PURPOSE CHIROPRACTIC

2850 National Drive Suite 105, Onalaska, WI, 54650
(608) 519-5767 www.purposechiro.com

Welcome to Purpose Chiropractic – wellness with a purpose!

About the office

Dr. Marty Lorentz

Phone: 608-519-5767

Fax: 608-519-5768

Website: www.purposechiro.com

Location: 2850 National Drive Suite 105, Onalaska, WI 54650

Hours:	Monday	8-11 & 3-6pm
	Tuesday	8-11 & 3-6pm
	Thursday	8-11 & 3-6pm
	Friday	7:30-10 & 1-3:30pm

Financial Information

If you have health insurance or another reimbursement account, we will provide you with everything you need to get credit/reimbursement for your care. We will give you the most accurate information regarding what your insurance may pay. This arrangement will allow us to provide the best care at a great value. Our goal is to make everything as simple and straightforward as possible so you are not surprised by any unexpected costs. Our fees are posted below.

New Patient Exam:	$70
Adjustment:	$53-$70
Reevaluation Exam:	$40
Cervical & Lumbar X-rays:	$150
Scan only:	$20

For cash patients that pay the day of service, a discount is applied to the fees above. We accept cash, check MasterCard, Visa and Discover. If you have any questions, please feel free to ask.

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Name (First, MI, Last) _____

Address _____ City, State, Zip _____

Home Phone _____Cell _____

E-mail address _____

Date of Birth _____ Age _____

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse's Name _____

Children(s) Names and Ages _____

_____

Have you seen a Chiropractor at another office? ☐ Yes ☐ No

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

The nature of chiropractic treatment: The doctor will use his hands in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible risks: As with any healthcare procedure, complications are possible following a chiropractic adjustment. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. Few patients may notice stiffness or soreness after the first few days of treatment. Some ancillary procedures could produce skin irritation, burns, or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment are rare. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also rare.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Non-covered charges: I understand that my insurance company may not cover all of the services performed in this office. I understand that any services not covered are my full responsibility and agree to pay such charges at the time they are performed.

I have had the preceding risks explained to me. I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment. I certify the above information to be true and correct to the best of my knowledge, and hereby authorize Purpose Chiropractic to provide me with chiropractic care in accordance with this state's statutes.

Signature _____(Parent or Guardian Signature) Date_____

PURPOSE CHIROPRACTIC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____, acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Purpose Chiropractic (3 pgs), which describes the Office's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Office.

Signature _____ Date _____

I would like to receive updates, newsletters, product discounts and other marketing information via mail or email. Initials _____

DISCLOSURE OF HEALTH INFORMATION

Please list the name(s) of those whom you authorize us to disclose your health information to as it relates to your care in this office.

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

EMERGENCY CONTACT INFORMATION

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

I authorize representatives of Purpose Chiropractic to disclose my health information to the above mention person(s). I understand that I may alter this list at any time and that this authorization will remain in effect until I provide written notice of its termination.

Signature _____ Date _____

PURPOSE CHIROPRACTIC NOTICE OF OUR PRIVACY PRACTICES

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your individually identifiable health information.

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (**IIHI**). In conducting our business, we will create records regarding you and your treatment and the services we provide for you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at this time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Purpose Chiropractic LLC

2850 National Drive #105 Onalaska, WI 54650

(608)519-5767

C. WE MAY USE AND DISCLOSURE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. Any of the people who work for our practice – including, but not limited to, our doctors and nurses, or indirectly with any provider we refer you to – may use or disclose your IIHI in order to treat you, or to assist others in your treatment. Additionally, we may need to disclose your IIHI to others who may assist in your care, such as your spouse, children, or parents.
2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment and health status to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members or insurance companies. Also, we may use your IIHI to bill you directly for services and items.
3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you receive from us, or to conduct cost-management and business planning activities for our practice.

4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you or a family member who answers the phone (or to leave a recorded message) to remind you of an upcoming appointment.
5. **Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.
6. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.
7. **Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to our office for care. In this example, the babysitter may have access to this child's medical information.
8. **Disclosures Required by Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. In general, we will require that the party that requests your records provide a records-release form, signed by you within the last 3 months.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identify or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organs and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation in you are an organ donor.

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a research that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being used only for the research and (iii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the research only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research, and if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your IIHI for worker's compensation and similar programs.

