101 E 5th St. Suite 227 St. Paul, MN 55101

REGISTRATION

Date: _____ Phone: _____

Patient: _____
Last Name First Name Initial

Street Address: _____

City/State/Zip Code: _____

Sex: ☐ M ☐ F Age: ____ Birthdate: _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security #: _____ Email: _____

Insured's Name: _____
Last Name First Name Initial

Present Complaints (Please circle the appropriate ones)

Headache	__/10	Feet/Hands Cold	__/10	Unbalanced	__ Yes __ No
Mental dullness	__/10	Depression	__/10	Fainting	__ Yes __ No
Loss of memory	__/10	Rib pain	__/10	Blurred vision	__ Yes __ No
Dizzy	__/10	Nervousness	__/10	Irritability	__ Yes __ No
Neck Pain	__/10	Eye strain/pain	__/10	Double vision	__ Yes __ No
Upper back pain	__/10	Shortness of breath	__/10	Loss of smell	__ Yes __ No
Lower back pain	__/10	Fear	__ Yes __ No	Chest pain	__/10
Midback pain	__/10	Confusion	__ Yes __ No	Ears ringing/buzzing	__Yes __No
Pins and needles in hands right/left	__/10	Pins and needles in arms right/left	__/10	Pins and needles in legs right/left	__ Yes __ No

Medical Implants: _____ **Medical alerts:** _____

Surgical Implants: _____ **Pregnancy: yes ____ no ____**

PAIN SCALE: Rate the severity of your pain by filling in the pain scales above.

Patient Name: _____ Date: _____

Doctor's Initials _____

Medications: *(please list all medications and supplements that you currently take)*

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies: *(please list all medications that cause allergic reaction)*

_____ _____ _____
_____ _____ _____
_____ _____ _____

Smoking: ___ Yes ___ No If yes, _____ Packs per Day for _____ years

Alcohol ___ Yes ___ No If yes, Number of drinks per week _____

Surgical History: Please list ALL previous surgery and the date on which it was performed:

Surgery _____ Date _____
_____ _____
_____ _____
_____ _____

Personal Medical History & Review of Systems:
Please indicate with an "X" any medical problems that you currently have or have had in the past.

□ **NO MEDICAL PROBLEMS** - no prior history of any significant medical problems

Lungs / Pulmonary – breathing disorders

□ asthma □ pulmonary embolism □ respiratory arrest
□ COPD □ pneumonia □ sleep apnea
□ emphysema □ tuberculosis □ other: _____

Cardiac / Heart and peripheral vascular disease

□ chest pain / angina □ high blood pressure □ irregular heartbeat, arrhythmia
□ heart attack □ heart murmur, valve disorder □ peripheral vascular disease
□ congestive heart failure □ mitral valve prolapse □ deep vein thrombosis
□ other: _____ □ bleeding problems

Neurologic Disorders

□ stroke or TIA □ Parkinson's □ cerebral palsy
□ peripheral neuropathy □ MS □ polio
□ other: _____

Bone & Joint Disorders

□ osteoarthritis □ gout □ osteomyelitis
□ rheumatoid arthritis □ lupus □ ankylosing spondylitis
□ other: _____

Patient Name: _____ Date: _____

Doctor's Initials _____

Gastrointestinal Disorders

□ peptic ulcer or stomach ulcer □ diverticulitis □ hepatitis - Type _____
□ acid reflux, GERD □ irritable bowel □ liver disease
□ GI bleed □ inflammatory bowel disease
□ other: _____

Genitourinary Disorders

□ urinary tract infection □ kidney problems □ dialysis, kidney failure
□ bladder problems □ kidney stones □ other: _____

Metabolic & Other Disorders

□ Diabetes x _____ years □ skin disorder _____ □ depression
□ thyroid problems □ psoriasis □ anxiety
□ sickle cell disease □ any skin ulcer □ alcohol or drug dependency
□ high cholesterol or lipids □ tooth abscess, gingivitis □ other: _____

Cancer: any type -- please specify

_____

Other medical problems NOT included above (explain)

_____

_____

Family History:

Please indicate with an "X" any significant family medical history or problems.

