

DATE _____

PATIENT:

NAME: First _____ M.I. _____ Last _____

Address _____

City _____ State _____ Zip _____

Phone # _____ Cell Phone # _____ Other # _____

Date of Birth _____ Martial Status _____ email: _____

Emergency Contact: Name _____ Phone # _____

Patient's Occupation _____

Employer _____

Employers Address _____

City _____ State _____ Zip _____

Employer's Phone # _____ Extension # _____

INSURED:

NAME: First _____ M.I. _____ Last _____

Address _____

City _____ State _____ Zip _____

Phone # _____ SS # _____ Occupation _____

D.O.B. _____ Martial Status _____ Employer _____

Employer's Address _____

City _____ State _____ Zip _____

Employer's Phone # _____

Copy Insurance Cards (both sides) on back

WORK/COMP HISTORY

Patient _____ Phone (____) _____

Address _____ City _____ State _____ Zip _____

Age _____ Birth date _____ Sex _____ Soc Sec # _____

Employer's Name _____ Phone (____) _____

Employer's Address _____ City _____ State _____ Zip _____

1. Type of Business _____ Your Occupation _____

2. Date injured _____ Hour _____ AM/PM Last Date Worked _____

3. Are you off work? Yes No

4. Accident reported to employer? Yes No Name of person accident reported to _____

5. Injured at _____ City _____ State _____ Zip _____

6. Length of time worked there prior to accident _____

7. Type of work being done at time of injury _____

8. In your own words, please describe accident: _____

9. Previous Worker's Compensation Injury? Yes No If so when? _____

Has the previous claim been settled? _____

Worker's Compensation Carrier (Office Use Only)

Carrier Name: _____

Carrier Address: _____

City: _____ State: _____ Zip: _____

Claim Number: _____ Assigned to: _____

Carrier Phone Number: (____) _____ Ext: _____

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you a copy of our privacy notice, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

Along with this consent form, you will be given a copy of our privacy notice that describes our privacy policies in detail. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this consent form and a copy of your privacy notice (Notice of Privacy Practices for Protected Health Information).

Printed Name

Authorized Provider Representative

Signature

Date

Date

APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (§164.524).

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

Patient name printed

Date

Patient Signature

Authorized provider representative

Personal representative Printed

Personal representative signature

Description of personal representative's authority to act for the patient.

WISCONSIN CHIROPRACTIC ASSOCIATION AUTHORIZATION

Your chiropractor and members of the practice staff may need to disclose your name, address, phone number, billing information and your clinical records to the Wisconsin Chiropractic Association (WCA). This disclosure will be made if we need the WCA's assistance to receive reimbursement for your services or, we need the WCA's assistance because the party responsible for reimbursing your services has improperly processed your claim.

By signing this form you are giving us authorization to send the WCA this information. You are also giving the WCA authorization to re-disclose your information to the party responsible for the payment of your services, the WCA's legal counsel, and state or federal agencies that may be asked to intercede on your behalf.

You may restrict the individuals or organizations to whom your health care information is released or revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we received your request to revoke your authorization.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by the person who receives the information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we may send to the WCA at any time. (§164.524).

This notice is effective as of _____. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

Patient name printed

Date

Patient Signature

Authorized Provider Representative

Personal representative printed

Personal representative signature

Description of personal representative's authority to act for the patient.

MARKETING AUTHORIZATION FOR CLINTON CHIROPRACTIC CLINIC

From time to time our practice would like to make you aware of products or services that you may have an interest in purchasing. This marketing could be done by our internal staff or by an outside marketing organization. Your chiropractor and members of the practice staff may need to use your health information including your name, address, phone number, and your clinical records for the purpose of marketing products and services from: Phyto Pharmica, Tyler, Omega Life, Dee Cee Labs, TV stations, Radio stations, Nordic Naturals, Nutrition Dynamics, Pure Encapsulations, Water OZ, Barleans Oils, Titan Labs, Scrip, Foot Maxx, Foot Levelers, Barge Supply, Hessco, Bedford Supply, Europa, Neurometrix, Anabolic Laboratories, Douglas Labs, HVS Laboratories, Metagenics, Alacer Corp.

We are specifically requesting authorization to market the following products and/or services to you:

- Recall lists
- Newsletters
- Testimonials
- Pictures of you
- TV commercials
- Books
- Brithday or Anniversary Cards
- E-Mail
- Thank you Board (in office), or Cards, for referrals, or being our patient.
- Information Mailing
- Local Food Pantry
- Special Activities such as school events.
- Appreciation Days Announcements
- Future Marketing

You may restrict the individuals or organizations to which your health care information is released or revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by the organization/s listed above and may no longer be protected by the federal privacy laws.

