RAPP CHIROPRACTIC

Patient Information

Date_____

Patient Name_____
Last Name

_____
First Name Middle Initial

Address_____

City_____

State _____ Zip_____

Sex ☐ M ☐ F Birthdate _____

☐ Married ☐ Single ☐ Partnered

Occupation_____

Employer_____

Home Phone (____) _____

Cell Phone (____) _____

Work Phone (____) _____

Email _____

How did you hear about us?_____

IN CASE OF EMERGENCY, CONTACT

Name_____

Relationship_____

Phone (____) _____

Insurance

Primary Insurance Co._____

Secondary Insurance Co._____

Auto Claim #_____

Policyholder_____

Policyholder's Date of Birth_____

Guarantor _____

Relationship to Patient_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with_____
Name of Insurance Company(ies)
and assign directly to Rapp Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Guardian or Personal Representative

_____
Print name of Patient, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

Patient Condition

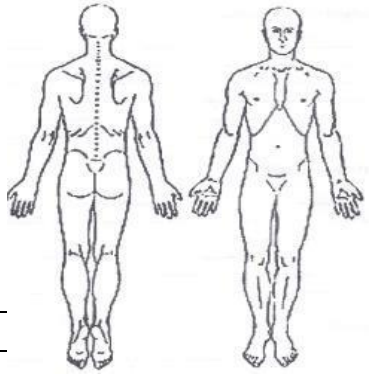
Reason for Visit_____

When did your symptoms start? _____

Are your symptoms getting progressively worse? Yes No Unknown

Rate the severity of your pain (average) on a scale from 0 (no pain) to 10 (severe pain) _____

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Please list all current medications, supplements, past traumas and surgeries:

If none, please write none

Medications/ Supplements:_____

Surgeries and appx. dates:_____

Past Traumas:_____

General Medical Information

For each of the conditions, please mark the Past/Present column as it pertains to your health history of medical condition. For any of the questions that you placed a check mark next to, please explain in the comment field (below) as clearly as possible.

What is your height? _____ft. _____in. What is your weight? _____ lbs.

Do you exercise regularly? ☐ Yes ☐ No

If yes, how often?_____

Past	Present		Past	Present		Past	Present	
☐	☐	Headache/Migraine	☐	☐	Chest Pain/Angina	☐	☐	Excessive Thirst
☐	☐	Neck pain	☐	☐	Heart Murmurs	☐	☐	Frequent Urination
☐	☐	Upper Back Pain	☐	☐	Stroke	☐	☐	Smoking/Tobacco Use
☐	☐	Mid Back Pain	☐	☐	Anemia	☐	☐	Drug/Alc. Dependency
☐	☐	Low Back Pain	☐	☐	Kidney Disorders	☐	☐	Depression
☐	☐	Shoulder Pain	☐	☐	Bladder Infection	☐	☐	Systemic Lupus
☐	☐	Elbow/Upper Arm Pain	☐	☐	Painful Urination	☐	☐	Epilepsy/Seizures
☐	☐	Wrist Pain	☐	☐	Loss of Bladder Control	☐	☐	Eczema/Skin Rash
☐	☐	Hip/Upper Leg Pain	☐	☐	Prostate Problems	☐	☐	Communicable Disease
☐	☐	Knee Lower Leg Pain	☐	☐	Weight Gain/Loss	☐	☐	Any Childhood Disease
☐	☐	Ankle/Foot Pain	☐	☐	Loss of Appetite	☐	☐	Anxiety
☐	☐	Jaw Pain	☐	☐	Abdominal Pain	☐	☐	Aneurysm
☐	☐	Joint Swelling/Stiffness	☐	☐	Ulcer			
☐	☐	Osteoporosis	☐	☐	Hepatitis	☐	☐	Pregnancy
☐	☐	Arthritis	☐	☐	Liver Disorder	☐	☐	Birth Control
☐	☐	Rheumatoid Arthritis	☐	☐	Gall Bladder Disorder	☐	☐	Hormone Replacement
☐	☐	Bone Fractures	☐	☐	Cancer	☐	☐	Chronic Pelvic Pain
☐	☐	General Fatigue	☐	☐	Tumor	☐	☐	Breast Lumps
☐	☐	Muscular Incoordination	☐	☐	Meningitis			
☐	☐	Visual Disturbances	☐	☐	Asthma			
☐	☐	Dizziness	☐	☐	Chronic Sinusitis	☐	☐	Testicular Lumps
☐	☐	High Blood Pressure	☐	☐	Allergies/Hay Fever	☐	☐	Difficult Urination
☐	☐	Heart Attack/Disease	☐	☐	Diabetes	☐	☐	Erectile Dysfunction

