Massart Chiropractic
1239 W. Mason St
Green Bay, WI 54303
Phone: 920-884-6100

PATIENT INFORMATION

Full Name _____ Birth Date_____ Gender: M F

Address _____ City_____ State_____ Zip_____

Cell Phone: _____ Home Phone: _____

E-mail Address:_____

Are you a Veteran: Yes_____ No_____ SS# _____-_____-_____

Marital Status: S M W D Sep / Spouse Name_____Birth Date_____

Are You A Student? Yes No / Full-Time Part-Time

Emergency Contact: Name_____Phone_____

Your Employer_____Your Occupation_____

Employer Address_____ City_____ State_____ Zip_____

Spouse's Employer_____ Spouse's Occupation_____

Primary Physician:_____ Phone:_____

Physician Address:_____

May our office contact your Primary Physician regarding your care? Y or N

Referred by: _____

- I authorize payment of medical benefits to this office.
- I will allow this office to treat me, with other health care providers present, and to record my medical information, including consultation and examination, for documentation purposes, if necessary.
- I give this office the right to use my name for any in-office publications.
- Authorization may be denied or retracted by notifying the office manager.
- I acknowledge having the right to review and obtain a copy of the Notice of Privacy Practices of this office. (Once information is disclosed, it may not be protected by law.)
- By supplying my phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, or other communications. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events.

Patient's Signature_____ Date_____

Spouse's or Guardian's Signature_____ Date_____

(Authorization expires 3 years from date above)

Massart Chiropractic
1239 W. Mason St
Green Bay, WI 54303
Phone: 920-884-6100

CASE HISTORY

FULL NAME: _____DATE: _____CASE#: _____

History of Present Injury/Illness

Please list below the complaint(s) you have in the order of importance. Also the length of time you have had these complaint(s).

1. _____How long? _____
2. _____How long? _____
3. _____How long? _____
4. _____How long? _____

Is your condition(s) related to an accident? ☐ YES ☐ NO
Date of accident:_____Type of Accident: ☐ Auto ☐ Work Related ☐ Other _____

What words best describe your present condition(s)? (ex. ache, burn)_____
Circle the number that matches your level of pain at its worst (0=no pain, 10=most severe)
0 1 2 3 4 5 6 7 8 9 10
When is your condition most severe? _____
When is your condition least severe? _____
What makes your condition feel worse? _____
What makes your condition feel better? _____
What activities are difficult because of your condition(s)? _____
Have you seen any other health care provider for your present condition? ☐ YES ☐ NO
Who? _____
Current Medications(Including Tylenol, aspirin ,aleve, ect)_____

Are you or could you be pregnant? ☐ YES ☐ NO

Are you experiencing or do you have any of the following?

☐ A sore that won't heal	☐ Difficulty swallowing	☐ Persistent cough/hoarseness
☐ Any bleeding/discharge	☐ Lump/thickening anywhere	☐ Wart/ mole changes
☐ Bladder/bowel problems	☐ Night pain	☐ Weight loss without trying
		☐ **None of the above**

Review of Systems

In addition to the symptom(s)/dysfunction(s) listed above, are you experiencing any of the following?

Neuromusculoskeletal System

☐ Anxiety	☐ Facial drooping	☐ Loss of balance	☐ Seizures
☐ Atrophy	☐ Headache	☐ Memory loss	☐ Sensory changes
☐ Concussion	☐ Joint deformity	☐ Mood swings	☐ Speech problems
☐ Depression	☐ Joint locking	☐ Muscle weakness	☐ Stiffness
☐ Difficulty walking	☐ Joint swelling	☐ Numbness	☐ Tremors
☐ Dizziness	☐ Lack of coordination	☐ Popping noises	☐ Twitches
☐ Extremity deformity	☐ Limited range of motion	☐ Psychiatric disorders	☐ Vision trouble
			☐ **None of the above**

Cardiovascular System

☐ Ankle swelling	☐ Chest pain	☐ Jaw pain	☐ Pin stroke
☐ Blood clots	☐ Dizziness	☐ Known vascular disease	☐ Previous stroke
☐ Carotid blockage	☐ Fainting	☐ Mitral valve prolapse	☐ Shortness of breath
☐ Changes in skin color	☐ Hypertension	☐ Phlebitis	☐ Varicose veins
			☐ **None of the above**

Past History

List any surgeries you have had and when?_____
List any hospitalizations. When hospitalized and why? _____
Have you ever been diagnosed as having a particular condition? (diabetes, heart trouble, cancer) _____
Are you currently under a doctors care for conditions other than the ones you are seeking care for?_____
Family Medical History:_____

Social History: How much per day or week (circle)?

