of Privacy Practices

Kramer Chiropractic
115 W Soo St.
Parkers Prairie, MN 56361

I understand that, under the Health Insurance Portability and Accountability Act of 1996(HIPAA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physical certifications.
- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

By signing this document, I acknowledge that you have provided me with a copy of your Notice of Privacy Practices. The Notice of Privacy Practices contains a more complete description of the uses and disclosures of my health information.

I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to such restrictions.

Patients Name:____

Relationship to Patient:____

Signature:____

Date:__________________

These forms are provided as a service to subscribers to HIPAAps.com, LLC and do not constitute legal advice. We try to provide quality information, but all forms should be reviewed by competent counsel to ensure that they apply correctly to the laws and regulations in your locale.

Authorization to Communicate by Phone Calls/Texting and/or Email

I, ______________________ , hereby consent and state my preference to have my physician, Travis Kramer, and other staff at Kramer Chiropractic communicate with me by email or standard SMS/text messaging, in addition to or to replace leaving phone messages, regarding various aspects of my health care, which may include, but shall not be limited to, test results, appointments, and billing. I understand that email and standard SMS/text messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS/text messaging regarding my medical care might be intercepted and read by a third party.

I give my permission to leave both appointment reminders AND my private health information at the following (please fill-in the ones you agree to):

Phone number_______________________ Email___________________________ Text______________________

I give permission to contact me, relative to appointment reminders only, by the following methods:

Phone message __________

Email messages _________

Text messages __________

Appointment reminders and private health information will be communicated to you only in the manners in which you have given specific written authorization and you have the option to opt out of any of those methods at any time by notifying our office. Email and standard SMS/text messaging are not confidential methods of communication and may be insecure.

CONFIDENTIAL PATIENT HEALTH QUESTIONNAIRE

Kramer Chiropractic Clinic, P.A.
Dr. Travis Kramer

Patient Name:________________________ **Age:**__________ **Date:**__________

1) Describe your primary symptoms ____

____

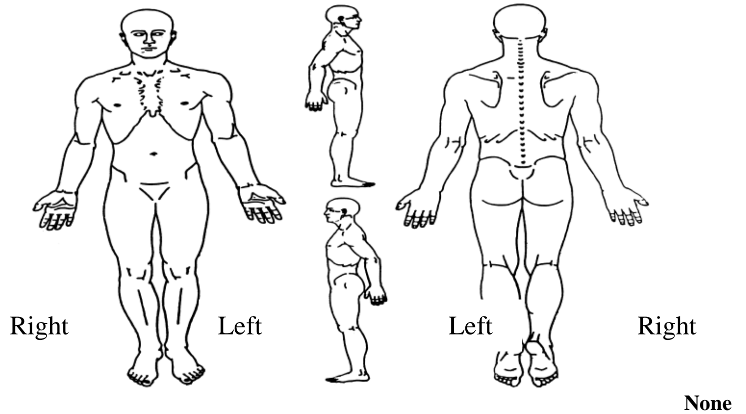
a) How and when did they begin?____

____

2) How often do you experience your symptoms?

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

Check or circle on the picture to the right where you have pain or other symptoms.



3) What describes the nature of your symptoms?

- O Sharp O Shooting
- O Dull ache O Positional
- O Numb O Tingling

4) How are your symptoms changing?

- O Getting Better
- O Not Changing
- O Getting Worse

5) What is the intensity of your symptoms at their:

	None										**Unbearable**
Worst	O	O	O	O	O	O	O	O	O	O	O
	0	1	2	3	4	5	6	7	8	9	10
Best	O	O	O	O	O	O	O	O	O	O	O

6) Are your symptoms worse in the… O **Upon waking** O **Increase through out the day** O **Night Time** O **Same all day**

7) How do your symptoms affect your ability to perform daily activities?

⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
No affect		Mild, forgotten, with activity		Moderate, interferes with activity		Limiting, prevents activity		Intense, preoccupied with seeking relief		Severe, no activity possible

8) What makes your symptoms worse? ____

9) What makes your symptoms better? ____

10) Have you had the same or similar symptoms in the past? O No O Yes How long ago?__________

If you have received treatment in the past for the same or similar symptoms, who did you see? O This office O Medical Doctor O Other O Other Chiropractor O Physical Therapist

11) What tests have you had for your symptoms? O None O X-rays O CT O MRI O Other

12) What is your occupation? ____

13) Type of care desired? O Temporary relief O Lasting correction OLive a healthier lifestyle

14) Any other secondary symptoms you would like to discuss with the doctor?

____

____

____

Please turn over this form and complete the reverse side, thank you

Kramer Chiropractic Clinic, P.A.
Dr. Travis Kramer

15) REVIEW OF SYSTEMS—PLEASE CIRCLE ANY OF THE CONDITIONS YOU NOW HAVE OR HAVE HAD IN THE PAST.

	Yes	No		
General	○	○	Recent sudden weight loss/gain or cancer	**Details** ________________
Skin	○	○	Rashes, mole changes, sores that won't heal	**Details** ________________
EENT	○	○	Difficulty swallowing, hay fever or allergies	**Details** ________________
Heart`	○	○	Heart attack or High blood pressure	**Details** ________________
Pulmonary	○	○	Persistent cough, wheezing or chest tightness	**Details** ________________
Gastrointestinal	○	○	Nausea, vomiting, in blood in stool or diarrhea	**Details** ________________
Genitourinary	○	○	Frequent, urgent urination or blood in urine	**Details** ________________
Endocrine	○	○	Thyroid dysfunction or diabetes	**Details** ________________
Neurological	○	○	History of seizures, headaches or depression	**Details** ________________

Are you pregnant? yes no If yes how many weeks ______________ Who is your Dr? __________________

16) Do any of your immediate family members suffer from…

○ Cancer ○ Heart Disease ○ High Blood Pressure ○ Diabetes ○ Chronic Back Problems

17) Social History:

Caffeine Use: ○ Yes ○ No How many per day? ______________

Tobacco Use: ○ Yes ○ No Packs/Cans per day? ______________

Alcohol Use: ○ Yes ○ No How many per day? ______________

Exercise: ○ None **How many minutes/ Day ? ____________________How many days / week? ______________**

18) Current Medications: (If you have a list with all your meds, present to receptionist.)

____

19) Allergies to Medications

____

20) Surgical History: Please list surgery and date

____

21) Supplement/Vitamin Usage

____

22) Would you like to know more information on nutrition and wellness?

____

I certify that I have read the above information and answered each question to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize Kramer Chiropractic Clinic, P.A. to treat myself and/or my dependent(s).

____ Date ___________________________

SIGNATURE OF PATIENT (PARENT IF PATIENT IS A MINOR)