Whom may we thank for referring you to this office → _____?

APPLICATION FOR CARE AT SPINAL HEALTH CENTER

Dr. Aaron Kirking Chiropractor

Today's Date: _____ HRN: _____

PATIENT DEMOGRAPHICS:

Name: _____ Birth Date: _____-_____-_____ Age: _____ □ Male □ Female

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

E-mail Address: _____ Home Phone: _____Mobile Phone:_____

Marital Status: ❑ Single ❑ Married Do you have Insurance: ❑ Yes ❑ No Work Phone: _____

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Spouse's Name _____Spouse's Employer _____

Number of children and Ages: _____

Name & Number of Emergency Contact: _____ _____Relationship: _____

HISTORY of COMPLAINT:

Please identify the condition(s) that brought you to this office: Primarily:

_____

Secondarily: _____ Third: _____ Fourth:

_____

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by c***ircling the number*:**

Primary or chief complaint is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaints is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? _____ When is the problem at its worst? □ AM □ PM □ mid-day □ late PM

How long does it last? □ It is constant **OR** □ I experience it on and off during the day **OR** □ It comes and goes throughout the week

How did the injury happen?_____

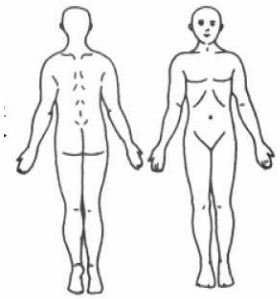
Condition(s) ever been treated by anyone in the past? □No □ Yes **If yes,** when: _____ by whom?

_____

How long were you under care: _____ What were the results?

_____

Name of Previous Chiropractor: _____ □ **N/A**



***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:
R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/ **S**tabbing **T= T**ingling

What relieves your symptoms? _____

What makes them feel worse? _____

LIST RESTRICTED ACTIVITY:	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL

Is your problem the result of ANY type of accident? □ Yes, □ No
Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

PAST HISTORY:

Have you suffered with any of this or a similar problem in the past? ❑ No ❑ Yes **If yes** how many times? _____ _ When was the last episode? _____ How did the injury happen?_____

Other forms of treatment tried: □ No □ Yes **If yes,** please state **what** type of treatment: _____, and who provided it: _____ **How long ago? _____**What were the results. □ Favorable □ Unfavorable→ please explain. _____ _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past*, C** for ***Currently*** have and **N** for *N**ever** have had*:

___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture ___Disability ___Cancer
___ Heart Attack ___Osteo Arthritis ___ Diabetes ___Cerebral Vascular ___ Other serious conditions:

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES→			
ADULT DISEASES →			

SOCIAL HISTORY:

1. Smoking: ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
2. Alcoholic Beverage: consumption occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
3. Recreational Drug use: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
4. Hobbies -Recreational Activities- Exercise Regime: How does your present problem affect the following, See pg 2- Activities of Life.

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes

If yes whom: ❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sister's ❑ brother's ❑ son(s) ❑ daughter(s)

Have they ever been treated for their condition? ❑ No ❑ Yes ❑ I don't know

2. Any other hereditary conditions the doctor should be aware of. ❑ No ❑Yes: _____

I hereby authorize payment to be made directly to Spinal Health, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Spinal Health for any and all services I receive at this office.

_____ _____ - _____ - _____

Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____

Doctor's Signature **Date Form Reviewed**

Patient's Name: _____ HR#: _____ ___/___/___

INFORMED CONSENT

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Spinal Health Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____ ● *Witness Initials*

Patient or Authorized person's Signature Date

REGARDING: X-rays/Imaging Studies

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

□ The first day of my last menstrual cycle was on ____-____-____ Date

□ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____ ● *Witness Initials*

Patient or Authorized person's Signature Date

Employee Name: _____
Date and Time of Call: _____

IN NETWORK/ PARTICIPATING:

Deductible
Indiv_____%_____
Family_____%_____

How much of deductible is met?
Indiv_____
Family_____

Visits per year_____
Co-pay _____
Max out of pocket _____
Max ins. pays per year_____
Calendar year or based on when plan began? _____

Is massage therapy a covered service? Y/N

Are therapies covered (97112, 97012)? Y/N

Prior Authorization? Y/N
After how many visits? _____
Patient DOB: _____
Spoke with_____

OUT OF NETWORK/NON-PARTICIPATING:

Effective Date_____

Deductible
Indiv_____%_____
Family_____%_____

How much of deductible is met?
Indiv_____
Family_____

Visits per year_____
Co-pay _____
Max out of pocket _____
Max ins. pays per year_____
Calendar year or based on when plan began? _____

Does deductible cross networks? Y/N

Exam and films
Subject to max? Y/N _____
Subject to deductible? Y/N_____

Does plan have a 4th quarter carry over? Y/N

WELCOME TO SPINAL HEALTH!

As a potential new patient, we feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read "Our Office Policies", if you have any questions or any of these policies are unclear to you, and you would like further explanation before submitting your ***Application for Care,*** please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved and the benefits derived from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

□ **PATIENT PRIVACY –** Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

□ **YOUR CARE** - When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at Spinal Health is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body's innate wisdom. The doctors use a myriad of techniques to accomplish this goal, including but not limited to Petibon, CBP, Diversified, Arthrostime, and CLEAR. It is important that you understand both the objective and the methods so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving your overall health.

