FORTIN CHIROPRACTIC
HEALTH & WELLNESS CLINIC, P.A.

75 Hamel Rd
PO Box 271
Hamel, MN 55340
763-478-3978
www.FortinChiropractic.com

Patient Registration and History

Please take a moment to complete the following intake form so we may obtain all necessary information in regard to your care.
If you have any questions please ask our office staff for assistance.

General Information

Date ____/____/_____

Last Name _____ First Name _____ MI _____

Preferred Name (nickname) _____ Date of Birth ____/____/_____ Age _____ ❑ Male ❑ Female

Street Address _____ City _____ State _____ Zip _____

Home Phone (_____)_____ Cell Phone (_____)_____ Email _____

Employer/School_____ Work Phone (_____)_____

Occupation _____ ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Separated

Spouse/Partner's Name _____ Phone (_____)_____

Emergency Contact _____ Relation _____ Phone (_____)_____
(other than above)

Referred by _____

Insurance Information (please present all insurance cards for photo copying)

Current Health Insurance Coverage ❑ Medicare ❑ Medicaid ❑ Health Insurance/Other ❑ None

Primary Insurance Carrier _____ Name of Insured _____

Relation _____ Insured DOB _____ Health Savings/Reimbursement account? ❑ Yes ❑ No

Secondary Insurance? ❑ Yes ❑ No if yes, Secondary Insurance Carrier _____

Name of Insured _____ Relation _____ DOB _____

Is current condition related to an accident? ❑ No ❑ Yes if yes please provide date of accident _____

Type of accident ❑ Auto ❑ Work ❑ Home ❑ Other _____

To who have your made report of your accident? ❑ Auto Insurance ❑ Employer ❑ Other _____

Accident/Injury Insurance _____ Claim # _____

Attorney _____ Phone _____

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Reason for Visit *(Please describe the reason for your visit today)*

Chief Complaint _____ (others may be checked on the following page)

Approximate date symptoms began _____ Have you had a similar condition in the past? ☐ Yes ☐ No

Have you received treatment for the above in the past? ☐ Yes ☐ No Type of treatment_____

Have you had x-rays or scans in the past 6 months in regard to the above? ☐ Yes ☐ No If yes please list date and type below:

_____

Below are lists of diseases and symptoms which may appear unrelated to the purpose of your appointment. However, please answer the questions carefully as such problems can have an effect on your overall course of chiropractic care:

Please check any of the following diseases you have past or present or check **NONE** if none of the following apply:

√ **None** ☐

☐ Pneumonia	☐ Mumps	☐ Influenza	☐ HIV/AIDS
☐ Multiple Sclerosis	☐ Asthma	☐ Pleurisy	☐ Eating Disorder
☐ Polio	☐ Osteoporosis	☐ Arthritis	☐ Crohn's Disease
☐ Tuberculosis	☐ Diabetes	☐ Epilepsy	☐ Other (please list) _____
☐ Leukemia	☐ Cancer	☐ Fibromyalgia	_____
☐ Anemia	☐ Heart Disease	☐ Lumbago	_____
☐ Measles	☐ Thyroid Problem	☐ Eczema	_____

Please place a check next each of the following that apply to your **current** condition:
If none apply please check **NONE** where appropriate

MUSCULOSKELTAL

√ **None** ☐

- ☐ Neck pain
- ☐ Pain between shoulders
- ☐ Low back pain
- ☐ Shoulder pain
- ☐ Arm pain
- ☐ Leg pain
- ☐ Joint pain or stiffness
- ☐ Problems walking
- ☐ Swelling of hands or feet
- ☐ Muscle Cramps
- ☐ General Stiffness
- ☐ Jaw pain/clicking

NEUROLOGIC/PSYCHIATRIC

√ **None** ☐

- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression/Anxiety
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

GASTRO-INTESTINAL

√ **None** ☐

- ☐ Lack of Appetite
- ☐ Excessive Appetite
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Excessive Thirst
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Frequent Gas/Bloating
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Abdominal Cramps
- ☐ Weight loss/gain

GENITOURINARY

√ **None** ☐

- ☐ Bladder Problems
- ☐ Painful Urination
- ☐ Excessive Urination
- ☐ Discolored Urine

CARDIOVASCULAR/RESPIRATORY

√ **None** ☐

- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Heart Disease
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

ENT

√ **None** ☐

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Loss
- ☐ Sinusitis

GENERAL

√ **None** ☐

- ☐ Fatigue
- ☐ Allergies
- ☐ Difficulty Sleeping
- ☐ Fever
- ☐ Frequent Headaches
- ☐ Migraine
- ☐ Weight Gain/Loss
- ☐ Rashes
- ☐ Hair Loss
- ☐ Excessive Dry Skin
- ☐ **Currently Pregnant**
- ☐ **Breast Feeding**

