Our Vision

To **Inspire** and **Empower** individuals, families and communities to make positive lifestyle changes so they can live the full expression of their life.

PATIENT HEALTH RECORD

About the Patient

Name_____

Address _____

City _____

State _____ Zip _____

Home Phone _____

Cell Phone _____

Birth Date _____Marital Status _____

Age _____Gender _____Number of Children __

Email Address _____

Employer_____

Work Phone _____

Type of Work _____

Social Security # _____

Driver's License#_____

Primary Insured

Name_____

Employer_____

Work Phone _____

Birth date _____

Who may we thank for referring you to our office?

_____

☐Telephone Book ☐Facebook

☐Massage Therapist ☐Office Staff

☐Community Event

Insurance Carrier _____

Doctor (which one) _____

Website (which one) _____

Other _____

For future appointments I would like to receive appointment reminders through:

Text * ☐

Cell Number_____

Cell Provider_____

*Message & Data Rates May Apply

Signature_____

Phone ☐

Preferred Number_____

I certify that the information provided is correct to the best of my knowledge

Signature:_____

Date: _____

Opp Family Chiropractic P.A.
23671 St. Francis Blvd. Suite 102 NW. St. Francis MN 55070
Office (763) 213-0615 · Fax (763) 213-0616

Name_____ Date_____

Automobile Accident Questionnaire

Nature of Accident

1. What was the time and date of this present injury? _____
2. Please explain in detail how your accident happened_____

   _____

   _____
3. Were you _____ Driver_____ Passenger _____Front seat _____ Back Seat_____
4. What direction were you headed? _____North _____South _____East _____West_____
5. What direction was the other vehicle headed? _____North _____South _____East _____West_____
6. Were you struck from _____ Behind _____ Front _____ Left Side_____ Right Side_____
7. How many cars were involved in the accident?_____
8. Were you wearing a seat belt? _____ Other protective devices? _____
9. Did you come in contact with any objects in the car?_____ If yes, what objects? (i.e. windshield, steering wheel, door frame)?_____
10. What parts of your body came in contact with the above object(s) _____

    _____
11. Were you unconscious as a result of the injury?

    _____If yes, how long?_____
12. Were you bleeding a result of the accident?

    _____
13. Where did you feel pain or unusual feeling immediately after the accident? (Please show the areas on the diagram also)

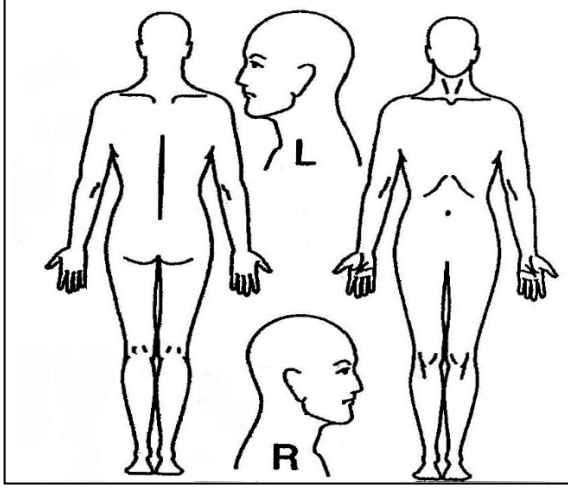
    _____
14. Were the police notified?_____
15. Was a report taken?_____
16. Where were you taken after the accident?

    _____
17. What treatment did you receive?_____

    _____

Show area(s) of pain or unusual feeling immediately after accident. Mark the areas on this body where you felt the describing sensations. Use appropriate symbols in all affected areas

Numbness	Pins & Needles	Burning	Aching	Stabbing
xxxxxx	•••••••	ooooo	vvvvv	IIIIIIII
xxxxxx	•••••••	ooooo	vvvvv	IIIIIIII
xxxxxx	•••••••	ooooo	vvvvv	IIIIIIII



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18. Was any other doctor consulted after your accident?_____ If yes, what is the doctor's Name?_____
    _____ DC _____MD _____DO _____DDS
19. Describe the doctor's diagnosis_____
20. What treatment did you receive?_____ _____
21. Are you still under a doctor's care?_____ If yes, please explain_____

