bloomington wellness center

Scoliosis Solutions Minnesota

bloomington
p: 952.881.2800
shakopee
p: 612.767.2800
wellbloomington.com

HIPAA Form

Patient Name _____

To the Patient – Please read the following statements carefully:

Purpose of Consent: By signing this form you will consent to our use & disclosure of your protected health information to carry out treatment, payment activities, healthcare & practice operations.

Notice of Privacy Practices: You have the right to read our notice of privacy practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, & healthcare operations, of the uses & disclosures we may make of your protected health information, & of other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully & completely before signing this consent.

We reserve the right to change our privacy practices as described in our notice of privacy practices. If we change our privacy practices, we will issue a revised notice of privacy practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our notice of privacy practices, including any revisions of our notice, at any time by contacting:

Contact Person: Cory Emberland, DC **Telephone:** 952-881-2800 **Fax:** 612-605-2788 **E-mail:** info@wellbloomington.com
Address: Bloomington Wellness Center / Scoliosis Solutions of MN - 5143 W 98th Street, Bloomington, MN 55437

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, & that we may decline to treat you or to continue treating you if you revoke this consent.

I, _____ , have had full opportunity to read & consider the contents of this consent form & notice of privacy practices. I understand that, by signing this consent form, I am giving my consent to use & disclosure of my protected health information to carry out treatment, payment activities, health care & practice operations. I also acknowledge that I have received a copy of, & agree to, Bloomington Wellness Center / Scoliosis Solutions of MN's notice of privacy practices.

Signature _____ Date _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:

_____

Relationship to Patient:

_____

You are entitled to a copy of this consent after you sign it.

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Intake & History Form

Patient Data

Patient Name: _____ Date: _____

Occupation: _____ Employer: _____

Social Security Number: _____ Date of Birth: _____ Age: _____ Gender: M / F

Address: _____ City:_____ State: _____ Zip: _____

Cell Phone: _____ Email: _____

Emergency Contact Information

Name: _____ Phone: _____ Relationship: _____

Children Name(s) & Age(s): _____

Referral Source: _____ Have you seen us on: __Google __Facebook __Website __Print Media

Condition Information

Current Symptoms: _____ Reason for Visit: _____

Have you seen any other providers for this: **Yes / No** Who & When: _____

When did it start: _____ How: **Accident / Work / Other:** _____

Does it radiate to any other part of your body: **Yes / No** Where: _____

Did it begin: **Gradually / Suddenly** How would you describe the intensity: **Mild / Mod. / Severe / 1-10:** _____

Is your pain: **Dull / Sharp / Burning / Numbness / Soreness / Stiffness / Deep / Surface / Other:** _____

Has your problem been getting: **Worse / Better / About the Same / Other:** _____

Does your pain: **Radiate / Come & Go / Constant / Other:** _____

What makes your symptoms better: _____

What makes your symptoms worse: **Sitting / Standing / Walking / Coughing / Driving / Sleeping / Bending / Sneezing**

Other: _____

What have you tried to alleviate your symptoms: _____

Has your conditions affected your daily activities: **Yes / No** **Explain:** _____

Have you had anything like this before: **Yes / No** **Explain:** _____

Health Information

Have you been diagnosed with any other conditions: **Yes / No** **Explain:** _____

Do you suffer from: **Headaches / Neck Pain / Upper Back Pain / Middle Back Pain / Lower Back Pain / Arm or Leg Pain**

Other: _____

Are you under a doctor's care presently for any type of health problem: _____

Have you ever had any past: **Auto Accidents / Work Injuries / Falls** **Other**: _____

List medications & supplements: _____

Have you ever undergone any surgery: **Yes / No** **What & When:** _____

Do you: **Smoke / Use Recreational Drugs** **List Alcohol Consumption:** _____

Do you have any allergies: **Yes / No** **Explain:** _____

Do any diseases run in your family: _____

Are you healthier today than you were 5 years ago: **Yes / No** **Explain:** _____

On a scale of 1-10 describe your stress level: (1=None / 10=Extreme) **Occupational Stress:_____** **Personal Stress:_____**

