1001 South Whitney Way Madison, WI 53711 608-274-6200

Welcome to Realief Neuropathy Center of Madison!

We are a fragrance free clinic. We are looking forward to meeting you at your appointment**.** We are located within Springtime Chiropractic at 1001 South Whitney Way in Madison. **Please arrive 15 minutes earlier for the check in process.**

Your appointment is scheduled for: ____

Dr. Lenz and her team are dedicated to providing you with quality pain management care while paying attention to your personal needs. We are here to further assist you in any way. Please read this letter to help enhance your visit with us.

Enclosed in this document are several policies and forms. **Please have the paperwork filled out and completed prior to your appointment. If you do not have them with you and completed, your appointment will be rescheduled.**

In your packet you will find:

- HIPAA Notice of Privacy and Acknowledgement Form: this advises you of your privacy rights and states you have received HIPAA information

- Medical History From and Health Status Questionnaire: please fill this out completely, this gives Dr. Lenz and her team the information they need to treat you.

- Release of Information Form; this allows us to release your medical records to your insurance company and/or other designated Persons and allows us to request records from your other Doctors and medical providers.

Prior to Your Appointment

- Complete the enclosed forms. Please *sign and date* in all required areas, as these forms are legal documents.
- Check with your insurance to find out if you need a referral from your primary care physician.

The Day of Your Appointment

- Please bring any medication that you are currently taking with you. Include a list of all herbs, supplements, and over the counter medication
- Bring your current medical insurance card(s) with you.
- Valid driver's license or photo identification card.

Please call us if you have any questions prior to your appointment. Thank you for choosing the Realief Neuropathy Center of Madison!

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Patient Information

Full name: ____

Address:____________________________________Telephone number: ____________________

City: ______________________________ **State**:__________________**Zip Code**:____________

Date of Birth: ______ / _______/________ **Age**: ________ **Social Security #:**______________

Cause of Neuropathy: Diabetes Chemotherapy Alcoholism Unknown Reason Trauma Medications

Other: ____

Date of onset of neuropathy : ____

Marital status (circle one) Married Single Separated Divorced Widowed

Name of spouse or partner: ____

Spouse or partner's phone number: ____

Party/Insurance

Please present the receptionist with your insurance card(s so copies can be made for our records).

Insurance Company _______________________________________Group # ID#

Subscriber's Name_______________________________________Birthdate SS#

Secondary Insurance (If Applicable)

Insurance Company _______________________________________Group # ID#

Subscriber's Name_______________________________________Birthdate SS#

Assignment and Release

I certify that I and/or my dependants have insurance coverage through the above named company and assign directly to Dr. Jamie Lenz all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Lenz may use my health care information and may disclose such information to my insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

____

Patient Signature (Parent, if minor)

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neuropathy therapy
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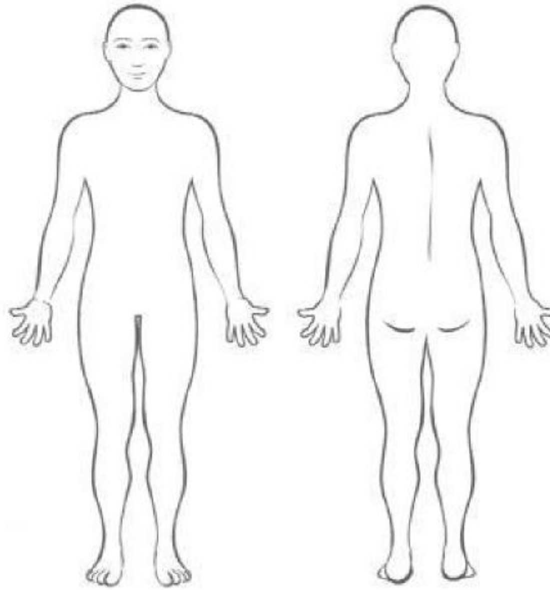
Neuropathy Related Symptoms

Draw in the areas of pain or other symptoms:

Also, please grade the intensity of pain in the areas below using 0---10 with 0 being no pain and 10 being the worst imaginable pain.



