CHAMPION CHIROPRACTIC
YOUR HEALTH COMES FIRST

New Episode Questionnaire

CONFIDENTIAL PATIENT INFORMATION

First Name: Middle Initial: Last Name: Date: / /20____

SSN: - - Date of Birth: / / Gender: Male/Female/Other

Street Address: Height: ft. in.

City: State: Zip Code: Weight: lbs.

Email: Cell Phone: ( ) Other Phone: ( )

PAYMENT STATUS: o Cash/Check/Credit card/HSA or FLEX card o Insurance*: _____
Please provide a copy of your photo ID and *insurance card(s) to the front desk.

ChiroHealthUSA Policy Holder: _____ Policy Date: _____ City: _____

CURRENT HEALTH CONDITIONS

What health condition(s) bring you into our office?

When did the condition(s) first begin? What caused it?

How did the problem start? o Suddenly o Gradually o Post-Injury o Other:

Location of condition(s): _____ o Right side o Left side o Both

Frequency: o Constant (100% of time) o Frequent (75%) o Occasional (50%)
o Intermittent (25% or less) o Unsure o On and off o Random o Recurring

Change since onset: o Improved o Stayed the same o Worsened o Relief which lasted for a while

Type of discomfort: o Sharp o Dull o Throbbing o Aching o Numbness o Burning o Cramping
o Shooting o Stiffness/Tightness o Swelling o Tingling o Annoying o Other:

Does it radiate/travel? o No o Yes, where to?

What makes the problem better? Worse?

Better/worse at certain time of the day? o No change o Better o Worse o When? _____

Have you received care for this problem before? o No o Yes, please explain:

Patient Name: Date:

Activities of daily living that are difficult and/or affected? o None o Sitting o Standing o Walking o Sleeping o Laying down o Working o Exercising o Lifting o Bending o Household chores o Personal care (washing/dressing/etc.) o Social life o Traveling and/or driving o Other: Difficult after approximately how long? o None o 5 mins o 15 mins o 30 mins o 60+ mins o ___mins
What is your pain RIGHT NOW? (0-no pain, 10-pain is unbearable) 0 1 2 3 4 5 6 7 8 9 10
What is your TYPICAL or AVERAGE pain? 0 1 2 3 4 5 6 7 8 9 10
What is your pain level AT ITS BEST? (How close to "0" it gets)? 0 1 2 3 4 5 6 7 8 9 10
What is your pain level AT ITS WORST (How close to "10" it gets)? 0 1 2 3 4 5 6 7 8 9 10
Goals: o Have no functional limitations o Sleep throughout the night w/o pain o Decrease swelling o Improve range(s) of motion o Lift without pain o Improve strength o Improve overall flexibility o Decrease stiffness o Relieve pain o Walk without limitation o Return to exercise without limitation o Return to work without limitation o Other:
Other current health conditions: o High Blood Pressure o High Cholesterol o Diabetes o Asthma o IBS/Colitis o Arthritis o Infertility o Chronic fatigue o Headaches o TMJ/Jaw Pain o Extremity pain (shoulders, elbows, wrists, hands, knees, ankles, feet) o Cancer/type:
Any other symptoms/conditions/surgeries or health history changes? o No o Yes, please explain:

ACKNOWLEDGEMENT & CONSENT

Patient Signature: _____ Date: / /20____

Patient Name: Date:

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Nature of Chiropractic Treatment: The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment: As a part of the analysis, examination, and treatment, you are consenting to the following procedures: spinal manipulative therapy, palpation, vital signs, range of motion testing, orthopedic testing, basic neurological testing, muscle strength testing, postural analysis testing, hot/cold therapy, EMS, trigger point therapy, IASTM and/or other.

Inherent risks in a chiropractic adjustment: As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications. The Doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the Doctor's attention it is your responsibility to inform the Doctor.

Probability of those risks occurring**:** Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination. Stroke and/or arterial dissection caused by the chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk for arterial stroke. The probability of adverse reaction due to ancillary procedures is also "rare".

Other Treatment Options: May include self-administered, over-the-counter analgesics and rest, medical care and prescription drugs such as anti-inflammatory, muscle relaxants, and pain killers, hospitalization, surgery. If you chose to use one of the noted options you should be aware there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

Risks and dangers attendant to remaining untreated: Remaining untreated may allow the formation of adhesions and reduce mobility which may set up pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

Concerns or questions: Please ask your Doctor of Chiropractic if you have any questions. Dr. Brittany LaRocque and the staff at Champion Chiropractic LLC have gone to great lengths to make your health and safety a top priority.