You have the right to refuse to give us this authorization. If you do not give us permission, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you for marketing purposes at any time. Our practice and staff will receive direct or indirect remuneration from our marketing activities.

This notice is effective as of **JANUARY 20, 2003**. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in any manner described above. I am also acknowledging that I have received a copy of this authorization.

Patient name printed

Date

Patient Signature

Personal Representative Printed

Description of personal representative's

Authorized Provider Representative
authority to act for the patient.

Personal Representative Signature

AUTHORIZATION FOR CLINTON CHIROPRACTIC CLINIC

From time to time in our practice a product may be recalled. This recall could be done by our internal staff or by an outside organization. Your chiropractor and members of the practice staff may need to use your information including your name, address, phone number, for the purpose of obtaining the recall from: Phyto Pharmica, Tyler, Omega Life, Dee Cee Labs, Nordic Naturals, Nutrition Dynamics, Pure Encapsulations, Water OZ, Barleans Oils, Titan Labs, Scrip, Foot Maxx, Foot Levelers, Barge Supply, Hessco, Bedford Supply, Europa, Neurometrix, Anabolic Laboratories, Douglas Labs, HVS Laboratories, Metagenics, Alacer Corp., or other suppliers.

We are also requesting authorization to the following products and/or services to you:

Calls from office/Dr to check your well-being
Testimonials
Birthday or Anniversary Cards
E-Mail
Thank you Board (in office), or Cards, for referrals, or being our patient.
Informational Mailings
Appreciation Days Announcements

You may restrict the individuals or organizations to which your information is released or revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by the organization/s listed above and may no longer be protected by the federal privacy laws.

You have the right to refuse to give us this authorization. If you do not give us permission, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you at any time.

This notice is effective as of **October 11, 2005**. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my information in any manner described above.

_____ Patient name printed

_____ Date

_____ Patient Signature

_____ Personal Representative Printed

_____ Description of personal representative's

_____ Authorized Provider Representative
authority to act for the patient.

_____ Personal Representative Signature

AUTHORIZATION FOR CLINTON CHIROPRACTIC CLINIC

From time to time in our practice a product may be recalled. This recall could be done by our internal staff or by an outside organization. Your chiropractor and members of the practice staff may need to use your information including your name, address, phone number, for the purpose of obtaining the recall from: Phyto Pharmica, Tyler, Omega Life, Dee Cee Labs, Nordic Naturals, Nutrition Dynamics, Pure Encapsulations, Water OZ, Barleans Oils, Titan Labs, Scrip, Foot Maxx, Foot Levelers, Barge Supply, Hessco, Bedford Supply, Europa, Neurometrix, Anabolic Laboratories, Douglas Labs, HVS Laboratories, Metagenics, Alacer Corp., or other suppliers.

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- Calls from office/Dr to check your well-being
- Testimonials
- Birthday or Anniversary Cards
- E-Mail
- Thank you Board (in office), or Cards, for referrals, or being our patient.
- Informational Mailings
- Appreciation Days Announcements

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_____ Patient name printed

_____ Date

_____ Patient Signature

_____ Personal Representative Printed

_____ Description of personal representative's

_____ Authorized Provider Representative
authority to act for the patient.

_____ Personal Representative Signature

Welcome to Clinton Chiropractic Clinic, Dr. Dittmann is a Chiropractic Physician.

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

All procedures performed will be based on medical necessity and within the scope of doctors' license. This will include physical therapy, rehabilitation, nutrition, as well as chiropractic manipulation when necessary. Modern chiropractic provides numerous techniques that Dr. Dittmann will provide based on your personal need. Some may provide a sound called an audible release, which is 100% normal.

The risks of complications due to chiropractic treatment have been described as "rare", in unique situations (about as often as complications are seen from the taking of a single aspirin tablet- with exception to aspirin allergies). The risk of cerebrovascular injury, or stroke, has been estimated at one in one million to one in ten million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

As with any health care procedure complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury, or stroke, could occur upon severe injury to arteries of the neck. The ancillary procedures could produce skin irritation burns or other complications.

I take responsibility to ask any questions and receive answers to my satisfaction.

OTHER TREATMENT OPTIONS THAT COULD BE CONSIDERED MAY INCLUDE THE FOLLOWING:

Over the counter analgesics. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.

Medical care, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.

Hospitalization in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.

Surgery in conjunction with medical care adds the risks of adverse reaction of anesthesia, as well as an extended convalescent period in a significant number of cases.

Any time you do not seek care delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition, and make further rehabilitation more difficult.

