GENERAL INFORMATION

Please full out the forms *completely* and *accurately* to the best of your ability so we can quickly get you on the road to health.

Today's Date: _____ Social Security Number (SSN): _____-_____-_____

Name: _____
Last First Middle Initial

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

Email (to enable the doctors to communicate with you): _____

Cell Phone Number: _____ Home Phone Number: _____

Preferred method of communication (select one): Email _____ Text _____ (Carrier's Name: _____)

Gender: Male _____ Female _____ Age: _____ Birthdate: _____

Are you: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____ Partnered for ___ years Minor _____

Preferred Language: _____ Ethnicity (select one): Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

Race (select one): American Indian or Alaskan Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / Decline to Answer

Your Employer or School: _____

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

Phone: _____ Occupation: _____

Spouse's Name: _____ SSN: _____-_____-_____ Phone: _____

Spouse's Birthdate: _____ Employer: _____

EMERGENCY CONTACT

Name of Emergency Contact: _____

Relationship: _____ Phone: _____

ACCIDENT INFORMATION

Is your condition due to an accident? Yes _____ No _____ Date of Accident: _____

Type of Accident: Auto _____ Work _____ Home _____ Other (please describe) _____

INSURANCE INFORMATION

Please complete this section regardless of your referral source (including non-referral external workshops). We are happy to verify your insurance coverage and provide your benefits information to you. We will NEVER bill your insurance without your permission.

Who is responsible for this account? _____ Relationship to patient: _____

Name of Insurance Company: _____ ID#: _____

Subscriber Name: _____ Birthdate: _____

ASSIGNMENT AND RELEASE:

I certify that I, and / or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Hruby, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of above signature — Relationship to Patient

X-RAY CONSENT

I hereby give my consent to Hruby Chiropractic Wellness and its representatives to take X-rays as deemed appropriate by the examining Doctor of Chiropractic. I also declare that to the best of my knowledge, I am not pregnant. I have read and understood all the above information.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of above signature — Relationship to Patient

FINANCIAL RESPONSIBILITY

Patient Name: _____

Dear Patient,

Hruby Chiropractic Wellness provides its services directly to you, not to your insurance company. You are ultimately liable for your bill. If you are billing your own claims, we will provide you with an itemized bill. However, as a courtesy to you, we will bill your insurance company for services rendered provided that your deductible has been met and you pay your co-payment at the time of service. In the event that we are billing your insurance company and a check is mailed to you, you MUST bring the check into the office within 7 days so that we may properly credit your account.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

YOUR VISIT

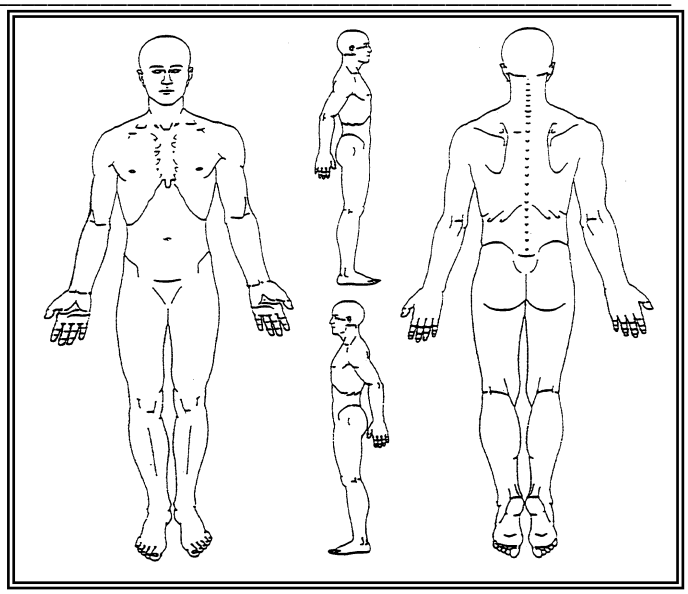
We appreciate you choosing our office. Is there anyone we can thank for referring you? _____

Please indicate the main reason you are seeing us today: _____

_____

If you are seeing us for a pain-related issue, USE THE SYMBOLS on the image to the right to show the type of pain you feel in each location.