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Name (First, Last) _____

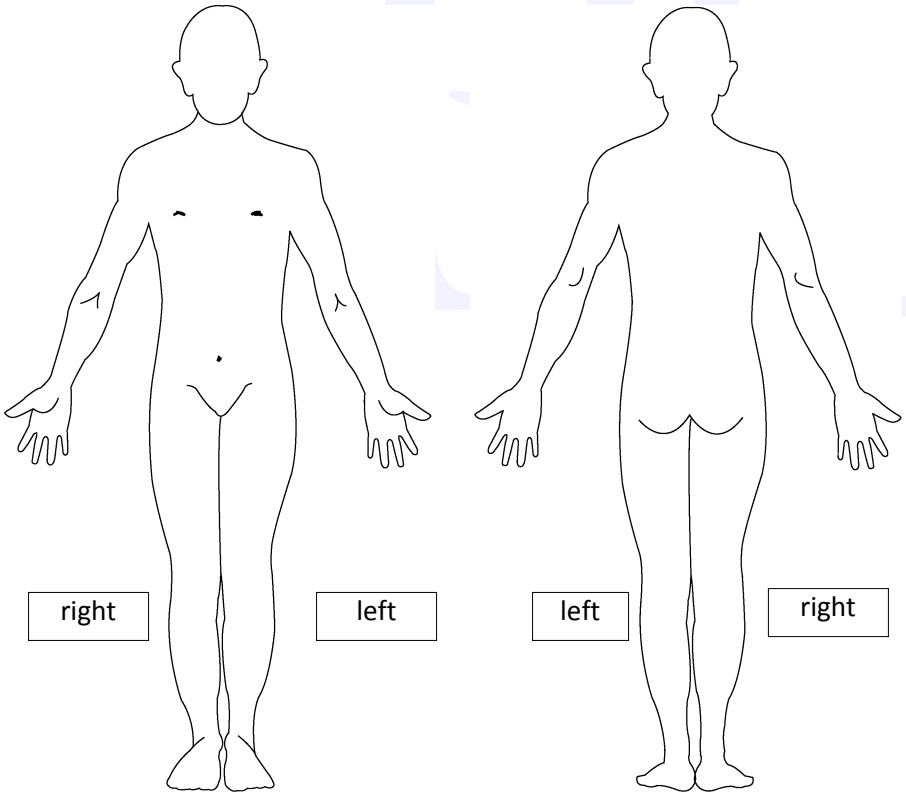
SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

Mark the areas on this body where you feel the described sensations.
Use the appropriate symbols. Mark areas of radiation.
Include all affected areas.

Numbness	**P**ins & Needles	**B**urning	**A**ching	**S**tabbing
NNNNN	PPPPP	BBBBB	AAAAA	SSSSS

Please mark on the pain scale from Zero to 10 the pain you feel with this condition.
10 being the worst pain you have felt with this condition.

Pain Chart



Neck-Shoulder-Arm-Pain
On a scale of zero to 10, I rate my discomfort as follows:
(_____)
0 10
no pain severe pain

Mid Back Pain
On a scale of zero to 10, I rate my discomfort as follows:
(_____)
0 10
no pain severe pain

Low Back and Leg Pain
On a scale of zero to 10, I rate my discomfort as follows:
(_____)
0 10
no pain severe pain

Date: _____ Signature _____

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How did you hear about our office? _____

What is the reason for your visit? ☐ Wellness ☐ Specific Problem _____

What is the goal of your care? ☐ Pain Relief ☐ Correct the Problem ☐ Increase Health

Please list any allergies you have: _____

The 3 most important things in your life are 1) _____
2) _____
3) _____

Family Health Profile:

At our office we are not only interested in your health and wellbeing but also that of your family and loved ones. Please mention below any health conditions or concerns you may have about your family including heart disease, cancer, stroke, diabetes or rheumatoid arthritis:

Children: _____
Spouse: _____
Mother: _____
Father: _____
Others: _____

Please list any supplements or medications you are currently taking: _____
_____

List all hospitalizations and surgeries: _____
_____

Have you been diagnosed with any diseases? ☐ Yes ☐ No
If yes, please list: _____
Describe your job: _____
_____

On average how many hours a week do you work? _____

Rate the physical stresses of your job: ☐ High ☐ Medium ☐ Low

List any recreational activities you enjoy? _____
_____

Are you able to participate at your expected level in all of the above? ☐ Yes ☐ No

What can we do to make your experience here exceptional (appointment times, financial arrangements, etc)?
_____
_____
_____
_____

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Review of Systems-below is a list of diseases that **may seem unrelated to the purpose of your appointment.** However, these questions must be answered carefully as the problems can affect your overall course of care.

