Patient Name: _____ **Birthdate:** _____ **Height:** _____

Social Security Number: _____ **Male** **Female** **Weight:** _____

Home Address: _____

Home Phone: _____ **Cell Phone:** _____

Email Address: _____

Who Referred You to Our Office? _____

Emergency Contact: _____ **Relation:** _____ **Phone:** _____

What are You Seeing the Doctor For? _____ Headache _____ Neck Pain _____ Back Pain _____ Other

Primary Care Physician: _____

May We Send Health Updates to this Physician? _____ Yes _____ No

	PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Company		
Group #		
Subscriber ID:		
Address:		
Insured's Name:		
Insured's Employer:		
Insured's SS#		
Relation / DOB:		

Martial Status: _____ Single _____ Married _____ Divorced _____ Widowed

Current Work Status: _____ Employed _____ Retired _____ Not Working _____ Light Duty

Occupation: _____

Handed: _____ Right _____ Left _____ Both

Have You Seen a Doctor in the Past for These Injuries/Conditions?

Doctor: _____ **Date:** _____ **Treatment:** _____

Doctor: _____ **Date:** _____ **Treatment:** _____

MEDICATIONS

MEDICATIONS	DOSE

ALLERGIES

ALLERGY	SEVERITY (MILD, MODERATE, SEVERE)

PAST SURGERIES

SURGERY	DATE

BACK PAIN

Location:

- _____ No back pain
- _____ Centrally located low back pain
- _____ Right sided low back pain
- _____ Left sided low back pain
- _____ Both sides into the hips
- _____ Between the shoulder blades

Describe Your Pain:

- _____ Deep dull
- _____ Sharp
- _____ Burning
- _____ Electric
- _____ Hot/tingling
- _____ Stiff and sore

When did your back pain begin?

- _____ After my accident
- _____ Years ago (Date) _____
- _____ A few days/weeks/months ago
- _____ Always had some pain/stiffness

Intensity:

- _____ Mild (1-3)
- _____ Moderate (4-7)
- _____ Severe (8-10)

Duration:

- _____ Constant
- _____ Intermittent

Have you had this pain in the past?

_____ Yes _____ No

Previous treatment for low back pain?

_____ Yes _____ No

Does your pain radiate?

- _____ Does not radiate to legs/feet/toes
- _____ Radiates into the right leg
- _____ Radiates into the left leg
- _____ Radiates into the right foot/toes
- _____ Radiates into the left foot/toes

How well do you function with your pain?

- _____ I have 100% function with usual activities
- _____ I have 75% function with usual activities
- _____ I have 50% function with usual activities
- _____ I have 25% function with usual activities
- _____ I cannot function

What makes your pain worse?

- _____ Flexion
- _____ Extension
- _____ Rotating left / right
- _____ Laying on back
- _____ Coughing / sneezing
- _____ Laying on side
- _____ Motion

What makes your pain better?

- _____ Cold/ice
- _____ Heat
- _____ Massage
- _____ Exercise and stretching
- _____ Rest
- _____ Laying on side
- _____ Laying on back

NECK PAIN

Location:

_____ No neck pain
_____ Centrally located low neck pain
_____ Right sided low neck pain
_____ Left sided low neck pain
_____ Both sides into the shoulders
_____ At the base of the skull

Describe Your Pain:

_____ Deep dull
_____ Sharp
_____ Burning
_____ Electric
_____ Hot/tingling
_____ Stiff and sore

When did your neck pain begin?

_____ After my accident
_____ Years ago (Date) _____
_____ A few days/weeks/months ago
_____ Always had some pain/stiffness

Intensity:

_____ Mild (1-3)
_____ Moderate (4-7)
_____ Severe (8-10)

Duration:

_____ Constant
_____ Intermittent

Have you had this pain in the past?

_____ Yes _____ No

Previous treatment for low back pain?

_____ Yes _____ No

Does your pain radiate?

_____ Does not radiate to arms/hands/fingers
_____ Radiates into the right arm
_____ Radiates into the left arm
_____ Radiates into the right fingers
_____ Radiates into the left fingers

How well do you function with your pain?

