



bloomington
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Pregnancy Intake Form

Case History for Pregnant Mothers

Name: _____

Date: _____

Prenatal History

Is this your first pregnancy? **Yes / No** (If no, please complete all pages)

If **No**, how many other births have you had? _____

Year(s): _____

How many weeks pregnant are you now? _____

Due Date: _____

Have you experienced any traumas during this pregnancy? (Accidents, falls, etc.) **Yes / No**

If **yes**, please describe: _____

Are you taking any medications or supplements during this pregnancy? **Yes / No**

If **yes**, list what and why for each: _____

Do you smoke or drink alcohol? **Yes / No** If **yes**, explain: _____

Have you had, or do you have any pregnancy evaluation procedures planned? **Yes / No**

(Ultrasound, amniocentesis, chorionic villus sampling, etc.)

If **yes**, please list the procedure and the reason for each: _____

How has your diet been during this pregnancy? **Excellent / Average / Poor**

Have there been any complications in this pregnancy? **Yes / No**

If **yes**, describe: _____

What are your most significant fears associated with this pregnancy or birth process? _____

Who is your birth care provider? _____

Will you have someone with you at the birth for coaching or support? **Yes / No**

If **yes**, specify who: _____

Where do you plan on delivering? _____

Do you intend to utilize a birth plan? **Yes / No**

If **no**, why? _____

Why are you seeking Chiropractic care during your pregnancy? _____

Previous Birth History

[_____ Check if not applicable & sign at bottom of page.]

Place of birth: Hospital / Birthing Center / Home / Other: _____

Delivering Practitioner: OB/Gyn / Nurse Midwife / Certified Practicing Midwife / Lay Midwife

Position of Delivery: Lithotomy position / Kneeling / Squatting / Chair / Birthing Tub / Caesarian / Other: _____

Was labor induced? Yes / No List details: _____

Were your membranes stripped or ruptured? Yes / No / Unknown

Did you utilize any pain medications or anesthesia? Yes / No / Unknown

If yes, please specify type used: _____

How did it affect labor? _____

Did you experience back pain during labor? Yes / No / Unknown

Baby presentation at time of delivery: Normal / Posterior / Brow / Fascial / Breech

Did your care provider assist the delivery with his or her hands? Yes / No / Unknown

If yes, was there any turning or pulling applied to the baby's neck? Yes / No / Unknown

Was there any visible injury to the baby? Yes / No / Unknown List: _____

Were operative devices used to facilitate the birth? Yes / No / Unknown

If yes, which type? Forceps / Vacuum Extraction / Other: _____

If yes, were there any visible signs of injury to the baby? Yes / No / Unknown

If yes, list: _____

Was there a birthing coach present? Husband / Doula / Friend / Other: _____

At what week of pregnancy was the baby born? _____

Did you have any complications during any of your previous pregnancies? Yes / No

If yes, please explain: _____

If miscarriages, please list dates and week gestation: _____

Print Name: _____ Date: _____

Signature: _____



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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:** _____

Intake & History Form - Continued

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: _____

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 signed 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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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.