NORTH STAR
CHIROPRACTIC
CENTER

OFFICE POLICY

The following is an explanation of our client policies. We believe that a clear definition will allow us both to concentrate on the most important issue: regaining and maintaining your health. We will be happy to answer any questions you may have regarding our policies, your account, or your insurance coverage.

Patient Payment Policy

We feel the patient's health needs are paramount; therefore, the following payment policy is an attempt to allow you, the patient, to receive the care you need and clear your balance with the least amount of difficulty.

New Patient Care Services

We require a minimum of 25% of the first visit charges due on the first day of service. The balance of these charges may be made in payments over the next six weeks, unless we bill your insurance for payment. Properly documented workers' compensation and auto accident claims are not required to pay at this time if appropriate forms and letters of protection are signed.

Established Patient Care Services

Patients with No Insurance

All payments are expected at time of service. Patient balances may not exceed $200.00 at any time, or professional services may be terminated.

Patients with Insurance

Most insurance policies do cover chiropractic care. We will be happy to file your insurance claims for you and do everything we can to assure you receive proper reimbursement. However, we cannot take responsibility for what your health insurance will or will not cover. You must clearly understand and agree that all services rendered to you are charged directly to you and that you are personally responsible for payment. All copayments are expected at time of service. Patient balances may not exceed $200.00 at any time, or professional services may be terminated.

Any balance due past 90 days will be sent to our collection agency and a $30.00 collection fee will be added to your balance. There is a $30.00 service fee for any returned checks.

Massage Therapy

All massage charges are due at the time of service and no payment plans will be allowed. We will be happy to bill your insurance company after collecting any copay. We require 24 hours' notice for any cancellation. If less than 24 hours' notice is given, or if you miss your appointment without calling, you will be charged for your appointment in the amount of $25.00 per half hour missed. We understand emergencies occur, and in special circumstances this fee may be waived.

Appointments

In order to better serve our patients, we ask that you call if you are unable to make your appointment or if you will be late. Your appointment time is reserved for you. If you fail to notify our office, it leaves a time slot open that could be used to help someone else. Please help us help others. Additionally, should more than a 3 month period elapse between office visits, an evaluative exam is necessary prior to reinstating treatment.

Questions and Answers

Your questions about any aspect of your care or account are invited. Please feel free to ask your doctor or any available staff member. We will make every effort to answer your inquiries. Lastly, it is the goal of this office to provide you with the finest quality chiropractic care available. We welcome your referrals and look forward to a doctor-patient relationship that works for our mutual benefit.

I, _____, have read the North Star Chiropractic Policies and will honor them,

_____ _____

Patient Signature Date

North Star Chiropractic Center

CONFIDENTIAL PATIENT INFORMATION

Date_____ Name_____ Date of Birth_____ Sex ____ Age____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed Social Security _____

Address_____ City_____ State_____ Zip_____

Cell Phone Number_____ Email _____

You will automatically be opted-in to text reminders. They will arrive 1 day prior, and 2 hour prior to your appt.

Occupation _____

Company_____

Emergency Contact _____

Emergency Contact Phone Number _____

Is your visit due to a personal injury claim? Y N
(If yes, please see front desk for personal injury intake forms)

Referral Source:
- ☐ Website (i.e. Google/Yelp)
- ☐ Social Media Ad (i.e. Facebook/Instagram)
- ☐ Walk – In
- ☐ Family/Friend _____
- ☐ Insurance Provider List
- ☐ Other _____

Your Present Complaint/Symptoms _____

Have You Been Treated by a Physician for Any Health Condition in the Last Year? Y N

Describe Condition_____ Date of Last Physical Exam_____

List All Medications Being Taken _____

List Any Allergies_____

Describe Any Operations You've Had & Dates _____

(Females Only) Are You Pregnant? Y N Date of Last Menstrual Period _____

Do you have children? Y N Age(s) _____

Personal Medical History: (Please Circle the Following Relevant to Your Medical History)

Cancer	Muscular Dystrophy	Rheumatic Fever	Digestive Disorders	Tuberculosis	Convulsions
Polio	Multiple Sclerosis	Scarlet Fever	Sinus Trouble	Concussion	Backaches
Diabetes	Nervousness	Numbness	Heart Trouble	Hepatitis	Dizziness
Asthma	Venereal Disease	High Cholesterol	High Blood Pressure	HIV	Hepatitis C

Do You Have Insurance? Y N Primary? Y N Secondary? Y N

Name of Insurance_____ Primary Policy Holder: Self / Spouse / Parent / Other

Name of Primary Policy Holder_____ Primary's Date of Birth: _____
(If spouse / parent / other)

Insurance ID Number_____ Group Number_____

I understand and agree that health and insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account, however, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if North Star Chiropractic Center extends credit to me and I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless prior arrangements are made. I hereby authorize North Star Chiropractic Center, and whomever he/she may designate as his/her assistants, to administer treatment as he/she deems necessary and I also authorize the release of any information required in the course of my examination or treatment. I certify that the above is true and correct.

