**Patient Admittance Form**

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name First Name Middle Initial\_\_\_\_\_\_

Address City State Zip code\_\_\_\_\_\_

Home Phone ( ) Cell Phone ( ) Work Phone ( )\_\_\_\_\_\_\_\_\_\_

Date of Birth Marital Status How did you hear of us?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address\* Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Your email will NOT be shared with any 3rd parties, and is used for occasional office announcements & promotions**

Race\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Emergency Contact's Phone ( )\_\_\_\_\_\_\_\_\_\_\_

Medical Doctor’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Clinic\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PERMISSION TO TREAT A MINOR (PARENT OR GUARDIAN)**

I give Zeiszler Chiropractic Clinic permission to examine, X-Ray, and treat\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT FINANCIAL INFORMATION**

Circle One: General Insurance Cash Payments Personal Injury

Workman's Compensation Other

Insurance Company Name Name of Insured\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID# Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Injury/Occurrence\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.**

Patient Signature Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Zeiszler Chiropractic Clinic

14635 Pennock Avenue, Suite #200

Apple Valley, MN 55124

(952) 432-0700

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**Patient Health Questionnaire—Page 2**

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What type of regular exercise do you perform?** None Light Moderate Strenuous

**What is your height and weight?** **Height:**\_\_\_\_\_\_\_ **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 (Females Only)**

\_\_\_ \_\_\_ Headaches \_\_\_ \_\_\_ Kidney Stones \_\_\_ \_\_\_ Birth Control Pills

\_\_\_ \_\_\_ Neck Pain \_\_\_ \_\_\_ Kidney Disorders \_\_\_ \_\_\_ Hormonal Replacement

\_\_\_ \_\_\_ Upper Back Pain \_\_\_ \_\_\_ Bladder Infection \_\_\_ \_\_\_ Pregnancy

\_\_\_ \_\_\_ Mid Back Pain \_\_\_ \_\_\_ Painful Urination

\_\_\_ \_\_\_ Low Back Pain \_\_\_ \_\_\_ Loss of Bladder Control

\_\_\_ \_\_\_ Shoulder Pain \_\_\_ \_\_\_ Prostate Problems

\_\_\_ \_\_\_ Elbow/Upper Arm Pain \_\_\_ \_\_\_ Abnormal Weight Gain/Loss

\_\_\_ \_\_\_ Wrist Pain \_\_\_ \_\_\_ Loss of Appetite

\_\_\_ \_\_\_ Hand Pain \_\_\_ \_\_\_ Abdominal Pain

\_\_\_ \_\_\_ Hip/Upper Leg Pain \_\_\_ \_\_\_ Ulcer

\_\_\_ \_\_\_ Knee/Lower Leg Pain \_\_\_ \_\_\_ Hepatitis

\_\_\_ \_\_\_ Ankle/Foot Pain \_\_\_ \_\_\_ Liver/Gall Bladder Disorder

\_\_\_ \_\_\_ Jaw Pain \_\_\_ \_\_\_ Cancer

\_\_\_ \_\_\_ Joint Swelling/Stiffness \_\_\_ \_\_\_ Tumor

\_\_\_ \_\_\_ Arthritis \_\_\_ \_\_\_ Asthma

\_\_\_ \_\_\_ Rheumatoid Arthritis \_\_\_ \_\_\_ Chronic Sinusitis

\_\_\_ \_\_\_ General Fatigue \_\_\_ \_\_\_ Diabetes

\_\_\_ \_\_\_ Muscular Incoordination \_\_\_ \_\_\_ Excessive Thirst

\_\_\_ \_\_\_ Visual Disturbances \_\_\_ \_\_\_ Frequent Urination

\_\_\_ \_\_\_ Dizziness \_\_\_ \_\_\_ Smoking/Tobacco Use

\_\_\_ \_\_\_ High Blood Pressure \_\_\_ \_\_\_ Drug/Alcohol Dependence

\_\_\_ \_\_\_ Heart Attack \_\_\_ \_\_\_ Allergies

\_\_\_ \_\_\_ Chest Pains \_\_\_ \_\_\_ Depression

\_\_\_ \_\_\_ Stroke \_\_\_ \_\_\_ Systemic Lupus

\_\_\_ \_\_\_ Angina \_\_\_ \_\_\_ Epilepsy

\_\_\_ \_\_\_ Chronic Sinusitis \_\_\_ \_\_\_ Dermatitis/Eczema/Rash

**Indicate if any 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 of the surgical procedures you have had and times you have been hospitalized:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Health Information Consent Form**