X X X X X X X X	DULL / ACHY
/ / / / / / / / / /	SHARP / STABBING
o o o o o o o o	NUMBNESS / TINGLING
s s s s s s s s s s	STIFF/TIGHT
- - - - - - - - - - - -	BURNING



Using the pain scale to the right, CIRCLE the pain level you experience when your problem is at its very worst.

0 = **No Pain**. No Discomfort
1 = **Minimal Discomfort**. Minor stiffness or tightness.
2 = **Discomfort**. Stiff, tight, sore. Muscle fatigue.
3 = **Minimal Pain**. More than just sore. Uncomfortable.
4 = **Mild Pain**. Noticeable pain but tolerable.
5 = **Moderate Pain**. Aggravating. Still allows movement.
6 = **Strong Pain**. Quite aggravating. Movement slightly limited.
7 = **Very Strong Pain**. Very aggravating. Movement definitely limited.
8 = **Very, Very Strong Pain**. Extremely aggravating. Movement very limited.
9 = **Severe Pain**. Brings tears. Almost impossible to move.
10 = **Excruciating Pain**. Agony. Unbearable. Cannot move. ER.

Is there any radiating pain into the arms or legs? Yes _____ No _____ Is there any numbness or tingling? Yes _____ No _____

How often do you experience your problem? (Please indicate for each of the body locations, if applicable)

Constant (75-100% of the time): _____ Frequent (50-75% of the time): _____
Occasional (25-50% of the time): _____ Intermittent (0-25% of the time): _____

List any MDs or Chiropractors you've already seen for this problem: _____

_____

What tests have you already had for this problem? X-rays _____ MRI _____ Myelogram _____ EMG / NCV _____ None _____
Other (please describe) _____

What makes your problem worse? Sitting _____ Standing _____ Changing Position _____ Walking _____ Bending _____
Lifting _____ Twisting _____ Reaching _____ Driving _____ Sleeping _____ Sneeze / Cough _____ Computer Work _____
Telephone _____ Going from Sit to Stand _____ Other (please describe) _____

MEDICAL HISTORY

Please list any significant conditions you've been diagnosed with or have been treated for over the course of your life: _____

_____

_____

Please list any surgeries you have had over the course of your life: _____

_____

Are you allergic to any medications? Yes _____ No _____ If yes, please list: _____

List any medications, herbs or supplements you are taking and the reason for their use: _____

_____

_____

_____

FAMILY HISTORY

Mother: Living _____ Deceased _____ List any medical problems: _____

Father: Living _____ Deceased _____ List any medical problems: _____

List any problems common to your family: Cancer _____ Diabetes _____ Heart disease _____ High blood pressure _____

Stroke Arthritis Scoliosis Thyroid disease Osteoporsosis Other (describe)

SOCIAL HISTORY

Are you: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____ Partnered for _____ years

Do you have any children? Yes _____ No _____ If yes, how many? _____

Do you drink alcohol? Yes _____ No _____ If yes, how much and how often? _____

Do you smoke? Yes _____ No _____ If yes, how much, how often and how long? _____

Are you currently employed? Yes _____ No _____

Who is your current employer? _____ How long have you been at this job? _____

What do you do most of the day in your job postures, positions and repetitive movements? _____

_____

On a scale of 0-10 (0 = Worst and 10 = Best) rate how well you think you are doing with the following:

Exercise _____ Sleep_____ Diet _____ Stress Level _____ Water Intake _____ Energy Level _____

REVIEW OF SYSTEMS

Please use the scale below (0 to 4) to rate each of the symptoms on this page according to your health status over the past 30 days:

0 = Never have this symptom
1 = Occasionally have this symptom, effect not severe
2 = Occasionally have this symptom, effect is severe
3 = Frequently have this symptom, effect not severe
4 = Frequently have this symptom, effect is severe