_____ I have 100% function with usual activities
_____ I have 75% function with usual activities
_____ I have 50% function with usual activities
_____ I have 25% function with usual activities
_____ I cannot function

What makes your pain worse?

_____ Moving head up
_____ Moving head down
_____ Rotating left / right
_____ Motion
_____ Coughing / sneezing

What makes your pain better?

_____ Cold/ice
_____ Heat
_____ Massage
_____ Rest
_____ Medication

HEADACHES

Location:

_____ No headaches
_____ Forehead
_____ Right side of head
_____ Left side of head
_____ Behind the eyes
_____ Back of head

Describe Your Pain:

_____ Deep pressure
_____ Dull ache
_____ Burning
_____ Throbbing
_____ Hot/tingling
_____ Stiff and sore

When did your headaches begin?

_____ After my accident
_____ Years ago (Date) _____
_____ A few days/weeks/months ago
_____ Always had some pain/stiffness

Intensity:

_____ Mild (1-3)
_____ Moderate (4-7)
_____ Severe (8-10)

Frequency:

_____ per week

History:

_____ History of headaches?
_____ Ever suffered a concussion?
_____ Prior epilepsy treatment?
_____ Prior history of seizures?

What makes your pain worse?

_____ Noise
_____ Light
_____ Food
_____ Motion
_____ Coughing / sneezing

What makes your pain better?

_____ Cold/ice
_____ Heat
_____ Massage
_____ Rest
_____ Medication

OTHER PAIN

Location: _____

Describe Your Pain: _____

Intensity:
- _____ Mild (1-3)
- _____ Moderate (4-7)
- _____ Severe (8-10)

Duration:
- _____ Constant
- _____ Intermittent

When did your pain begin?
- _____ After my accident
- _____ Years ago (Date) _____
- _____ A few days/weeks/months ago
- _____ Always had some pain/stiffness

Have you had this pain in the past?
_____ Yes _____ No

Previous treatment for low back pain?
_____ Yes _____ No

Does your pain radiate? _____

How well do you function with your pain? _____

What makes your pain worse? _____

What makes your pain better? _____

REVIEW OF SYSTEMS

Have you noticed any of the following?

- _____ Unexpected weight loss or gain
- _____ Blurred / double vision
- _____ Headache
- _____ Chest pain
- _____ Shortness of breath
- _____ Nausea
- _____ Painful urination
- _____ Joint pains
- _____ Skin rash
- _____ Dizziness
- _____ Depression
- _____ Easy bruising
- _____ Excessive thirst or urination
- _____ Reaction to foods / environment

PAST MEDICAL HISTORY

Have you had any of the following?

- _____ Hypertension
- _____ Coronary Artery Disease
- _____ Arthritis
- _____ Cancer
- _____ Overweight
- _____ Osteoporosis
- _____ Immune Disorder
- _____ Other: _____

Do you consume alcohol?

_____ I do not drink _____ I am a recovering alcoholic _____ I drink occasionally

Do you smoke?

_____ Yes _____ No _____ I used to smoke

Do you use recreational drugs?

_____ No _____ I have previously used _____ I currently use

FAMILY HISTORY

Has anyone in your immediate family ever had the following?

- _____ Cancer
- _____ Stroke
- _____ Hypertension
- _____ Alcoholism
- _____ Bleeding tendency
- _____ Other: _____

Everything I have answered is true and correct to the best of my knowledge.

Signature: _____ Date: _____

INFORMED CONSENT FOR CHIROPRACTIC CARE

PLEASE READ DOCUMENT CAREFULLY

This document contains important information to understand prior to your chiropractic care. Please ask questions before you sign if there is anything that is unclear. You are the decision maker for your health care. Part of your role is to provide you with information to assist you in making informed choices. This "informed consent" involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive care. I understand this is an elective service and I willingly and knowingly consent to the treatment with the full understanding and disclosure of the risks associated with receiving care during the COVID-19 pandemic.

CHIROPRACTIC ADJUSTMENTS

I understand that the primary treatment used by Doctor of Chiropractic is spinal manipulative therapy. I, the Doctor of Chiropractic, will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

EXAMINATION, ANALYSIS, AND TREATMENT

I understand that there will be conducted examination and analysis procedure. Any examination or tests conducted will be carefully performed.