No Warranty: I understand my doctor at Champion Chiropractic LLC, cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand my doctor will share with me her opinion regarding potential results from chiropractic treatment for my condition and will discuss treatment options with me before I consent to treatment. I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I certify the information obtained in the health history is correct to the best of my knowledge and will not hold the doctor or staff responsible for errors or omissions I have made in completion of this form. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment now and in the future.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTOOD THE ABOVE.

_____	_____	_____
Printed Name	Signature	Date

Champion Chiropractic, LLC

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our HIPAA Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the HIPAA Notice of Privacy Practices on the date below on behalf of **Champion Chiropractic, LLC.**

I understand that the Notice describes the uses and disclosures of my protected health information by **Champion Chiropractic, LLC** and informs me of my rights with respect to my protected health information.

_____ _____

Patient's Signature or that of Legal Representative *Printed Name of Patient or that of Legal Representative*

_____ _____

Today's Date *If Legal Representative, Indicate Relationship*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation, it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

_____

_____ _____

Employee Name *Today's Date*

1115 Wilshire Blvd, Stevens Point, WI 54481
Phone: (715) 341-2644 Fax: (715) 544-0870
www.stevenspointchiropractor.com
Effective date: 09/28/2021

Name: _____ DATE: _____

Champion Chiropractic, LLC

Financial Policy

Our office, Champion Chiropractic, LLC, has adopted the following financial policies to better serve our patients and reduce misunderstanding between our patients and the practice. If you have any questions regarding these policies, please discuss them with us. We provide the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Your Payment/Insurance:

• If you are not using insurance, payment will be due at the time of service. If you are unable to pay your balance in full, you will need to make prior arrangements with us.
***** Ask about ChiroHealthUSA for prices*****

• We are contracted with several insurance companies, but it is your responsibility to make sure the physician is in your plan. It is also your responsibility to know your insurance benefits. We will attempt to verify insurance benefits initially; it is only a quote and not a guarantee of insurance payment.

• As a courtesy to our patients we will file primary insurance forms from our office. In order to do this, we will require information from you. We will need all your demographic and insurance information at your first appointment. We will also request an update on this information approximately every six months thereafter. We ask that at the time of your appointment you bring your insurance card, a photo ID, and any other forms that will assist in making sure that your claim is filed correctly.

• At the time of service, you will be responsible for all fees that are not covered by your insurance, including co-pays, co-insurance, deductibles and noncovered services or items received. The copay cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier. We strive to be as accurate as possible in calculating your financial responsibility but, with so many variations in policies and fee schedules, we are not always exact. You may receive a statement from our office for any balance due. For your convenience we accept cash, checks, credit cards, HSA /FLEX Spending cards and money orders.

• If your health plan determines a service to be "not covered," you will be responsible for the complete charge. We will bill your health plan for all services provided in our office. Any balance due is your responsibility and is due upon receipt of a statement from our office.

• For all services rendered to minor patients, we will look to the adult accompanying the patient or the parent or guardian with custody for payment.

*****As you may have heard, in light of stricter federal guidelines, healthcare providers are now required to implement "Compliance Programs" which include review of billing policies and assure that improper discounts are not being offered to patients. Compliance Programs are designed to eliminate potential fraud and abuse.**

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Although we may not always agree with the stricter rules and limitations, we must comply with them in order to protect our practice. As part of our commitment to providing affordable care, we have chosen to participate in a program that allows us to provide discounted fees to our patients who become members and still remain compliant with federal law. ChiroHealthUSA is a network that works in conjunction with a Discount Medical Plan Organization giving patients access to the same discounts that are typically only negotiated by the insurance companies. ChiroHealthUSA is NOT insurance, however, and should not replace your insurance. It simply allows us to lower the cost for your non-covered services at our clinic. ***

Becoming a member of ChiroHealthUSA is easy.

- **Join right here in our clinic in just minutes**
- **Pay just $49 per year**
- **Membership covers you and your legal dependents**
- **Receive discounts with any ChiroHealthUSA provider nationwide**

Missed Appointment Policies: In order to reach your healthcare goals, please keep your appointments as scheduled or contact Champion Chiropractic LLC within 24 hours to make any changes.

Late payment policies: We will send three statements for any payments due and make reasonable attempts to collect payment for any due services. After making three attempts for payment, we may submit the amount due to collections. Collection agencies can legally contact the patient daily until the amount due is paid. If there is balance on a patient's account after three attempts made, the balance will be due before the patient can be scheduled again.

