

Crossroads Chiropractic Intake Form:

Date:_____ Name:_____ Preferred Name:_____

Date of birth:_____ Social Security #:_____ Sex at birth:_____

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

Email address:_____

Permission to send electronic statements to email: Yes/No

Mobile phone:_____ Occupation:_____

Employer:_____ Employer phone:_____

Emergency contact/phone:_____ Relationship:_____

Where did you hear about us? _____

Medications: _____

Are you pregnant? Y/N/NA Have you had x-rays/imaging? _____

Family history: _____ Heart disease/high blood pressure _____ Cancer _____ Diabetes

_____ Stroke _____ Arthritis _____ Dementia/Alzheimer's _____ Back/disc problems

Major concern today? _____

How did it happen? _____

Insurance Company: _____ ID: _____ Group #: _____

WC/Auto Injury: Insurance company: _____

Claim #: _____ Date of injury: _____

Adjuster name and phone: _____

Name: _____ Date: _____ Phone #: _____

Have you had any new accidents or injuries since your last visit? Y or N

Are you missing work because of these symptoms? Y or N

Please circle the appropriate number on the scale for questions below:

I would rate the intensity of symptoms as:

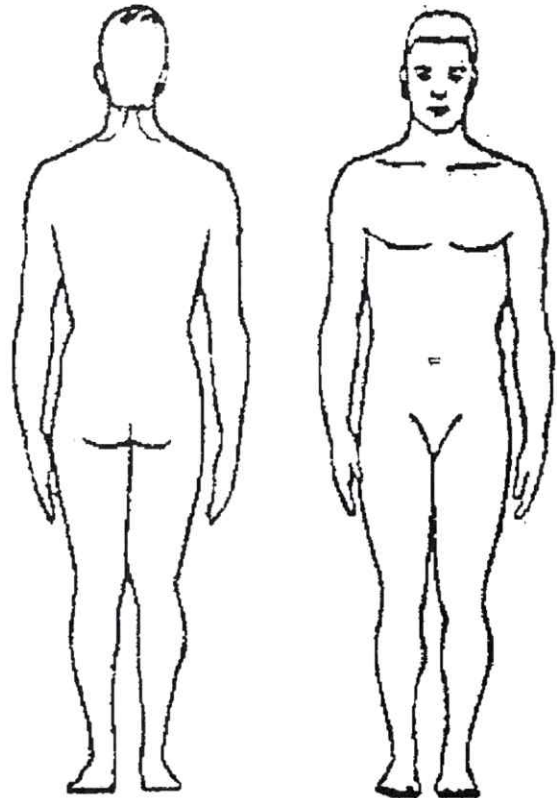
1 2 3 4 5 6 7 8 9 10
Very Mild Mild Moderate Severe

I feel the symptoms:

1 2 3 4 5 6 7 8 9 10
Seldom On & Off Constant

Use these symbols on the diagram to the side:

xxx Sharp Pain /// Dull Pain *** Burning Pain
:::: Pins & Needles === Numbness +++ Radiating Pain



Doctor's Findings:

Date of injury/onset:

History of Complaint:

Radicular Pain: Y or N Upper Extremities/Lower Extremities

Family History:

MSRs: WNL / C5 / C6 / C7 / L4 / L5 / S1

ROM: Decreased C / T / L

Other:

Check symptoms you have noticed:

☐ Headaches	☐ Pain in Shoulders	☐ Low back pain
☐ Head feels heavy	☐ Muscle spasm in shoulders	☐ Low back muscles spasm
☐ Lightheaded	☐ Pain in neck	☐ Pain in buttock
☐ Loss of balance	☐ Stiff neck	☐ Thigh pain
☐ Dizzy	☐ Muscle spasms in neck	☐ Pain down the leg
☐ Nervousness	☐ Pain in arms or hands	☐ Pain in the ankle
☐ Fatigue	☐ Pins & needles in arms/hands	☐ Pain in the foot
☐ Loss of hearing	☐ Loss of grip strength	
☐ Blurred vision	☐ Mid back pain	
☐ Chest pain	☐ Pain between shoulders	

When did the pain or problem start: _____

What aggravates the condition: _____

What helps the condition: _____

Is it worse during certain times of the day: Y or N If so when: _____

Is the condition getting worse: Y or N

Any home remedies: _____

Have you seen anyone else for this condition: _____

Any other previous illness such as cancer or fractures: _____

Read and sign below:

If you are accepted as a patient you are expected to pay at the end of each visit unless other arrangements are approved. Also, this office will gladly prepare medical claim forms, but we cannot render services on the assumption that our charges will be paid by an insurance company. You are responsible for payment whether or not paid by insurance.

Date: _____

Patient Signature: _____

ASSIGNMENT OF BENEFITS AND POWER OF ATTORNEY TO CASH CHECKS

I hereby assign all benefits, to major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, auto or any other health/medical plan, to issue payment check(s) directly to CROSSROADS CHIROPRACTIC CLINIC PA, for medical services rendered to myself and/or my dependents regardless of my benefits, if any. If these payments are made out to me, I grant the office below to endorse any and all checks and drafts or money orders. I hereby authorize the doctor to release all information.

