31 Navaho Ave
Mankato, MN 56001

INFORMED CONSENT

Dated:___/___/____

Like all treatment options there are possible risks associated with manual therapy techniques used by doctors of chiropractic. Your doctor will use their best clinical judgment to ensure these risks are minimal and adjust treatment techniques to cater to your specific condition. In particular you should note:

A. While rare, some patients may experience short term stiffness or soreness in the area being treated. Muscle and ligament strains or sprains can occur as a result of manual therapy techniques. Although uncommon, rib fractures have been known to occur following certain manual therapy procedures.
B. There are reported cases of a stroke associated with visits to both medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. The possibility of such injuries occurring in association with upper cervical adjustment is estimated between one in 1 million and one in 5 million cervical adjustments.
C. There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustments, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment.
D. There are infrequent reported cases of burns or skin irritation in association with use of some types of electrical therapy offered by some doctors of chiropractic.

Other treatment options that you may elect to pursue for your condition include:

1. Self-administered over the counter analgesics and rest
2. Medical care and prescription medications for pain and inflammation.
3. Physical therapy and rehabilitation
4. Hospitalization or surgery

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustments), the treatment options and recommendations for my condition, and the contents of this consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any spinal adjustments. I understand, and I am informed that, as is with all healthcare treatments, results are not guaranteed and there is no promise to cure. I intend this consent to apply to all my present and future chiropractic care.

Patient's Name (Print):_________________________

Doctor Name:____________________________

Patient's Signature: ___________________________
(Legal Guardian)

Signature of
Treating Doctor: __________________________

Mankato Chiropractic Center Patient Health Questionnaire

Name:____ **Date:**______________

Describe your symptoms in detail:____

____

When did these symptoms start?____

What caused your symptoms to begin?____

How often do experience symptoms?

- ☐ Constantly (100-76% of the day)
- ☐ Frequently (51-75% of the day)
- ☐ Occasionally (26-50% of the day)
- ☐ Intermittently (1-25% of the day)
- ☐ Sporadically (symptoms are not daily)

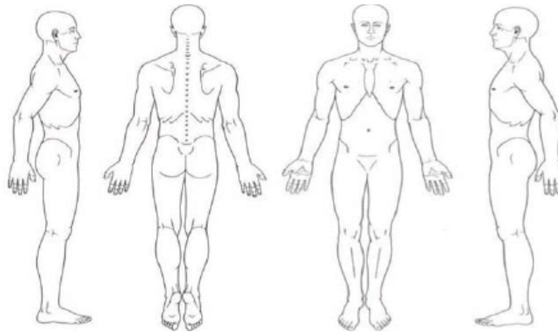
How are your symptoms progressing?

- ☐ Getting Better
- ☐ Not Changing
- ☐ Worsening

What best describes the nature of your pain?

☐ Sharp	☐ Burning	☐ Achy
☐ Stabbing	☐ Tingling	☐ Stiffness
☐ Shooting	☐ Spasming	☐ Tightness
☐ Dull pain	☐ Throbbing	☐ Pinching

Mark on the picture below where you have pain or other symptoms



Grade your pain level TODAY:	(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)
Grade the Average intensity of your pain the past week:	(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

How much does your pain interfere with your daily activities? (work, exercise, socially, activities of daily living, etc.)

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Have you been treated for this episode? ☐ Yes ☐ No When?___________________________

If yes, by whom? ☐ MD ☐ Chiropractor ☐ Massage Therapist ☐ PT ☐ Other__________________________

What treatment did you receive? ____

Have you been treated for a similar problem in the past? ☐ Yes ☐ No When?___________________________

If yes, by whom? ☐ MD ☐ Chiropractor ☐ Osteopath ☐ Physical Therapist ☐ Other_______________

What treatment did you receive? ____

What has helped in the past?____

Your general physical activity: ☐ No regular exercise ☐ Light exercise ☐ Moderate exercise ☐ Strenuous exercise

Your general stress level: ☐ Little or no stress ☐ Minimal stress ☐ Moderate stress ☐ Greatly stressed

Occupation: ___________________________________ ☐ Full time ☐ Part time

Physical activity at work:

☐ Sitting more than 50% of the day ☐ Light manual labor ☐ Manual labor ☐ Heavy labor ☐ Repeated motion

