Hull Chiropractic
521 Black Forest Rd, Suite 4
Hull, IA 51239

## Patient Information

**Name**_____ **Birth Date**_____
**Guardian's Name** (If applicable)_____
**Address**_____
**City**_____ **State**_____ **Zip**_____
**Home Phone (___)**_____ **Cell (___)**_____
**Email**_____
**Sex:** □M □F **Age**_____ **SS#**_____
□ Single □ Married □ Widowed □ Separated □ Divorced
**Race:** □White □Am. Indian □Alaska Native □Asian
□Native Hawaiian □Black or African American
□Other Pacific Islander □Decline to State
**Ethnicity:** □Hispanic or Latino □Not Hispanic or Latino
**Occupation**_____ **Employer**_____
**Employer City**_____
**Employer Phone**(___)_____
**Whom may we thank for referring you?** _____

## Emergency Contact

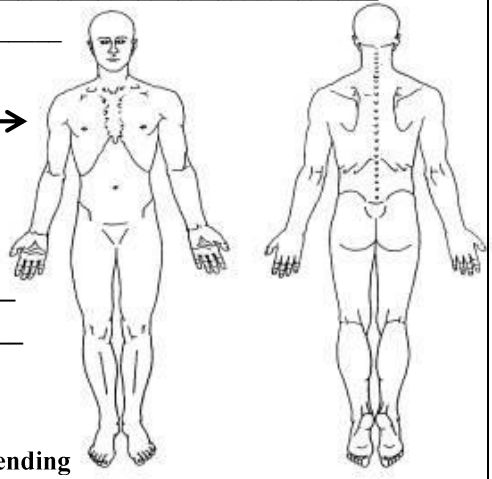
**Name**_____ **Relationship**_____
**Home (___)**_____ **Cell(___)**_____
**Employer**_____ **Work Phone (___)**_____

## Accident Information

**Is this condition due to an accident?**
□ **Yes** □**No** **Date**_____
**If so, please get the appropriate paperwork from the front desk.**
**Type of accident:**
□ **Auto** □**Work** □**Home** □ **Other**
**To whom have you made a report of your accident?**
□ **Auto Insurance** □ **Employer** □ **Worker Comp.** □ **Other**
**Attorney Name**_____ □ **N/A**

## Condition Information

**In your own words, where is the problem?** _____
**When did your symptoms appear?** _____
**Is this condition getting:** □ **Better** □ **Worse** □ **Stays the same** □ **Unknown**
**Mark an X on the picture where you have pain, numbness, or tingling** →



**Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)**_____
**Type of pain:** □ **Aching** □ **Burning** □ **Dull** □ **Pulling** □ **Sharp** □ **Shooting** □ **Stabbing**
□ **Stinging** □ **Throbbing** □ **Cramping** □ **Stiffness** □ **Swelling**
**How often do you have pain? (Daily, Weekly, Monthly, ect.)** _____
**Is it constant or does it come and go throughout the day?** _____
**Does it interfere with your:** □ **Work** □ **Sleep** □ **Daily Routine**
□ **Getting comfortable at night** □ **Recreation**
**Activities or movements that are difficult to perform:** □ **Sitting** □ **Standing** □ **Walking** □ **Bending**
□ **Lying Down** □ **Coughing** □ **Sneezing** □ **Bowel movements**
**What makes your pain feel better?** □ **Ice** □ **Heat** □ **Medication** □ **Stretches** □ **Other** _____

## Treatment History

**What treatment(s) have you received for this condition?** □**Medical/Medications** □**Surgery** □**Physical Therapy** □**Chiropractic**
□ **Acupuncture** □**None** □**Other**_____
**Name of the provider who gave previous services?** _____

## Other Symptoms

| | | | | | |
|---|---|---|---|---|---|
| □Neck Pain | □Neck Stiffness | □Tension | □Dizziness | □Abnormal Weight Gain | □Nausea |
| □Back Pain | □Back Stiffness | □Numbness | □Shortness of Breath | □Abnormal Weight Loss | □Vision Changes |
| □Shoulder Pain | □Headaches | □Weakness | □Change in Smell | □Abnormal Heart Rate/Rhythm | □Irritability |
| □Arm Pain | □Jaw Problems | □Sleep Difficulty | □Abnormal Bruising | □Change in Taste/Vision/Hearing | □Night Sweats |
| □Leg Pain | □Grip Problems | □Fatigue | □Memory Loss | □Blood in Stool/ Urine/ Sputum | □Chest Pressure |