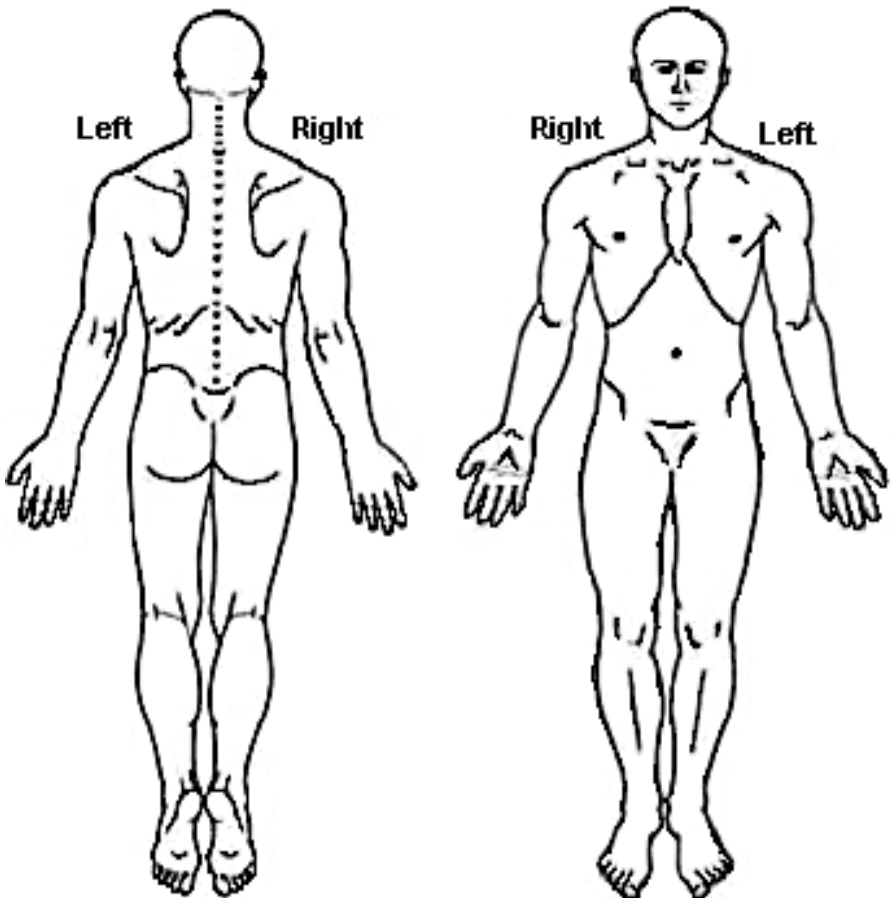
Caffeine_____Day/Week Liquor/Beer_____Day/Week Tobacco_____Day/Week
Exercise: Type and Frequency_____
Special diets_____

Pain Drawing

Name_____ Date_____

Mark the area on your body where you feel the following sensation.

Aches	/\/\/\	Numbness	ooo	Pins and Needles	. . .	Burning	xxx	Stabbing	///	Other	/\/\/\
	/\/\/\		ooo		. . .		xxx		///		/\/\/\
	/\/\/\		ooo		. . .		xxx		///		/\/\/\



Indicate the severity of your pain by marking an "X" at the appropriate point on the pain line.

How bad is your neck pain? 0 _____ 10
No Pain Worst Pain

How bad is your back pain? 0 _____ 10
No Pain Worst Pain

How bad is your arm pain? 0 _____ 10
No Pain Worst Pain

How bad is your leg pain? 0 _____ 10
No Pain Worst Pain

INFORMED CONSENT

Dear Patient,

Every type of health care is associated with some risk of a potential problem. This includes chiropractic health care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called "informed consent".

Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of a machine. Frequently, adjustments create a "pop" or "click" sound/sensation in the area being treated. In this office we use trained staff personnel to assist the doctor with portions of your consultation, examination, x-ray taking, physical therapy application, traction, massage therapy, exercise instruction, etc.

Stroke: Stroke is the most serious problem associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive enough oxygen from the brain stem. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. Chiropractic adjustments have been associated with strokes that arise from the vertebral artery only; this is because the vertebral artery is actually found inside the neck vertebrae. The most recent studies (Journal of the CCA Vol. 37 No. 2, June 2, 1993) estimate that the incidence of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that the average chiropractor would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

Disc Herniation: Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. This includes disc hernations in both the neck and the back. Yet occasionally chiropractic treatment (adjustments, traction, etc.) will aggravate the problem. These problems occur so rarely, that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissues primarily refer to muscles and ligaments. Muscles move the bones and ligaments limit the amount of joint movement. Rarely will chiropractic adjustments, traction, massage therapy, etc., tear some muscle or ligament fibers. If this does occur the result is a temporary increase in pain and necessary treatments for resolution, but there are no long term effects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

Rib Fracture: The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely will chiropractic adjustments "crack" or fracture a rib bone. This occurs only on patients who have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients very carefully, especially those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

Physical Therapy Burns: Some of the machines we use generate heat. We also use both heat and ice, and recommend them for home care on occasion. Everyone's skin has different sensitivity to these modalities, and rarely, either heat or ice can burn or irritate the skin. If a burn occurs the result is a temporary increase in skin pain. In extreme cases, some blistering of the skin may occur. These problems occur so rarely that there are no available statistics to quantify their probability.