OTHER please list any additional symptoms here: _____
_____

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Past Medical History (please describe and list each date of occurrence)

Major Surgeries _____

Major accidents or falls _____

Hospitalization (other than above)_____

_____

Family and Social History

Daily Habits:

Do you smoke? ☐ Yes ☐ No if yes, list amount per day _____ if you quit please list date _____

Do you consume alcohol? ☐ Yes ☐ No if yes, list frequency _____ per _____

Do you consume caffeine? ☐ Yes ☐ No if yes, list type and amount per day _____

Do you have a high level of stress? ☐ Yes ☐ No if yes, list main reason _____

Regular Exercise: ☐ None ☐ Light ☐ Moderate ☐ Intense Frequency _____ times per _____

Daily work includes: ☐ Sitting ☐ Standing ☐ Light lifting ☐ Moderate to heavy lifting ☐ Computer work
(check all that apply)

Family Health History:
Please list any significant health issues in your immediate family (mother, father, grandparents, siblings)

Family Member	Health Issue(s)

Medications
Please list below all medications you are currently taking. Please include over the counter and nutritional supplements:

1. _____ **for** _____ **5.** _____ **for** _____
2. _____ **for** _____ **6.** _____ **for** _____
3. _____ **for** _____ **7.** _____ **for** _____
4. _____ **for** _____ **8.** _____ **for** _____
5. _____ **for** _____ **9.** _____ **for** _____

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Authorization and Release

Patient Name: _____

I authorize the release of any information concerning my health and health care services, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care, to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me under any insurance or pre-paid health plan.

I understand that the benefits quoted by my insurance company are not a guarantee of payment and all charges are considered at the time claims are processed. I understand that my insurance carrier may pay less than the actual bill for services rendered. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree to notify your office of any and all insurance changes that would affect the filing of claims or payment for the treatment I receive.

I understand that payment in full is due at the time of service unless other arrangements have been made.

Signature of patient or guardian _____ **Date** _____

Informed Consent for Treatment

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatment) and any other associated procedures that may include but not limited to physical examination, diagnostic testing and x-ray and physical therapy procedures.

I understand with chiropractic treatment, as well as any health care procedures, there are certain risks and complications associated with this type of treatment. Such complications include but are not limited to: post treatment soreness or discomfort, soft tissue injury, dislocation, and fractures. Although rare, some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications. I wish to rely upon the doctor to exercise judgment during the course of the treatment which the doctor feels at the time, based on the facts then known, are in my best interest.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. By signing below, I state that I have been informed and weighed the risks involved in chiropractic treatment. If you have any questions concerning the above, please ask your doctor of chiropractic.

Having carefully read the above, I give my informed consent to have chiropractic treatment administered.

Signature of patient or guardian _____ **Date** _____

Consent to Treat a Minor (if applicable)

Having carefully read the above, as the parent or legal guardian of _____ I give my informed consent to allow chiropractic treatment to be administered to my child.

Signature of patient or guardian _____ **Date** _____

HIPAA Privacy Practice Acknowledgement

I have received or was offered and declined a notice of privacy practices.

Signature of patient or guardian _____ **Date** _____

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Our Billing Policy

I request that payments from my insurance company, third party or other health service plans are made directly to Fortin Health & Wellness Clinic. I authorize Fortin Chiropractic Health & Wellness Clinic, P.A. to release all health information about me to my insurance company, third party, other health service plans made for the purpose of billing, payment of insurance claims and fraud investigations.

I also agree to pay for services provided by Fortin Chiropractic Health & Wellness Clinic, P.A. that were not paid for by my insurance company, third party or other health service plans. I will pay within thirty days from the date of each monthly billing statement my total balance. There will be no finances charges for first 30 days on unpaid balances. Unpaid balances greater than 31 days will receive a finance charge of .5% or 6% annually. Patient may at any time pay the full amount plus any finance charges. If a payment plan is needed, please call the office to arrange a plan to pay off your account.

All unpaid balances of 120 days will be sent to our collection agency including but not limited to collection fees, billing and mailing fees, service fees, attorney fees and legal fees. I agree to pay Fortin Chiropractic Health & Wellness Clinic, P.A. for all costs incurred to collect payments(which is usually 30% added fee to the current balance) including but not limited to legal costs such as attorney fees, cost and fees for billing and mailings, service fees and collection service fees. I release my information and services rendered to me to accomplish the collection of my balance owed to Fortin Health & Wellness Clinic, PA.

I Have Read the Authorization Form and Agree

Signature_____ Date _____

Print_____

Patient Representative (If patient is a minor or unable to sign)

Signature_____ Date _____

Relationship to 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 all this chiropractic office to submit requested PHI to the Health Care 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 purposes of treatment, payment, and health care operations, the chiropractic physician has the right to refuse to give care.

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

Name of Patient_____ Date _____