Patient Contact and Health Information

How did you find us?

Patient Name ______ Minor: Y ☐ N ☐

Address ______ City ______ State ______ Zip ______

E-mail Address ______ Home Tel # ______

Cell # ______ Date of Birth ______ Age ______ Sex ______ SS # ______

☐ Married ☐ Single ☐ Widowed ☐ Divorced Occupation ______ Employer ______

☐ F/T ☐ P/T Employer Address ______ Work Phone / Ext. ______

Emergency Contact Name ______ Telephone # ______

Name of Spouse ______ Date of Birth ______ SS # ______

Employer & Address ______ Work Phone / Ext. ______

If Minor - Responsible Party ______ Address ______

City/State/Zip ______ E-mail Address ______

Home Tel # ______ Work Phone / Ext. ______

Cell # ______ Date of Birth ______ Age ______ Sex ______ SS # ______

Injury? ☐ Y ☐ N Auto ☐ On-the-Job ☐ Date ______ Time ______ ☐ AM ☐ PM Was Injury / Accident Reported? ☐ Y ☐ N

Reason For Appointment ______

When Did This Condition Begin? ______ Has This Condition Occurred Before? ☐ Y ☐ N

Have you had treatment for this condition? ☐ Y ☐ N Type of Treatment ______

Performed By ______ City / State ______ Phone # ______

Date of Last Visit ______ Results ______

Medications You Are Currently Taking: ☐ Pain Killers/ Muscle Relaxers ☐ Blood Pressure Med's ☐ Thyroid Med's ☐ Insulin ☐ Birth Control

☐ Hormones ☐ Anti-depressants Other: ______

Other Conditions You Suffer From ______

Primary Care Physician ______ City / State ______

Phone # ______ Previous Chiropractic Care? ☐ Y ☐ N Date of Last Visit ______

Doctor's Name ______ City / State ______

Phone # ______ Past injuries, accidents, hospitilizations and dates ______

______

If needed use back of form for additional information

To be completed by MindMenders Clinic Staff Primary Dr. ______ Date of 1st visit ______ File # ______

NOTICE OF PRIVACY PRACTICES

Please read this carefully. It concerns your individual, private healthcare information and how this information may be used and disclosed by this office and how you can get access to this information. Please review it carefully.

1) We have a legal, ethical and moral obligation to protect your confidentially. Any information about you and/or your family will be held strictly confidentially by all employees. No discussions about you outside of the patient care framework will be allowed, and any conversation between staff members that pertains to delivering you quality care will be held in a confidential and professional manner.

2) In order to provide quality care to you, as well as operate this office in an efficient manner, we will need to access your private health care information for the purposes of treatment, payment and operations (such as quality assurance). In using this information this office will comply with all state and federal laws pertaining to your privacy rights, including the Privacy and Security protections provided to you by the Health Insurance Portability and Accountability Act ("HIPPA").

3) Specifically, we will need to disclose your private information under the following circumstances:

    a) **Sharing information for purposes of treatment**: We will share information with all members of your treatment team, both within this office and with other providers (personal and Institutional) in order to provide you with the quality care and the education/wellness programs.

    b) **Sharing of information for the purposes of payments:** We will share all necessary information with your insurer(s), payor(s), governmental entities (such as Medicare, Medicade, Americade, etc.) and their representatives (including, but not limited to benefit determination and utilization review) as well as our representatives involved in the billing process (including, but not limited to claims representatives, data warehouses, billing companies, etc.).

    c) **Sharing of information for purposes of operations:** We will share all information necessary for ongoing operations of this office, including (but not limited to) credentialing processes, peer review, accreditation and compliance with all federal and state laws.

4) Your consent for use and disclosure of information as described may be revoked in writing at any time. Please notify the office/Privacy Officer if you ever decide to revoke your consent.

5) Your specific authorization will be required for the release of any information not included above. Your authorization will need to be in writing and it will be specific to the disclosure requested.

6) This office will not release any information other than those incidents described above unless disclosure is required by law, a court, a legal process or government agencies.

7) You have the right to inspect and copy your protected information, amend your record, have reasonable requests for confidential communications accommodated and may obtain an accounting of disclosures. All other rights afforded to you by state and federal law will be honored as they are created. This office will attempt to comply with any of your requests if feasible. Please contact the Privacy Officer if you have any questions about your rights, or with any other privacy related questions you may have.

