Knewtson Health Group

New Patient
Adult

Name _____
Address _____
City _____ State _____ ZIP _____
Phone Numbers (Home) _____ (Cell) _____
Is it O.K. to contact you at work? O Yes O No Work # _____
E-mail Address _____
SS# _____ Birthdate _____ Age _____
Occupation _____ Employer _____
Marital Status O Single O Married O Separated O Divorced O Widowed
Spouses Name _____ Phone Number(s) _____
Children's Names and ages _____
_____
Emergency contact name _____
Relationship _____ Phone Number(s) _____
Favorite hobbies and interests _____

Financial Responsibility

Who is responsible for payment? _____

How will you pay for your care? _____

Insurance Co. _____ Group Policy # _____

Address _____ Phone # _____

Policy Holder's Name _____ Policy Holder's DOB _____

Relation _____ Policy Holder's Employer _____

What Brings you here?

Have you ever had chiropractic care? O Yes O No
If yes, please tell us the doctor's name. _____
Were you pleased with your care? O Yes O No
How did you find out about our office? _____
Is this appointment related to: O Work O Sports O Auto O Personal Injury O Other

_____

When did the accident occur? _____

Attorney (if applicable)_____Phone Number(s) _____

Are you receiving care from other health professionals? O Yes O No

If yes, please name them and their specialty._____

_____

Please list any drugs or medications you are taking. _____

_____

_____

_____

Please list any vitamins/herbs/homeopathics/others you are taking. _____

_____

_____

_____

Are you pregnant? O Yes O No If yes, what month? _____

Current Health

What are your most pressing health concerns?_____

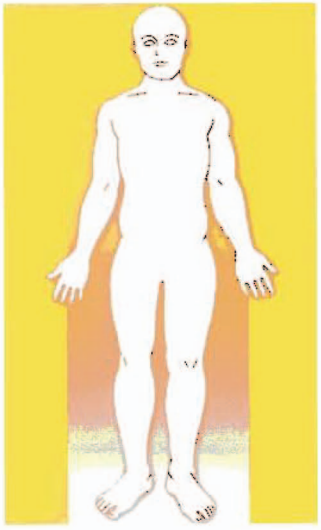
_____

_____

For how long? _____

Is it: O Getting Worse O Improving O Intermittent O Constant O Can't Say

Where is the problem? Please use the illustrations and lines below to explain.



Front _____

_____

_____

_____

_____

_____

Back_____

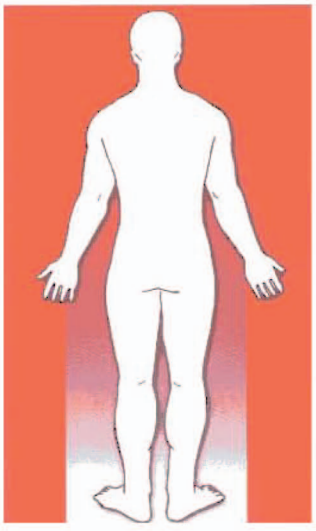
_____

_____

_____

_____

_____



23505 Smithtown Road, Suite 100, Excelsior, MN 55331 952-470-8555

Do you have: O Pain O Numbness O Tingling O Aches

Is your pain: O Sharp O Dull O Throbbing O Constant O Intermittent

Are your symptoms affected by:	O Sitting O Bending	O Standing O Lying Down	O Walking O Weather

Please explain. _____

Do you feel:	O Cramps O Swelling	O Burning O Stiffness	O Other _____

Do your symptoms Interfere with:	O Work O Day-to-Day Activities	O Sleep O Play	O Other _____

Please explain._____

_____

On a scale of 1 – 10 (1 least, 10 most), please rate the severity of your symptoms:

1 2 3 4 5 6 7 8 9 10

Health History

Do you have or have you had, any of the following: *(Please check all that apply)*

O Pneumonia	O Mumps	O Influenza	O Rheumatic Fever	O Stroke
O Pleurisy	O Polio	O Chickenpox	O Thyroid Disease	O Diabetes
O Epilepsy	O Cancer	O Depression	O Whooping Cough	O Anemia
O Rashes	O Measles	O Arthritis	O Heart disease	O Other

If you have been diagnosed with another disease or condition, please describe.

_____

Does any member of your family have/had any of the above conditions? If yes, list here.

_____

Do you use:	O Coffee O Alcohol	O Tea O Cigarettes	O Artificial Sweeteners O Recreational Drugs	O Sugar

Have you ever suffered from: *(Please check all that apply)*

O Neck Pain	O Difficulty Breathing	O Excessive Urination
O Low Back Pain	O Stuffy Nose	O Discolored Urine
O Headaches	O Allergies	O Gas/Bloating After Meals
O Migraines	O Fainting	O Heartburn
O Arm Tingling	O Weight Loss	O Colitis
O Back Tingling	O Poor Appetite	O Irritable Bowels
O Shoulder Pain	O Excessive Appetite	O Black or Bloody Stools
O Hand Pain/Tingling	O Nervousness	O Constipation

O Leg Pain/Tingling
O Jaw Pain
O Chest Pain
O Lung Problems
O Heart Problems
O Abnormal Blood Pressure
O Irregular Heartbeat
O Ankle Swelling
O Cold Extremities
O Blurred Vision
O Vision Problems

O Confusion
O Depression
O Dental Problems
O Excessive Thirst
O Frequent Nausea
O Vomiting
O Prostate Problem
O Breast Pain/Lump
O Cramps
O Painful Urination
O Bladder Trouble