Head: _____ *Headaches* _____ *Faintness* _____ *Dizziness* _____ *Insomnia*	***Energy / Activity:*** _____ *Fatigue / Sluggishness* _____ *Apathy / Lethargy* _____ *Hyperactivity* _____ *Restlessness*	***Lungs:*** _____ *Chest Congestion* _____ *Asthma, Bronchitis* _____ *Shortness of Breath* _____ *Difficulty Breathing*
Eyes: _____ *Watery or Itchy Eyes* _____ *Swollen, Red or Sticky Eyelids* _____ *Bags or Dark Circles Under Eyes* _____ *Blurred or Tunnel Vision (not including near or far sightedness)*	***Weight:*** _____ *Binge Eating / Drinking* _____ *Craving Certain Foods* _____ *Excessive Weight* _____ *Compulsive Eating* _____ *Water Retention* _____ *Underweight*	***Heart:*** _____ *Irregular or Skipped Heartbeat* _____ *Rapid or Pounding Heartbeat* _____ *Chest Pain*
Ears: _____ *Itchy Ears* _____ *Earaches, Ear Infections* _____ *Drainage from Ear* _____ *Ringing in Ears, Hearing Loss*	***Emotions:*** _____ *Mood Swings* _____ *Anxiety / Fear / Nervousness* _____ *Anger / Irritability / Aggressiveness* _____ *Depression*	***Digestive Tract:*** _____ *Nausea, Vomiting* _____ *Diarrhea* _____ *Constipation* _____ *Bloated Feeling* _____ *Belching, Passing Gas* _____ *Heartburn* _____ *Intestinal / Stomach Pain*
Nose: _____ *Stuffy Nose* _____ *Sinus Problems* _____ *Hay Fever* _____ *Sneezing Attacks* _____ *Excessive Mucus Formation*	***Mind:*** _____ *Poor Memory* _____ *Confusion, Poor Comprehension* _____ *Poor Concentration* _____ *Poor Physical Condition* _____ *Difficulty Making Decisions* _____ *Stuttering or Stammering* _____ *Slurred Speech*	***Mouth and Throat:*** _____ *Chronic Coughing* _____ *Frequent Need to Clear Throat* _____ *Sore Throat, Hoarseness* _____ *Swollen or Discolored Tongue* _____ *Canker Sores*
Skin: _____ *Acne* _____ *Hives, Rashes, Dry Skin* _____ *Hair Loss* _____ *Flushing, Hot Flashes* _____ *Excessive Sweating*	***Joints / Muscles:*** _____ *Pain or Aches in Joints* _____ *Arthritis* _____ *Stiffness or Limited Movement* _____ *Pain or Aches in Muscles* _____ *Weakness or Fatigued Muscles*	***Other:*** _____ *Frequent Illness* _____ *Frequent or Urgent Urination* _____ *Genital Itch or Discharge*

Total:

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care relationship, 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 PHI, 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 Hruby Chiropractic 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 Hruby Chiropractic and its' employees to submit requested PHI to the health insurance company (ies) 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 company (ies) 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 not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during 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 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 officer about any possible violations of these policies and procedures.

8. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, Hruby Chiropractic 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**

INFORMED CONSENT OF CHIROPRACTIC CARE

Dr. Hruby will use his hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or "Spinal Adjustment". As the joints in your spine are moved, you may experience a "pop" as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Homer's Syndrome (also known as oculosympathethetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

He is aware of these complications, and in order to minimize their occurrence he will take precautions. These precautions include, but are not limited to taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell him when he takes your clinical history.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of above signature Relationship to Patient

FEES AND PAYMENTS

_____ **INSURED PATIENTS**

Your insurance is an agreement between you and your insurance company, not between your insurance company and this clinic. It is policy of this office that all services rendered are charged directly to you, the patient, and that ultimately, it is the patient who is responsible for all the charges including those not reimbursed by a third party payer. All deductibles and co-payments are due at the time of service or at the end of that week. Patient's balances may not exceed $200.00 at any time. Since we do not own your insurance policy, we may at some point ask for assistance in dealing with your insurance carrier.

_____ **CASH PATIENTS**

It is the policy of this clinic that cash patients pay their balance at each visit or at the end of that week. It is $50.00 for an adjustment and is up to the patient if they would like therapy or not. All therapies will be a $20.00 extra charge. Prepay cash plans are available.

_____ **MEDICARE PATIENTS**

We do accept assignment from Medicare; therefore, we will receive the check from Medicare. We will then bill your secondary insurance if you have one. Wisconsin has a special mandate that requires supplemental insurance to pay for chiropractic services even if Medicare doesn't. (Two exceptions are if your place of employment is self-insured or if the policy is very old then the mandate may not apply). As of October 1, 2004 Medicare will no longer be covering maintenance care. However, once Medicare denies the claims we will submit these charges to your supplemental insurance.