POSSIBLE RISKS OF CARE

I understand that as with any health care 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 myelopathy, 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. This occurs in 3-4 of every 100,000 people, whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractor can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in a one million to one in two million cervical adjustments. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindication to care however if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

THE PROBABILITY OF RISKS OCCURRING

I understand that fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is conclusive as to a

specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

OTHER TREATMENT OPTIONS

I understand that other treatment options for my condition may include: Self-administered, over-the-counter analgesics and rest, medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers, hospitalization with traction, and surgery. If you chose to use one of the above noted "other treatments' ' options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

CONTRAINDICATIONS TO MANIPULATION / ADJUSTMENTS

I understand that you will not give me a manipulation / adjustment, X-ray, modalities, or therapies if you feel that such are contraindicated. If the Care does not include such procedures, I have discussed all contraindications with you and fully understand them.

POSSIBLE RISKS REMAINING UNTREATED

I understand if I remain untreated it 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.

CONSENT TO TREATMENT (MINOR)

I hereby request and authorize Dr. Heather Flatgard to perform diagnostic tests and render chiropractic adjustments and other treatments to my minor child _____. As of this date, I have the legal right to select and authorize health care services for the minor child name above (if applicable). Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other patient is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the Doctor 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 have been informed of the risks, I hereby give my consent for chiropractic treatment and therapy.

PATIENT'S NAME: _____

PATIENTS SIGNATURE: _____ **DATE:** _____

SIGNATURE OF PARENT OR GUARDIAN (if a minor): _____ **DATE:** _____

DOCTOR'S NAME: Dr. Heather Flatgard

SIGNATURE: _____ **DATE:** _____

We may use and disclose your PHI (private health information) in response to a court or administrative order if you are involved in a lawsuit or similar proceeding. We may also disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute.

We may use or disclose your PHI for workers compensation or similar programs.

We may use a sign-in sheet at the front desk and we may call you in to see the doctor by name.

We may contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may mail you a postcard reminding you to make an appointment and we may leave a message for you on any answering device or with any person who answers the phone at your residence.

You can make a reasonable request for us to use alternative methods of communicating with you in a confidential manner. These requests must be submitted in writing in a clear and concise fashion. We are not required to agree to your request. However, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when information is necessary to treat you.

Rights you have:

- You have the right to request restrictions on some of the uses or disclosures described above. Except as stated, we are not requested to agree to such restrictions.
- You have the right to inspect and obtain copies of your mediation information. (A fee for the costs of copying, mailing, labor, and supplies associated with your requests will be charged.)
- You have the right to request amendments to your medical information. Such requests must be in writing and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any request amendment, we will further notify you of your rights.
- You have the right to request an accounting of any disclosure we make of your medical information except for disclosures to make to you, to carry out treatment, payment, or healthcare operations, as requested by your written authorization, as permitted, or required under 45 CFR 164.502, for emergency or notification purposes, for national security or Intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law.
- You have the right to receive a paper copy of this notice. To obtain a paper copy of this notice, please contact our office manager.
- You have the right to file a complaint if you believe your privacy rights have been violated. You may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing and addressed to this office at the above address. You will not be penalized for filing a complaint.

This privacy policy is subject to change as circumstances dictate. Any changes will be effective upon the release of a revised privacy policy, which will be made available to patients upon request.

Please sign and date below, acknowledging that you have read this policy and that you consent to the terms of our privacy policy as stated in this notice.

PATIENT'S NAME: _____

PATIENTS SIGNATURE: _____ **DATE:** _____

EXCELSIOR & GRAND CHIROPRACTIC
5605 w. 36TH Street STE 100C
SAINT LOUIS PARK, MN 55416
(952)920-9247

FINANCIAL POLICY

It is our office policy that payment for services rendered is ultimately the responsibility of the patient, whether you have third party assistance with your financial obligation. We are happy to extend a payment plan to you so that you can follow through with all the care you may require.