Patient's (Parent or Guardian's) Signature _____

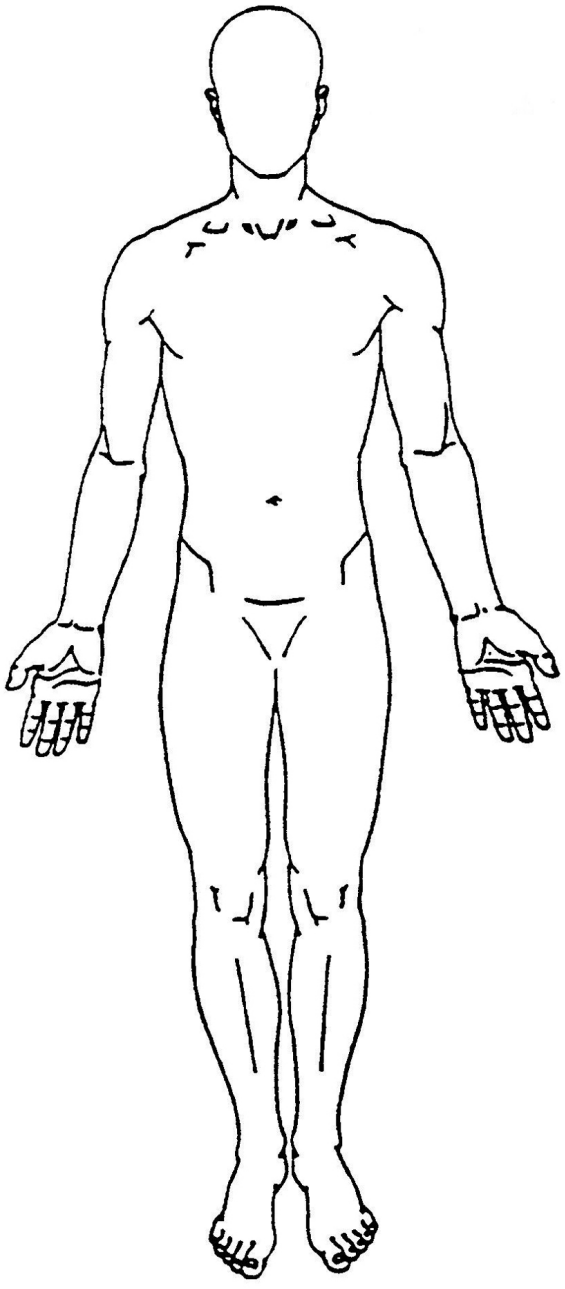
PAIN DRAWING

Patient Name_____ **Date**_____

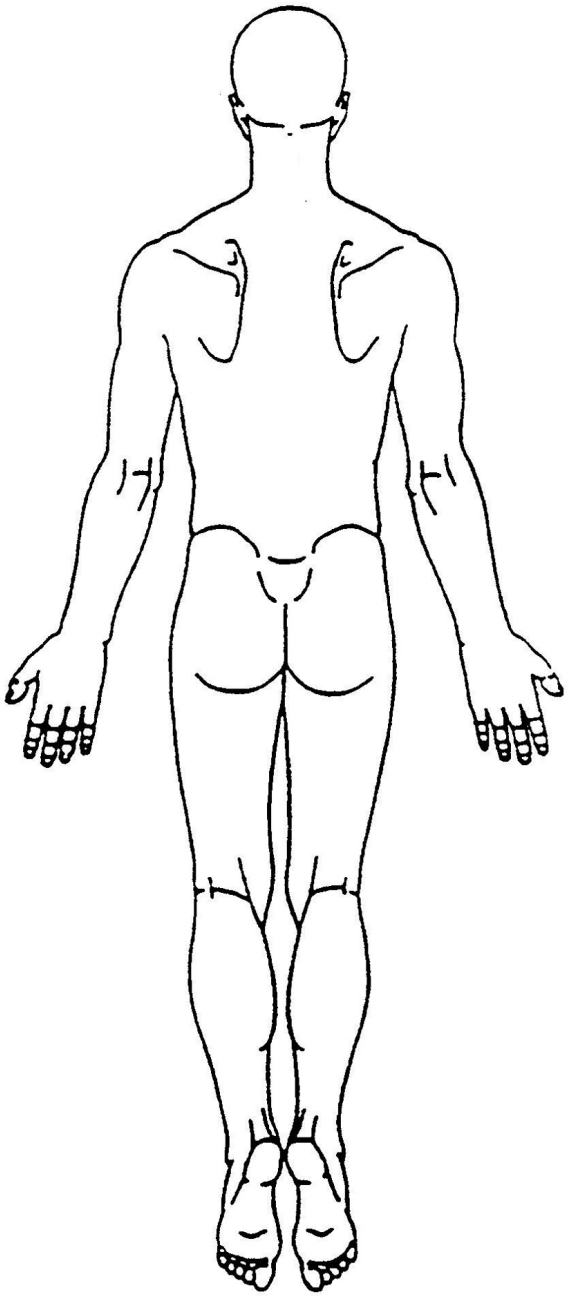
Attending Doctor_____

Using the letters below, mark the areas on your body where you feel the described sensations. Include all affected areas. Please complete the picture by drawing your face. ☺

