FJ CHIROPRACTIC
JOURNEY TOWARDS A MENDED LIFE

Patient Demographic Information

Full Name:_____

Address:_____

City:_____ State:_____ Zip:_____

E-mail:_____ Preferred Phone:_____

Birth Date:_____ Race:_____ Sex: _____

Height: _____ ft _____ in Weight: _____ lbs

Occupation:_____ Full/Part Time:_____

Employer: _____ Employer's Address:_____

Office Phone:_____

Marital Status: Married Single Divorced Widowed

Spouse Name: _____

How many children? _____ Names and Ages of Children:_____

_____

Emergency Contact: _____

Relation:_____ Phone: _____

How were you referred to our office? _____

Family Medical Doctor: _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? _____

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company (if any): _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. 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. The following person(s) have my permission to receive my personal health information:

_____

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Reason For Visit

WOMEN ONLY: Are you pregnant or do you believe you might be? Yes No | Date of last period:_____

Purpose of this visit related to: Wellness Injury (Personal) Injury (Worker's Comp) Injury (Auto Accident)

If injury is job related, have you made a report of your accident to your employer? Yes No

If injury is from an auto accident, have you filed a police report? Yes No

Primary Complaint: _____

Describe the location of your pain/symptoms: _____

Describe how injury occurred in detail: _____

_____

Date symptoms appeared or accident happened: _____

Since above date, has this condition: Gotten Worse Gotten Better Stayed Constant Come and gone

Is this problem affecting any other area of your body? (Menstrual, constipation, energy) If yes, please explain:

_____

Have you been able to attend work? Yes No If no, how many days lost from work? _____

If yes, do your symptoms increase while performing your normal work duties? Yes No

If yes, select amount you feel your symptoms increase at work: 10%-20% 30%-40% 50%-60% 70%+

Have you had previous X-Rays, CTs, Ultrasounds, or MRIs for this condition? Yes No

Have you ever had the same or a similar condition? Yes No - If yes, when and describe in detail including if you have been treated by other doctors for it, what their treatment was and results of their treatment:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions **previously**. (N = Now P = Previously)

Headaches/Migraines		Loss of taste		Joint pain/swelling	
Neck pain		Unusual bowel patterns		Menstrual difficulties	
Loss of balance		Cold feet		Chest pains/tightness	
Fainting		Cold hands		Dizziness	
Stiff neck		Arthritis		Shoulder/neck/arm pain	
Sleeping problems		Muscle spasms		Numbness in fingers	
Back pain		Frequent colds		Numbness in toes	
Nervousness		Fever/Rheumatic fever		High/low blood pressure	
Tension		Sinus problems		Difficulty urinating	
Irritability		Diabetes		Weakness in extremities	
Loss of smell		Indigestion problems		Breathing problems	
Fatigue		Lights bother eyes		Ears ring	
Excessive bleeding		Rheumatoid arthritis		Broken bones/fractures	
Osteoarthritis		Heart surgery/pacemaker		Stroke	
Ruptures		Eating disorder		Drug addiction	
Gallbladder problems		Ulcers/Colitis		Sudden weight loss/gain	
Depression		Loss of memory		Buzzing in ears	
Circulation problems		Seizures/Epilepsy		Low blood pressure	
Osteoporosis		Heart troubles/disease		Cancer	
Coughing blood		Alcoholism		HIV Positive	
Hepatitis		Pain between shoulders		Kidney problems	
Congenital heart defect		Asthma		Venereal disease	
Tuberculosis		Shingles		Chemotherapy	
Anemia		High cholesterol		Thyroid Problems	

I certify the above information provided is accurate to the best of my knowledge:

Signature of Patient/Legal Guardian_____ Date_____

FJ Chiropractic - Berlin

Ty Rebedew, D.C.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the chiropractic physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnoses, and analysis. The chiropractic adjustment or other clinical procedures or therapies are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, therapy, or health care if he is aware that such care may be contraindicated. It is the responsibility of the patient (or guardian) to make it known or to learn through healthcare procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the chiropractic physician.

RESULTS

The purpose of chiropractic services is to promote health naturally, through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule of effectiveness of the chiropractic procedures. Sometimes the response is phenomenal. In most cases, there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care.

CONSENT

I, the undersigned, have read and fully understand the above statement. My signature (or guardian's signature) authorizes release of medical information to my insurance company as well as assignment of benefits to FJ Chiropractic - Berlin.

