

# Sturgis CHIROPRACTIC

*Specific Chiropractic*

824 1<sup>st</sup> Street, Sturgis, SD 57785

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**PATIENT INFORMATION**

First Name: \_\_\_\_\_ M. I. \_\_\_\_\_

Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_

\*Cell Phone: \_\_\_\_\_

\*Email: \_\_\_\_\_

Sex:  M  F Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Married  Widowed  Single  Minor

Separated  Divorced  Partnered

Employer/School: \_\_\_\_\_

Occupation: \_\_\_\_\_

**SPOUSE INFORMATION**

Spouse's Name: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_

Spouse's Occupation: \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Contact Number: \_\_\_\_\_

**Who may we thank for referring you?**

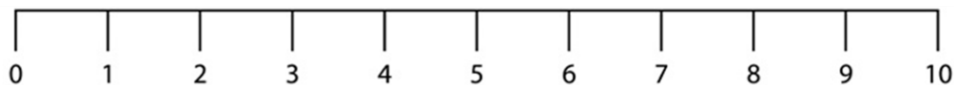
\_\_\_\_\_

**HOW CAN WE HELP YOU?**

What brings you in today? \_\_\_\_\_

If you are already experiencing a symptom, explain: \_\_\_\_\_

How intense are your symptoms 0-10? (circle)



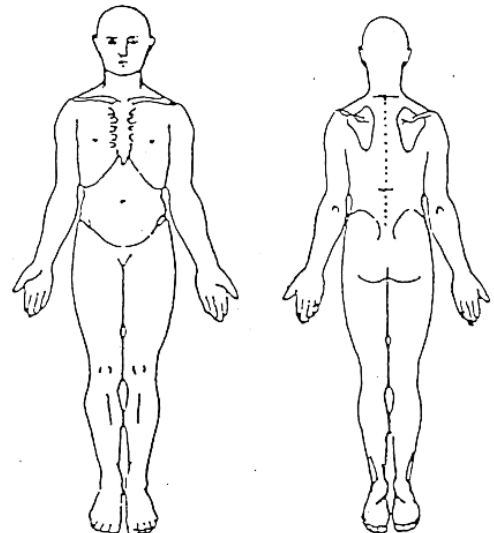
NO  
SYMPTOMS

INTENSE  
SYMPTOMS

Please circle areas where you have pain or other symptoms:

Describe your symptoms: (check where appropriate)

- |                                    |                                       |
|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Numbness  | <input type="checkbox"/> Sharp        |
| <input type="checkbox"/> Tingling  | <input type="checkbox"/> Shooting     |
| <input type="checkbox"/> Stiffness | <input type="checkbox"/> Burning      |
| <input type="checkbox"/> Dull      | <input type="checkbox"/> Throbbing    |
| <input type="checkbox"/> Aching    | <input type="checkbox"/> Stabbing     |
| <input type="checkbox"/> Cramping  | <input type="checkbox"/> Swelling     |
| <input type="checkbox"/> Nagging   | <input type="checkbox"/> Other: _____ |



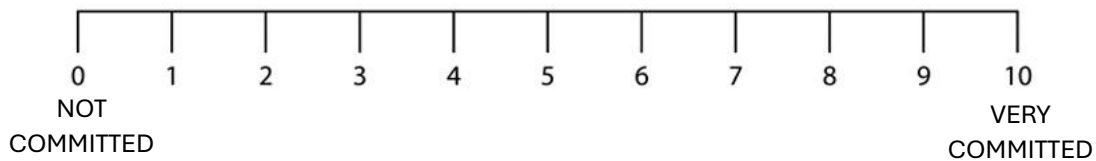


### IMPACT OF YOUR SYMPTOMS

How is this symptom/condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attitude	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Productivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Creativity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How committed are you to correcting this issue 0-10? (circle)



### PATIENT WELLNESS ASSESSMENT



On the arrow diagram above:

- A. What number do you think represents your health today? \_\_\_\_\_
- B. In what direction is your health currently headed? \_\_\_\_\_

What are your health goals?

IMMEDIATE: \_\_\_\_\_

SHORT TERM: \_\_\_\_\_

LONG TERM: \_\_\_\_\_



**CHILDREN & PREGNANCY**

How many children do you have? \_\_\_\_\_

Children's ages? \_\_\_\_\_

Children's health concerns? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you currently pregnant?

No  Yes, I'm due: \_\_\_\_\_

Number of past pregnancies? \_\_\_\_\_

Health concerns regarding this pregnancy? \_\_\_\_\_

\_\_\_\_\_

**HEALTH & ILLNESS HISTORY**

Please check any box beside any condition that you have or have had.