□ **FIRST THINGS FIRST**- Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

□ **PATIENT'S REPORT OF FINDINGS** – To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a 'Doctor's Report of Findings'. The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctor's recommendations for care, will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient's family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

I hereby acknowledge receiving a copy of the practices 'Office Policies' a two page document, the first page of which I have read and retained. This second page is recognized by me as the signature page and will be retained by the practice as evidence of my receiving and understanding this 'Notice'. I further acknowledge that any concerns regarding these 'Policies 'as well as all my questions have been answered by a qualified member of the staff to my complete satisfaction.

_____ _____ __ _____

Patient's Name DOB HR#

_____ _____

Patient signature Date

_____ _____

Witness Date

SPINAL HEALTH NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or imminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -**we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Dr. Aaron Kirking at (952) 746-1256. If he is unavailable, you may make an appointment with our receptionist to see him within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Spinal Health's NOTICE REGARDING YOUR RIGHT TO PRIVACY continued….

I have received a copy of Spinal Health Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at an time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____ _____

Patient's Name DOB HR#

_____ _____

Patient signature Date

_____ _____

Witness Date

X-RAY REPORT

Patient Name: _____ DOB:_____ HR#: _____ Date of Study:___/___/___

( ) Male ( ) Female

Cervical Spine

( ) AP, LATERAL ( ) FLEXION/EXTENSION ( ) OBLIQUE ___*LEFT* ____ *RIGHT*
( ) **NEGATIVE** FOR RECENT FRACTURE OR GROSS PATHOLGY; BODIES, PEDICLES AND DISC SPACES APPEAR NORMAL
( ) LORDOTIC CURVE ( ) MILD DECREASE ( ) SEVERE DECREASE ( ) KYPHOTIC
( ) SCOLIOSIS ( ) LEFT ( ) RIGHT ( ) MILD ( ) MODERATE ( ) SEVERE *APEX:* _____
( ) NARROWED DISC SPACES BETWEEN: _____
( ) OSTEOARTHRITIS OF: _____
( ) ENCROACHMENT OF NEUROFORAMINA BETWEEN: _____
( ) HYPERTROPHIC ARTHRITIC CHANGE OF ( ) ANTERIOR ( ) POSTERIOR LEVEL: _____
( ) END PLATE DEFORMITY OF: _____
( ) SPINA BIFIDA LEVEL: _____
( ) CLINICAL RATIONALE FOR TAKING FILMS:_____

Thoracic Spine

( ) AP, LATERAL ( ) OBLIQUE ___*LEFT* ___ *RIGHT*
( ) **NEGATIVE** FOR RECENT FRACTURE OR GROSS PATHOLGY; BODIES, PEDICLES AND DISC SPACES APPEAR NORMAL
( ) KYPHOTIC CURVE ( ) MILD INCREASE ( ) SEVERE INCREASE ( ) LORDOTIC
( ) SCOLIOSIS ( ) LEFT ( ) RIGHT ( ) MILD ( ) MODERATE ( ) SEVERE *APEX*: _____
( ) NARROWED DISC SPACES BETWEEN: _____
( ) OSTEOARTHRITIS OF: _____
( ) ENCROACHMENT OF NEUROFORAMINA BETWEEN: _____
( ) HYPERTROPHIC ARTHRITIC CHANGE OF ( ) ANTERIOR ( ) POSTERIOR LEVEL: _____
( ) END PLATE DEFORMITY OF: _____
( ) SPINA BIFIDA LEVEL: _____
( ) CLINICAL RATIONALE FOR TAKING FILMS:_____

Lumbar Spine

( ) AP, LATERAL ( ) FLEXION/EXTENSION ( ) OBLIQUE ___*LEFT* ___*RIGHT*
( ) **NEGATIVE** FOR RECENT FRACTURE OR GROSS PATHOLGY; BODIES, PEDICLES AND DISC SPACES APPEAR NORMAL
( ) LORDOTIC CURVE ( ) MILD DECREASE ( ) SEVERE DECREASE ( ) KYPHOTIC
( ) SCOLIOSIS ( ) LEFT ( ) RIGHT ( ) MILD ( ) MODERATE ( ) SEVERE *APEX*: _____
( ) NARROWED DISC SPACES BETWEEN: _____
( ) OSTEOARTHRITIS OF: _____
( ) ENCROACHMENT OF NEUROFORAMINA BETWEEN: _____
( ) HYPERTROPHIC ARTHRITIC CHANGE OF ( ) ANTERIOR ( ) POSTERIOR LEVEL: _____
( ) END PLATE DEFORMITY OF: _____
( ) SPONDYLOLISTHESIS ( ) GRADE 1 ( ) GRADE 2 ( ) GRADE 3 ( ) GRADE 4 LEVEL: _____
( ) CALCIFIED ABDOMINAL AORTA ( ) MILD ( ) MODERATE ( ) SEVERE
( ) LUMBARIZATION OF S1 SACRAL SEGMENT
( ) SACRALIZATION OF L5
( ) HYPERTROPHIC ARTHRITIC CHANGE ( ) ANTERIOR MOTOR UNIT OF: _____
( ) POSTERIOR MOTOR UNIT OF: _____
( ) SACROILIAC ARTICULATION ( ) LEFT ( ) RIGHT ( ) BILATERAL
( ) ACETABULUM ( ) LEFT ( ) RIGHT ( ) BILATERAL
( ) SPINA BIFIDA LEVEL: _____
( ) CLINICAL RATIONALE FOR TAKING FILMS:_____
( ) CHECK HERE IF MORE NOTES ON BACK OF THIS SHEET