Circle of the words that describe your pain symptoms:

Aching	Dull	Tender	Cramping
Pressing	Pinching	Pulsing	Prickling
Electric	Sharp	Crushing	Stabbing
Tightness	Throbbing	Knot like	Gnawing
Burning	Pounding	Shooting	Other:

Circle if you experience any of the following:

Loss of balance	Numbness
Burning: Hot Cold	Tightness
Tingling	Use of walker/cane
Insomnia/waking due to symptoms	Itching
Oversensitivity	Pain with sitting

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How frequent do you experience pain? (Circle the one that applies to you)

Constant ______x per day ______x per week ______ x per month ______x per year

How long does this pain last at a time? ______Never stops _____Min _____Hrs. _____Days

What time of day does your pain typically occur? ______ AM ______ PM ______ All day

What seems to improve your symptoms?

____

____

____

____

____

What seems to aggravate your symptoms?

____

____

____

____

____

Describe how your symptoms have changed since they started:

____

____

____

____

____

List things you can no longer do because of your symptoms:

____

____

____

____

How long can you perform these activities before your symptoms stops you from continuing?

Sit: _____hour(s) _____min(s) Stand:_____hour(s) _____min(s) Walk:_____hour(s)_____min(s)

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Current/Past Medications (attach addition information sheet if needed):

List your current medications, supplement, enzymes, herbs, OTC medications, vitamins and dosages:

____

____

____

Past medications tried for treatment of neuropathy (Circle all that you have taken)

Pregabain (Lyrica) Gapapentin (Neurontin) Oxacarbazine (Trileptal) Topiramate (Topomax)

Lamotrigine (Lamictal) Duloxetine (Cymbalta) Amitriptyline (Elavil) Nortriptyline (Pamelor)

Venlafaxine (Effexor) Oxycodone CR (Oxycontin) Fentanyl (Duragesic Transdermal System)

Methadone (Dolophine) Lidocaine Patch Capsaicin

____

____

Allergies/Drug Reactions

Do you have any allergies/drug reactions to medications? Yes or No

If yes, please list:

____

Current Immunizations:

____

Previous Trauma/Hospitalizations

Have you had any previous trauma: Yes or No

Where: At home / at work / auto / other:

____

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Describe trauma and treatment (car accident, broken bones, knocked unconscious):

____

____

____

Any previous surgeries/hospitalizations: Yes or No

____

____

____

Treatments: Check the ones you have received in the past or currently

Past	Currently	Past	Currently	Past	Currently
○	○ Acupuncture	○	○ Antibiotics	○	○ Birth Control Pills
○	○ Blood transfusions	○	○ Chemotherapy	○	○ Chiropractic Care
○	○ Dialysis	○	○ Herbs	○	○ Homeopathy
○	○ Hormone Replacement	○	○ Inhaler	○	○ Massage therapy
○	○ Physical Therapy				

Family History

	State of Health	Illnesses	Age at Death	Cause of death
Mother				
Father				
Sister 1				
Sister 2				
Brother 1				
Brother 2				

Are there any other hereditary health issues that you know about?

____

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Social History:

Alcohol use: ○ Daily ○ Weekly How much? _____ Prayer or Meditation? ○ Yes ○ No
Tobacco use: ○ Daily ○ Weekly How much? _____ Job pressure/ stress? ○ Yes ○ No
Water intake:○ Daily ○ Weekly How much? _____ Financial Peace? ○ Yes ○ No
Pain relievers:○ Daily ○ Weekly How much? _____ Vaccinated? ○ Yes ○ No
Coffee Use: ○ Daily ○ Weekly How much? _____ Mercury fillings? ○ Yes ○ No
Soft Drinks: ○ Daily ○ Weekly How much? _____ Recreational Drugs? ○ Yes ○ No
Exercising/ Physical Activity: ○ Daily ○ Weekly How much? _____ What Type? ___________________
Hobbies: ____
Typical Breakfast: __________________________
Typical Lunch: _____________________________
Typical Dinner: _____________________________
Typical Snacks: ____________________________
How many meals do you eat out? _________________

Goals for my Care

Please check the type of care desired so we may be guided by your wishes whenever possible.

- ○ **Relief Care – Symptomatic relief of pain or discomfort**
- ○ **Corrective Care – Correcting and relieving the cause of the problem as well as the symptoms**
- ○ **Comprehensive Care – Bring whatever is malfunctioning in the body to the highest state of health possible.**
- ○ **I want the Health Care Provider to select the type of care appropriate for my condition.**

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Review of Systems

Have you had any of the following **pulmonary (lung-related)** issues?
❑ Asthma/difficulty breathing ❑ COPD ❑ Emphysema ❑ Other ❑ None

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
❑ Heart surgeries ❑ Congestive heart failure ❑ Murmurs or valvular disease ❑ Heart attacks/MIs ❑ Heart disease/problems ❑ Hypertension ❑ Pacemaker ❑ Angina/chest pain ❑ Irregular heartbeat ❑ Other ❑ None

