Welcome to
Schmidt Chiropractic Center
320 Hill Street Norwood Young America, MN 55368
Patient Admittance Form

Name: _____ Date :_____
(First) (MI) (Last)

Address: _____
(Street Address) (City) (State) (Zip Code)

Home Phone #: _____ Cell Phone #: _____

Email Address: _____ Marital Status: M S D W
(Please circle one)

Date of Birth: _____ Age: _____ Social Security #:_____

Parent/Guardian Name(s) if patient is a Minor: _____

How did you hear about our office? ◯ Family ◯ Friend ◯ Newspaper ◯ Facebook

◯ Waconia Business Newsletter ◯ Community Event ◯ Other _____

Whom can we Thank for referring you?_____

Healthcare Providers

Have you seen a chiropractor in the Past? ◯ Yes ◯ No

If so, please list who and when seen? _____

Name of your Primary Medical Doctor and Clinic: _____

Employment Information

Occupation: _____

Employer:_____
(Name/Address/City/State) (Phone #)

Please mark if your situation is the result of…

- ❑ Work Injury
- ❑ Auto Accident
- ❑ Farm Injury/Accident
- ❑ Other:_____

Date of Injury:_____

Patient Health Questionnaire - PHQ

Form PHQ-202

rev 7/18/05

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

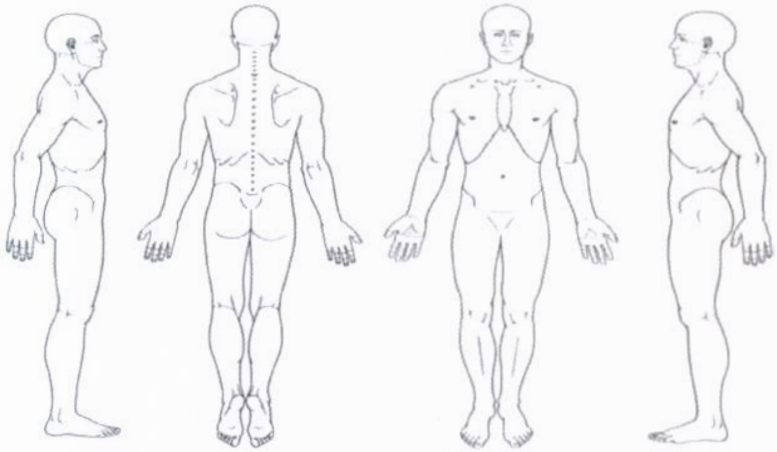
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

① No One ③ Medical Doctor ⑤ Other
② Chiropractor ④ Physical Therapist

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office ③ Medical Doctor ⑤ Other
② Chiropractor ④ Physical Therapist

10. What is your occupation?

① Professional/Executive ④ Laborer ⑦ Retired
② White Collar/Secretarial ⑤ Homemaker ⑧ Other
③ Tradesperson ⑥ FT Student

_____

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time ③ Self-employed ⑤ Off work
② Part-time ④ Unemployed ⑥ Other

Patient Signature _____ **Date** _____

Patient Health Questionnaire - page 2

ACN Group, Inc PHQ-102

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height [ ][ ][ ] (Feet / Inches) Weight [ ][ ][ ] lbs.

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present	
○	○	Headaches	○	○	High Blood Pressure	○	○	Diabetes
○	○	Neck Pain	○	○	Heart Attack	○	○	Excessive Thirst
○	○	Upper Back Pain	○	○	Chest Pains	○	○	Frequent Urination
○	○	Mid Back Pain	○	○	Stroke			
○	○	Low Back Pain	○	○	Angina	○	○	Smoking/Use Tobacco Products
						○	○	Drug/Alcohol Dependence
○	○	Shoulder Pain	○	○	Kidney Stones			
○	○	Elbow/Upper Arm Pain	○	○	Kidney Disorders	○	○	Allergies
○	○	Wrist Pain	○	○	Bladder Infection	○	○	Depression
○	○	Hand Pain	○	○	Painful Urination	○	○	Systemic Lupus
			○	○	Loss of Bladder Control	○	○	Epilepsy
○	○	Hip/Upper Leg Pain	○	○	Prostate Problems	○	○	Dermatitis/Eczema/Rash
○	○	Knee/Lower Leg Pain				○	○	HIV/AIDS
○	○	Ankle/Foot Pain	○	○	Abnormal Weight Gain/Loss			
			○	○	Loss of Appetite	***Females Only***		
○	○	Jaw Pain	○	○	Abdominal Pain	○	○	Birth Control Pills
			○	○	Ulcer	○	○	Hormonal Replacement
○	○	Joint Swelling/Stiffness	○	○	Hepatitis	○	○	Pregnancy
○	○	Arthritis	○	○	Liver/Gall Bladder Disorder	○	○	
○	○	Rheumatoid Arthritis						
			○	○	Cancer	***Other Health Problems/Issues***		
○	○	General Fatigue	○	○	Tumor	○	○	
○	○	Muscular Incoordination				○	○	
○	○	Visual Disturbances	○	○	Asthma	○	○	
○	○	Dizziness	○	○	Chronic Sinusitis			

Indicate if an immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○ _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

Patient Signature _____ **Date** _____

Doctor's Additional Comments

_____

_____

_____

Doctors Signature _____ **Date** _____

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score _____

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score _____

Schmidt Chiropractic Center

320 E Hill St, PO Box 215
Norwood Young America, MN 55368

PATIENT CONSENT FOR CHIROPRACTIC TREATMENT

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask your Doctor any questions that you have about the information below. You can ask questions at any time before, during, or after your treatment.