8) This office will continue to respect you and your family's privacy and confidentiality. The Privacy Officer is available to discuss any questions or concerns you may have regarding the security and privacy of you and/or your family's private health information.

- I have received a copy of the "Notice of Privacy Practices" which details my rights of privacy.
- I consent and authorize MindMenders Clinic, to utilize my PHI (Private Health Information), for health/wellness and treatment purposes as well as for internal administrative purposes.
- I consent and authorize the releasing of my PHI from MindMenders Clinic to another service organization in direct regard to my health/wellness and treatment being performed by MindMenders Clinic.
- I consent and authorize MindMenders Clinic to discuss, document, provide and/or request PHI to/from another organization for means of collection of payment or reimbursement.
- I consent and authorize MindMenders Clinic to discuss, document, provide and/or request PHI from another organization for administrative purposes.
- I have the right to deny and/or limit the use of my PHI. Should my requests and or choices affect my care as deemed necessary by the doctor, I understand that I may be released as a patient of MindMenders Clinic.

Patient Name (printed)_______________________________ **Responsible Party (signature)**____

Date __________________

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

INTAKE: ☐ Coffee ☐ Cigarettes / Tobacco ☐ Tea ☐ Alcohol ☐ Soda ☐ Pain Relievers ☐ Antacids

CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE HAD:

☐ Pneumonia	☐ Anemia	☐ Chicken Pox	☐ Psoriasis	☐ Mental Disorders
☐ Rheumatic Fever	☐ Measles	☐ Diabetes	☐ Influenza (Flu)	☐ Alcoholism
☐ Polio	☐ Arthritis	☐ Cancer	☐ Pleurisy	☐ Eczema
☐ Tuberculosis	☐ Mumps	☐ Heart Disease	☐ HIV + / AIDS	☐ Hepatitis / Liver Disease
☐ Whooping Cough	☐ Small Pox	☐ Thyroid Problems	☐ Epilepsy	

☐ Other: ______________________________

CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE HAD THE LAST 6 MONTHS:

MUSCULO-SKELETAL

☐ Low Back Pain	☐ Pain between Shoulders	☐ Shoulder / Arm / Hand Pain	☐ Walking Problems	☐ General Stiffness
☐ Mid Back Pain	☐ Neck Pain	☐ Joint Pain / Stiffness	☐ Difficulty Chewing / Clicking Jaw	☐ Grinding / Popping in Joints

NERVOUS SYSTEM

☐ Numbness	☐ Weakness	☐ Dizziness / Light-headed	☐ Forgetfulness	☐ Depression	☐ Convulsions	☐ Stress
☐ Tingling Sensation	☐ Paralysis	☐ Ringing in Ears	☐ Confusion	☐ Fainting	☐ Nervousness	☐ Tremor

GENERAL

☐ Fatigue ☐ Allergies ☐ Bruise Easily ☐ Headaches ☐ Fever ☐ Sleeping Problems

GASTRO-INTESTINAL

☐ Poor / Excessive Appetite	☐ Vomiting	☐ Hemorrhoids	☐ Abdominal Problems	☐ Gas / Bloating after Meals
☐ Excessive Thirst	☐ Diarrhea	☐ Liver Problems	☐ Colitis	☐ Heartburn
☐ Frequent Nausea	☐ Constipation	☐ Gallbladder Problems	☐ Weight Trouble	☐ Black / Bloody Stool

GENITO - URINARY

☐ Bladder Trouble ☐ Painful / Excessive Urination ☐ Discolored Urine

MALES ONLY

☐ Prostrate Problems ☐ Erection/Ejaculation Difficulties ☐ Genital Infection / STD ☐ Lump in Testicles ☐ Breast Lump

C-V-R

☐ Chest Pain	☐ Blood Pressure Problems	☐ Pounding Heart	☐ Lung Problems / Congestion	☐ Ankle Swelling
☐ Shortness of Breath	☐ Irregular Heartbeat	☐ Heart Problems	☐ Varicose Veins	☐ Cold Extremities

EENT

☐ Vision Problems	☐ Dental Problems	☐ Ear Aches	☐ Difficulty Swallowing	☐ Persistent Cough
☐ Hearing Difficulty	☐ Sore Throat	☐ Stuffed Nose	☐ Nose Bleeds	☐ Facial or Sinus Pain

FEMALES ONLY

☐ Menstrual Irregularity	☐ Menopause	☐ Painful intercourse	☐ STD
☐ Menstrual Cramps	☐ Vaginal Pain / Infection	☐ Discharge: Nipple or vaginal	☐ 1st Day of Your Last Period: ______________
☐ PMS	☐ Breast Pain / lumps	☐ Abnormal Pap Smear	☐ Date of Last Pap Smear: ______________

Patient Name: ______________________________________
(Print)

CONSENT TO SERVICES AND TREATMENT

At each new year you will be asked to sign a new Consent to Services.