See other side for more patient information ➡

Mankato Chiropractic Center Patient Health Questionnaire Page 2

Neurologic		
Past	**Present**	**Condition**
○	○	Headaches or migraines
○	○	Dizziness/ loss of consciousness
○	○	Seizures/ Epilepsy
○	○	Concussion
○	○	Weakness
○	○	Tremor
○	○	Numbness or tingling
○	○	Sudden vision change
Musculoskeletal		
○	○	Swelling
○	○	Fractured bones
○	○	Arthritis
○	○	Scoliosis
○	○	Joint replacement
○	○	History of neck or back surgery
Systemic Issues		
○	○	Fever
○	○	Bowel or bladder dysfunction
○	○	Gastrointestinal dysfunction
○	○	Lung and breathing issues
○	○	Chest pain
○	○	High blood pressure
○	○	Other heart conditions
○	○	Kidney dysfunction

Specific Conditions		
Past	**Present**	**Condition**
○	○	Diabetes
○	○	Lupus
○	○	Multiple Sclerosis
○	○	Lyme Disease
○	○	Rheumatoid Arthritis
○	○	Pacemaker
○	○	Osteoporosis
○	○	Anemia
○	○	Hepatitis
○	○	HIV or AIDS
Cancer:		
○	○	Breast
○	○	Prostate
○	○	Skin
○	○	Lung
○	○	Brain
○	○	Bone
○	○	Other:

Check One:

○ Current every day smoker

○ Current occasional smoker

○ Former smoker

○ Never a smoker

Are you currently pregnant? ____________ Due date ____

Are you here because of an accident? ____________ What type? _______________________________________

Have you experienced any recent trauma?____

List all Prescription medications and supplements you are currently taking (if you have a list the front desk can make a copy):____

____

List all allergies to medications: ____

List all surgical procedures you have had performed: ____

Patient Signature ____ Date______________________

Mankato Chiropractic Center
31 Navaho Ave, Mankato, MN 56001 (507)345- 4035

Please print all information Date: _______________ Dr.________________________

Name: ____

(First Name) (MI) (Last Name)

Address: _________________________________ City:_________________________ State:______ Zip Code: ____________

Home Phone: ___________________________ Cell Phone: ____

Age: _________ Birth Date ________________ Female: ______ Male: _____ Other: _____

Social Security #: _____________________________ Email: ____

Occupation: _________________________________ Employer: ___________________________________

Employer Address: _________________________City: _________________________ State: _____ Zip Code: _________

Work Phone: _____________________________ May we Contact you at this number? ____yes ____no

Marital Status: M S W D Spouse's/Parents Name: ______________________ Birth Date: ___________

Financially Responsible Party If other than self:

Name: ____

Relationship to patient: ____

Address: ____

City: ____ State: ___________ Zip Code:_________________

Social Security #:______________________________________

Home Phone: ____________________________________ Work Phone:____

CO-PAYMENT IS EXPECTED AT THE TIME OF EACH VISIT (UNLESS OTHER ARRANGEMENTS ARE MADE)

The following information is necessary to submit claims to your insurance. Failure to give Mankato Chiropractic Center the complete information below will require the patient to be responsible for services rendered.

Are you insured? YES NO Company: ____

Name of Insured: ____________________________________ (spouse, mother, father, child)

Insured's Date of Birth: ____________________ (cannot process claims without insured's date of birth)

In consideration of services provided, I am agreeing to pay for services provided to me, to my spouse, and to my minor children. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Mankato Chiropractic Center files insurance claims as a courtesy to their patients. You are strongly encouraged to contact your insurance company or legal counsel to determine the likelihood of reimbursement for chiropractic services. We will not become involved in disputes between the patient and their insurance company regarding deductible, co-payment, covered charges, secondary insurance, usual and customary charges, etc. Do not assume under any circumstances that you are relieved of any financial obligations. Furthermore, I understand that, if I wish, Mankato Chiropractic Center will prepare necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Mankato Chiropractic Center will be credited to my account upon receipt. However, I clearly directly to use and that we are personally responsible for timely payment. Failure of timely payment on my part of any charged billed to me may result in collection action.