Have you had any of the following **neurological (nerve-related)** issues?
❑ Visual changes/loss of vision ❑ One-sided weakness of face or body ❑ History of seizures ❑ One-sided decreased feeling in the face or body ❑ Headaches ❑ Memory loss ❑ Tremors ❑ Vertigo ❑ Loss of sense of smell o Strokes/TIAs ❑ Other ❑ None

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
❑ Thyroid disease ❑ Hormone replacement therapy ❑ Injectable steroid replacements ❑ Diabetes ❑ Other ❑ None

Have you had any of the following **renal (kidney-related)** issues or procedures?
❑ Renal calculi/stones ❑ Hematuria (blood in the urine) ❑ Incontinence (can't control) ❑ Bladder Infections ❑ Difficulty urinating ❑ Kidney disease ❑ Dialysis ❑ Other ❑ None

Have you had any of the following **gastroenterological (stomach-related) issues**?
❑ Nausea ❑ Difficulty swallowing ❑ Ulcerative disease ❑ Frequent abdominal pain ❑ Hiatal hernia ❑ Constipation ❑ Pancreatic disease ❑ Irritable bowel/colitis ❑ Hepatitis or liver disease ❑ Bloody or black tarry stools ❑ Vomiting blood ❑ Bowel incontinence ❑ Gastroesophageal reflux/heartburn ❑ Other ❑ None

Have you had any of the following **hematological (blood-related) issues**?
❑ Anemia ❑ Regular anti-inflammatory use (Motrin/lbuprofen/Naproxen/Naprosyn/Aleve) ❑ HIV positive ❑ Abnormal bleeding/bruising ❑ Sickle-cell anemia ❑ Enlarged lymph nodes ❑ Hemophilia ❑ Hypercoagulation or deep venous thrombosis/history of blood clots ❑ Anticoagulant therapy ❑ Regular aspirin use o Other ❑ None

Have you had any of the following **dermatological (skin-related)** issues?
❑ Significant burns o Significant rashes ❑ Skin grafts ❑ Psoriatic disorders ❑ Other ❑ None

Have you had any of the following **musculoskeletal (hone/muscle-related)** issues?
❑ Rheumatoid arthritis ❑ Gout ❑ Osteoarthritis ❑ Broken bones ❑ Spinal fracture ❑ Spinal surgery ❑ Joint surgery ❑ Arthritis (unknown type) ❑ Scoliosis ❑ Metal implants ❑ Other ❑ None

Have you had any of the following **psychological issues?**
❑ Psychiatric diagnosis ❑ Depression ❑ Suicidal ideations ❑ Bipolar disorder ❑ Homicidal ideations ❑ Schizophrenia ❑ None

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PAYMENT POLICY

If your insurance policy provides for Realief services, this is our payment plan.

LIMITED ASSIGNMENT: We will submit a bill for services to your insurance company and wait for payment directly from them. This can take anywhere from 30 to 90 days. If you have a deductible, **you will be responsible** for any amount that you have not met to date. We will send you a statement at the beginning of the month that will include the portion you owe. Any unpaid balances are due on the 15th of the month.

Copays are due at time of service or a $10.00 surcharge will be added.

If you require services that are not covered by your insurance company, you will be expected to pay for those services. (Prices are available before the service is performed.) If you require an appointment after hours, there is a $50.00 emergency charge that is not covered by your insurance company. Payment is expected at the time of service.

Please note that your insurance coverage is a contract between you and your insurance company and that you are ultimately responsible for your bills at Springtime Chiropractic/Realief Neuropathy Center of Madison. It is therefore important that **you** contact your insurance company to know your specific chiropractic benefits.

Any charges not paid are considered delinquent. Delinquent charges will be assessed an interest rate of (10%) ten percent monthly. In the event that an account becomes delinquent in excess of three months, collective action will take place. A fee of $27.00 will be charged for any returned checks.

NO SHOW POLICY

We expect a phone call if you are unable to keep your appointment. If we do not hear from you by the time of your appointment, you will be charged a fee of $20.00 for the missed appointment.

Thank you for your consideration and understanding. We hope that this explanation will answer your questions and clarify our policy.

Feel free to ask us any questions regarding the above payment policy.

I have read the above payment policy and understand the terms of payment for this office.