- **CONSENT TO SERVICES AND TREATMENT** initials________

I authorize the licensed doctor and whomever he/she designates to perform diagnostics, therapeutic procedures and administer care as medically needed.

- **CONSENT TO TREATMENT OF A MINOR** initials________

I authorize the licensed doctor and whomever he/she designates to perform diagnostics, therapeutic procedures and administer care as medically needed

to ____, my ____________________.
Minors Name Relationship to Minor

- **FEMALE PATIENTS** initials________

This certifies that to the best of my knowledge that I am NOT PREGNANT. I authorize MindMenders Clinic to take x-rays as medically needed. Beginning date of your last menstrual cycle:__________________

Signature (patient or guarantor):____ **Date:**________________________

CONSENT TO CONTACT

Please write down the names of any person(s) that we are able to communicate with regarding general issues, ***non-medical in nature*** including anyone in the household or at work able to retrieve messages left on answering machine, retrieve mail, answer the phone on your behalf or schedule your appointments, etc.).

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

This authorization is irrevocable until request of change is submitted in writing to MINDMENDERS CLINIC.

______________________________ ______________________________ ______________
Patient Name (Printed) Patient or Responsible Party (Signature) Date

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I authorize MindMenders Clinic and its authorized representatives, to ***discuss my care-medical in nature*** with the following:

I authorize MindMenders Clinic and its authorized representatives to request and / or release ***medical records*** to / or from the following:

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

This authorization is irrevocable until request of change is submitted in writing to MindMenders Clinic

______________________________ ______________________________ ______________
Patient Name (Printed) Patient or Responsible Party (Signature) Date

MindMenders Clinic

Private Health Insurance

FINANCIAL AGREEMENT & ASSIGNMENT OF BENEFITS

The purpose of this document is to clarify the financial details regarding your care. Please read the agreement below and initial each.

- _____Our fees are based on the area averages for the specific services rendered. The severity of your condition coupled with the amount of time needed for you to reach your health goals will determine the amount and types of services that you will receive.
- _____The information received at the "verification of benefits" is in NO WAY a guarantee of payment by your insurance carrier. They reserve the right to deny payment.
- _____You have employed your insurance company to work for you. We will not become involved in any disputes between you and your insurance company regarding the policy as purchased. At all times you are financially responsible for all services.
- _____All product purchases are to be paid in full, at the time of purchase.
- _____MindMenders Clinic reserves the right to modify the financial agreement, discontinue the accepting of insurance or the manner of collection of payment for services rendered without notice.

We ask that you give a **full business days' notice** for schedule changes or cancellations. This allows us time to contact patients that are waiting for appointment availability.

A MINIMUM fee of $25 will be charged and collected if proper notice is not given for a schedule change or cancellation. The fee will not be billed to your insurance company you will be responsible for the payment.

In cases of a "no show" or a "last minute cancellation" the dollar amount charged and collected will be that of the usual charge for your visit. Of course, individual circumstances will be taken into consideration.

If you might be, or are running late for an appointment, please contact the office as soon as possible so that we can do our best to accommodate you. This then allows us to make adjustments in the schedule—if possible. If we do not receive a call and you arrive late for the appointment there is a possibility that the visit will need to be rescheduled in order to provide you and the patients following with a complete and effective visit.

These policies are in place so that we are able to provide each of you with the very best care possible. Affording each and every patient with the quality time they deserve and need is imperative. Providing prompt, quality service to each of our patients is just one of the things that sets this clinic apart.

Patient Agreement: I authorize assignment of any and all benefit, payment, claim or judgment to MindMenders Clinic. I understand that I am directly and fully responsible to MindMenders Clinic for all financial obligations incurred and that this agreement is made solely for the protection of MindMenders Clinic. I have read this agreement, been given the opportunity to ask questions and understand the agreement. (A copy of this signed agreement is provided to the signer upon request.)

______________________________	______________________________	______________
Responsible Party (Signature)	Patient Name (Printed)	Date