Patient Signature:_____ **Date:**_____

Print Name: _____

Guardian Signature:_____ **Date:**_____

Print Name:_____

FJ Chiropractic - Berlin
Ty Rebedew, D.C.
147 N State St | Berlin WI 54923
920-361-2733

FINANCIAL ARRANGEMENTS

_____1. **PERSONAL PAY** - I have no insurance or third parties liable for my health expenses. I understand that I am completely responsible for payment at time of service, unless other arrangements have been authorized by this office.

_____2. **HEALTH INSURANCE** — My health insurance will be billed for services rendered for my care. I understand that any deductible or co-pay, as designed by my health insurance, is my responsibility and is due at the time of service.

_____3. **MEDICARE** — I understand that Medicare does not pay for chiropractic examination, therapies, and x-rays; therefore, I am responsible for that amount. I understand that if I have a supplemental insurance, all the policies in statement #2 will apply.

_____4. **WORKER'S COMPENSATION** — I was injured in the course of employment, and I am eligible to have my expenses covered under Worker's Compensation. I agree to complete the forms necessary for processing my claims.

_____5. **AUTO ACCIDENT**— I was injured in an auto accident.

☐ A. I have an attorney representing my interests (provide information).
☐ B. I have Med-pay benefits in my auto policy (provide information).
I understand that in either case A or B above, I must sign a Doctor's Lien.

_____6. **ACCIDENTAL/PERSONAL INJURY**— I have been injured and my health insurance has a Supplemental Accident Benefit that will pay for the services rendered and/or I have an attorney representing my interests (provide information).

**********AUTHORIZATION & POLICY STATEMENT**********

I hereby assign the benefits to FJ Chiropractic - Berlin for the care that I am eligible to receive.

* I authorize Ty Rebedew, D.C. to release any information, to any insurance company, adjuster, or attorney that will assist in payment of a claim.

* I FULLY UNDERSTAND AND AGREE THAT THE INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE COMPANY AND MYSELF, NOT THE PROVIDER. I WILL BE RESPONSIBLE FOR ANY EXPENSES THE INSURANCE COMPANY DOES NOT MEET.

I have read the above and understand all statements.

Signed:_____ Date:_____

FJ Chiropractic

Your Rights Under HIPAA

This Notice describes how healthcare information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

FJ Chiropractic is dedicated to ensuring the privacy of your protected health information (PHI). We are required by law to provide you with this Notice of Privacy Practices, and to inform you of your rights, and our obligations, concerning your PHI. We are required to follow the privacy practices described below while this Notice is in effect. The terms of this Notice apply to all staff at our office.

Uses and Disclosures of Your PHI: The following sections describe different ways that we may use and disclose your PHI. For each section of uses of disclosures, there will be a description given. Some information, such as certain drug and alcohol information, HIV information and mental health information is entitled to special restrictions related to is use and disclosure. Not every use or disclosure will be listed. All of the ways the office is permitted to use and disclose information, however, will fall within one of the following categories:

Treatment: We may disclose your PHI to another healthcare facility and/or healthcare provider, transport company, community agency, family member or other third party to provide and/or coordinate health care services and treatments.

Payment: We may use and/or disclose your PHI to bill and obtain payment for treatment and/or services you receive at our office.

Healthcare Operations: We may use and disclose your PHI in connection with our healthcare operations. Healthcare operations include, but are not limited to; clinical education, quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance.

Billing Associates: We may disclose your PHI to businesses performing billing services for FJ Chiropractic such as processing claims, data analysis, billing, benefit management, practice management, re-pricing and legal assistance. We will have a written contract in place with the business associate requiring protection of the privacy and security of your health information.

Appointment Reminders: We may contact you to remind you that you have an appointment at FJ Chiropractic.

Individuals Involved in Your Care or Payment: Unless you have provided a specific written or witnessed verbal consent, we will not disclose any information to a person who is involved in your healthcare or pays for your care. There is an exception for minor children or patients who have a power-of-attorney.

Disaster Relief Efforts: We may disclose your PHI to an entity assisting in a disaster relief effort so your family can be notified about your condition, status, and location.

Legal: We will disclose health information about you when required to do so by federal or state law. We may disclose PHI in response to judicial proceedings and law enforcement inquiries as permitted by law. We may also disclose PHI in response to a subpoena, discovery request, warrant, summons or other lawful process.

To Avert a Serious Threat to Health and Safety: We may use and disclose your PHI when necessary to prevent or lessen serious and imminent threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to someone able to help stop or reduce the threat.

Public Health Purposes: We may use or disclose your PHI when we are required to do so by law, for public health reasons, including, but not limited to: Reporting certain communicable diseases to health officials; reporting child abuse or neglect; reporting elder abuse, neglect or exploitation.