Constitutional: □ Not Applicable
□ Chills □ Fatigue □ Fever □ Night Sweats □ Abnormal Weight Gain/Loss

Ears, Nose and Throat: □ Not Applicable
□ Difficulty Swallowing □ Dizziness □ Ear Infections □ Ear Pain □ Fainting
□ Headaches □ Hearing loss □ Loss of Smell □ Sinus Infection
□ Snoring or Sleep Apnea □ Ringing in the Ears □ TMJ Problems □ Head Injury (history)

Respiration: □ Not Applicable
□ Asthma □ Cough □ Shortness of Breath □ Wheezing

Cardiovascular: □ Not Applicable
□ Chest Pain □ Heart Problems □ High Blood Pressure □ Palpitations □ Cold hands or feet

Skin: □ Not Applicable
□ Changes in Skin Color □ Skin Lesions/Ulcers □ Hives □ Rash □ Itching
□ Mole-abnormal

Gastrointestinal: □ Not Applicable
□ Abdominal Pain □ Belching □ Black, Tarry Stools □ Constipation
□ Rectal Bleeding □ Heartburn □ Hemorrhoids □ Indigestion
□ Nausea □ Diarrhea □ Vomiting □ Difficulty Swallowing

Female: □ Deny any Female issues □ Deny any possibility of being pregnant
□ Pregnant □ Irregular Menstrual Cycle □ Birth Control □ Hormone Therapy
□ Burning Urination □ Breast Lumps/Pain □ Menstrual Cramps □ Vaginal Discharge

Male: □ Deny any Male issues
□ Burning Urination □ Frequent Urination □ Erectile Dysfunction □ Hesitancy/Dribbling □ Prostate Problems

Endocrine: □ Not Applicable
□ Temperature Intolerance □ Diabetes □ Excessive Appetite □ Excessive Thirst
□ Hair Loss □ Unusual Hair Growth □ Goiter □ Voice Changes

Nervous System: □ Not Applicable
□ Dizziness □ Facial/Limb Weakness □ Headaches □ Strokes □ Stress □ Tremors
□ Numbness/Tingling □ Loss of Consciousness □ Sleep Disturbance □ Slurred Speech □ Seizures

Psychological: □ Not Applicable
□ Anxiety □ Depression □ Insomnia □ Memory Loss □ Mood Changes

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Childhood History:

Did you have any childhood illnesses? ☐ Yes ☐ No
Did you play youth sports? ☐ Yes ☐ No
Did you take medications including antibiotics or inhaler? ☐ Yes ☐ No
Were you in any car accidents as a child? ☐ Yes ☐ No
Did you suffer any other traumas (physical or emotional) ☐ Yes ☐ No
As a child, were you under regular chiropractic care? ☐ Yes ☐ No
Please share any additional information: _____

_____

Adult – (18 to present)

How many hours do you sleep a night? _____
Do you have any sleep problems? ☐ Yes ☐ No
How many days per month do you use pain relievers? _____
How many days per week do you exercise? _____
What types of exercise do you perform? ☐ Strength ☐ Cardio ☐ Weights ☐ Anaerobic ☐ Stretching
Please list any major stresses you have: _____

How do you rate your physical health? ☐ Exceptional ☐ Good ☐ Fair ☐ Poor
How do you rate your nutrition? ☐ Exceptional ☐ Good ☐ Fair ☐ Poor
How do you rate your emotional health? ☐ Exceptional ☐ Good ☐ Fair ☐ Poor
How do you rate your overall "quality of life? ☐ Exceptional ☐ Good ☐ Fair ☐ Poor
Compared to 5 years ago, are you in? ☐ Better Health ☐ Same Health ☐ Worse Health
One year from now will you be in? ☐ Better Health ☐ Same Health ☐ Worse Health
Do you have a plan to improve your health? ☐ Yes ☐ No

Please list any other health related goals or things you are trying to improve on: _____

_____

Signature _____ Date: _____

Doctor Signature _____ Date: _____