A = Ache **B** = Burning **N** = Numbness **P** = Pins & Needles **S** = Stabbing



FRONT



BACK

Patient Signature_____

North Star Chiropractic Center

Acknowledgement of Receipt of Notice of Privacy Practices

North Star Chiropractic Center is concerned about the privacy of our patients' health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. HIPAA requires a chiropractic practice to make a good faith effort to obtain a signed acknowledgement from the patient prior to releasing any medical information.

I acknowledge that North Star Chiropractic Center staff has explained to me the Privacy Practices of their office. I understand that I have a right to receive and review a copy of the Privacy Practices Notice if I request it.

_____

Patient Name (please print)

_____ _____

Patient Signature Date

OR

_____

Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

- ❑ Parent
- ❑ Guardian
- ❑ Power of Attorney
- ❑ Other_____

North Star Chiropractic Center

PERSONAL INJURY HISTORY FORM

Instructions: Please carefully consider and answer each question as completely as possible.

Name: _____ Today's Date: (____/____/____) Date of Injury: (____/____/____)

Describe how your injury occurred: _____

_____

_____

Choose factor/s which directly or indirectly caused the injury to occur (please select all that apply):

❑ Struck by Flying/Thrown Object ❑ Struck by an Object/Person ❑ Faulty Equipment ❑ A Fall

❑ Caught In/Under/Between Objects ❑ Struck Against Object ❑ Fluid Exposure ❑ Other

Did you lose consciousness? ❑ Yes ❑ No If yes, please explain: _____

_____

Were you stunned (disoriented/confused/in a state of shock)? ❑ Yes ❑ No How long? _____

Did you feel or hear popping, tearing, or ripping noise in your neck or back? ❑ Yes ❑ No If yes, please explain: ____

_____

Did you feel any pain? ❑ Yes ❑ No If yes, where? _____

_____

How long after the injury? _____

Did you find any bruises? ❑ Yes ❑ No If yes, where? _____

Instructions: Please check symptoms you have experienced since the injury:

❑ Headache
❑ Skull or Head Pain
❑ Neck Pain
❑ Neck Stiffness
❑ Head Feels too Heavy
❑ Shoulder Pain
❑ Shoulder Stiffness
❑ Arm Pain
❑ Arm Numbness
❑ Pins and Needles in Arms
❑ Numbness in Hands/ Fingers
❑ Cold Hands
❑ Upper Back Pain
❑ Upper Back Stiffness
❑ Chest Pain

❑ Mid Back Pain
❑ Mid Back Stiffness
❑ Low Back Pain
❑ Low Back Stiffness
❑ Rib Pain
❑ Hip Pain
❑ Buttock Pain
❑ Leg Pain
❑ Leg Numbness
❑ Pins and Needles in Legs
❑ Numbness in Feet/Toes
❑ Cold Feet
❑ Sinus Trouble
❑ Loss of Smell
❑ Loss of Color

❑ Dizziness
❑ Fainting
❑ Eye Strain
❑ Difficulty Focusing
❑ Pain Behind the Eyes
❑ Eyes Sensitive to Light
❑ Double Vision
❑ Buzzing or Ringing in Ears
❑ Loss of Balance
❑ Palpitations
❑ Shortness of Breath
❑ Difficulty Rising to Walk
❑ Painful Breathing
❑ Tremors
❑ Loss of Taste

❑ Excessive Perspiration
❑ Loss of Perspiration
❑ Cold Sweats
❑ Fever
❑ Swelling
❑ Depression
❑ Anxiety
❑ Tension
❑ Irritability
❑ Nervousness
❑ Mental Dullness
❑ Loss of Memory
❑ Difficulty Sleeping
❑ Fatigue
❑ Face Flushed

Instructions: Please check the degree of difficulty you have experienced in daily living:

Riding in car:
❑ Light ❑ Moderate ❑ Excessive ❑ Unable

Bending:
❑ Light ❑ Moderate ❑ Excessive ❑ Unable

Standing:
❑ Light ❑ Moderate ❑ Excessive ❑ Unable

Twisting/Turning:
❑ Light ❑ Moderate ❑ Excessive ❑ Unable

Sitting:
❑ Light ❑ Moderate ❑ Excessive ❑ Unable

Walking:
❑ Light ❑ Moderate ❑ Excessive ❑ Unable

Lifting:
❑ Light ❑ Moderate ❑ Excessive ❑ Unable

Other: _____
❑ Light ❑ Moderate ❑ Excessive ❑ Unable