_____ **PERSONAL INJURY (auto, etc.)**

We will be billing your personal automobile insurance medical pay first. We will be as helpful as we can in filing your claims ASAP, but to do so it is very important to receive your information right away. Some claims may take as long as 3-4 years to settle so we will be willing to make payment arrangements with you while we wait for the insurance company to pay.

_____ **WORKERS COMPENSATION**

We will be as helpful as we can in filing your work comp claim, however, if your employer does not accept liability, the charges will be your responsibility. We can then bill your regular insurance company but your help will be needed in keeping your balance low.

Please note that should your account go unpaid and into collections, you will be responsible for all costs incurred including, but not limited to, collection agency fees, attorney fees, and court fees. Please initial here to acknowledge your understanding._____

Lastly, it is the goal of this office to provide you with the best quality care. Please, if you ever have any questions, don't hesitate to ask. Thank you for choosing our office.

I, the undersigned, have read and agree with the above policy.

Signed:_____ **Date:**_____

Cancellation/Late Policy

As a Chiropractic Patient, your health and wellness depends on maintaining your treatment plan. As healthcare professionals, it is difficult to help you progress if you do not follow the recommendations given. Below are a few guidelines that will aid in providing a positive treatment experience for you here at Hruby Chiropractic Wellness.

- PLEASE arrive 5 minutes early for all appointments. Failure to arrive early or on time **may result** in you having to wait until the next available appointment time to be seen.
- New Patients **must** fill out an evaluation form prior to the session. It is important for the therapist and/or Doctor to know about your health history, lifestyle and concerns in order to provide the best care. **PLEASE ARRIVE 30 MINUTES EARLY IF YOU ARE A NEW PATIENT**.
- **A $50 fee will be applied to your account, if you do not give <u>at least</u> 24 HOURS notice when canceling an appointment.** The same applies if you are a no call, no show or do not reschedule within 24 hours of the original appointment. Leaving a voicemail to cancel is fine, the voicemail records the time of all messages.
- **Payment is required prior to your next visit.**

I verify that I have read and understand the above statements and guidelines. ***I understand that Hruby Chiropractic Wellness has a cancellation policy and that a charge of $50 will be applied to my account and payable prior to my next appointment***, if I do not show, cancel and /or do not reschedule within 24 hours of my original appointment.

Signature: _____ Date: _____

WELLNESS/STRESS QUESTIONNAIRE

Name: _____ Date:_____

Cell Number: _____ Email _____

Address:_____

- What is your biggest healthcare challenge/stressor right now?
  _____

- If you had a magic wand and could get rid any of the healthcare challenge or symptomatic problems below that you currently have, what would it be?

  ↑ Low Back Pain ↑ Shoulder Pain ↑ Tension Across Top of Shoulders ↑ Hip Pain
  ↑ Ankle/Foot Pain↑ Pain between Shoulder Blades ↑ Neck Pain ↑ Wrist/Hand Pain
  ↑ Heart Problems/High Blood Pressure↑ Dizziness ↑ Fatigue ↑ Digestive Problems
  Other_____

- How would you describe your current Wellness Habits on a scale of 1-10, with 1 being poor & 10 being excellent, on the following wellness essentials the help the body recover from stress?

  - Exercise (Cardio, Flexibility Training and Strength Training) _____
  - Sleep (7-8 hours a day & no problem waking up feeling refreshed) _____
  - Diet (plenty of fruits and vegetables/not a lot of refined carbs or processed food) _____
  - Stress Management (Ability to cope with stress through stress mngt. techniques) _____
  - Water Intake (8 oz of water 8 times a day) _____
  - General Health (your overall energy level is the best indicator of general health) _____

- If you had a magic wand & could instantly improve one of the following, which one would it be?

↑ Lose Weight	Get off Medication
↑ Better Energy	Improve Posture/Spinal Mobility
↑ Start Exercising	↑ Improved Sleep
↑ Improve Outlook	↑ Decrease Stress
↑ Improve Blood Pressure	↑ Better Eating Habits

  ↑ Other:_____

- On a scale of 1-10 (10 being the highest), if we could help you with at least one of these healthcare challenges or healthcare goals, how interested are you in doing that? _____