Worker's Compensation: We may disclose PHI as necessary for worker's compensation or similar programs that provide benefits for work-related injuries or illness, as authorized or required by law.

Health-Oversight Activities: We may disclose PHI to governmental, licensing, auditing and accrediting agencies as authorized or required by law.

Military and Veterans: If you are or were a member of the armed forces, we may release PHI to military command authorities as authorized or required by law.

National Security, Intelligence Activities & Protected Services: Under certain circumstances we may disclose PHI to military authorities and to authorized federal officials for lawful intelligence, counterintelligence, and other national security activities.

Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information: Special privacy protections apply to HIV-related information, alcohol and substance abuse treatment information, mental health PHI, and genetic information. This means that parts of the Notice may not apply to these types of information because stricter privacy requirements may apply. If your treatment involves this information, you may contact anyone at our office to ask about special protections.

Inmates: Under certain circumstances we may disclose PHI relating to inmates or patients to correctional institutions or law enforcement personnel having lawful custody of those individuals.

Other Uses of PHI: Other uses and disclosures of PHI not covered by this Notice or laws that apply to us will be made only with your written authorization.

Patient Rights

Access to Your PHI: You have the right to access, inspect, and/or receive paper and/or electronic copies of the PHI that we maintain about you, with limited exceptions. This office will provide to an individual, upon written request, access within 30 calendar days of the day this office receives a request, to inspect and/or copy their PHI. If you request paper copies, we will charge you our standard copying fee for each page as well as postage if you want the copies mailed to you. If you request an alternative format, we will charge a reasonable cost-based fee for providing your PHI in that format. If you prefer, we will prepare a summary or an explanation of your PHI for a fee. Fax or mail a written signed request at the above fax or address.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your PHI for treatment, payment and healthcare operations purposes. Depending on the circumstances of your request, we may or may not agree to those restrictions. If we do agree to your requested restrictions, we must abide by those restrictions, except in emergency treatment scenarios.

Amendments to your Records: You have the right to request that we amend your PHI. Such requests must be made in writing and must explain why the information should be amended. *We are not obligated to make all the requested amendments* but will give each request careful consideration. In order to be considered by us, all amendment requests must be in writing and signed by you or your representative and must state the reasons for the amendment request. If an amendment or correction you request is made by us, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. Please note that even if we accept your request, we may not delete any information already documented in your health records. Contact us if you are interested in receiving a summary of your information instead of copies.

Accounting of Disclosures: Upon written request, you have the right to receive a list of instances in which we or our business associates disclosed your PHI for purposes, other than treatment, payment, healthcare operations and other activities authorized by you, for the last 6 years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Confidential Communications: You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations (e.g., at your place of business rather than at your home). Such requests must be made in writing, must specify the alternative means or location, and must provide a satisfactory explanation how communication should be handled under the alternative means or location you request.

Changes to this Notice: We reserve the right to change this Notice and the privacy practices described herein at any time in accordance with applicable law. Prior to making significant changes to our privacy practices, we will alter this Notice to reflect the changes, and make the revised Notice available to you on request. Any changes we make to our privacy practices and/or this Notice may be applicable to PHI created or received by us prior to the date of the changes.

Complaints: If you are concerned that we may have violated your privacy rights, or you disagree with any decisions we may make regarding use, disclosure, or access to your health information, you may make a formal complaint in writing to this office. You also may submit a written complaint to the U.S. Department of Health and Human Services in Washington D.C. All complaints must be made in writing and in no way will affect the quality of care you receive at FJ Chiropractic Office.

Breach Notification: We are required to notify you in writing of nay breach of your secured PHI as soon as possible, but in any event, no later than 60 days after we discover it.

Paper Copy of this Notice: You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you receive this Notice electronically, you are still entitled to a paper copy.

I understand the above and where necessary, a staff person has explained it to me: Received copy? (Y) (N) Patient Initials: _____

_____
Print Name

_____
Signature

_____
Date

FJ Chiropractic Office Representative:

_____
Signature

_____
Date

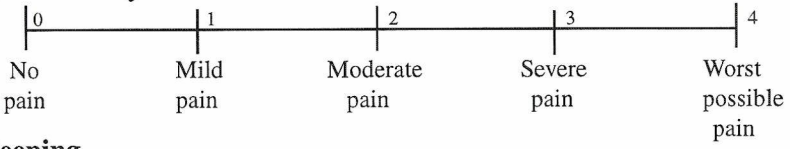
Original Eff. Date May 20, 2014; Updated August 30, 2022

Functional Rating Index

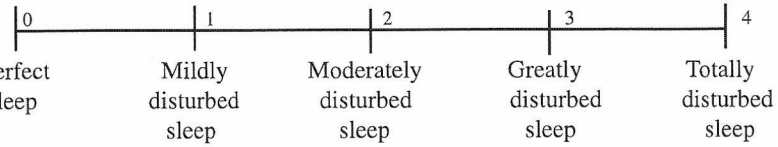
For use with **Neck and/or Back Problems** only.