The nature of chiropractic adjustment: The primary treatment your Doctors of Chiropractic uses is spinal manipulative therapy. We will use that procedure to treat you. We may use our hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible "pop" or "click", much as you have experienced when you "crack" your own knuckles. You may also feel a sense of movement.

Examination and Treatment: In addition to spinal manipulation, we may use a variety of other therapies and examination procedures. As a part of the analysis, examination, and treatment, you are consenting to the following additional procedures:

- Spinal manipulative therapy
- Palpation
- Vital signs
- Orthopedic testing
- Range of motion testing
- Basic neurological exam
- Muscle strength testing
- Ultrasound
- Radiographic studies
- Rehabilitation/core strengthening
- Nutritional therapy
- Mechanical traction/flexion distraction
- Other_____

We will explain these procedures to you and answer any questions you have about them.

The material risks inherent in chiropractic adjustment: Some patients will feel some stiffness and soreness following the first few days of treatment. We will make every reasonable effort during the examination to screen for contraindications to care. However, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke.

Chiropractic is a safe and comfortable form of health care for most people. If a potential risk is identified, you will be informed and offered either treatment or a referral to the appropriate health care specialist for evaluation and care.

The probability of risks occurring:

Soreness: It is not uncommon to experience some localized soreness following a manipulation. This type of soreness is usually minor and occurs most often following the initial few visits. It is similar to the soreness you may experience after exercise.
Fracture: Fractures caused from spinal manipulations are extremely rare. It is so rare that an actual number of incidences per manipulation have never been determined. Patients suffering from bone weakening conditions like Osteoporosis are in a higher risk category. Alternative forms of spinal manipulation may be utilized for this type of patient.
Ruptured/Herniated Disc: There have been some reports of herniated or ruptured discs caused by spinal manipulations. Alternative spinal adjusting methods are often utilized to minimize the risk and help the patient recover from serious disc-related pain.
TIA/Stroke: According to the literature, possible neurological complications can arise in 1 per 1-8 million office visits or 1 per 2-5.85 million adjustments. Screening tests are performed when necessary to rule out high-risk patients. Alternative spinal adjusting is utilized when necessary to minimize any potential risks.
Other complications: These include but are not limited to: dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns.
The availability of other treatment options: Other treatment options for your condition may include:

- Self-administered, over-the-counter medications
- Medical care and prescription drugs, such as anti-inflammatories, muscle relaxants, and pain killers
- Hospitalization
- Surgery

If you choose to use one of the above noted "other treatment" options, you should be aware that there are also risks and benefits with each one of those options and you may wish to discuss these with your primary medical physician.

The risks and dangers associated with remaining untreated: Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

Notices of Privacy Practices: Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in the Notice of Privacy Practices. We will provide you with a copy of the revised Notice of Privacy Practices upon your request.

Consent to Release of Information:

- In accordance with Minnesota Statutes § 144.335, I consent to the release by my provider of my health records and medical information about me to physicians, providers, and staff as necessary for treatment, to insurers as necessary to receive payment for services, and to third parties for purposes of reviewing quality of care and for health care operations (so long as the release is in compliance with applicable law), including releases for internal or external audits, research and quality assurance, or licensing/accreditation purposes.
- I give my permission to my provider to communicate information about me to those people involved in my care for the purpose of my treatment as designated in my medical record.
- I give permission for my provider to communicate with me regarding my medical care, such as results of tests/reports through voicemail messages via the phone numbers I have supplied in my medical record.
- In order to assure proper quality and continuity of care, I authorize Medicare, my insurance company or health maintenance organization, other payers, payer network organizations, or third party administrators to share my health records and information obtained from my health care provider or any other provider, with my health care provider, other providers from whom I have received services, or any other payer, payer network organization, or third party administrators as needed for payment and health care operations.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

PATIENT CONSENT FOR CHIROPRACTIC TREATMENT

I understand this Consent to Release of Information does not expire unless I revoke it or provide a specific expiration date here: _____

I, _____, have read, or have had read to me, the above explanation of the chiropractic adjustment and related treatment. **BY SIGNING BELOW, I CONSENT TO ALL OF THE USES AND DISCLOSURES ABOVE, AND I ACKNOWLEDGE THAT I HAVE BEEN OFFERED A COPY OF THE NOTICE OF PRIVACY PRACTICES.** I have discussed it with my provider and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. I do not expect the doctor to be able to anticipate and explain all the risks and complications. Having been informed of the known risks, I hereby give my consent to that treatment. I intend this consent to apply to all of my present and future chiropractic care.