On a scale of 1-10 describe your: (1=Poor / 10=Excellent)

Exercise: _____ Sleep: _____ **Diet: _____** **Emotional Health: _____** **General Health: _____**

Women Only: Pregnant **Yes / No** Trying to conceive **Yes / No** Nursing **Yes / No** Taking oral contraceptives **Yes / No**

Goals for Care *(Select One)*

___ **Relief Care:** Help me out of this acute pain, that's all I need.

___ **Comprehensive Care:** Help me with my immediate issue, then help me learn how to manage it for the long-term.

Authorization & Consent

1. I certify that I am the patient or legal guardian listed above. I have read & understand the included information & certify it to be true & accurate to the best of my knowledge. I consent to the collection & use of the above information.
2. I consent to treatment provided by this clinic. I understand that my condition may necessitate modifications from time to time of the type of treatment rendered & the portions of my body that may need to be examined. I understand & consent to clinic staff providing me with verbal descriptions, when there are changes to my examination & treatments, consent to the clinic staff providing said treatments & exams & hereby consent to any similar subsequent treatments or exams. If I do not consent, I will immediately inform clinic staff. There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or insurance. I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform clinic staff.
3. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating &/or temporary increase in symptoms, lack of improvement of symptoms, burns &/or scarring from electrical stimulation & from hot or cold therapies, including but not limited to hot packs & ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, & sprains. Safety & satisfaction are paramount concerns of the doctors & clinic, but I do understand that there is risk involved in my treatment, & I understand it is never possible to consider every possible complication to care.
4. I have had an opportunity to ask questions about this document, & by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance.
5. I intend this consent to cover the entire course of care from all providers in this office for my present condition & for any future conditions for which I seek chiropractic care from this office.

Patient / Guardian Signature: _____ Date: _____

Print Patient / Guardian Name: _____

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Financial Policy & Agreement

I, the undersigned, in consideration of this office's services, agree to the following terms:

Definitions. In this Agreement, "Office" & "Clinic" shall refer to Bloomington Wellness Center, PA located at 5143 West 98th Street, Bloomington, MN 55437 & 4109 West Dean Lakes Blvd, Shakopee, MN 55379.

Personal Responsibility for My Charges. I understand that I am personally responsible for my charges & that at any time, I can request a copy of my total charges from the office. Except where provided otherwise by law or by contract, I agree to pay the full amount of my charges to the office upon its demand. I understand that the office's assignment does not constitute an agreement by the office to await payment of my charges. Unless otherwise mutually agreed to in writing on a form provided by the office, I agree that any partial payments received by the office towards my charges, or any delay by the office in collecting from me, shall not constitute acceptance of any installment payment plan, shall not constitute a waiver of the office's right to receive payment-in-full upon demand, & shall not constitute an "accord & satisfaction" of my charges, regardless of any such terms or restrictions indicated on, or included with, any payments.

Personal Responsibility for Verifying the Limitations in My Coverage; Financial Responsibility for Non-Covered Charges. I understand that in any given situation, a payer may initially refuse to make payment to the office, may delay payment for an indefinite or unreasonable amount of time, or may actually request a refund from the office after making payment, & do so either in whole or in part with respect to any given charge incurred at the office (collectively, "deny payment"). For example (without limiting this agreement), I understand that a payer may deny payment, stating that the charge is "not a covered benefit" under its policy or exceeds some other limitation. I further understand that a payer may deny payment stating that the individual provider who actually renders the treatment or procedure is out-of-network. I also understand that a payer may claim, based on internal criteria, that a particular charge is or was not medically necessary or was not sufficiently documented, & should therefore be denied or down-coded. I also understand that a payer may require certain charges to be pre-certified or preauthorized.
I understand that there may be many other situations where a payer may deny payment based on a particular contractual term applicable to me or to the office (collectively, "terms of non-coverage"). To the extent permitted by law or by contract, I agree that I am solely & exclusively responsible for verifying all terms of non-coverage prior to incurring any charges at the office. I agree that if I have any questions about the terms of non-coverage, I can ask to see copies of the office's verification (e.g., eligibility, pre-authorization) forms to gain further understanding. I further agree that should the office assist me in any way in the verification, pre-authorization, or billing process, I assume the risk that the payer and/or the office may in my opinion not accurately understand and/or communicate the terms of non-coverage and/or bill my charges to my payers. Should any payer deny payment, or should any payer be likely to deny payment as determined by the office in its sole discretion, I agree that I am personally, fully, & immediately responsible for the portion of my charges denied or likely to be denied. In no event shall I hold the office responsible or liable in any of the foregoing instances.