□ asthma □ tuberculosis □ sleep apnea
□ COPD or Emphysema □ other lung :_____
□ heart attack, myocardial infarction □ congestive heart failure
□ irregular heartbeat, arrhythmia □ bleeding problems □ Peripheral neuropathy
□ MS or Parkinson's □ other neuro :_____
□ osteoarthritis □ Lupus □ gout
□ rheumatoid arthritis □ Other bone & joint: _____
□ acid reflux, GERD □ inflammatory bowel disease □ hepatitis - Type _____
□ liver disease □ other GI :_____
□ kidney problems □ dialysis, kidney failure
□ diabetes □ psoriasis □ high cholesterol or lipids
□ thyroid problems □ sickle cell disease □ any skin ulcer
□ Malignant hyperthermia

Cancer: any type -- please specify

_____

Other medical problems NOT included above (explain)

_____

_____

Patient Name: _____ Date: _____

Proactive Healthcare

Doctor's Initials _____

PATIENT INSURANCE INFORMATION:

Please check any and all insurance coverage you or your spouse has applicable in this case.

☐ Medicare	☐ Blue Shield	☐ Auto Accident
☐ Medicaid	☐ Major Medical	☐ Union Plan
☐ Blue Cross	☐ Worker's Compensation	☐ Other

Insurance Identification Number: _____

Medicare/Medicaid Identification Number: _____

Major Medical or Auto Insurance:

Date of Accident: _____
Insurance Company Name: _____
Adjuster: _____
Address/Phone: _____
Claim #: _____ Policy #: _____ Effective Date: _____

Primary Care Physician:
Name & Address:
_____
_____
Phone #: _____

LEGAL INFORMATION:

Attorney Name & Address:
_____
_____
Attorney Phone #: _____

*Person to contact in an emergency (Name and Phone #):
_____

Patient Name: _____ Date: _____

Proactive Healthcare

Doctor's Initials _____

Proactive Healthcare
101 E 5th St. Suite 227 St. Paul, MN 55101
www.proactivemn.com
(651) 778-0080

Informed Consent Document

PATIENT NAME: _____

To the Patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as 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.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

___ spinal manipulative therapy ___ palpation ___ vital signs
___ range of motion testing ___ orthopedic testing ___ basic neurological testing
___ muscle strength testing ___ postural analysis testing
___ ultrasound ___ hot/cold therapy ___ EMS
___ radiographic studies
___ Other (please explain)

_____

_____

The risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. 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.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke and /or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

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The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

CONSENT TO TREATMENT (MINOR)

I hereby request and authorize (*insert your name*) to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter:_____. This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above. (If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with *(insert your name)* and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____ **Dated:** _____

_____ _____

Patient's Name **Doctor's Name**

_____ _____

Signature **Signature**

_____

Signature of Parent or Guardian (if a minor)

101 E 5th St. Suite 227 St. Paul, MN 55101 (651) 778-0080 Fax (651) 778-0195

We may use and disclose your PHI (private health information) in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We may also disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute.

We may use or disclose your PHI for workers compensation and similar programs.

We may use a sign-in sheet at the front desk and we may call you in to see the doctor by name.

We may contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may mail you a postcard reminding you to make an appointment and we may leave a message for you on any answering device or with any person who answers the phone at your residence. You can make a reasonable request for us to use alternative methods of communicating with you in a confidential manner. These requests must be submitted in writing in a clear and concise fashion. We are not required to agree to your request. However, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when information is necessary to treat you.

Rights that you have:
You have the right to request restrictions on some of the uses or disclosures described above. Except as stated, we are not required to agree to such restrictions.

You have the right to inspect and obtain copies of your medical Information. (A fee for the costs of copying, mailing, labor and supplies associated with your request will be charged.)

You have the right to request amendments to your medical information. Such requests must be in writing, and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosure we make of your medical information except for disclosures we make to you, to carry out treatment, payment or healthcare operations, as requested by your written authorization, as permitted or required under 45 CFR 164.502, for emergency or notification purposes, for national security or Intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law.

You have the right to receive a paper copy of this notice. To obtain a paper copy of this notice, please contact our office manager.

You have the right to file a complaint if you believe your privacy rights have been violated. You may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing and addressed to this office at the above address. You will not be penalized for filing a complaint. This privacy policy is subject to change as circumstances dictate. Any changes will be effective upon the release of a revised privacy policy, which will be made available to patients upon request.

Please sign and date below, acknowledging that you have read this policy and that you consent to the terms of our privacy policy as stated in this notice.

