CHIROPRACTIC REGISTRATION & HISTORY

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

PHONE NUMBERS

Home Phone (____) _____ Cell Phone (____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (____) _____ Work Phone (____) _____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

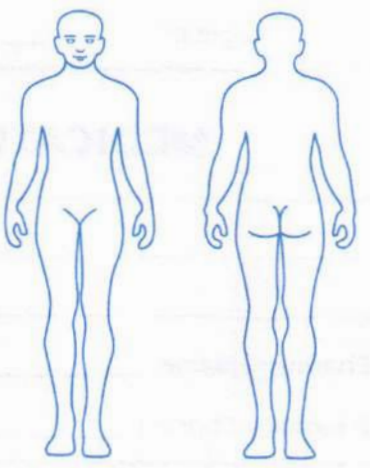
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down



HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No		
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No	Other _____	
Chicken Pox	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
				Rheumatoid Arthritis	☐ Yes ☐ No		

EXERCISE

- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY

- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS

- ☐ Smoking — Packs/Day _____
- ☐ Alcohol — Drinks/Week _____
- ☐ Coffee/Caffeine Drinks — Cups/Day _____
- ☐ High Stress Level — Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS

_____

_____

_____

Pharmacy Name _____

Pharmacy Phone (____)_____

ALLERGIES

_____

_____

_____

_____

_____

VITAMINS/HERBS/MINERALS

_____

_____

_____

_____

_____

Lotus Healing Arts, LLC

Mark Ensweiler, D.C., L. Ac.
Charity Millard, D.C.
P.O. Box 908, 2610 Post Road, Plover, WI 54467
(715) 345-0655

_____ _____
Name Date

Financial Agreement

I have read and signed the payment policy sheet and understand the financial responsibilities that I have undertaken in receiving professional health care services at Lotus Healing Arts. The services rendered to me (or _____, under 18 years old) will be compensated by:

_____ I will be paying (cash, check, Visa/MasterCard) on the same day that I receive these services.

_____ I have private health insurance that will reimburse for a portion of the professional fees. I have checked my policy and know that specific professional chiropractic and acupuncture services are covered. (We need a copy of your card.)

_____ I have <u>not</u> yet met my deductible for this year and will be paying 100% for services rendered, at the time of service, until my deductible has been met in full and other arrangements are made.

_____ My policy may pay for a <u>percentage</u> of professional services offered. I will pay the remaining percentage that I am responsible for at the time services are rendered. This percentage is _____.

_____ I have been involved in a reported and documented work-related injury while on the job and will be or have filed a Workmen's Compensation claim. The insurance carrier is responsible for professional services.

_____ I have been involved in an automobile or personal injury accident where my insurance company (or the other party(s) involved will be reimbursing Lotus Healing Arts directly upon receiving current billing and clinical documentation.

_____ I have consulted with an attorney and my medical/chiropractic bills will not be reimbursed until there is a final settlement.

_____ I am under Medicare-Part B. I agree to pay for professional services rendered and will be reimbursed for chiropractic services directly from Medicare.

_____ Additional services not covered by Medicare will be paid at the time services are rendered.

_____ I am not paying for professional serviced rendered at the time of service, in full, for the following reasons:

_____

_____

_____

_____

_____ If so, how and when would I plan on paying for professional services rendered at Lotus Healing Arts?

_____

_____

_____

_____

_____ I understand that unpaid balances at Lotus Healing Arts (beyond 45 days) will be charged interest at the rate of 1-1/2% per month, unless other arrangements have been made. Please note that all nutritional and herbal supplements supplied through Lotus Healing Arts are payable when picked up at our office.

_____ _____

Patient/Client
(Parent or guardian if under 18 years old)

Date

Lotus Healing Arts, LLC

Mark Ensweiler, D.C., L. Ac. • Charity Millard, D.C.
Debrah Ensweiler, Ms. T.
P.O. Box 908, 2610 Post Road, Plover, WI 54467
(715) 345-0655

Professional Fees, Insurance, and Payment Policies

The fees charged in this office are comparable to those charged by other specialists with similar qualifications in this geographic area. As certified and licensed health care providers, our fee structure is based on the types of services rendered and the amount of time that is spent with each patient/client to render a particular service or procedure.

Ideally, payment for health care services and recommended supplements or supplies at our office is an expression of an investment in one's health and well-being and, while we accept a wide variety of insurance plan payment options, not all people have insurance policies that will pay for the health care services and products rendered to you at Lotus Healing Arts. If you have an insurance plan that will re-imburse for part or all of the services rendered at our office, we are happy to do all of the necessary paperwork for you. If you do not have options to receive insurance re-imbursement, you will be expected to pay for professional services rendered at the time of your visit. We accept cash, personal check, Visa and MasterCard. If you cannot pay for services rendered at the time of the visit, please let us know ahead of time what your plans are for payment for services. To avoid misunderstandings, we invite early discussion of financial problems or questions regarding fees, payment from insurance carriers, etc. We offer certain discounts for same-day payments, senior citizens, and a sliding-fee scale for those with current and proven financial hardships.

The highest quality health care can be provided only on the basis of mutual understanding. We, therefore, encourage our patients and clients to discuss any questions that you might have regarding our policies.