Direction to the Office to Apply the Lowest Mandatory Fee Reduction When Two or More Payers Are Involved. Unless otherwise agreed to in writing, I authorize & direct the office to submit my charges, as well as a copy of the assignment & lien, to any & all payers including, without limit, my health benefit plan. I understand that some or all of these payers may utilize fee schedules which (a) the office has agreed to accept, directly with said payers in writing, or (b) law expressly imposes on the office to accept (collectively, "mandatory fee reductions"). I further understand that the mandatory fee reductions imposed on the office with respect to one payer may exceed the mandatory fee reductions imposed on the office with respect to another payer. In such an event, I hereby authorize & direct the office insofar as permitted by law to apply the lower of the two mandatory fee reductions to its charges. I further agree that in the special event that mandatory fee reductions are imposed on the office by virtue of laws which regulate or restrict "balance billing," I hereby waive the application of such laws. In the event that no mandatory fee reductions are actually imposed on the office with respect to a payer, I authorize & direct the office to collect up to its full charges from such payer.

Authorization to Sign My Name on Payments; Transfer of Credit Balances. I authorize the office to endorse or sign my name on any & all payments listing me as a payee which are received by the office for payment of charges incurred by me, my spouse or my dependents. In such cases, my printed name, followed by the phrase, "(by Bloomington Wellness Center, PA)," shall serve as a properly authorized endorsement. I further authorize the office to apply any credit balances on my charges to any other outstanding charges still owed by me, my spouse, or my dependents, regardless of whether these other charges are related to my condition.

Miscellaneous Provisions. I have reviewed the office's "assignment" & health insurance election forms & further agree to the terms & definitions set forth in these documents. Said documents are incorporated herein by reference.

Payment Election Agreement

Choose One (initial choice):

____ Option 1 – **I do not have health insurance. / I don't want the clinic to file my health insurance. / I am a cash paying patient.**

I want the services we discuss, but either I don't have health insurance or I don't want you to bill or submit paperwork to my health insurance. The clinic may ask to be paid now as I am responsible for payment. I understand that if my claims or forms are not submitted to my health insurance in a timely manner, my payer may decline to pay on my claims & I may not be able to appeal this decision.

____ Option 2 – **I want the clinic to file my health insurance & also to help me verify my benefits.** To help the clinic receive payment, I'll make partial estimated payments and/or sign an assignment & financial policy.

I want the services offered by the clinic, but I also want the clinic to bill my health insurance for an official decision on payment. Please help me verify any terms of non-coverage. If I have any questions, I will verify my coverage on my own. The clinic may ask to be paid now for estimated co-pays, co-insurance, deductibles & other non-covered amounts. I understand that these are just estimates. In the event that my health insurance denies payment, I will be responsible for payment as described in your financial policy, but I understand that I will be able to appeal to my health insurance following its directions. I have reviewed, understand & been offered a copy of the financial policy form.

____ Option 3 – **I want the clinic to file my health insurance, but I'll pay in-full at the time of service or pre-pay**. If insurance pays, the clinic will give me a refund.

I want the services we discuss, but I also want the clinic to bill my health insurance for an official decision on payment. However, the clinic may ask to be paid now. If my health insurance does pay, the clinic will refund any payments I made, less co-pays, co-insurance, & deductibles, & also discounts (mandatory fee reductions) as described in the financial policy. In the event that my health insurance denies payment, I can appeal to my health insurance following its directions.