Soreness: It is common for chiropractic adjustments, traction, massage therapy, exercise, etc., to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but please tell your doctor about it.

Other Problems: There may be other problems or complications that might arise from chiropractic treatment, other than those noted above. These other problems or complications occur so rarely that it is impossible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and therefore, as with any healthcare delivery system, we cannot promise a cure for any symptom, disease or condition as a result of treatment in this clinic. We will always give you our best care, and if the results are not acceptable, we will refer you to another provider who we feel will assist your situation. If you have any questions on the above, please ask your doctor. When you have a full understanding, please sign and date below.

Patient's Name Printed	Today's Date
Patient's Signature	Parent/Guardian Signature for Minor
Witness	Today's Date

Massart Chiropractic
1239 W. Mason St. Green Bay WI 54303
Phone: 920-884-6100 Fax: 920-884-6311

Massart Chiropractic
1239 W. Mason St.
Green Bay, WI 54303

Financial Agreement

Purpose:
We would like to take a moment to welcome you to our office and assure you will be receiving the very best care available for your condition. The purpose of this agreement is to clarify the financial aspects of your care. This way we can devote our efforts to helping you get the best results. Please understand that payment of your bills is considered part of your treatment.

Services:
The first day of your office visit fees vary based upon the severity of your condition, the amount of time needed to help you, and the management of your care. The established office visit fee ranges from $40-$125 depending on the management level of care typically received during the first couple weeks of care.

Physical therapy, progress examinations, diagnostic testing, post-radiological imaging, supports, nutrition, and supplies are at additional cost. Our fees are reviewed periodically to ensure they are usual, customary, and reasonable (UCR) within the local chiropractic community. Fees are subject to change without notice, but will be updated on the office Super Bills.

Forms of Payment:
We offer several methods of payment for your care and you may choose the plan which best suit you. Our main concern is your health, and we will do our best to help you. We operate a zero balance clinic, meaning that we do not bill our patients. We do all of our collections at the front desk. Any account balances must be cleared by the end of each week, unless prior arrangements are made with the Office Manager.

Insurance

Most insurances cover our services, which we will pre-verify as a service to you, and which we will bill the insurance company directly on your behalf. You will be responsible for that portion that your policy may not cover. This will include the deductible, co-payment, and any unpaid balances.

A. **In-Network Provider:** Co-Pay is what is listed on your insurance card
B. **Out-of-Network Provider:** Most out-of –network insurances have a deductible, which must be met yearly, before the plan takes effect. Once you have met your deductible, your policy will cover a percentage of your care, which equates to approximately the following:

Insurance	Your Copayment
100%	0%
90%	10%
80%	20%
70%	30%

Note: Your plan may pay at 100% after a maximum out of pocket has been reached.

***Note: You will receive Explanation of Benefits (EOB) in the mail showing what procedures were performed on certain dates of service. Many times we have patient that do not understand how to read these forms and sometimes get concerned when an insurance company sends this to them. Whatever you receive, we receive as well. If you should have any questions regarding these forms, please bring it to our attention so we may answer all of your questions. However, it is very important that your policy is an agreement between you and the insurance company, not the doctor. We will make every effort to verify coverage for you. We cannot guarantee coverage's in all aspects of care. We will not become involved in disputes with your insurance company regarding deductibles, co-payments, secondary insurance, usual and customary charges.
***Collections: I also understand that if my account is sent to collections, 20% will be added to the balance I owe.

Financial Consent/Patient Agreement

I certify that I have read, understand, and agree to this financial agreement. I agree to be fully responsible for total payment of procedures incurred by me or as a guardian for a minor receiving care in this office.

X_____
Print Patient's Name

X_____ Date_____
Patient Signature

X_____ Date_____
Office Signature

Patient Acknowledgement and Receipt of

Notice of Privacy Practices Pursuant to HIPAA and Consent

For Use of Health Information

Name_____(Print Patient's Name) Date_____

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office' s HIPAA Compliance Manual is available upon request.

The undersign does herby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manuel, State Law and Federal Law.

Dated this_____ day of_____, 20___

By_____(Patient's Signature)

If patient is a minor or under guardianship order as defined by State Law:

By_____(Signature of Parent/Guardian)