I HAVE READ THE ABOVE EXPLANATION OF CHIROPRACTIC TREATMENT. I HAVE FULLY EVALUATED THE RISKS AND BENEFITS OF UNDERGOING TREATMENT. I HAVE FREELY DECIDED TO UNDERGO THE RECOMMENDED TREATMENT, AND HEREBY GIVE MY FULL CONSENT TO TREATMENT.

PRINTED NAME

SIGNATURE

DATE

Name: _____ SS #: _____ Date of Birth: _____

Handed: Right Left Height: _____ inches Weight: _____ pounds

Where did you hear about us? _____

List your WORST current symptom: _____

Date it began: _____

Describe how it happened: _____

Describe type of pain (check all that apply):

_____ Dull _____ Sharp _____ Aching _____ Cutting _____ Throbbing

_____ Burning _____ Numbing _____ Tingling _____ Cramping _____ Spasms

_____ Stinging _____ Shooting _____ Pounding

Pain Frequency:

_____ Up to 1/4 of my awake time _____ 1/4 to 1/2 of my awake time

_____ 1/2 to 3/4 of my awake time _____ Most of my awake time

Does the pain radiate into other parts of the body, if so where? _____

List your SECOND worst current symptom: _____

Date it began: _____

Describe how it happened: _____

Describe type of pain (check all that apply):

_____ Dull _____ Sharp _____ Aching _____ Cutting _____ Throbbing

_____ Burning _____ Numbing _____ Tingling _____ Cramping _____ Spasms

_____ Stinging _____ Shooting _____ Pounding

Pain Frequency:

_____ Up to 1/4 of my awake time _____ 1/4 to 1/2 of my awake time

_____ 1/2 to 3/4 of my awake time _____ Most of my awake time

Additional Symptoms? _____

Social/Occupational:

Are you: Single	Married	Smoker?	<input type="checkbox"/> Y	<input type="checkbox"/> N
Divorced	Widowed	Drinker - occasional?	<input type="checkbox"/> Y	<input type="checkbox"/> N
		Drinker - moderate?	<input type="checkbox"/> Y	<input type="checkbox"/> N
# of children _____		Recreational Drugs?	<input type="checkbox"/> Y	<input type="checkbox"/> N

Hobbies/Exercises _____

Employed by: _____ as a _____

Are your Job Duties Physically demanding for you? [] Yes [] No

Have you had any disability time? [] Yes [] No

If you are currently working, which are you performing?

[] Regular Duties

[] Limited – Light Duties

Medical History 1:

Other doctors seen for this current problem: _____

You have had the following treatments for this problem:

- | | | |
|--|--------------------------------------|--|
| <input type="checkbox"/> Hot packs/ultrasound | <input type="checkbox"/> Massage | <input type="checkbox"/> Electrical stimulation |
| <input type="checkbox"/> TENS Unit | <input type="checkbox"/> Aerobics | <input type="checkbox"/> Body mechanics training |
| <input type="checkbox"/> Strengthening Exercises | <input type="checkbox"/> Traction | <input type="checkbox"/> Bed Rest |
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Osteopathy | <input type="checkbox"/> Biofeedback |
| <input type="checkbox"/> Trigger Point Injection | <input type="checkbox"/> Back Brace | <input type="checkbox"/> Epidural Injections |
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Naturopathy | |

List past surgeries: _____

Motor Vehicle Accidents: _____

List Hospitalizations: _____

Medicine you are currently taking: _____

Number of pregnancies: _____

Following diagnostic tests performed: X-rays CT Scan MRI
 Myelogram Discogram EMG Bone Scan

Do you have any previous back and/or neck problems? Yes No

If yes, please list: _____

Medical History 2

Have you had the following symptoms in the past 5 years?

- | | | |
|---|---|--|
| <input type="checkbox"/> unexplained fevers | <input type="checkbox"/> night sweats | <input type="checkbox"/> weight loss of 10 pounds or more |
| <input type="checkbox"/> loss of appetite | <input type="checkbox"/> excessive fatigue | <input type="checkbox"/> problems with depression |
| <input type="checkbox"/> difficulty sleeping | <input type="checkbox"/> excessive bleeding | <input type="checkbox"/> unusual stress at work |
| <input type="checkbox"/> unusual stress at home | <input type="checkbox"/> easy bruising | <input type="checkbox"/> dark black stools |
| <input type="checkbox"/> blood in stools | <input type="checkbox"/> muscle tenderness | <input type="checkbox"/> pain/burning when urinating |
| <input type="checkbox"/> chest pains or tightness | <input type="checkbox"/> skin rashes | <input type="checkbox"/> difficulty urinating – start/stop |
| <input type="checkbox"/> persistent/unusual cough | <input type="checkbox"/> trouble lying flat | <input type="checkbox"/> lump in neck, armpit or groin |
| <input type="checkbox"/> coughing up blood | <input type="checkbox"/> swollen ankles | <input type="checkbox"/> trouble breathing with exercise |
| <input type="checkbox"/> change in bowel habits | <input type="checkbox"/> stomach pain | <input type="checkbox"/> persistent diarrhea |
| <input type="checkbox"/> excessive constipation | <input type="checkbox"/> blood in urine | <input type="checkbox"/> need to urinate more at night |
| <input type="checkbox"/> morning stiffness | <input type="checkbox"/> dry eyes or mouth | <input type="checkbox"/> persistent eye redness |
| <input type="checkbox"/> joint pain or swelling | | |