Patient's Signature: ____

Parent's or Guardian's Signature: ____

SEE OTHER SIDE

ASSIGNMENT OF INSURANCE

I understand Mankato Chiropractic Center/Mankato's Healing Touch will process my insurance claim for payment of my treatment on my behalf. I hereby assign to Mankato Chiropractic Center/ Mankato's Healing Touch any rights I have to payment of chiropractic treatment and supplies under any worker's compensation policy, auto insurance policy, liability policy, health insurance policy, or other type of insurance policy or benefit plan. I authorize Mankato Chiropractic Center/ Mankato's Healing Touch to receive direct payment from any such insurer or plan administrator. I authorize Mankato Chiropractic Center/ Mankato's Healing Touch to release to any insurer, plan administrator, or attorney any records or information concerning me necessary to obtain direct payment of my bills.

FINANCIAL RESPONSIBILITY

I understand that I am personally responsible to pay for any treatment or supplies provided to me by Mankato Chiropractic Center/ Mankato's Healing Touch which are not paid for by my insurer, or from any settlement proceeds or judgement I obtain from any third party. I understand that for patient balances greater than 30 days past due, I can be charged up to 8% per annum interest on the past due balance, or charged the current interest rates that are permissible by state law at the time.

____

I hereby acknowledge that I have read and understood the assignment of insurance and financial responsibility information as stated above, and I am authorized to sign as the responsible party on behalf of the named patient below if it is someone other than myself.

Patients Name (Print): ______________________________

Responsible Party Name: ____________________________

Responsible Party Signature: _________________________ Date: _____/______/________

EMAIL AND OTHER ELECTRONIC METHOD CONTACT

When you provide Mankato Chiropractic and Healing Touch an email or telephone number, you consent to receiving communications, including but not limited to, prerecorded or artificial calls, text messages and calls made by an automatic dialing system from Mankato Chiropractic and Healing Touch or an agent regarding your account or care. Calls and messages may incur access fees from your cellular provider.

Initials___________

31 Navaho Ave
Mankato, MN 56001

NOTICE OF PRIVACY PRACTICES CONSENT

I, __________________________ (Patient Name) consent to Mankato Chiropractic Center, and Mankato's Healing Touch, ("the Practice's") use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.
For purposes of this consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practices have acted in reliance on this consent.

Patient Name (Print): ____________________________________

(or Responsible Party)

Patient Signature: _______________________________________

(or Responsible Party)

Date: ____/____/_____

Description of Responsible Party's Authority: ______________________

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LATE APPOINTMENT POLICY

Our providers at Mankato Chiropractic and Healing Touch do their best to keep appointments on schedule. Out of respect for patients who have arrived on time for their appointment, you may be asked to reschedule your appointment if you arrive later than your scheduled appointment time. We will make every effort to honor your appointment and “work in” as the schedule allows upon arrival, but there may be times when this will not be possible and you will have to reschedule. If you are running late, please contact the office as soon as you become aware that you will not be on time. New patients and updates are instructed to arrive 20 minutes prior to their scheduled appointment to complete any portion of the new patient and update paperwork in the office. If you are late 3 times you are subject to become a “walk-in” only patient.

NO SHOW/MISSED APPOINTMENT POLICY

Mankato Chiropractic and Healing Touch is committed to providing access and appointment availability to all of our patients in a manner that fits your needs and availability. In order to maintain this access, we currently strive to confirm appointments with everyone. If you will not be able to make your scheduled appointment, please contact the office as soon as possible to cancel or re-schedule your appointment. Missed appointments reduce access and increase costs for all of our patients by forcing other patients to seek costlier care options at urgent care centers and emergency departments. Patients with multiple no shows for appointments may be subject to become a “walk-in” only patient.

I hereby acknowledge and accept the above policies:

Patient Signature: ____ Date:___________________

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

I, _______________________, (Patient’s Name) acknowledge that I have received and agree to the Notice or Privacy Practices of Mankato Chiropractic Center and Mankato’s Healing Touch, which describes the Practice’s policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

____________________ Date

____ Patient Name (Print Name)

____ Patient Signature

FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO PATIENT

The Practice has made a good-faith effort to obtain an acknowledgement of receipt of our Notice of Privacy Practices for ______________________, (Patient's Name). In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

ڤ Patient Unavailable
ڤ Patient Physically Unable
ڤ Patient Unwilling

In an effort to obtain the patients acknowledgement, the Practice has attempted to provide patient with a Notice of Privacy Practices in the following manner (check all that apply):

ڤ Personally ڤ Mail ڤPhone Follow Up
ڤ Other______________

______________________ ____
Date Signature

____
Print Name of Physician

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