McCarron Lake Chiropractic

CONFIDENTIAL PATIENT INFORMATION

The following information is needed for our files so we can better serve you as a patient. Please fill in all portions of the form. If you need any help, please ask the receptionist.

Date_____

How did you hear about our clinic?_____

Name_____ Home Phone_____ SS #_____

Address_____ City_____ State_____ Zip _____

Age_____ Birth Date_____ Marital Status_____ Children_____ Cell Phone_____

EMAIL address: _____

Gender M or F Ethnicity: Hispanic/Latino Asian African American American Indian White Other Decline

Occupation_____ Employer _____

Primary Care Provider/Clinic _____

In case of Emergency contact_____ Phone #_____

Insurance Data (Clinic policy requires payment arrangements be made on the first visit.)

For Non-Auto Accident & Work Comp.

Do you have insurance?_____

What company?_____ Policy #_____

Is there secondary insurance?_____ What_____ Policy #_____

Name of party responsible for payment_____ (if different from above) Phone #_____ (if different from above)

Auto Accident Insurance & Work Comp

When did the accident occur?_____

Have you reported your accident to your insurance company _____ What is your Claim #?_____

Your Insurance Co._____ Policy #_____

Driver Name_____ *(Of the vehicle you were in, if applicable)* Insurance Co_____ *(Skip if you are driver)* Policy#_____ *(Skip if you are driver)*

Have you retained an attorney?_____ If yes, who_____ Phone #_____

CONSENT FOR TREATMENT: By signing this form, I consent to and authorize my health care provider to examine and treat me today and in the future. I understand that this could include x-rays, education or other diagnostic procedures. I understand that my provider is available and it is my responsibility to ask them to explain the purpose of the procedures and treatment and that I have the right to refuse the recommendation treatment under any circumstances.

PAYMENT POLICIES: If your deductible has not been met, you will be expected to pay for services as rendered until the total deductible has been met. Important: your insurance coverage is a contract between you and your insurance company and you are ultimately responsible for your bills here. It is therefore, necessary for you to contact your insurance company to find out specific benefits. There will be a $5.00 late fee each month for bills that are more than 30 days late.

AUTO/WORK COMP INSURANCE COVERAGE: We will bill your insurance company for you and have payment come directly to McCarron Lake Chiropractic. But, you are responsible for any charges not covered by your insurance company. If checks are sent directly to you from your insurance company then you are solely responsible for that account with no deduction from that bill.

Patient's Signature (or guardian)_____ Date_____

Patient Name:_____ Date of Birth_____

Personal Medical History (if any of the following are relevant to your medical history, please mark the appropriate box)

Have	Had		Have	Had		Have	Had		Have	Had	
____	____	Cancer	____	____	Muscular Dystrophy	____	____	Osteoporosis	____	____	Scoliosis
____	____	Polio	____	____	MS	____	____	Rheumatism	____	____	Anxiety
____	____	Tuberculosis	____	____	Convulsions	____	____	Nervousness	____	____	Depression
____	____	High BP	____	____	Epilepsy	____	____	Asthma	____	____	High Cholesterol
____	____	Heart Trouble	____	____	Concussion	____	____	Emphysema	____	____	Poor Circulation
____	____	Diabetes	____	____	Dizziness	____	____	Anemia	____	____	Excessive Bruising
____	____	Hepatitis	____	____	Arthritis	____	____	Backaches	____	____	Pneumonia
____	____	STD's	____	____	Numbness	____	____	Sinus Trouble	____	____	Anorexia or Bulimia
____	____	Psoriasis	____	____	Kidney Issues	____	____	Immune Issue	____	____	Sleep Apnea
____	____	PMS	____	____	Hypoglycemia	____	____	Prostate Issues	____	____	Stroke

Family History (Have past or present family members had any of the below? If yes, write who next to the condition)

- ☐ Cancer
- ☐ Polio
- ☐ Tuberculosis
- ☐ High Blood Pressure
- ☐ Heart Trouble
- ☐ Diabetes
- ☐ Muscular Dystrophy
- ☐ Multiple Sclerosis
- ☐ Convulsions
- ☐ Epilepsy
- ☐ Back Pain
- ☐ Stroke
- ☐ Osteoporosis
- ☐ Rheumatism
- ☐ Alzheimer's
- ☐ Asthma
- ☐ Neuritis
- ☐ Anemia
- ☐ Kidney Problems
- ☐ TB
- ☐ Digestive Problems
- ☐ Alcoholism
- ☐ Arthritis
- ☐ Hepatitis

Social History

Alcohol Use Daily_____ Weekly_____ How much?_____

Coffee Use Daily_____ Weekly_____ How much?_____

Tobacco Use Daily_____ Weekly_____ How much?_____

Exercise Daily_____ Weekly_____ How much/What?_____

Pain Relievers Daily_____ Weekly_____ How much/What?_____

Soft Drinks Intake Daily_____ Weekly_____ How much?_____

Water Intake Daily_____ Weekly_____ How much?_____

Recreational Drugs Daily_____ Weekly_____ How much/What?_____

Job Stress? Yes or No **Vaccinated?** Yes or No

Supplements Use Daily_____ Weekly_____ How much/What?_____

_____

Prescribed Medication How much/What?_____

_____

_____

Are you allergic to any medication?_____ If so, what_____

Are you **pregnant**?_____ If yes, how far along_____ Date of last menstrual period_____