At our office we accept assignment for a number of health and auto accident policies and for all workmen's compensation injuries that have been appropriately reported to one's employer. If you would like your health insurance to cover all or part of your fees, you will need to first check with your plan and/or insurance representative to see what your actual coverage is and the status of your deductible, if any.

Patients who have health insurance need to know that professional services are rendered and charged to the patient and not to the insurance company, unless your particular policy involves a "managed care" contract (PPO, HMO, etc.) and this office has contracted with that insurance company to accept their payment as complete and full.

Insured patients are expected to take care of their fees as services are rendered unless previous arrangements have been made. This would include timely payments for unmet deductibles, co-insurance payments, etc. It is important that you understand the provisions of your insurance policy/plan. We cannot guarantee payment of your claims. If your insurance company pays only a portion of the bill or rejects your claim, this does not relieve the financial obligation to our office that you have incurred. (Exceptions to this rule might be seen, however, with various "managed care", PPO, HMO contracts that this of fice has contracted with.)

Our office does participate with Medicare and Medicaid for the professional services that they cover. We have a senior citizen discount rate and payment is due as services are rendered unless other arrangements are made. We perform all the necessary paperwork for Medicare re-imbursement at no extra charge to you and they will re-imburse you, the patient, directly.

Our office location, staff, and equipment are chosen to provide you with quality health care services in a pleasant and efficient atmosphere. Should you have any questions with regards to our services, credentials, fees, etc., please let us know. Our ultimate goal is to provide appropriate professional health care services to you in a personal and individual manner and we invite any questions that you may have.

I have read and understand the above mentioned policies and procedures.

_____

Patient (Parent or guardian if under 18 years old) **Date**

_____

Witness

Lotus Healing Arts, LLC

Mark Ensweiler, D.C., L. Ac. • Charity Millard, D.C.

P.O. Box 908, 2610 Post Road, Plover, WI 54467 • (715) 345-0655

DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC

INFORMED CONSENT

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialists of Chiropractic, Osteopathy and Medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the Chiropractic Doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from Chiropractic health care services.

ANALYSIS

A Doctor of Chiropractic (D.C.) conducts a clinical analysis to determine whether there might be evidence of structural problems/imbalance in the human body. These include: vertebral and extremity joint fixation/ subluxation complexes, myofascial trigger points & myofascial pain syndromes, muscular and joint nerve entrapment syndromes, and structural distortions that manifest as postural imbalances and the above mentioned problems. When these types of complexes are found, Chiropractic adjustments & myofascial therapies and other ancillary procedures may be utilized in an attempt to restore structural alignment allows for proper nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers and that structure and function can often be inter-related in the human body. Due to the complexities of nature and the nature and state of each patient's health status, no doctor can promise you specific results. This depends on a wide ranges of factors including the inherent recuperative powers of the body.

DIAGNOSIS

Although Doctors of Chiropractic are experts in Chiropractic diagnosis involving various types of structural disorders and spinal alignment, they are not internal medical specialists. Every Chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your Doctor of Chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Doctor of Chiropractic, gives the Doctor permission and authority to care for the patient in accordance with the Chiropractic tests, diagnosis and analysis. The Chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a Chiropractic adjustment, or health care, if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would other wise not come to the attention of the Doctor of Chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Doctor of Chiropractic provides a specialized, non-duplicating health service. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS

The purpose of Chiropractic services is to promote natural health through the re-alignment of the spine, joints, and muscles. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the Chiropractic procedures. Sometimes the response is rapid.

In most cases, there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same Chiropractic care. Many medical failure find quick relief through Chiropractic. In turn, we must admit that conditions which do not respond to Chiropractic care may come under the control or be helped through medical science. The fact is that the science of Chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have great strides in alleviating pain and controlling disease.

TO THE PATIENT

Please discuss any questions or problems with the Doctor **before** signing this statement of policy.

I have read, and understand the foregoing.

DATE _____ SIGNATURE _____

[Lotus Healing Arts]

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing this form, you acknowledge that *Lotus Healing Arts* has given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations. We must try to have you sign this form on your first date of service with us. This includes the situation where your first date of service occurred electronically.

If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

I have received Lotus Healing Art's Privacy Notice.

_____ _____

Print Name **Unique Identifier**

_____ _____

Patient's Signature **Date**

For office use only:
Patient Name: _____
Medical Record #: _____
Date of Admission: _____
Filed electronically: ___Yes ___No
Forward completed form to HIS to file in patient's chart: ____Yes ___No

[Name of Covered Entity] staff should complete if Acknowledgement Form is not signed:

1. Does patient have a copy of the Privacy Notice? [ ] Yes [ ] No

2. If you answered "No" above, please explain why the patient did not sign an acknowledgement form and *[Name of Covered Entity]* efforts in trying to obtain the patient's signature (check all that apply):

[ ] Patient Unable to Comprehend
[ ] Patient Communication Barrier
[ ] Legal Representative not Available
[ ] Patient/Legal Representative Left before Signature Obtained
[ ] Emergency Admission/Patient Not Present for Registration
[ ] Patient bypassed Registration – Not Available
[ ] Other: _____

3. Completed by:

_____ _____ _____

Workforce Member Signature Title Date

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____