COMPREHENSIVE HEALTH CLINICS
236 2ND AVE. SW, CAMBRIDGE, MN 55008

PHONE: 763-689-2462
FAX: 763-689-1688

PATIENT INFORMATION

Full Name:_____
First MI Last

Address: _____ **City**: _____ **State**: _____ **Zip**:_____

Email Address: _____

Age: _____ **DOB**:_____ **Gender**: ☐ Female ☐ Male

Primary Phone: _____ ☐ Home ☐ Cell ☐ Work

Alternate Phone: _____ ☐ Home ☐ Cell ☐ Work

Preferred Method of Contact: ☐ Call ☐ Text ☐ Email

Race: ☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic ☐ Native American ☐ Other: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Spouse's Name: _____ **Spouse's DOB**: _____

Emergency Contact:_____ **Phone Number**: _____ **Relation:**_____

Who is your Primary Medical Physician:_____ **Clinic**:_____

PROVIDE RECEPTIONIST WITH DRIVER'S LICENSE & INSURANCE CARD TO BE SCANNED FOR PERMANENT MEDICAL FILE

Is this Workers' Compensation, Personal Injury, or Automobile Accident injury? ☐ YES ☐ NO

Primary Insurance: _____**Secondary Insurance:** _____

Insurance Policy Holder (*Complete if other than the Patient*)

Policy Holder: _____ Relationship to Patient: _____

Address:_____ City: _____State: _____ Zip:_____

Phone: _____ Date of Birth: _____

Guarantor / Person Responsible for Payment (*Complete if a Minor or there is a Power of Attorney*)

Guarantor: _____ Relationship to Patient: _____

Address: _____ City: _____ State:_____ Zip:_____

Phone: _____Date of Birth:_____

WELCOME

Welcome to our clinic which offers chiropractic, rehabilitation, and acupuncture services. Hereinafter "facility" is defined as this facility and/or an associated facility. We will strive to help restore or improve your health but there are no guarantees or promises of improvement or complete recovery. Patients are prohibited from using cell phones while in our office due to federal privacy rules and/or unauthorized photography of our patients and are strongly encouraged to leave valuables at home or with an accompanying family member or friend because this Facility shall not be liable for the loss of or damage to any personal property including, but not limited to money, credit cards, clothing, jewelry, glasses/contacts, dental devices, hearing aids, furs, documents or any other items. Your signature on this document fully authorizes our staff & doctors to perform any examinations, diagnostic tests &/or treatment as we may consider medically necessary & to release all information pertinent to your health, insurance or benefits to any & all applicable parties which we deem on your behalf. Our office and staff are committed to providing all patients regardless of race, color, national origin, age, sex, disability or religious or political beliefs quality health care services delivered with dignity and concern. HIPAA requires that we have you read & sign the federally governed Health Care Privacy Notice which is detailed on the backside of this document. The Health Care Privacy Notice will explain when, where and why your confidential health information may be used, stored and/or shared and is a part of this document that is a permanent part of your medical records which is maintained in this office. You may receive a free photocopy of this document that you have signed just by asking one of our staff. Your signature on this document confirms that you have read, understand and agree to comply with all of the terms & conditions of the Health Care Privacy Notice and all policies, consents, terms & conditions regarding your responsibilities to this facility and that you grant the physicians, therapists and/or all staff of this facility to use and share your confidential health information with others in order to treat you and/or in order to arrange for payment of any money you may owe this facility and/or for issues that concern this facility operations and responsibilities. We encourage questions and/or concerns to avoid misunderstandings, so please direct any questions or concerns to a member of our staff. Office hours allow our patients convenience to schedule appointments before & after work as well as during lunch. If you must miss an appointment please notify us at least 24 hours in advance. As a courtesy to you, we may call you when an appointment is missed. If you do not wish for us to call you or contact you please let us know in writing for your file.