I also grant permission to communicate my personal health information to others involved in my care for the purpose of treatment, results of tests and medical care at the following numbers.
Please specify your contact preference:
_____Home Phone:_____
_____Cell phone:_____ Text: Yes or No
_____Email:_____

_____	_____	_____
Date	Signature of patient or authorized person	Authority to act on behalf of patient (Proof Required)

Schmidt Chiropractic Center
320 E Hill St, PO Box 215 - Norwood Young America, MN 55368
www.schmidtchiro.net P: (952)467-2505 F: (952)467-9104
Dr. Julie Schmidt, DC & Dr. Samantha Jones, DC

Financial Policy

Participating Health Insurance

This clinic is a participating provider with the following insurances (these are subject to change at any time, and may include other healthcare plans):

- Blue Cross Blue Shield of Minnesota
- Preferred One Products & Select Care/Laborcare
- Medica, Principal Financial Group, United Health Care, Great-West Healthcare (Including Senior Plans)
- HealthPartners, Ucare, Cigna Health Care, Patient Choice (Including Senior Plans)

It is the responsibility of the patient to verify insurance coverage for chiropractic care. Benefits quoted are a general outline and are not a guarantee of payment. As a provider, the clinic cannot hold a patient responsible for any usual and customary provider reductions. Depending upon your plan, you may be responsible for a percentage, copay and or deductible at each visit. Services that are not covered by your healthcare plan's chiropractic benefits, and are not eligible for reimbursement, are your financial responsibility. Copays are due at time of service. If patient account is 90 days delinquent, the account will be turned over to a credit agency.

☐ I choose to have the clinic submit my chiropractic treatments to my health insurance.

_____

Patient Signature Date

_____

Printed Name

Time Of Service Discount- Cash Rate

Patients without medical insurance, or those who have insurance and choose not to utilize their insurance benefits, are required to pay for their chiropractic treatment the same day that treatment was received at this clinic. By paying same day, you will be eligible for a ***Time of Service*** discounted rate of $52.00 per treatment. By law, our clinic is also required to administer an initial exam. The cash rate for this one time initial exam service is $100.00. You may also be responsible for services including, but not limited to: soft tissue massage prior to treatment and the spinal/extra spinal adjustments. Time of Service cash rates do not apply toward your annual out-of-pocket spending limits or yearly deductible. Cash, checks, all major credit cards or HSA/Flex spending cards are all forms of cash payments. If patient account is 90 days delinquent, account will be turned over to a credit agency.

Please note: Time of Service discounted rate fees will not be submitted to any insurance.

☐ I choose to pay the *Time of Service Rate* of $52.00 for my chiropractic treatments.

_____

Patient Signature Date

_____

Printed Name

FULCRUM HEALTH

Provider Name: _____

Provider Address: _____

Provider Phone: _____

Non-Covered Services: Financial Disclosure Form (Medicare Advantage)

Your health care coverage may not cover all items or services requested by you or your provider. As part of your treatment plan, your provider will discuss the coverage and costs of any non-covered items/services, including those no longer considered medically necessary (also known as Maintenance/Wellness Care). Your health care provider may charge you for non-covered items/services should you choose to accept them. Before signing this form:

- Read this notice and the instructions so you can make an informed choice about your care.
- Ask your health care provider any questions that you may have.

I, _____ *(patient's name)* understand the following items/services are not expected to be covered or have been denied by my health plan. Nonetheless, I agree to accept them and agree to pay the charge(s) for the following service(s):

Treatment Start Date: _____ *Treatment End Date: _____

***Note: A new Financial Disclosure Form must be reviewed and signed with the patient every 12 weeks for care not covered under their plan, for elective care after a new acute episode that has achieved maximum therapeutic benefit (even if it is within a previous 12-week period). Form must be signed prior to rendering non-covered items/services. Failure to fill out this form in its entirety will make the form invalid and charges will be provider liable.**

Non-Covered Chiropractic Service	Reason Item/Service is not covered	Cost per Visit	Patient Initials
Exam(s)			
Manipulation (for maintenance care or wellness)			
X-Ray(s)			
Therapies/Modalities (circle all that apply) Electric Stimulation Acupuncture Ultrasound Exercise Education Other_____			
Durable Medical Equipment (circle all that apply) Braces Orthotics Ice pack Other: _____			
Massage			
Other (specific)			
TOTAL COST:			

I acknowledge that I am signing this statement voluntarily, and that by signing this form, I will be fully responsible for the total billed charge(s) related to non-covered services.

Patient/Authorized Representative Signature: _____ **Date:** _____

Provider/Clinic Administrator Signature: _____ **Date:** _____

Note to Provider: All fields above must be entered accurately and completely, including dates, costs, and reason why services are not covered. The patient must acknowledge each non-covered line with their initials to be considered valid.

Addition for Medicare Advantage Patients: Providers must request an Organization Determination for any non-covered items/services for which Fulcrum will issue a determination. Only following an adverse determination can this form be used. Forms dated prior to a Fulcrum denial, or after services have been rendered, will make the form invalid and charges will be provider liable.

This form is based on requirements detailed in Fulcrum's Noncovered Services Policy NM007, available on ChiroCare.com xxxxx