Print Patient Name: ____

Patient's Signature: ____Date:

If minor:

Parent's/Guardian Name: ____

Signature____ _____Date:

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NOTICE OF PRIVACY PRACTICES (HIPPA)

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Here are some examples of how we might have to use or disclose your health care information:

1. Your health care provider or a staff member may have to disclose your health information including all of your clinical records to another health care provider or facility if it is necessary to refer you to them for diagnosis, assessment, or treatment of your heath condition.
2. Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are potentially responsible for the payment of your services.
3. Your health care provider and members of the staff may need to use your health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run his/her practice.
4. Your health care provider and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If you are not at home to receive an appointment reminder a message will be left on your answering machine.
    a. You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.
    b. You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.
    c. **Permitted uses and disclosures without your consent or authorization**
    d. Under federal law we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:
5. We are permitted to use or disclose your health information to the extent that we are required to do so by applicable federal or state laws.
6. We are permitted to use or disclose your health information to a public health authority for a wide range of public health activities when the public health authority is authorized to collect or receive your health information under state or federal law.
7. We are permitted to use or disclose your health information to an appropriate government authority if we reasonably believe you are the victim of abuse, neglect or domestic violence.
8. We are permitted to use or disclose your health information for state and federal health oversight activities of the health care system and government benefit programs.
9. We are permitted to use or disclose your health information in response to a court order or in response to a subpoena, discovery request, or other lawful purpose.
10. We are permitted to use or disclose your health information to a law enforcement official as required by laws that require us to report certain types of wounds or physical injuries or to comply with court orders, a grand jury subpoena, or administrative requests authorized by the law.
11. We are permitted to use or disclose your health information to an appropriate law enforcement authority if the disclosure is necessary to prevent or lesson a serious and imminent threat to the health and safety of a person or the public.
12. We are permitted to use or disclose your health information to a correctional institution if we provide health care services to you as an inmate.
13. We are permitted to use or disclose your health information if we provide health care services to you in an emergency.

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14. We are permitted to use or disclose your health information if we provide care to you that is related to a
15. workplace injury to the extent necessary to comply with Wisconsin's workers compensation laws
16. Other than the circumstances described in the preceding examples, any other use of disclosure of your health information will only be made with your written authorization.

Your right to revoke your authorization: You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

1. If we have already released your health information before we receive your request to revoke your authorization.
2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Your right to limit uses or disclosures

If there are health care providers, hospitals, employers, insurers, or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

Your right to receive confidential communication regarding your health information

We normally provide information about your health to you in person at the time you receive chiropractic services from us. We may also mail you information regarding your health or status of your account. We will do our best to accommodate any reasonable request if you would like receive information about your health or the services that we provide at a place other than your home or, if you would like the information in a different form. To help us respond to your needs, please make any request in writing.

Your right to inspect and copy your health information

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. Your request to inspect and/or copy your health information must be in writing. We may refuse your request if the information is for use in a civil, criminal, or administrative action or proceeding which is anticipated to occur in a time frame reasonable proximate to your request. There may be a cost associated with your request if we must copy information for you.

Your right to amend your health information

You have the right to request that we amend your health information for seven years from the date the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

Your right to receive an accounting of the disclosures we have made of your records

You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except:

1. Those disclosures required for your treatment, to obtain payment for your services, or to run our practice.
2. Those disclosures made to you.
3. Those disclosures we are permitted to make without your consent or authorization as described above.
4. Those disclosures made based on an authorization you signed.
5. Those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved with your care.
6. Those disclosures for national security or intelligence purposes.
7. Those disclosures made to correctional officers or law enforcement officers.
8. Those disclosures that were made prior to the effective date of the HIPAA privacy law.

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9. We will provide the first accounting within any 12-month period without charge. There is a fee for any additional requests during the next 12 months. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw of modify your request.

Our duties

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.
We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notice. If we make a change to the terms of our privacy agreement we will notify you in writing when you when you come in for treatment or by mail. If we make a change in our privacy terms the change will apply for all of your health information in our files.

Re-disclosure

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

Your right to complain

You may complain to us or to the Secretary of Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will take any action against you if you do so. While you may make an oral complaint at any time, written comments should be sent to us at the address listed below.

To contact us

If you would like further information about our privacy policies and practices please contact:

Dr Jamie Lenz
1001 S Whitney Way Madison WI 53711
Ph: (608) 274-6200 Fax: (608) 278-4586

This notice is effective as of 6/20/2018. This notice will expire seven years after the date upon which the record was created.

Print Patient Name: ____
Patient's Signature: ____
Date: ____