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## Health History

**Please mark on "Current" or "Past" to indicate if you have or have had any of the following:**

| | Current | Past | | Current | Past | | Current | Past |
|---|---|---|---|---|---|---|---|---|
| **Acid Reflux** | ☐ | ☐ | **Epilepsy** | ☐ | ☐ | **Parkinson's** | ☐ | ☐ |
| **AIDS/HIV** | ☐ | ☐ | **Glaucoma** | ☐ | ☐ | **Pinched Nerve** | ☐ | ☐ |
| **Alcoholism** | ☐ | ☐ | **Goiter** | ☐ | ☐ | **Prostate Problem** | ☐ | ☐ |
| **Allergy Shots** | ☐ | ☐ | **Gout** | ☐ | ☐ | **Prosthesis** | ☐ | ☐ |
| **Anemia** | ☐ | ☐ | **Heart Disease** | ☐ | ☐ | **Rheumatoid Arthritis** | ☐ | ☐ |
| **Anorexia** | ☐ | ☐ | **Hepatitis** | ☐ | ☐ | **Psychiatric Care** | ☐ | ☐ |
| **Appendicitis** | ☐ | ☐ | **Hernia** | ☐ | ☐ | **Stroke** | ☐ | ☐ |
| **Arthritis** | ☐ | ☐ | **Herniated Disc** | ☐ | ☐ | **Suicide Attempt** | ☐ | ☐ |
| **Asthma** | ☐ | ☐ | **Herpes** | ☐ | ☐ | **Thyroid Problems** | ☐ | ☐ |
| **Bleeding Disorders** | ☐ | ☐ | **Kidney Disease** | ☐ | ☐ | **Tonsillitis** | ☐ | ☐ |
| **Breast Lump** | ☐ | ☐ | **High Blood Pressure** | ☐ | ☐ | **Tuberculosis** | ☐ | ☐ |
| **Bronchitis** | ☐ | ☐ | **High Cholesterol** | ☐ | ☐ | **Tumors/Growths** | ☐ | ☐ |
| **Bulimia** | ☐ | ☐ | **Migraine Headaches** | ☐ | ☐ | **Ulcers** | ☐ | ☐ |
| **Cancer** | ☐ | ☐ | **Miscarriage** | ☐ | ☐ | **Venereal Disease** | ☐ | ☐ |
| **Chicken Pox** | ☐ | ☐ | **Mononucleosis** | ☐ | ☐ | | | |
| **Diabetes** | ☐ | ☐ | **Multiple Sclerosis** | ☐ | ☐ | **Other**_____ | | |
| **Drug Abuse** | ☐ | ☐ | **Osteoporosis** | ☐ | ☐ | | | |
| **Emphysema** | ☐ | ☐ | **Pacemaker** | ☐ | ☐ | _____ | | |

## Please list any of the following you have had:

**Falls**_____ **Date**_____
**Head Injuries**_____ **Date**_____
**Broken Bones**_____ **Date**_____
**Dislocations**_____ **Date**_____
**Surgeries**_____ **Date**_____

## Family History

**Please list any member of your family (parents, grandparents, brothers or sisters) who have had the following:**

**Heart Disease**_____ **Rheumatoid Arthritis** _____ **Stroke**_____
**High Blood Pressure**_____ **Diabetes**_____ **Cancer**_____

## Exercise

| Frequency | Type |
|---|---|
| ☐None | ☐Cardiovascular |
| ☐Occasional | ☐Light |
| ☐Frequent | ☐Heavy |
| ☐Daily | |

## Social Habits

☐Smoking **Packs/Day**_____
☐Alcohol **Drinks/Week**_____
☐Caffeine Drinks **Cups/Day**_____
**Stress Level (1-10)** ____ **Why?** _____

## Work Activity

☐Sitting
☐Standing
☐Light Labor
☐Heavy Labor

## Allergies

_____
_____
_____
_____

## Medications

_____
_____
_____
_____

## Supplements

_____
_____
_____
_____

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# Chiropractic Informed Consent for Diagnosis and Treatment

I hereby give my consent to the performance of diagnostic tests and procedures and chiropractic treatment or management of my condition(s).

Chiropractic treatment or management of conditions almost always includes the chiropractic adjustment, a specific type of joint manipulation. Like most health care procedures, the chiropractic adjustment carries with it some risks. Unlike many such procedures, the serious risks associated with the chiropractic adjustment are extremely rare.

**Following are the known risks:**

Temporary soreness or increased symptoms or pain: It is not uncommon for patients to experience temporary soreness or increased symptoms or pain after the first few treatments.

Dizziness, nausea, flushing: These symptoms are relatively rare. It is important to notify the chiropractor if you experience these symptoms during or after your care.

Fractures: When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening disease or condition. If your chiropractor detects any such condition while you are under care, you will be informed and your treatment plan will be modified to minimize risk of fracture.

Disc herniation or prolapse: Spinal disc conditions like bulges or herniations may worsen even with chiropractic care. It is important to notify your chiropractor if symptoms change or worsen.

Stroke: A certain extremely rare type of stroke has been associated with chiropractic care. Although there is an association between this type of stroke and chiropractic visits, there is also an association between this type of stroke and primary care medical visits. According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care. The increased occurrence of this type of stroke associated with both chiropractic and medical visits is likely explained by patients with neck pain and headache consulting both doctors of chiropractic and primary care medical doctors before or during their stroke.

Other risks associated with chiropractic treatment include: rare burns from physiotherapy devices that produce heat and bruising from soft tissue manipulation.

I understand that the practice of chiropractic, like the practice of all healing arts, is not an exact science, and I acknowledge that no guarantee can be given as to the results or outcome of my care.

