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#__________________________________

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_______________________________

Primary Insured

Name____

Employer____

Work Phone ______________________________________

Birth date _______________________________________

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

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.

<u>Co-Pays & Deductibles</u>
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.

<u>Cancellation/No Show Policy</u>
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.

<u>Failure to Meet Financial Responsibility</u>
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.
<u>Patient Acknowledgment</u>

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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PATIENT PAYMENT AUTHORIZATION

EXPLANATION OF AUTOMATED RECURRING PAYMENT OPTION

Opp Family Chiropractic ("OPP") offers an automated payment option to our patients for their convenience. If you (a patient or a payer on behalf of a patient) return this completed Patient Payment Authorization, OPP will automatically charge your credit/debit card for any outstanding balance due to co-pays, deductibles or non-covered services.

Name on Card			
Billing Street Address			
Billing City, State, Zip			
Type of Card	- - -		
Credit Card Number	☐ Visa ☐ MasterCard ☐ Discover		
Expiration Date		CVV Code	

BY MY SIGNATURE BELOW, I AUTHORIZE OPP FAMILY CHIROPRACTIC P.A. TO PROCESS MY DEBIT/CREDIT CARD FOR 100% OF THE PATIENT'S OUTSTANDING BALANCE IN FULL IF AFTER SEVEN (7) DAYS OF THE RECEIPT OF AN E-MAILED OR MAILED BILLING STATEMENT A BALANCE REMAINS OWING FOR CO-PAYS, DEDUCTIBLES OR NON-COVERED SERVICES. I UNDERSTAND I MAY REVOKE THIS AUTHORIZATION BY GIVING MY NOTICE IN WRITING TO OPP FAMILY CHIROPRACTIC P.A.

THIS AUTHORIZATION IS TO REMAIN IN FULL FORCE AND EFFECT UNTIL ALL AMOUNTS OWED RELATED TO THE TREATMENT RENDERED TO PATIENT ARE PAID IN FULL, OR UNTIL I CANCEL THIS AUTHORIZATION. TO CANCEL, I MUST NOTIFY OPP IN WRITING AND GIVE REASONABLE OPPORTUNITY TO ACT.

I AGREE THAT OPP, IN ITS SOLE DISCRETION, MAY TERMINATE THIS AGREEMENT IF MY ACCOUNT SHOULD LACK SUFFICIENT FUNDS FOR PAYMENT. IN THE EVENT OPP IS UNABLE TO SECURE FUNDS FROM MY BANK ACCOUNT OR CREDIT CARD FOR ANY REASON, I MAY BE CHARGED FOR FURTHER COLLECTION ACTION THAT MAY BE UNDERTAKEN TO THE FULL EXTEND PROVIDED BY LAW.

☐ **CHECK HERE IF YOU WOULD LIKE A PHONE CALL BEFORE WE CHARGE YOUR ACCOUNT**

☐ **CHECK HERE IF YOU WOULD LIKE US TO CHARGE YOUR ACCOUNT WITHOUT A PHONE CALL**

Patient Name	
Cardholder Name	
Cardholder Signature	

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HEALTH HISTORY

Name ____ Date ______________

Occupation ______________________________ Age ______ Height ______ Sex ______ Number of Children ______

Marital Status: ❑ Single ❑ Partner ❑ Married ❑ Separated ❑ Divorced ❑ Widow(er)

Are you recovering from a cold or flu? ____________ Are you pregnant? ____________

Reason for office visit: Date began:

____ ______________________

____ ______________________

____ ______________________

List current health problems for which you are being treated: ______________________________

____

____

____

What types of therapies have you tried for these problem(s) or to improve your health over-all:

❑ diet modification ❑ fasting ❑ vitamins/minerals ❑ herbs ❑ homeopathy ❑ chiropractic ❑ acupuncture ❑ conventional drugs

❑ other ____

Do you experience any of these general symptoms EVERY DAY?

❑ Debilitating fatigue	❑ Shortness of breath	❑ Insomnia	❑ Constipation	❑ Chronic pain/inflammation
❑ Depression	❑ Panic attacks	❑ Nausea	❑ Fecal incontinence	❑ Bleeding
❑ Disinterest in sex	❑ Headaches	❑ Vomiting	❑ Urinary incontinence	❑ Discharge
❑ Disinterest in eating	❑ Dizziness	❑ Diarrhea	❑ Low grade fever	❑ Itching/rash

Current medications (prescription or over-the-counter): ______________________________

____

____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):

____

Outcome ____

____

____

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): ____________________

Do you consider yourself: ❑ underweight ❑ overweight ❑ just right Your weight today ____________

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? ________________

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, etc.)?

____

What are your current health goals: ______________________________________

____

____

____

____

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Medical History

- ❑ Arthritis
- ❑ Allergies/hay fever
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Autoimmune disease
- ❑ Blood pressure problems
- ❑ Bronchitis
- ❑ Cancer
- ❑ Chronic fatigue syndrome
- ❑ Carpal tunnel syndrome
- ❑ Cholesterol, elevated
- ❑ Circulatory problems
- ❑ Colitis
- ❑ Dental problems
- ❑ Depression
- ❑ Diabetes
- ❑ Diverticular disease
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Epilepsy
- ❑ Emphysema
- ❑ Eyes, ears, nose, throat problems
- ❑ Environmental sensitivities
- ❑ Fibromyalgia
- ❑ Food intolerance
- ❑ Gastroesophageal reflux disease
- ❑ Genetic disorder
- ❑ Glaucoma
- ❑ Gout
- ❑ Heart disease
- ❑ Infection, chronic
- ❑ Inflammatory bowel disease
- ❑ Irritable bowel syndrome
- ❑ Kidney or bladder disease
- ❑ Learning disabilities
- ❑ Liver or gallbladder disease (stones)
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological problems (Parkinson's, paralysis)
- ❑ Sinus problems
- ❑ Stroke
- ❑ Thyroid trouble
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Pneumonia
- ❑ Sexually transmitted disease
- ❑ Seasonal affective disorder
- ❑ Skin problems
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Urinary tract infection
- ❑ Varicose veins