Do you feel that you have trouble with:

- anxiety
- depression
- irritability

Females

- Vaginal bleeding other than periods
- Pap smear within the last 2 years
- Painful menstrual periods
- Back pain with menstrual periods
- Other menstrual problems

I do or do not have a home exercise program that I follow on a regular basis?

What do you do to relieve the pain? _____

HEADACHES (if applicable)

Part of the head affected:

Front	_____	Left	_____	Right	_____	Both
Top & Side	_____	Left	_____	Right	_____	Both
Back	_____	Left	_____	Right	_____	Both

How much of your awake time is affected by your headaches?

- | | |
|--------------------------------|-------------------------------|
| _____ Up to ¼ of my awake time | _____ ¼ to ½ of my awake time |
| _____ ½ to ¾ of my awake time | _____ Most of my awake time |

How does it affect your daily living?

- | | |
|--------------------------------------|-----------------------------------|
| _____ Minimal, does not affect it | _____ Slight, some affect |
| _____ Moderate, seriously affects it | _____ Marked, prevents activities |

Activities of Daily Living 1

Rating

Rate your pain on a scale of 1-10 _____
(1 mild, 10 severe)

Describe the overall severity of the pain:

- Mild nuisance
- Mild to moderate, but can live with it
- Moderate, having trouble dealing with it
- Severe, it is ruining my quality of life

Progression

How is your pain now, compare to when it first started?

- Much improved
- A little worse
- Somewhat improved
- Much worse
- No change

Activities of Daily Living 2

- I stay at home most of the time due to the problem. Y N
- I change position frequently to try to get more comfortable. Y N
- I walk more slowly than usual because of the problem. Y N
- I do not do jobs around the house because of the problem Y N
- I have to use handrails to get up stairs. Y N
- I have to lie down frequently and rest due to the problem. Y N
- I have to hold on to something to sit or stand from a chair. Y N
- I have to get other people to do things for me. Y N
- I have difficulty getting dressed due to the problem. Y N
- I can only stand for short periods due to this problem. Y N
- I have difficulty bending or kneeling due to the problem. Y N
- I have difficulty turning over in bed due to the problem. Y N
- I have a loss of appetite due to this problem. Y N
- I can only walk short distances due to the problem. Y N
- I have difficulty sleeping because of this problem. Y N
- I have to get dressed with someone's help. Y N
- I have to sit most of the day due to this problem. Y N
- I am more irritable due to this problem. Y N
- I have difficulty climbing stairs. Y N
- I stay in bed most of the day due to this problem. Y N

What recreational activities did you participate in before this problem that you can no longer perform, or cannot perform as well or as often? _____

How often do you have to stop your activities and sit or lie down to control these symptoms?

- Several times per day
- Occasionally
- Approximately once per day
- Never
- All Day

FINANCIAL RESPONSIBILITY

This office is committed to providing you with the most accurate information we can regarding insurance benefits. Because insurance companies will not guarantee coverage until they receive a billing, we in turn cannot guarantee quoted coverage. It is always good practice for you to consult your insurance company if you have any questions.

A disclosure of fees is available for viewing at any point in time. These fees may change periodically. If you ever have any questions regarding our charges, please ask.

I understand that I am responsible for payment of all deductibles and co-payments related to my care. I understand that if I have a balance for any services not paid, regardless if insurance said they would cover the services and are not paying for them, or if they request any fees returned to them for whatever reason, I will make a minimum payment of \$50.00 each month or 25% of the outstanding balance whichever is greater. I promise to pay any and all collection, court, and attorney fees in the collection of my account. I further understand that if my treatment is associated with a personal injury or accident claim, all medical bills will be paid at 100% of the above fee schedule regardless of the outcome of my case. I understand that if a check or debit is returned for insufficient funds, I will be charged a \$35.00 service charge.

I have read and fully understand the above financial terms. I am also aware I may view the current disclosure of fees at any time.

If my balance is not paid in a timely and monthly fashion, I authorize my treating doctor or assignee to pursue collection via small claims court or higher court of law to assist in collection of any outstanding bill.

Signed _____ Date _____