We want you to know how your Patient Health Information (PHI) is going to be used in this office as well as your rights concerning those records. Before we will begin any healthcare operations, we must require you to read and sign this consent form, stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the **HIPAA NOTICE** that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the Insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient’s written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during the care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy, and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment, and healthcare operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Financial Policy**

Dear Patient:

The following information is provided to you in order to avoid any misunderstanding or disagreements concerning payments for professional services:

* All co-payments are due at time of service
* Patient accounts are due and payable within 30 days of services rendered. The patient responsibility portion, follow insurance payment, is due within 30 days of receipt of bill.
* Insurance referrals are the PATIENT'S responsibility. If you are not sure whether or not your insurance requires a referral contact your insurance company.
* As a courtesy to you, we will establish a reasonable monthly payment plan to accommodate needs. We do offer a financial hardship program for patients who qualify.
* Any patient refusing to remit payment before 90 days of notice without pending insurance or financial arrangement will cause us to limit your future credit until previous balance is paid in full or written financial arrangements are accomplished.
* We will Process your insurance claims as a courtesy to you, but you are ultimately responsible for your bill.
* **There is a $25 dollar fee for missed appointments and or appointments canceled with less than 24hours notice.**
* A $15 dollar administration fee is added monthly to balances over 60 days old.
* Any patient that is in default of this agreement will pay all reasonable legal fees, court costs, and other costs necessary to collect the debt, including fees charged by collection agencies (typically 35%)
* If qualify for first 2 visits at no charge per commercial or ad those visits must be used within 30 days of first appointment or we have the right to not honor those visits anymore.

Please notify us immediately if a mistake appears on the statement

Please select the option that best fits your needs. Feel free to discuss any of the options with receptionist.

Make Monthly Payments.

Pay deductible and or co-pays and we will bill your insurance.

Special Considerations Agreement, ask the receptionist for details.

Our practice firmly believes that good doctor-patient relationship is based upon understanding and open communication. The staff at Zeiszler Chiropractic has been instructed to make every effort to clarify any misunderstanding you have concerning your balance.

If you have questions concerning our policy or need assistance, please contact us immediately at (952) 432-0700

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

Zeiszler Chiropractic Clinic

14635 Pennock Avenue, Suite #200

Apple Valley, MN 55124

(952) 432-0700

**Informed Consent to Chiropractic Examination, Diagnostic Procedures, Chiropractic Adjustments & Care, Axial Decompression, and Peripheral Neuropathy Treatment**

I hereby request and consent to the performance of: physical examinations and evaluations and performance of any tests or x-rays required to be performed to diagnose my condition(s), of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, of axial decompression, on me (or on the patient named below, for whom I am legally responsible) by or under the supervision of the doctor of chiropractic named below and/or other licensed doctors of chiropractic: who now or in the future treat me while employed by, working, or associated with, or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below, or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below, and/or with other office or clinic personnel, the nature and purpose of axial decompression, chiropractic adjustments, and other procedures, I understand that the results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains, and burns. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest.

I have read, or had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition(s) and for future condition(s) for which I seek treatment.

Patient care, examinations, and treatment are administered by Dr. Ryan Sward.

Dr. Sward is a graduate of an accredited chiropractic college but has not yet completed requirements for Minnesota licensure. Please notify the office staff if you have any questions or concerns regarding this Office Policy Statement. If you are in agreement with this statement, please sign your name and date on the space provided below.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To be completed by patient: To be completed by patient’s representative, if necessary, e.g. if patient is a minor or is physically or mentally incapacitated

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Patient’s Name Print Patient’s Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient Print Name of Patient’s Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Signed Signature of Patient’s Representative

As:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_ Relationship to Patient

**To be completed by doctor or staff: Print name(s) of doctor(s) treating this patient:**

**Dr. Eric Zeiszler**

**Dr. Ryan Sward**

**Zeiszler Chiropractic Clinic**

**14635 Pennock Avenue Suite #200**

**Apple Valley, MN 55124**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_**

**Witness to Patient’s Signature: Date Translated by: Date**