Date of last physical exam_____

Have you ever had **broken bones**? Y / N _____

Have you ever been **hospitalized**? Y / N _____

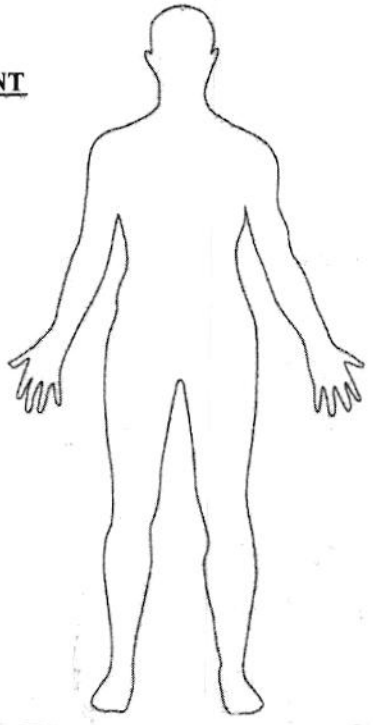
Have you ever been in an **auto accident**? Y / N _____

Have you ever had **surgery**? Y / N _____

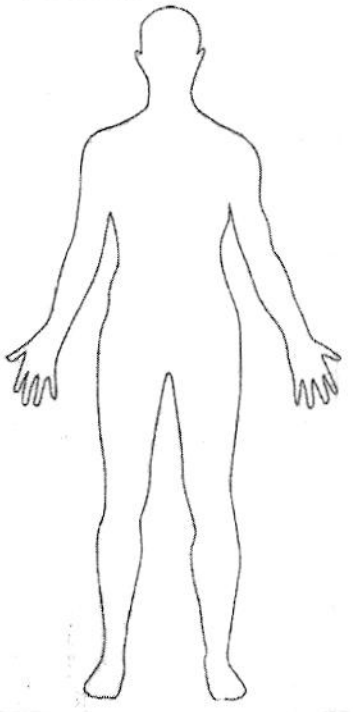
Patient Name_____ DOB_____ Date_____

Please "X" on the images above where you have complaints

FRONT



BACK



Please describe how your problem began:

_____

_____

_____

_____

When did your problem begin?_____

Have you seen anyone else for this problem? Yes or No

If yes, who have you seen and what did they do for you?_____

_____

_____

Have you had an X-rays, CTs, or MRIs for this problem? Yes or No

If yes, what was done, where and when was it done?_____

_____

_____

Patient Name _____ Today's Date _____

Date of Birth _____

Activities of Daily Living (How does this condition currently interfere with your life and ability to function?)

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

Please cirlce any of the below that provide you some relief from your problem:

Over the counter medication	Prescription medication
Ice therapy	Walking
Heat therapy	Exercise
Massage therapy	Stretching
Chiropractic care	Running
Physical therapy	Yoga
Sleep	Standing
Sitting	Acupuncture
Hot Shower	Hot Bath

Other: _____

McCarron Lake Chiropractic

Financial Agreement

Please remember that insurance is considered a method of reimbursing the patient for fees put to the doctor and is NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

YOUR INSURANCE MANDATES WE COLLECT COPAYS AT THE TIME OF SERVICE. CO-INSURANCES AND DEDUCTIBLES WILL BE BILLED TO YOU.

If this account is assigned to an attorney/outside agency for collections and/or suit, McCarron Lake Chiropractic shall be entitled to reasonable attorney's fees and/or collection fees.

I authorize payment of medical benefits to the physicians or supplier at McCarron Lake Chiropractic for services I receive.

I authorize the release of any medical records or other information necessary to process this claim, to determine liability for payment, and to obtain reimbursement on any claim.

_____
Print Name

_____
Insured's Signature
(If different than patient)

_____
Patient Signature

____/____/____
Date of Birth

___/___/___
Today's Date

McCarron Lake Chiropractic
1820 Rice Street
St. Paul, Mn 55113

Clinic Consent and Relationship Form

TO OUR PATIENTS: Before you begin treatment at McCarron Lake Chiropractic, the law requires that we explain your rights and responsibilities while a patient at our office. If you have a complaint or concern about your care, please discuss it first with your care provider. Please read and sign the form below. Ask questions if you do not understand it. If you need a language interpreter we can provide one for you.

I understand I have the right to revoke this consent, in writing, at any time except where McCarron Lake Chiropractic has already made disclosures in reliance on this consent. I have reviewed the options above and have initialed all that apply below. I understand that I am paying for services rendered and not for results obtained from these treatments.