Past History

1. Have you ever injured this area before? _____ If yes, when?_____
2. Have you been involved in any previous accidents of any kind? (Personal injury, automobile accident, or workers' compensation) _____ If yes, please explain dates and details _____
   _____
3. Have you enjoyed good health prior to this accident? _____ If no, please explain (i.e., illness, or injuries)_____

Present Information / Disability

1. Have you returned to work? _____ If yes, date returned_____
2. Job description_____
3. Are your work activities restricted as a result of this accident? _____ If yes, please explain_____
   _____
4. Do you notice any activity restrictions as a result of this accident? _____ If yes, Please explain_____
   _____
5. Since this injury are your symptoms: Improving _____ , getting worse _____ , or the same _____

Legal Representation

1. Have you retained an attorney? _____ If yes, name and address_____
   _____

I certify that I have read and understand the above information. To the best of my knowledge the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

_____ _____
Patient's Signature Date

_____ _____
Doctor's Signature (upon review) Date

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PATIENT FINANCIAL RESPONSIBILITY
POLICY & ACKNOWLEDGEMENT

Opp Family Chiropractic appreciates your confidence in choosing us to provide for your health care needs. We are committed to providing you with the best possible care for your total body wellness. The treatment you have elected to participate in includes a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our services. Contact your insurance company to determine what is covered and what is not. You are ultimately responsible for payment of any services and care received at Opp Family Chiropractic whether they are covered by your insurance company or not. Be sure to bring your insurance card to each visit. Always notify our office of any changes to your insurance. And last, be prepared to pay any portions your insurance company does not cover.

Co-Pays & Deductibles

If your insurer requires you to pay a co-pay or a deductible, please be aware of the amount of your co-pay or deductible at the time of services. You will be asked to pay all co-pays or deductibles at the time of service. If you do not pay your co-pay or deductible at the time of service, we will bill you and may charge you a reasonable service fee to offset the cost of sending you a statement. All bills are due within seven (7) days of the date it was mailed or e-mailed to you.

Cancellation/No Show Policy

When you make an appointment, we reserve time specifically for you. Unfortunately, when a patient does not show for their scheduled appointment, another patient loses an opportunity to be seen. Therefore, if you need to cancel or re-schedule, you are asked to notify us as soon as possible, but no later than 24 hours in advance. Appointment cancelled without 24 hours notice may be assessed a cancellation fee of $25. Habitually cancelling appointments may cause us to ask you to seek another chiropractor for your healthcare needs.

Failure to Meet Financial Responsibility

If you fail to meet the financial obligations agreed upon in this financial policy and acknowledgement, your outstanding balance will be sent to a collection agency and the complete balance will have to be paid before receiving any further treatment. Your future status with this office will be considered at that time and may lead to being discharged from care at Opp Family Chiropractic. If you have any questions, please contact the billing department.

Patient Acknowledgment

I have read and understand Opp Family Chiropractic's Patient Financial Responsibility Policy. I agree to assign insurance benefits to Opp Family Chiropractic whenever necessary. I authorize Opp Family Chiropractic to release information to a collection agency or attorney in the event I don't fulfill my financial responsibilities. I understand that if I fail to meet my financial obligations to Opp Family Chiropractic then I will be responsible for all costs and reasonable collection and/or attorney fees. I expressly authorize Opp Family Chiropractic to charge any outstanding balance, due to co-pays, deductibles or non-covered services, on my credit card pursuant to the terms I agreed to in this Acknowledgement and the *Patient Payment Authorization* I signed.

I would like Opp Family Chiropractic to (check all that apply):

☐ Mail my billing statements to:

☐ E-mail my billing statements to:

Signature of Patient/Responsible Party Date

Printed Name of Patient

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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 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 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 effect 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. 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.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I agree to allow Opp Family Chiropractic to leave voice messages on my phone containing personal information. ☐ YES ☐ NO

Check all phone numbers that apply:

☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Other:_____

I agree to allow Opp Family Chiropractic to send me emails containing personal information.
☐ YES ☐ NO

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

Patient Name and Signature Date

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