Dismissal Policy

• If you are "dismissed" from the practice it means you can no longer schedule appointments or consider us to be your doctor. You must find a doctor in another practice. Common Reasons for Dismissal: Failure to keep appointments, frequent no-shows, non-compliance (meaning you won't follow physician instructions about an important health issue), abuse to staff, or failure to pay your bill.

• Dismissal Process: We will send a letter to your last known address, via certified mail, notifying you that you are being dismissed. If you have a medical emergency within 30 days of the date on this letter, we will see you. After that, you must find another doctor. We will forward a copy of your medical record to your new doctor after you let us know who it is and sign a release form.

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Please read and initial each line to show that you have read and understand our financial policy. We have an obligation to each and every patient to have transparency in our billing procedures.

_____ Exam: **99202 NP Exam – straightforward- $145 99203 NP Exam Detailed - low complexity- $215**
99212 EP Exam – straightforward- $110 99213 EP Exam - low complexity- $150
Exam Fees will be billed if you are a new patient, if your last exam was a year ago, if your insurance requires/ recommends an exam, if you have a new episode of injury, or if the physician feels an exam is necessary. You are considered a new patient if you have not been treated here for more than 3 years.

_____ Spinal Adjustment: **98940 (1-2 regions)- $65, 98941 (3-4 Regions)- $90, 98942 (5+ regions)- $120**
In order for your services to be covered by insurance, it must be an active problem that is being actively treated, by following a treatment plan. A treatment plan will be developed by the Doctor of Chiropractic with specific goals and a time limit. You may be responsible for a copay, deductible, or co-insurance depending on your plan. You will receive a statement for the amount that you are responsible for after insurance has paid.

_____ Extraspinal Adjustment: **98943- $60**
Includes joints outside of the spine, including but not limited to: Shoulders, elbows, wrists, knees, ankles, and TMJ. This is service is not covered by Medicare, Medicaid or some insurance policies.

_____Maintenance/Wellness Adjustment: **S8990- $90**
This service is offered to all patients as a means to maintain optimal spinal alignment while not being actively treated for an injury or new complaint. This service is NOT billable to insurance and payment is due at time of service.

_____ Electrical Stimulation: **G0283- $40**
This is service is not covered by Medicare, Medicaid or some insurance policies.

_____ Therapeutic Procedure/Exercise: **97110- $75**
This is service is often not covered by Medicare, Medicaid or some insurance policies.

_____ Other procedures: (Listed here with price) _____

_____

Signature Date

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Champion Chiropractic, LLC

Consent for Treatment of a Minor

Treatment of minors requires a team effort by the medical care provider(s) and the minor's parent or guardian. The parent or guardian's responsibility includes supporting the medical directives given by the medical provider. The medical provider's role includes ensuring that the parent or guardian is aware of and concurs with the treatment their child or charge receives.

Treating Minors in the Clinic

It is the policy of Champion Chiropractic, LLC that all minors seeking chiropractic treatment be accompanied by a parent/legal guardian during the first office visit for a new problem. After the initial appointment, a minor may be seen by Champion Chiropractic, LLC for treatment of the same diagnosis without the parent/legal guardian present if this consent form is filled out and maintained in the minor's medical record. In the event of an appointment in which a parent/legal guardian is not present, but the appointment is for the treatment of the initial diagnosis, a Champion Chiropractic, LLC staff member will be present to supervise the appointment. If a new diagnosis is rendered during a return visit, the parent/legal guardian will need to be contacted and permission will need to be granted before a new diagnosis can be treated.

Consent for Treatments

This form authorizes Champion Chiropractic, LLC to evaluate and treat your child. This permission includes treatment of musculoskeletal conditions by the use of chiropractic adjustments, along with Active Release Techniques, modalities, and rehabilitation exercises.

I authorize and give consent for the treatment of my child to Champion Chiropractic, LLC if a parent/legal guardian is not present. Additionally, I consent to the presence of a Champion Chiropractic, LLC staff member to supervise the treatment session of my child if a parent/legal guardian is not otherwise present.

*This authorization must be completed annually until the minor is 18 years of age.

Name of Patient: _____ Patient Date of Birth: _____

Printed Name of Parent/Guardian: _____ Relationship to Patient: _____

Signature of Parent/Guardian: _____ Phone of Parent/Guardian: _____

Today's Date: _____

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