--PLEASE PROCEED TO BACKSIDE OF THIS DOCUMENT—

HEALTH CARE PRIVACY NOTICE - INFORMED CONSENT - ASSIGNMENT OF BENEFITS - AUTHORIZATION & LIEN

We understand that medical information about you and your health is personal. This facility is required by law to abide by the terms of HIPAA, the Health Care Privacy Notice, The Security Rule, as well as other applicable federal and state laws governing privacy practices in health care so the doctors, therapists & staff at this office are committed to protecting your medical information but the federal government, under HIPAA, the Privacy Notice, the Security Rule and our own office administration requires us to make sure you are aware and be sure you understand, agree to adhere with and have read or have had read to you all of the following policies & procedures. In addition this office is committed to providing patients with quality health care services delivered with dignity and concern. Fulfilling this commitment requires the efforts of the doctors, therapists, staff and patient working together as a team to obtain the maximum results because your satisfaction is a vital interest to us. Our facility may change and/or modify the terms of this Notice at anytime without additional notice to you except to publicly post in our facility and/or make available to patients updated notices. Photocopy of this Notice is available to you upon request. The term facility refers to this office or clinic. The term Provider refers to doctors and/or licensed professionals of this Facility. Our facility & staff are committed to maintaining the privacy of your protected health information (PHI). PHI includes but is not limited to your medical records and personal information such as your name, social security number, address, birth date, phone number and includes demographic information that may identify you and that may be related to your present, future and past physical or mental health or condition and the care and treatment you receive from our practice or records from another facility that have been forwarded to our office and are now a part of your medical record. This Notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read this Notice and direct questions, misunderstandings or concern to the Compliance Officer of this facility. Our facility may use & disclose your PHI with or without your written authorization to anyone at anytime for any reason including but not limited to health care delivery purposes, your care, treatment(s), collecting money due this facility, to support any operation of this practice. Your doctor and the staff will take all reasonable measures to maintain the confidentiality of your PHI. The Privacy Rule allows you the right to review and receive copies of your health care records as it relates to your health care. All requests must be in writing, allowing your provider 30 days to respond. Your provider may deny your request if it will cause harm to you or to another person. Your provider may charge a copy fee or a processing fee for their time which will be in compliance with state law. You may request to have an amendment placed in your record if you disagree with anything in your record. This does not mean that anything will be removed or changed and the provider has the right to respond with a rebuttal statement if he/she feels it is necessary. You may revoke authorization, in writing, at any time, except in the event that the provider has acted as indicated in the doctor's Authorization Notice. You have the right to file a written complaint with our Compliance Officer if you believe that any of your privacy rights have been violated. You can obtain a complaint form from the Compliance Officer and/or the Office of the Civil Rights. All complaints must be filed within 180 days of when you knew or should have known that the violation occurred. The Privacy Law prohibits our facility from taking any retaliatory actions against anyone who files a complaint. I understand that this facility, its doctors & staff are accepting my case based on examination findings & believe the outlined treatment should produce change and/or improvement. However as with any diagnostic test, procedure, examination or doctor's care, a guarantee of improvement or complete recovery cannot be made and it is even possible that no change will occur. I further understand that in the practice of medicine, surgery, chiropractic, podiatry, psychological counseling, massage, physical, occupational , speech & respiratory therapy there are some risks including but not limited to fractures, disk injuries, strokes, heart-attacks, dislocations, sprains-strains, drug interactions, procedural complications, reactions, cardio-pulmonary arrest, death and/or other incidents which may be short or long term or side effects which cannot be pre-determined. I do not expect the doctor, therapist or provider to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor and/or provider to exercise judgment during the course of the procedure(s) which the doctor/provider feels at the time is in my best interest. In addition, because psycho-social, spiritual, and cultural values affect a patient's response to care, patients are allowed to express and follow spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of treatment. Patients have the right to refuse treatment, but must be aware of the probable consequences of refusing treatment and/or failing to cooperate with the prescribed treatment. Should you refuse and/or fail to comply with prescribed treatment your provider will discuss specific consequences with you. Therefore, I give my full consent to the doctor, therapist, provider or staff member to render treatment on me or the minor for whom I am legally responsible by a health care provider of this facility. I, the assignee, being the patient or legal guardian for said minor listed below, do hereby irrevocably authorize, direct, assign and give a full lien to the office named above and listed, hereinafter referred to as the "facility" against any & all insurance benefits, proceeds of any settlement, judgment or verdict which may be paid to the undersigned as a result of an accident, injury, illness or health condition for which I have been treated by the facility. I further irrevocably agree to pay all money and/or charges owed this facility in full within 60 days of the date of occurrence, service or treatment, even if an insurance claim submitted on my behalf is delayed or denied for any reason and/or a case manager or attorney representing me for any accident, injury or illness has not settled my case. I, the assignee further authorizes and instructs any and all insurance company(ies), attorney and any & all third party payers to pay directly to the facility in full all sums of money due them for any & all services rendered to me or minor by whom I am fully responsible for by reason of accident, injury, illness or health condition and by any & all reason of any other bills that are due or may become due, and to withhold such sums from any health, accident, workers compensation and or including all insurance or third party benefits. Also by my signature and as the assignee I irrevocably agree that this facility & staff may process medical reports, deliver medical records, consultations, depositions and/or court appearances which must be paid in full in advance by me, and authorize this facility to release any information pertinent to said health care to any insurance company, adjuster, attorney or legal service bureau to facilitate collections under the terms of this document. Assignee grants the facility a full power of attorney to endorse &/or sign my name on any & all checks for payment of any indebtedness owed this facility & assignee.