INITIAL TO INDICATE APPROVAL

_____ **CONSENT FOR TREATMENT:** By signing this form, I consent to and authorize my health care provider to examine and treat me today and in the future. I understand that this could include x-rays, education or other diagnostic procedures. I understand that my provider is available and it is my responsibility to ask them to explain the purpose of the procedures and treatment and that I have the right to refuse the recommendation treatment under any circumstances.

_____ **INSURANCE/MEDICARE/MEDICAID ASSIGHMENT OF BENEFITS PAYMENT TO MCCARRON LAKE CHIROPRACTIC MEDICAL BILLS:** I would like a "third party Payer" (for example, my insurance company/Medicaid/Medicare or its related organizations) to pay the bills for my services at McCarron Lake Chiropractic to the extent the Payer is required to do so under my policy of insurance or the law. Therefore, I request that payment of my bills by the "third party payer" be made to McCarron Lake Chiropractic on my behalf for my services furnished to me by or in McCarron Lake Chiropractic. I assign the benefits payable for physician's services to the physicians or organizations furnishing the services. In consideration of clinic visits, I agree to pay McCarron Lake Chiropractic for all charges not covered by any third party payer. A photo copy of this Assignment shall be considered as effective and valid as the original.

_____ **RELEASE OF MEDICAL RECORDS FOR BILLING PURPOSES:** In many instances a "third party payer" will pay a portion of my entire medical bill related to today's visit. Examples of "third party payer' are medical and auto insurance companies, workers' compensation insurance carriers, Medicaid, Medicare or its related organizations. In order for a "third party payer" to pay any or all of my bills related to visits at McCarron Lake Chiropractic. I understand the "third party payer" may require information about the care and treatment I received. I authorize McCarron Lake Chiropractic or its related entities to release to the "third party payers" any information needed to determine the payments related to the medical treatments I receive.

_____ **PAYMENT POLICIES:** If your deductible has not been met, you will be expected to pay for services as rendered until the total deductible has been met. Important: your insurance coverage is a contract between you and your insurance company and you are ultimately responsible for your bills here. It is therefore, necessary for you to contact your insurance company to find out specific benefits. There will be a $5.00 late fee each month for bills that are more than 30 days late.

_____ **AUTO/WORK COMP INSURANCE COVERAGE:** We will bill your insurance company for you and have payment come directly to McCarron Lake Chiropractic. But, you are responsible for any charges not covered by your insurance company. If checks are sent directly to you from your insurance company then you are solely responsible for that account with no deduction from that bill.

_____ **X-RAY RELEASE:** It is the policies of McCarron Lake Chiropractic to mail all x-rays to any physician you want and not handed to the individual for transport. We will have the x-rays sent the same day we receive a signed release from you. We will pay postage, etc.

_____ **RELEASE OF MEDICAL RECORDS FOR MY MEDICAL CARE OR AS REQUIRED BY LAW:** I understand that it is important that my medical providers have access to any of my medical records which will help them to safely treat me and manage my medical care. I agree that a copy of my medical records, with the exception of psychotherapy notes, may be sent to any of my physicians or healthcare providers. I also agree that McCarron Lake Chiropractic can release my medical records to accrediting or regulating agencies if those agencies request my records and if the law allows those agencies access to my records. (Records are not automatically sent to your referring physicians. They must be requested.)

Health Care Facility Requesting Records From: _____

Date Of Services Requested: ALL AND ANY RECORDS ON FILE AS WELL AS RADIOGRAPHIC STUDIES (FILMS & REPORTS)

_____ _____ _____
Print Name Patient Signature/Other Date

_____
If other, relationship

McCarron Lake Chiropractic
Notice of Privacy Practices

Protecting the privacy of your person health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of a request to do so. There may be a reasonable cost-based fee for the photocopying, postage and preparation.

You have the right to request that we correct, amend or delete information in your records. We will respond to each request as require by law. All such requests should be in writing.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you via telephone, email or by letter for appointment reminders, announcements, and to inform you about our practice and its staff. You have the right to refuse these contacts or receive information by alternative means.

We do the majority of our therapeutic modalities in an "open treatment" environment and therefore it is possible that another person could overhear a conversation. If you object or are uncomfortable with this situation you may request a private treatment room.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about our privacy violations by contacting Dr. Jason A. Smith at 651-489-6550.

_____
Print Name

_____
Signature

_____
Date

**********For Office Use Only**********

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but the acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communication barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining the acknowledgement
- o Other_____

Massage Cancellation Policy

We kindly ask that you give a 24-hour notice when canceling your appointment. We understand that sometimes longer notice cannot be given due to certain circumstances.

However, if you have two cancelations or if you have two no-show's, you will be required to pay 50% of all future massage appointments in advance AND *will not be refunded should you miss or cancel the appointment without a 24-hour notice.*

***NOTE* If you are treating through an auto accident or workers' compensation injury, you will not be allowed to schedule future massages.**

Thank You for Your Understanding!

Patient Name: _____ Date: ___/___/___

Patient Signature: _____