Indicate if an immediate family member has had any of the following (parents, siblings, grandparents, aunts, uncles)**:**

☐ Rheumatoid Arthritis ☐ Heart Problems ☐ Diabetes ☐ Cancer ☐ High Blood Pressure

Other:

Other Comments or Concerns:

RAPP CHIROPRACTIC

CHIROPRACTIC INFORMED CONSENT

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

Typical chiropractic treatment consists of a chiropractic adjustment which is a specific type of joint manipulation. The doctor may use his or her hands or a mechanical instrument in a way to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement. Other therapies/modalities (ex. stim, therapeutic ultrasound, instrument assisted soft tissue manipulation, etc.) may be a part of your treatment plan. Like most healthcare procedures, treatment can carry some risks with it. The doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the doctor's attention it is your responsibility to inform the doctor. Unlike many procedures the serious risks associated with chiropractic treatment are extremely rare. The following list below includes possible side effects to chiropractic treatment**:**

Temporary soreness or an increase in symptoms/pain. After the first few treatments it's not uncommon for patients to experience temporary soreness or increased symptoms/pain. That should continue to improve with every treatment so please inform us if that is not the case for you.

Dizziness/nausea/ flushing. These symptoms are relatively rare but can happen. Please inform the chiropractor if you experience these symptoms during or after your care.

Instrument assisted soft tissue mobilization or trigger point therapy may result in temporary soreness or bruising. Please inform your chiropractor if you are on any blood thinners or if you have an increased risk for easy bruising.

Burns. Rarely some of the modalities we use to help assist care can burn as they produce heat.

Some individuals may have underlying conditions that weaken their bones like osteopenia or osteoporosis. This can make them more susceptible to fractures. Please inform your chiropractor if you have been diagnosed with any condition that may weaken the bone. Your chiropractor will make modifications in treatment style to minimize risk of fracture. Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history. Disc herniations or lesions-while these conditions typically respond well to chiropractic care, in some instances, they may worsen even with chiropractic care. Please notify your chiropractor of any symptom changes or if any symptoms start to worsen. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedures to identify patients with neck pain who are at risk of arterial stroke.

I have read (or had this 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 name) _____ Relationship to patient (if applicable) _____

PATIENT'S SIGNATURE_____ Date_____

RAPP CHIROPRACTIC

PATIENT FINANCIAL ACKNOWLEDGEMENT

CANCELLATION POLICY

NOTICE OF PRIVACY PRACTICES

Patient Financial Acknowledgement

I certify that I, and/or my dependent(s), have health insurance coverage. I assign all insurance benefits directly payable to Rapp Chiropractic. I understand that I am financially responsible for all charges whether or not paid by insurance and guarantee payment of all charges incurred for treatment. I authorize the use of my signature on all insurance submissions. The doctor(s) may use my health care information and may disclose such information to the Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end one year from the date signed below. A photocopy of this assignment is considered as valid as the original.

I understand there is a $10 per year charge for unpaid services. After one year of non-payment, services may be sent to collections and I will be responsible for all debt and collection charges.

Cancellation Policy

Rapp Chiropractic is dedicated to providing you with a great patient experience. We honor your time and appreciate your respect for our daily schedule to allow our staff to be on time for your appointment. We ask you arrive to your appointments 5 minutes early or on time in order to get the most out of your office visit.

- Please give as much notice as possible if you cannot make your appointment. Many clinics require 24-hour notice to cancel your appointment. We ask you give at least a 4-hour notice for same day cancellations so we can see other patients who may need our care. We encourage you to leave a voicemail at 651-423-2900 the day before if you know you need to cancel for the next day appointment.
- A no call/no show will result in a $35 charge. This is defined as not calling to cancel or reschedule your appointment within 4 business hours of your appointment. The charge also applies if you are late to your appointment and we cannot accommodate the time change.

We greatly appreciate your business and thank you for your cooperation with this policy.

Notice of Privacy Practices Acknowledgement and Consent

The Health Insurance Portability and Accountability Act (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept confidential. This act gives you, the patient, the right to understand and control how your health information is used. If you would like a copy of our Notice of Privacy Practices please ask our front desk staff and we will provide one for you. If you would like to read the notice in office, please ask our front desk staff and a laminated copy will be provided for you to read while in the office. By signing below, I give consent to Rapp Chiropractic to use or disclose my personal health information as noted in the Notice of Privacy Practices.

_____ _____ _____

SIGNATURE (PATIENT/ GUARDIAN SIGNATURE) **PRINT NAME** **DATE**