WORKERS COMPENSATION HISTORY

GENERAL INFORMATION			
PATIENT NAME:			DATE:
ADDRESS:		CITY:	STATE/ZIP CODE:
EMAIL:		CELL PHONE NUMBER:	
WORK PHONE:		EMERGENCY CONTACT AND PHONE NUMBER:	
SOCIAL SECURITY NUMBER:	DATE OF BIRTH:	AGE:	GENDER:

EMPLOYER INFORMATION		
EMPLOYER NAME:	SUPERVISOR NAME:	
EMPLOYER ADDRESS:	CITY:	STATE/ZIP CODE:
WORK PHONE:	OCCUPATION:	

COMPENSATION CARRIER INFORMATION		
COMPENSATION CARRIER NAME:	COMPENSATION CARRIER PHONE:	
COMPENSATION CARRIER ADDRESS:	CITY:	STATE/ZIP:
CLAIM NUMBER:		

ACCIDENT/INJURY DETAILS	
DATE OF INJURY:	TIME OF INJURY (A.M. OR P.M.):
EXPLAIN THE DETAILS OF THE ACCIDENT:	
ARE YOU OFF WORK? ❑ YES ❑ NO	IF YES, DATE YOU LEFT WORK:
HAVE YOU RETURNED TO WORK SINCE THE ACCIDENT? ❑ YES ❑ NO	IF YES, DATE YOU RETURNED TO WORK:
HAVE YOU BEEN TREATED BY ANY OTHER DOCTORS FOR THIS CONDITION? ❑ YES ❑ NO	IF YES, LIST THE DOCTOR(S) NAMES & PHONE NUMBERS:
HAVE YOU HAD ANY PREVIOUS WORKERS COMPENSTATION INJURIES? ❑ YES ❑ NO	DATE(S) OF PREVIOUS WORKERS COMPENSATION INJURIES:
PRIOR TO THE ACCIDENT, HAD YOU HAD SIMILAR COMPLAINTS TO THE ONES YOU ARE EXPERINCING NOW? ❑ YES ❑ NO	
IF YES, PLEASE DESCRIBE:	

SIGNATURE	
PATIENT SIGNATURE:	DATE:

INSURANCE INFORMATION

INSURANCE COMPANY NAME:

ADJUSTERS NAME: ADJUSTERS PHONE NUMBER:

INSURANCE COMPANY ADDRESS: CLAIM NUMBER:

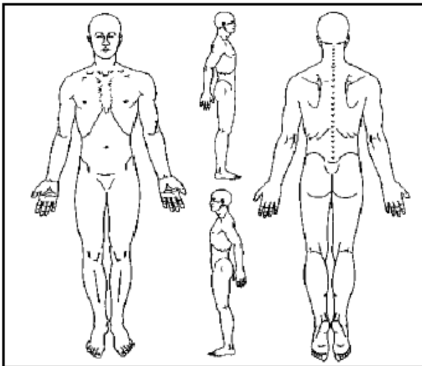
SYMPTOMS

INSTRUCTIONS: *Check (✓) any/all symptoms noted after the accident.*

❑ HEADACHE	❑ DIZZINESS	❑ LIGHT BOTHERS EYES
❑ NECK PAIN	❑ HEAD SEEMS HEAVY	❑ LOSS OF MEMORY
❑ NECK STIFFNESS	❑ PINS & NEEDLES IN ARMS	❑ EARS RING
❑ SLEEPING PROBLEMS	❑ PINS & NEEDLES IN LEGS	❑ FACE FLUSHED
❑ BACK PAIN	❑ NUMBNESS IN FINGERS	❑ BUZZING IN EARS
❑ NERVOUSNESS	❑ NUMBNESS IN TOES	❑ LOSS OF BALANCE
❑ TENSION	❑ SHORTNESS OF BREATH	❑ FAINTING
❑ IRRITABILITY	❑ FATIGUE	❑ LOSS OF SMELL
❑ CHEST PAIN	❑ DEPRESSION	❑ LOSS OF TASTE
❑ DIARRHEA	❑ FEET FEEL COLD	❑ UPSET STOMACH
❑ CONSTIPATION	❑ HANDS FEEL COLD	❑ OTHER: ______________
❑ FEVER	❑ COLD SWEATS	❑ OTHER: ______________

INTRUCTIONS: *Please mark the area and type of pain on the drawings using the codes listed below:*

N=Numbness P=Pain A=Ache T=Tingling S=Stiffness/Soreness



COMMENTS:

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PLEASE PROVIDE ANY OTHER PERTINENT INFORMATION YOU THINK WE SHOULD KNOW:

DOCTOR ONLY

DOCTOR COMMENTS:

SIGNATURE

PATIENT SIGNATURE: DATE:

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

Ownership of X-ray Films: *It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.*

SIGNATURE:	DATE:
GUARDIAN OR SPOUSE AUTHORIZING CARE SIGNATURE:	DATE:

WHO SHOULD RECEIVE BILLS FOR PAYMENT ON YOUR ACCOUNT?

❑ PATIENT ❑ SPOUSE ❑ PARENT ❑ WORKERS COMP ❑ AUTO INSURANCE ❑ MEDICARE ❑ HEALTH INSURANCE

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is only when the patient understands both the objective and the method that they will be able to attain it. This will prevent any confusion or disappointment.

An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine.

Health is a state of optimal physical, mental and social well being, not merely the absence of disease.

Vertebral Subluxation is a misalignment of one or more of the joints of the body. This can cause pain or alteration of nerve function and interference of the transmission of nerve impulses, lessening the body's innate ability to maintain maximum health.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I have read and fully understand the above statement. Any questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

SIGNATURE:	DATE:
WITNESS SIGNATURE:	DATE:

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. 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 your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & 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:

- *Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician's certifications.*

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

PATIENT NAME (PLEASE PRINT):	RELATIONSHIP TO PATIENT:
SIGNATURE:	DATE:

PATIENT CASE HISTORY

FOR OFFICE USE ONLY

CHIEF CONCERNS:
HISTORY OF CONDITION:
ASSOCIATED SYMPTOMS:
AGGRAVATING FACTORS:
WHAT HAS BEEN DONE TO HELP THIS CONDITION:
PRIOR ILLNESS, SURGERY, ACCIDENTS:
FAMILY HEALTH HISTORY:
OTHER:

☐ SYSTEMS CHECK COMPLETE

Family First Chiropractic Center
11901 Hwy 65
Blaine, MN 55434

NOTICE OF CANCELLATION POLICY

CANCELLATION POLICY -- EFFECTIVE NOVEMBER 1, 2019

It is the policy of Family First Chiropractic Center to assess a $25 missed visit fee to patients who cancel appointments with less than a 5 hour notice. One missed visit will not result in the assessment for a fee, but you will be charged for any additional missed visits. This clinic provides care for many individuals and families, and missed visits result in time lost that could have been used to provide care for others.

My signature below indicates that I understand the above missed visit policy

SIGNATURE:____ DATE:__________________

PAYMENT AUTHORIZATION -- EFFECTIVE NOVEMBER 1, 2019

My signature below states that I authorize Family First Chiropractic Center to process my cancellation fee within 30 days of the missed appointment. I agree to provide a credit/debit card to keep on my secure account for any future payments.

SIGNATURE:____ DATE:__________________

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