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities.
For each item below, **please circle the number which most closely describes your condition right now.**

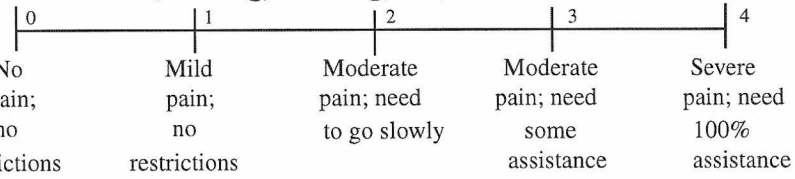
1. Pain Intensity



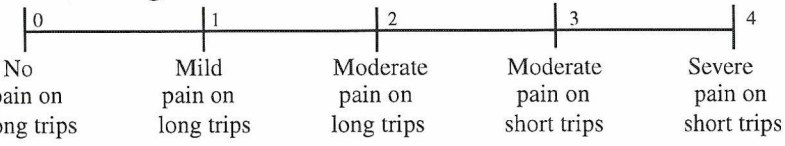
2. Sleeping



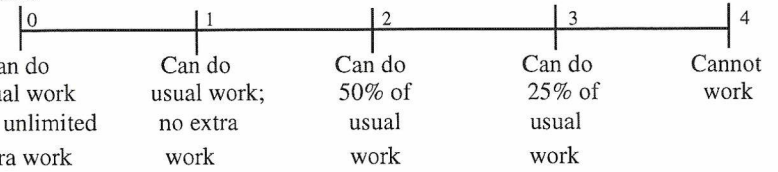
3. Personal Care (washing, dressing, etc.)



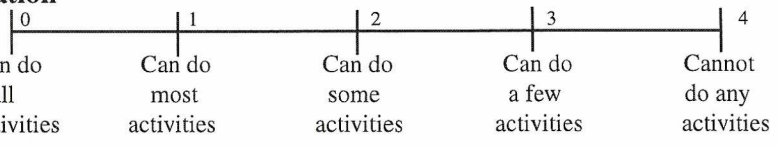
4. Travel (driving, etc.)



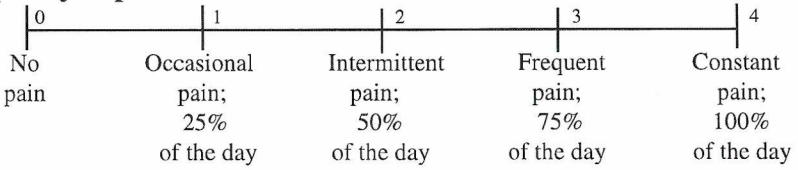
5. Work



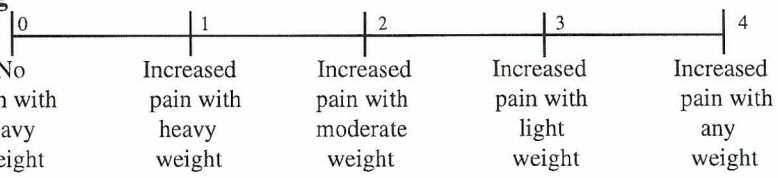
6. Recreation



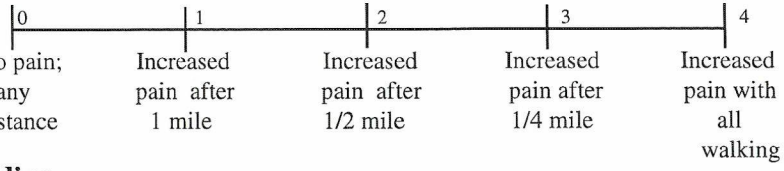
7. Frequency of pain



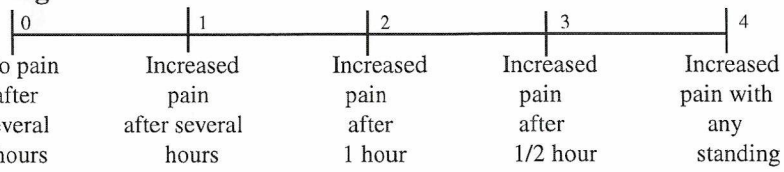
8. Lifting



9. Walking



10. Standing



Total Score _____

Name _____
PRINTED

_____
Signature

_____
Date