Signature of Patient or Legal Guardian:_____ Date:_____

Print Name of Patient or Legal Guardian:_____ Date:_____

DIRECT ASSIGNMENT OF BENEFITS & RIGHTS

In consideration of your undertaking to render care, I agree to the following:

1. RELEASE OF INFORMATION: You are authorized to release any information you deem appropriate concerning my physical condition to any Insurance company, attorney, or adjuster To process any claim for reimbursement of charges incurred by me at your treatment facility.
2. RIGHT TO RECEIVE INFORMATION: I authorize my chiropractic provider authority to affix my necessary signature as noted below to obtain medical information from any hospital, medical provider, etc., as It relates to the care being provided by my chiropractic doctor.
3. RIGHT TO RECEIVE PAYMENT: I irrevocably authorize and assign to you, the chiropractic provider, the right to receive direct payment from my attorney or any Insurance company which may become obligated to pay me any sums. The Patient(s) grant(s) to the Provider a Limited Power of Attorney to receive funds, negotiate any drafts or checks and execute any documents related to payment for services rendered to me.
4. ASSIGNMENT OF RIGHT TO SUE: In the event, any insurance company or attorney obligated by contractual agreement to make payment to me for your service charges refuses to make such payment upon demand by you, I irrevocably hereby assign and transfer to you the cause of action that exists in my favor against any such company or attorney and authorize you to prosecute said action either in my name or your name as you otherwise resolve the said claim as you see fit. I understand that whatever amounts you do not collect from said insurance proceeds (whether it be all or part of what is due) shall be paid by me.
5. RIGHT TO LIEN: I also irrevocably assign to you, the chiropractic provider, and grant the right of lien against any and all claims against any third party whose negligence may have caused my Injury, Including their insurance, up to the amount of the bill for treatment, as it relates to my healthcare as provided by you. I also irrevocably instruct my attorney to pay this office in full for services rendered to me for my accident-related injuries from any proceeds or settlements, claims, or judgment regarding said injuries. My legal counsel or successor or any representative is to pay the doctor/clinic before distributing any proceeds to me. I instruct said legal counsel or representative not to attempt to reduce by means of negotiation my Doctor's bill for services that have been provided to me for the accident/injury/illness, which I have agreed to pay in full.
6. RIGHT FOR INFORMATION: I irrevocably authorize my attorney, or successor or legal representative, insurer, or any other party regarding my care or case to release financial information about the proposed settlement, settlement/verdict payments, or amounts owed included, but not limited to other providers or legal representatives, liens, billing amounts, and balances. I also instruct all representatives to include all financial information from all facets of my case, including, but not limited to, third-party, uninsured motorists and underinsured motorists.
7. I irrevocably waive the Statute of Limitations regarding my Doctor's right to recover from me directly.
8. I hereby acknowledge that I am receiving (or about to receive) health care services, and I am advised that they are willing to wait for payment for these services, provided there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim. I understand that if it is determined either (a) there Is no insurance company obligated to pay for the services, or if the insurance company Involved refuses to acknowledge an assignment to the Doctor(s) or make other provisions for the protection of the interest of the Doctor(s); or (b) if a liability claim exists and my attorney refuses to agree to protect the interest of the Doctor(s) or If I have not engaged the services of an attorney, payment for services rendered by the above-named Doctor(s) will be made on a current basis and my account paid In full

(continued)

Immediately. In any event, I hereby promise to pay my bill in full within (10) days from the date my liability claim Is settled or after the passage of three (3) months from the date of my last treatment, whichever comes first.

9. If any payment for any services rendered under this agreement becomes delinquent, the patient or patient's guardian shall be responsible for payment of any and all court costs, attorney's fees, service of process fees, and any reasonable additional costs incurred in order to collect or that are associated with collecting monies due on the patient's· account.
10. No Surprise Act: Our fees are derived from the Medical Fees in the United States by the Physicians Medical Information corporation 2022. They have been geographically modified and are billed at the **75th** percentile. A good faith estimated cost for the items and services that would be furnished by this provider or facility plus the cost of any items or services reasonably expected to be provided in conjunction with such items or services will be provided after my first visit. I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible, out-of-pocket limit, or be covered. I'm giving up some consumer billing protections under federal law. I may get a bill for the full charge for these services or have to pay out-of-network cost-sharing under my health plan. I irrevocably consent in accident cases to have balances applied towards liens or letters of protection with my attorney. With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured.
11. I understand that this document is irrevocable, may not be rescinded, and that my attorney shall not honor any such recession. I hereby instruct that in the event another attorney is substituted in my case, the new attorney honor this lien as inherit to the settlement, judgment, verdict, or any other disposition of any litigation filed or contemplated on my behalf and enforceable upon the case as if it were executed by him/her. I hereby direct my attorney, on-demand, to provide the status of such litigation to the provider or his attorney engaged in any collection efforts. Furthermore, I direct my attorney to contact the provider before disbursement of any funds to ascertain any outstanding balances due and owing.

Dated Signature ___ day of _____ 20 __

Patient Signature_____

Witness Signature _____

Lawyer's Receipt Verification

Sent via Certified US Mail

Sent via Fax with Receipt Confirmation

Staff Name [print] _____

Staff Name [sign] _____

Date: _____