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**● PATIENT PLEASE REVIEW ● PRINT & SIGN NAME ●**

***I have read or had read to me this informed consent document. I have discussed or been given the opportunity to discuss any questions or concerns with my chiropractor and have had these answered to my satisfaction prior to my signing this informed consent document. I have made my decision voluntarily and freely.***

PATIENT'S NAME (Print) _____

_____ _____ _____ _____
(PATIENT / GUARDIAN SIGNATURE) (DATE) (TRANSLATOR / INTERPRETER SIGNATURE) (DATE)

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**CLINICIAN ONLY**

Based on my personal observation and the patient's history, I conclude that throughout the informed consent process the patient was:

| | | |
|---|---|---|
| ☐**Of Legal Age** | ☐**Appears Unimpaired** | ☐**Fluent in English** |
| ☐**Consent Given Through Guardian** | ☐**Oriented x3** | ☐**Assisted with a Translator** |

_____, D.C. _____
(DC SIGNATURE) (DATE)

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# HIPAA Notice of Privacy Practices

Hull Chiropractic is committed to patient privacy and the confidentiality of personal health information entrusted to us.

The ways in which we may use or disclose your health information are detailed in the Notice of Privacy Practices.

**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, we will provide you with a Limitation of Use and Disclosure of Protected Health Information Request form.

**Your Right to Request that Your Patient Record be Amended:** You have the right to request that we amend the information in your patient record. If you would like to amend any information in your record we will provide you with a Request to Amend Protected Health Information form.

**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.

YOU HAVE A RIGHT TO REFUSE CONSENT FOR DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION. WITHOUT YOUR CONSENT, HOWEVER, THE NWHSU-CLINIC SYSTEM WILL NOT BE ABLE TO SUBMIT CLAIMS TO INSURANCE CARRIERS OR OTHER THIRD PARTY PAYERS AND MAY NOT ACCEPT YOU AS A PATIENT/CLIENT.

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By signing below, I give consent to the Hull Chiropractic clinicians or staff to use or disclose my personal health information as noted in the Notice of Privacy Practices.

_____
Printed Name

_____
Signature

_____
Date

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# FINANCIAL POLICY

Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. We ask that you read and understand our policy as it applies to your particular situation.

**Billing**
Any outstanding balances are billed on the 1st of the month and considered past due 15 days after the invoice date or when special arrangements are not met. Bills will be sent for all covered services (after deductible has been met) after hearing from your insurance company.

**Cash Payment**
Patients without insurance coverage may pay for care by cash, check, debit card, or credit card. Payment for service is due at the time the service is rendered. A time of service discount is available on all chiropractic services. This discount does not apply to acupuncture, nutritional supplements, customized orthotics or supplies.

**Group or Individual Insurance**
We gladly accept insurance assignment if the insurance company 1) Verifies that the deductible has been met, 2) provides details of the available coverage, and 3) agrees to make payment directly to our office. Our office will file the necessary claim forms at no charge. Payment will be due by you at the time of service for any non-covered services, deductibles or co-payments.

**Medicare**
The doctor in this office is a Medicare provider. We will submit all claims to Medicare and secondary plans for you. The ***only*** chiropractic service Medicare reimburses for is manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. If you have a supplement plan, they will normally cover the other 20% of the allowable fee once the Medicare deductible has been met. You are responsible for payment in full for non-covered services at the time of service. This would include examinations, acupuncture, therapies, nutritional supplements and supports. If you do not have a supplement plan, you are responsible for the 20% that Medicare does not reimburse as well as any non-covered services listed above at the time of service.

**Personal Injury/Automobile Accidents/Worker's Compensation**
If you have been involved in a motor vehicle accident/injured on the job, it is important that you report the accident to your insurance agent/employer and request a claim number and the appropriate billing information. We will submit your claims at no charge. Although you as the patient are ultimately responsible for the bill, we will take assignment as long as you are under active care. Once the claim is settled, or if you suspend or terminate care, any fees for services are due immediately.

**Special Arrangement**
We have never denied anyone the benefits of chiropractic care because of their inability to pay our published fees. If financial hardship exists, it requires an Individual Consideration Contract. Please speak with the front desk staff for more information.

**PATIENT AGREEMENT**

I have read and understand the payment policy of Hull Chiropractic. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Hull Chiropractic and my insurance company. I request Hull Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by Dr. Patrick Froehlich, that fees will be due and payable immediately. I also understand that all balances more than 30 days past due will be assessed a 1.5% finance charge, unless the balance is the responsibility of my insurance company. Once my insurance company has paid and a balance remains on my account, a 1.5% finance charge will be assessed monthly until the balance is paid in full. I understand that Hull Chiropractic asks that I provide at least a 24 hour notice if I am unable to keep my scheduled appointment. Failure to provide at least a 24 hour notice may result in a penalty fee, at the discretion of Hull Chiropractic. By signing this document, I assign directly to Dr. Patrick Froehlich all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the use of this signature on all insurance submissions.

_____ _____
Patient's signature (or guardian if a minor) Date

_____
Relationship to patient (If not the patient)