INSURANCE BENEFITS – CREDIT POLICIES – PAYMENT TERMS & CONDITIONS

As a courtesy, the facility will attempt to obtain a verification of your applicable insurance benefits and will report them to you or assume they are accurate as they are quoted to us but some third party payers, case managers and/or attorneys misquote benefits, coverage and liability so our facility & staff are not responsible for what a third party payer, representative, case manager and/or attorney may tell us. Any and all contractual, written, verbal or other obligations or arrangements between you and an attorney, case manager, insurance company, liable or third party payer are between you and said person or company and do not delay your obligation to pay.

1. Our facility will file initial insurance claims for you and or secondary claim submissions and/or additional reports or documents sent for your benefit may result in an additional filing or medical report charges, which you are responsible to pay.
2. Co-pays, deductibles and all non-covered service charges are due the day the service is rendered.
3. Patients are fully responsible for all charges for all service(s) and/or product(s) which may be denied or not covered for any reason by an insurance carrier, case manager, attorney and/or when a third party and/or insurance carrier does not reimburse this facility enough to meet our cost of service.
4. All account balances, including automobile accident and work injury claims must be paid in full within 60 days of treatment. Patients are fully responsible for all money owed this office and such payment is not contingent on any settlement, claim, judgment, or verdict by which they may eventually recover said fee and it is also regardless of any attorney liens or pending settlement(s). If a third party payer fails to pay this facility the said balance in full within the 60-day period, the patient must pay the balance in full. Assignee is fully responsible for all money owed this facility for any and all treatment, products & services rendered to the patient or minor shown below.
5. A non-discriminatory "Time of Service Discount" (TOS) is offered to anyone who pays for services the day they are rendered. The "TOS" is only offered on the day the service is rendered and does not apply to the following items & services including but not limited to durable medical equipment, orthopedic supports, orthotics, physical therapy equipment rentals or purchases, vitamins, supplements, ointments, acupuncture treatments, weight loss programs, psychological counseling, massage therapy and other services.
6. A service charge is computed by a 'periodic rate' of 1½ % per month – 18% per annum & is added to all balances owed 60+ days. Any balance past due 90 days or more may be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all monthly service charges, interest, costs related to but not limited to all collection related expenses, attorney fees, court & filing fees. Returned checks, debit & credit charges made payable to this facility for insufficient funds, stop payments or other reasons of non-payment will be assessed a $50.00 charge.
7. Patients are eligible for a maximum $250 personal credit limit when approved by our insurance manager and we accept most major credit & debit cards.

By my signature below I acknowledge that I have read or have had read to me and understand and agree to be irrevocably responsible for all terms and conditions. I also acknowledge that I have received a photocopy upon my request of this document and have had all of my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valid as an original.

PATIENT CONSENT & SIGNATURE

By my signature below I acknowledge that I have read or have had read to me and understand and agree to be irrevocably responsible for all terms and conditions. I also acknowledge that I have received a photocopy upon my request of this document and have had all of my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valid as an original.