HEALTH INSURANCE CARE [Acute Conditions Only]

As a courtesy to our patients, this office will bill third party payers, accept assignments, and wait to be paid for some portion of our patients' financial responsibility. The privilege of insurance assignment begins when our office receives and verifies your insurance information. Until that time, you are considered a "cash" patient and payment is expected at the time of service. As a courtesy to you, our office will pre-qualify your insurance coverage, to help you determine what coverage is available to you under your policy. We will make the best estimate of your coverage for the recommended services.

_____ **Patient Initial**

This service is a courtesy to you and is not a guarantee of coverage:

DEDUCTIBLE: _____ AMOUNT REMAINING: _____ Allowed Amount:: _____

OUT-OF-POCKET: _____ AMOUNT REMAINING: _____ COINSURANCE:_____

LIMITS VISITS: _____ ADDITIONAL NOTES: _____

No one can predict what an insurance company will pay for the usual and customary charges for services rendered. If your insurance has not paid on an assigned bill within 30 days, you will be notified. Since we do not own your policy, we ask that you stay in communication with our office and act with your insurance company at that time. If it remains unpaid within 90 days, the balance becomes due and payable immediately and your assignment is revoked.

All patients whose treatment visitation schedule is once per month or longer will no longer be eligible for insurance assignment as this level of care is rarely covered by insurance. I understand that after any initial promotional services all care is rendered at usual and customary fees.

_____ **Patient Initial**

CASH / OUT OF POCKET CARE [No Insurance/Maintenance Care/Chronic Conditions]

I understand I am responsible for all bills incurred in this office. This office offers prompt payment discounts of 15% when payment is made at the time of service. I understand that after any initial promotional services all care is rendered at usual and customary fees. We may bill you for any outstanding balance beyond this or credit your account if an overpayment occurs. ☺ For your convenience, all financial arrangements are made before care begins. If care ends prematurely, you are only responsible for the visits you have had. All payments must be paid by your last visit. This office does not turn away any patient due to their ability to pay. If you feel you might qualify for our financial hardship policy, notify the office immediately so we can begin your qualification process. You are welcome to use your Health Savings Account (HSA) or Flex Spend cards to pay for your treatment if that is an option for you.

All returned checks and/or credit card transactions will be charged a fee of $30 to offset the charges we will incur

_____ **Patient Initial**

5605 w. 36TH Street STE 100C
SAINT LOUIS PARK, MN 55416
(952)920-9247

ACUPUNCTURE & MASSAGE CARE

Our Massage Therapist is not in-network with any health insurance companies, and we do not bill insurance for services provided. Our Acupuncturist is in-network with BCBS. If your insurance company (that's not listed) covers acupuncture and massage services, we are happy to provide you with a superbill for you to submit to your insurance company for possible out-of-network reimbursement. I understand I am responsible for payment for all costs of treatment, and that payment is due at the time of service. You are welcome to use your Health Savings Account (HSA) or Flex Spend cards to pay for your treatment if that is an option for you. I also understand that if I no-show or do not give 36-hours' notice that I am canceling or rescheduling my appointment, I will be charged E&G Chiropractic's cancellation fee (per cancellation & rescheduling policy).

_____ **Patient Initial**

CANCELLATION & RESCHEDULING POLICY *updated 11/1/2023*

We value your time and your appointment, if you need to cancel or reschedule a new patient, re-examination, review of findings, or any acupuncture or massage appointment, please do so at least 36 hours before your scheduled appointment time. *All appointments needing to be canceled or rescheduled with less than 36 hours notice will be charged a $50 cancellation fee to the card on file. If you are 15-mins, or more, tardy to your scheduled appointment, you will be asked to reschedule and be responsible for the cancellation fee.*

I have read and understand this financial policy. I understand that I must pay for any out-of-pocket expenses at the time of service. I understand the cancellation policy, and that tardiness to my scheduled appointment may result in cancellation & being responsible for the cancellation fee. Furthermore, I understand that I am ultimately responsible for any outstanding balance on my account and that my credit card will be on file. After 30-days of receiving a statement via email, any outstanding balance will be charged to my credit card on file.

PATIENT'S NAME: _____

PATIENTS SIGNATURE: _____ **DATE:** _____