Other ______________________
____

Medical (Men)

- ❑ Benign prostatic hyperplasia
- ❑ Prostate cancer
- ❑ Decreased sex drive
- ❑ Infertility
- ❑ Sexually transmitted disease

Other ______________________
____

Medical (Women)

- ❑ Menstrual irregularities
- ❑ Endometriosis
- ❑ Infertility
- ❑ Fibrocystic breasts
- ❑ Fibroids/ovarian cysts
- ❑ Premenstrual syndrome (PMS)
- ❑ Breast cancer
- ❑ Pelvic inflammatory disease
- ❑ Vaginal infections
- ❑ Decreased sex drive
- ❑ Sexually transmitted disease

Other ______________________

Date of last GYN exam _______

Mammogram ❑ + ❑ –

PAP ❑ + ❑ –

Form of birth control ___________

# of children _________________

# of pregnancies ______________

❑ C-section __________________

Age of first period _____________

Date - last menstrual cycle ______

Length of cycle __________ days

Interval of time between cycles ______________________days

Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _______________

- ❑ Surgical menopause
- ❑ Menopause

Family Health History (Parents and Siblings)

- ❑ Arthritis
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Cancer
- ❑ Depression
- ❑ Diabetes
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Genetic disorder
- ❑ Glaucoma
- ❑ Heart disease
- ❑ Infertility
- ❑ Learning disabilities
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological disorders (Parkinson's, paralysis)
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Stroke
- ❑ Suicide

Other _____________________

Health Habits

❑ Tobacco:

Cigarettes: #/day ____________

Cigars: #/day _______________

❑ Alcohol:

Wine: #glasses/d or wk ________

Liquor: #ounces/d or wk ________

Beer: #glasses/d or wk _________

❑ Caffeine:

Coffee: #6 oz cups/d ___________

Tea: #6 oz cups/d _____________

Soda w/caffeine: #cans/d _______

Other sources _________________

❑ Water: #glasses/d____________

Exercise

- ❑ 5-7 days per week
- ❑ 3-4 days per week
- ❑ 1-2 days per week
- ❑ 45 minutes or more duration per workout
- ❑ 30-45 minutes duration per workout
- ❑ Less than 30 minutes
- ❑ Walk - #days/wk _____________
- ❑ Run, jog, other aerobic - #days/wk ___________________________
- ❑ Weight lift - #days/wk__________
- ❑ Stretch - #days/wk____________
- ❑ Other ______________________

Nutrition & Diet

- ❑ Mixed food diet (animal and vegetable sources)
- ❑ Vegetarian
- ❑ Vegan
- ❑ Salt restriction
- ❑ Fat restriction
- ❑ Starch/carbohydrate restriction
- ❑ The Zone Diet
- ❑ Total calorie restriction

Specific food restrictions:

❑ dairy ❑ wheat ❑ eggs

❑ soy ❑ corn ❑ all gluten

Other ________________________

Food Frequency

Number of servings per day:

Fruits (citrus, melons, etc.) _______

Dark green or deep yellow/orange vegetables __________________

Grains (unprocessed) __________

Beans, peas, legumes __________

Dairy, eggs _________________

Meat, poultry, fish _____________

Eating Habits

- ❑ Skip meals - which ones ______ ___________________________
- ❑ One meal/day
- ❑ Two meals/day
- ❑ Three meals/day
- ❑ Graze (small frequent meals)
- ❑ Generally eat on the run
- ❑ Eat constantly whether hungry or not

Current Supplements

- ❑ Multivitamin/mineral
- ❑ Vitamin C
- ❑ Vitamin E
- ❑ EPA/DHA
- ❑ Evening Primrose/GLA
- ❑ Calcium, source ____________
- ❑ Magnesium
- ❑ Zinc
- ❑ Minerals, describe __________
- ❑ Friendly flora (acidophilus)
- ❑ Digestive enzymes
- ❑ Amino acids
- ❑ CoQ10
- ❑ Antioxidants (e.g., lutein, resveratrol, etc.)
- ❑ Herbs
- ❑ Homeopathy
- ❑ Protein shakes
- ❑ Superfoods (e.g., bee pollen, phytonutrient blends)
- ❑ Liquid meals (Ensure)

Others ______________________
____

I Would Like To:

ENERGY - VITALITY

- ❑ Feel more vital
- ❑ Have more energy
- ❑ Have more endurance
- ❑ Be less tired after lunch
- ❑ Sleep better
- ❑ Be free of pain
- ❑ Get less colds and flu
- ❑ Get rid of allergies
- ❑ Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- ❑ Stop using laxatives and stool softeners
- ❑ Improve sex drive

BODY COMPOSITION

- ❑ Loose weight
- ❑ Burn more body fat
- ❑ Be stronger
- ❑ Have better muscle tone
- ❑ Be more flexible

STRESS, MENTAL, EMOTIONAL

- ❑ Learn how to reduce stress
- ❑ Think more clearly and be more-focused
- ❑ Improve memory
- ❑ Be less depressed
- ❑ Be less moody
- ❑ Be less indecisive
- ❑ Feel more motivated

LIFE ENRICHMENT

- ❑ Reduce my risk of degenerative disease
- ❑ Slow down accelerated aging
- ❑ Maintain a healthier life longer
- ❑ Change from a "treating-illness" orientation to creating a wellness lifestyle

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