X

SIGNATURE (if patient is a minor, parent/legal guardian must sign)

PRINT NAME

DATE

Patient Health Questionnaire

Patient Name:_____ **DOB:**___/____/_____ **Date of Visit:**___/___/____

General Information

What is your occupation? _____

What is your employment status? ☐Full time ☐Part time ☐Unemployed ☐Retired ☐Sick Leave ☐Disability

Who is your Primary Doctor? _____ **What Clinic?** _____

Do you use tobacco? ☐ Current daily smoker ☐ Occasional smoker ☐ Former smoker ☐ Never smoked

Do you consume alcohol? ☐Never ☐Rare ☐Occasional **If yes, how often?** _____

Are you pregnant? ☐ Yes ☐No ☐N/A **If yes, when is your due date?** _____

Current Issue/Ailment

What is your chief problem or symptom? _____

What caused the problem to occur? _____

When did the problem/symptom begin? (Date of Injury) _____

Have you seen another doctor for this problem? ☐Yes ☐No

What tests and procedures have been performed? _____

Have you had this problem/symptom in the past? ☐Yes ☐No **Have you tried any other treatments?** ☐Yes ☐No

Has the problem/symptom changed? ☐Getting worse ☐Staying same ☐Improving

Pain/Symptom Evaluation

Describe your pain/symptoms (check all that apply)

Please rate your current discomfort level (Circle) (1=mild, 10= intense) 1 2 3 4 5 6 7 8 9 10

How much has it interfered with your normal work? ☐Not at all ☐A little bit ☐Moderately ☐Extremely

In general, how would you describe your overall health? ☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor

What, if anything, gives you relief? _____

What irritates it or makes it worse? _____

Frequency
- ☐Constant
- ☐Rare
- ☐Comes and Goes
- ☐Recurring
- ☐Frequent

Quality
- ☐Aching
- ☐Dull
- ☐Sharp
- ☐Shooting
- ☐Burning
- ☐Numbness
- ☐Tingling
- ☐Tight
- ☐Stiff
- ☐Sore
- ☐Pressure
- ☐Pulling
- ☐Pinching
- ☐Weakness
- ☐Dizziness
- ☐Throbbing

Pattern
- ☐While resting
- ☐Daily
- ☐During Activity
- ☐Nightly
- ☐Other: _____

Cause
- ☐Trauma/Injury
- ☐Chronic
- ☐Post-Surgical
- ☐Work Related
- ☐Motor Vehicle Accident
- ☐School Sports
- ☐Unknown
- ☐Other: _____

Please Proceed to the Backside of this Document

Allergies

Please list any allergies below:

☐ **No allergies (medications, latex, iodine, etc.)**

Medications

Please list medication name and amount below: (if it is more than 6 medications, please provide us with a separate list)

Medication	**Type** (blood pressure, cholesterol, diabetes, etc.)

☐ **No Medications**

Severe Accidents/Trauma/Surgical History

Severe Accidents/Trauma **Surgeries**

Accident/Trauma Details	**Date**	**Type of Surgery**	**Date**

☐ **No History of Accidents/Trauma/Surgery**

Medical History

Current or past conditions/ailments - check all that apply:

☐Stroke
☐Diabetes
☐Heart disease/attack
☐Cancer
☐Hepatitis B/Hepatitis C
☐HIV/AIDS
☐High Cholesterol
☐Chest Pain/Shortness of breath
☐Headaches
☐Dizziness
☐Seizures
☐Emphysema/COPD
☐Asthma/Bronchitis
☐Broken Bones
☐Concussion
☐Arthritis/Gout
☐Neuropathy
☐Depression/Anxiety
☐Chronic Fatigue
☐Thyroid Problems
☐Irregular Heartbeat
☐Digestive Problems
☐Difficulty Swallowing
☐Ringing in Ears
☐Eye Pain/Strain
☐Jaw Pain
☐Pregnancy
☐Female Disorders
☐Urinary Problems

☐**None of these apply to me**

Family History

Mother	**Father**	**Brothers**	**Sisters**
☐Living ☐Deceased	☐Living ☐Deceased	☐Living ☐Deceased	☐Living ☐Deceased
If deceased, how old? _____	If deceased, how old? _____	If deceased, how old? _____	If deceased, how old? _____
☐Heart Disease	☐Heart Disease	☐Heart Disease	☐Heart Disease
☐Stroke or Heart Attack	☐Stroke or Heart Attack	☐Stroke or Heart Attack	☐Stroke or Heart Attack
☐Cancer -Type_____	☐Cancer -Type_____	☐Cancer -Type_____	☐Cancer -Type_____
☐Diabetes	☐Diabetes	☐Diabetes	☐Diabetes
☐Other:_____	☐Other:_____	☐Other:_____	☐Other:_____

☐ **No Family History**