Date: _____

Patient Signature: _____

Crossroads Chiropractic Clinic

Notice of Privacy Practices

Acknowledgement

Patient Name: _____

DOB: _____

I have received the practice Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. This notice includes:

- A statement that this practice is required to abide by the terms of the notice that is currently in effect.
- A statement that this practice is required by law to maintain the privacy of protected health information.
- Types of uses and disclosures that this practice is permitted to make to each of the following purposes: treatment, payment, and healthcare operations.
- A description of each of the other purposes for which the practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- My individual rights with respect to protected health information and a brief description of how I exercise these rights in relation to:
 - The right to complain to this practice and to the secretary of HHS if I believe my privacy rights have been violated.
 - The right to request restrictions on certain uses and disclosures of my protected health information and that this practice is not required to agree to a requested restriction.
 - The right to receive confidential communications of protected health information.
 - The right to inspect and copy protected health information.
 - The right to amend protected health information.
 - The right to receive an accounting of disclosures of protected health information.
 - The right to obtain a paper copy of the notice of privacy practice on request.

I understand and acknowledge the statements listed above:

Signature: _____

Date: _____



Jeffrey J. Varner D.C. — Eric M. Oltmanns D.C. – Tammy Dickinson D.C.

INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustment and other chiropractic procedures including various modes of physical therapy, and if necessary, diagnostic x-rays on me by the chiropractic physicians and/or anyone working in this office authorized by the chiropractic physicians.

I further understand that such Chiropractic services may be performed by the physicians of Chiropractic, Dr. Varner/Dr. Oltmanns/Dr. Dickinson and/or other licensed physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Varner / Dr. Oltmanns / Dr. Dickinson or other clinic personnel, the nature and/or purpose of chiropractic adjustments and other procedures, I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medical and all healthcare, the practice of chiropractic carries some risks to treatment including but not limited to; fractures, disc injuries, strokes (CVA), dislocations and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgement during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

I have read or have had read to me the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

Patient Name

Doctor Name

Patient Signature Date

Doctor Signature Date

(Parent Signature, if a minor)

251 County Road 120, St. Cloud, MN 56303 – PH: 320-252-3711 – Fax: 320-240-0608

crossroadschiropracticclinicpa.com

Crossroads Chiropractic – Appointment Etiquette

APPOINTMENTS

Please arrive on time for your appointments. The doctors do their best to stay on schedule and need your cooperation. Once a treatment plan is set, try to not alter the length of time between recommended visits until the doctor releases you to an as needed basis. If you are unable to keep an appointment for any reason, please call our office prior to the appointment to either reschedule or cancel so that we can accommodate another patient. Thank you for your cooperation.

LATE ARRIVALS

If you happen to arrive late for an appointment, your visit may be shortened and end at the normal allotted time to stay timely for the other patients whose appointments follow yours. Depending on how late you arrive, it is possible that you may have to reschedule.

RESCHEDULED, CANCELLED, and NO-SHOW APPOINTMENTS

Missed appointments represent a cost to us and to other patients that could have been seen from our waiting list in the time that was scheduled for you. This interferes with our clinic flow and creates scheduling issues for other patients.

If you cannot attend your appointment as scheduled, please call us 24 hours prior to the start of your appointment time by calling 320-252-3711. This allows us to call other patients that are on our waiting list. Since we turn away other patients to hold your appointment, any no-show/no-call appointments will result in a cancellation fee charged directly to the patient, not your insurance company.

The fee for a no-show visit will be \$50 that will be billed directly to you. This fee will be due prior to scheduling another visit.

Emergencies will be handled on a case-by-case basis. If you have an emergency where you are unable to call us, please let us know the circumstance and we will gladly waive the fee.

I have read and understand the terms of this form. I also understand that the no-show fees have nothing to do with my co-pay or deductible and cannot be billed to my insurance company. Furthermore, I understand that if I fail to adhere to the above policies, I will be billed/charged by Crossroads Chiropractic Clinic for any fees that are incurred.

Patient Name

Signature

Date

Staff initials: _____ Date: _____

Crossroads Chiropractic Clinic
251 co Rd 120, St. Cloud, MN 56303
(320)252-3711

Non-Covered Services: Financial Disclosure Form

As your Doctors of Chiropractic, we want to provide you with the best care possible. While your policy covers some chiropractic services, there are others that our Doctors may recommend but are not covered by your health insurance coverage. If you agree to receive these services, and they are later determined to not be eligible for reimbursement through your health care plan policy, your signature on this form signifies your agreement to pay for them in full. While you may choose to not obtain these services, we reassure you that our doctors will only recommend care they believe will benefit your health.

Services that we expect to NOT be eligible for reimbursement through your plan's benefits, and therefore will likely be your financial responsibility should you elect to receive them, are outlined below:

Non-Covered Services	Cost Per Visit
Medicare Exam	\$50.00
Electrical Stimulation	\$15.00
Ultrasound Therapy	\$15.00
Acupuncture	\$50.00
Medical Equipment or CBD products	Price Varies

I believe these services will not be eligible for reimbursement through your health plan because;

- They are maintenance or elective care rather than treatment to improve a clinical condition.

OR

- They are excluded from your chiropractic coverage, even when related to treatment to improve a clinical condition.

I acknowledge that I am signing this statement voluntarily and that it is not being signed after the services have already been provided. I have had ample opportunity to ask questions about my liability and other covered treatment alternatives. I understand that I have the right to refuse this care and that by signing this form, I will be fully responsible for the total billed charge(s) related to non-covered services.

Patient's Name: _____

Patient's Signature: _____

Date: _____