O Hemorrhoids
O Liver Problems
O Stroke
O Paralysis
O Tingling
O Numbness
O Fatigue
O Dizziness
O Loss of Sleep
O Difficulty Hearing
O Ear Pain

If applicable, date of last menstrual period. _____

Past injuries can affect present health. *(Please check all that apply)*

O Fall/Accidents
O Sports Injuries
O Spinal Tap
O Use(d) Cane or Walker
O Knocked Unconscious

O Head Injuries
O Broken Bones
O Surgery
O Extensive Dental Work

O Fights
O Dislocations
O Traction
O Dental Appliances

If Yes to any of the above, please describe. _____
_____

Are there other health concerns or anything else you'd like us to know about you?
O No O Yes If yes, please tell us. _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

The above is accurate to the best of my knowledge.

_____ _____
(Signature) (Date)

I, parent/guardian, give permission for minor's care.

_____ _____
(Signature) (Date)

23505 Smithtown Road, Suite 100, Excelsior, MN 55331 952-470-8555

Knewtson Health Group

Credit Policy And Patient Responsibility

Thank you for choosing Knewtson Health Group as your health care provider. We are committed to your treatment being successful. Please understand that prompt payment of your bill is considered part of your treatment. We have put together the details of our Credit and Financial Policies below. Please read carefully and sign below to begin treatment.

All patients complete our information and insurance forms.

Co pays are due at time of service.

For your convenience, we accept cash, check, Visa, Master Card and Discover.
(We do not accept American Express)

We offer physical therapy and chiropractic cash plans. Payment is due at time of service.

We offer payment plans with prior credit approval and signed agreements.

Patients with insurance coverage

We may accept assignment of insurance benefits at first visit. However, we do require your co-payment be paid at the time of the service. The balance incurred is your personal responsibility whether your insurance company pays or not. Coverage amounts vary from policy to policy. You understand that your insurance policy is a contract between you and your insurance company. This office holds no party to that contract and will not be held responsible in the event that your insurance denies any claim.

Usual and customary rates

Our practice is committed to providing the best treatment for our patients. We charge what is usual and customary for our area. You are responsible for all usual and customary charges, regardless of what your insurance company's arbitrary discrimination of usual and customary rates.

Delinquency

In event your account becomes past due and is referred to an outside collection agency or attorney you will be responsible for the collection costs (up to 33% of the balance due), along with reasonable attorney fees and court costs incurred by this office.

I have read and understand Knewtson Health Group Credit and financial policy with the respect to payment on my account.

Patient Signature_____**Date**_____

23505 Smithtown Road, Suite 100, Excelsior, MN 55331 952-470-8555

Knewtson Health Group

Patient Consent

TO OUR PATIENTS: Please read and sign the form below. Ask questions if there is something you do not understand.

Please check to indicate approval:

____ **RELEASE OF MEDICAL RECORDS FOR MY MEDICAL CARE OR AS REQUIRED BY LAW:**
-to health care providers directly involved in my care.
-to State, Federal and accrediting bodies for required reporting data and/or surveys for compliance.
-for purposes of my care and for business operations.
Note: Records are not automatically sent to your physician. They must be requested.

____ **ASSIGNMENT OF BENEFITS/BILL MY INSURANCE:**
-I authorize Knewtson Health Group to send my bills for my medical care and treatment to my insurance company and/or Medicare or Medicaid for payment, to the extent my insurance company and/or Medicare or Medicaid id required to pay the bill under terms of my insurance policy or by law.
-I request that my insurance company and/or Medicare or Medicaid pay Knewtson Health Group and the providers who are involved in my treatment.
-I consent to the release of my medical records by Knewtson Health Group to my insurance company and/or Medicare or Medicaid (and organizations working on their behalf) if necessary in order for my bills to be paid.
-I agree to pay for charges not covered by my insurance.
-I understand that if I do not check this box Knewtson Health Group will send a bill directly to me for payment.

____ **RELEASE OF MEDICAL RECORDS FOR MEDICAL OR SCIENTIFIC RESEARCH:**
-I agree that my records may be used by Knewtson Health Group for medical or scientific study.
-No information which can identify me as a patient or participant in any such study will be shared.
-I may revoke this in writing at any time.

By signing this form, I consent and authorize my medical health provider to assess and treat me. I understand that my provider is available to explain the purpose of treatment, and that I have the right to refuse recommended treatment. I understand I have the right to revoke this consent, in writing, at any time except where Knewtson Health Group has already made disclosures in reliance to the consent.

I consent to the treatment(s) provided by this clinic. I understand that my condition may necessitate modifications from time to time due to the type of treatment(s) rendered and the portions of my body that may need to be examined. I understand and consent to clinic staff providing me with verbal descriptions, when there are changes to my exam(s) and treatment(s), consent to the clinic staff providing said treatment(s) and exam(s) and hereby consent to any similar subsequent treatment(s) or exam(s). If I do not consent, I will immediately inform clinic staff. There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or insurance. I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff.

Patient Name:_____Date_____

Patient/Guardian Signature:_____ Date _____

If applicable, patient's relationship to guardian: _____

Check only if applicable (one-time acknowledgment)

_____**I acknowledge that I have been offered a copy of Knewtson Health Group's Privacy Practices Information. If I would like a copy in the future, I will ask for one.**

23505 Smithtown Road, Suite 100, Excelsior, MN 55331 952-470-8555