Assignment & Agreement

1. I understand & fully accept the financial policy as outlined on this document.
2. I understand that this election will remain in effect until a new election is signed with the clinic's consent. This election supersedes any prior health insurance election.
3. I understand & agree that all services rendered to me are charged directly to me & I am personally responsible for timely payment. I also understand that if I suspend or terminate my care & treatment any fees for professional services rendered to me will be immediately due & payable. This authorization is valid until I provide you with written cancellation.
4. I authorize the clinic & its staff to examine & treat my condition appropriately as determined by the doctors of the clinic.
5. I hereby authorize the clinic to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement for charges incurred by me.
6. I grant the use of my singed statement of authorization with my signature for required insurance submissions. I understand & agree that health/accident insurance policies are an arrangement between an insurance carrier & myself, the clinic offers assistance with your insurance as a courtesy.
7. I understand that a 24-hour notification is required for appointments that need to be cancelled or rescheduled. If proper notification is not given, a $30 charge will be applied to my account.

I have read, understood, & agree to the terms of this Agreement.

Patient Name:_____

Authorized Signature:_____**Date:** _____

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Pediatric Intake Form (12 & Under)

Child's Name _____ Date of Birth _____ Age _____ Gender M / F

Parent/Guardians Name's _____

Address _____ City, State, Zip _____

Home Phone _____ Cell Phone_____

Email _____ Referred by_____

Reason for Visit _____

Other providers for this condition? Y / N If so, who? _____ When_____

Emergency Contact _____ Phone_____

Consent to evaluate and treat a minor child (through age 18)

I, _____ , being the parent or legal guardian of_____

hereby grant permission for my child to receive treatment at Bloomington Wellness Center.

Signature _____ Date_____

Pediatric Health History

Chief health concern? _____

Other health concerns? _____

Any recent traumas or play contact sports? **Y / N** If **Yes**, please describe _____

Has your child been seen on an emergency basis? **Y / N** If **Yes**, please describe _____

List other hospitalizations: _____

List Rx & OTC drugs and supplements, include reason for use: _____

_____

Pediatric Health History -Continued-

Please check any of the following conditions your child has suffered from past and present:

___Allergies	___Chicken Pox	___Fatigue	___Meningitis	___Rubeola
___Asthma	___Colds	___Fevers	___Mumps	___Seizures
___ADHD / ADD	___Colic	___Growing Pains	___Neck Pain	___Scoliosis
___Back Pain	___Diarrhea	___Headaches	___Poor Posture	___Sleeping Disorders
___Bedwetting	___Digestive Problems	___Irritability	___Rashes	___Whooping Cough
___Breathing Problems	___ Ear Infections	___Measles	___Rubella	___Other:

Was your child vaccinated? **Y / N** If **Yes:** Full Schedule / Partial Reactions: _____

On a scale of **0 - 10** describe your child's stress level: **(0 = None / 10 = Extreme)**

On a scale of **0 - 10** describe your child's: **(0 = Poor / 10 = Excellent)**

Exercise: _____ Sleep: _____ Diet: _____ Emotional Health: _____ Overall Health: _____

Prenatal Health History (children up to age 5)

Problems during pregnancy? _____

Alcohol, smoking, illicit, prescription or over-the-counter drug use during pregnancy? **Y / N / Unsure**

If **Yes**, please list: _____

Circle type of birth: **Vaginal / Forceps / Vacuum / Breech / Cesarean** - **Planned** or **Emergency**

Problems during labor/delivery? _____

Medication or anesthesia during L/D? **Y / N / Unsure** If **Yes**, please list: _____

Visible injury to the baby after delivery? **Y / N / Unsure** If **Yes**, please list: _____

Developmental History (Children up age 5)

At what age was your child able to respond to:

Sound:_____ Visual Stimuli:_____ Hold Head Up:_____ Sit Up:_____

Cross Crawl:_____ Stand Alone:_____ Walk Alone:_____ First Words:_____

Are you concerned about any developmental delays? **Y / N** If **Yes**, please list: _____

Child's Name:_____

Parent / Guardian Name: _____

Parent / Guardian Signature: _____ **Date:** _____