- ADHD/ADD
- Focus/Memory Issues
- Uncoordinated
- Seizures
- Dizziness
- Stroke
- Facial Paralysis
- Difficulty with Speech
- Hand Trembling
- Loss of Sensation
- Muscle Pain
- Muscle Weakness
- Muscle Cramps
- Muscle Twitching
- Joint Pain
- Joint Stiffness
- Shoulder Pain
- Arm/Hand Pain
- Ankle/Foot/Knee Pain

- Stiff Neck
- Neck Soreness
- Pain/Numbness in Arms/Hands
- Pain/Numbness in Legs/Feet
- Angina
- Heart Murmur
- Hypertension
- Anemia
- Asthma/Difficulty Breathing
- Tonsillitis/Strep Throat
- Sinus Congestion
- Sinus Infections
- Ear Ringing
- Earache
- Diabetes
- Thyroid Condition
- Heat Intolerance
- Cold Intolerance
- Hair Changes

- Autoimmune Dx
- Allergies
- Depression
- Anxiety
- Difficulty Swallowing
- Abdominal Pain
- Heartburn/Indigestion
- Diarrhea/IBS/Crohn's Dx
- Constipation
- Menstrual Cramps
- Reproductive Issues
- Endometriosis
- Breast Changes
- Bladder Trouble
- Urinary Trouble
- Weak Grip
- Cancer: \_\_\_\_\_
- Other: \_\_\_\_\_

**ALLERGIES, MEDICATIONS & SUPPLEMENTS**

ALLERGIES (list)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

MEDICATIONS (list)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

SUPPLEMENTS (list)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Are you interested in Nutritional/Lifestyle Coaching? \_\_\_\_\_ If yes, circle below:  
 Inflammation/Gut Health/Cardiovascular/Hormonal/Immune System/Weight Loss/Sleep, Other: \_\_\_\_\_

Wellness Goals you would like to achieve: \_\_\_\_\_

Please READ AND INITIAL the following:

**Acknowledgement of Receipt of Notice of Privacy Practices:** I have read/acknowledged the Notice of Privacy Practices for Protected Health Information. Notice of Privacy Practices is available at the front desk upon request.

Initials: \_\_\_\_\_

**Payment Policy:** I acknowledge I am financially responsible for all charges incurred at Sturgis Chiropractic, P.C. **It is the policy of this office that payment be made at the time of service for all services rendered.** If the incorrect insurance is provided at the time of service, these visits will be considered self-pay. If care is ceased, any remaining balance must be paid in full. **A credit/debit card must be on file and will be run for fees at the time of service or the remaining account balance.**

If the chiropractic services received are deemed maintenance/wellness/corrective care, the visits will not be submitted to insurance and the patient is responsible for the associated fees. Payment delinquency over 180 days will result in an additional 30% collection fee.

Initials: \_\_\_\_\_

**Insurance Assignment:** I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive. If the incorrect insurance is provided at the time of service, these visits will be considered self-pay.

**If the chiropractic services received are deemed maintenance/wellness/corrective care, the visits will not be submitted to insurance and the patient is responsible for the associated fees.**

Initials: \_\_\_\_\_

Signature of Patient or Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

## INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of procedures, including chiropractic adjustments, examinations, various modes of physiotherapy, shockwave treatment, diagnostic x-rays, massage therapy, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the Sturgis Chiropractic and /or other licensed providers and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up providers, including those working at the clinic or office.

I will discuss with the Sturgis Chiropractic provider and/or with other office or clinic personnel the nature and purpose of the procedures, if I choose to do so.

I understand, as with all healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as with all healthcare treatments, there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, fractures, disc injuries, strokes, dislocation and sprains. I do not expect the Sturgis Chiropractic provider to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor/health care provider to exercise judgment during the procedure which the doctor/health care provider feels at the time, based upon the facts then known, is in my best interests.

I further understand that treatment is designed to improve health. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final, and no refunds will be issued. I further understand that there are treatment options available for my condition, these treatment options include, but not limited to self-administered, over the counter analgesics, bracing, rest or medical care. I understand I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I will ask the doctor/health care provider questions about its consent if I have any, and by signing below I agree to the above-named procedures. I consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**INSURANCE ABN**  
**Advanced Beneficiary Notice**

**Deductible needs to be met before services are covered.**

**To use insurance, you must have a neuromusculoskeletal injury or problem.**

Insurance companies state the patient can utilize a certain number of visits, but unless it is for an injury, our contract with the insurance company indicates: **“Services to be billed must be medically necessary.”**

**\*Insurance only covers visits that are medically necessary, no maintenance/wellness or corrective care.**

\*Insurance pays for one chiropractic visit per day when allowed.

**\*Covered visits must be in a treatment plan with a current diagnosis and visits must be used within a certain time frame.**

\*Treatment plan must be reasonable within healthcare guidelines showing progress.

\*It is fraudulent to continue billing insurance once treatment plan is finished.

\*Progress exams are a required part of treatment plan and **not covered by insurance.**

**\*The Gonstead Chiropractor seeks the cause of dis-ease through the use of x-ray analysis to deliver a specific adjustment.**

**Non-Covered Charges:**

**NEW PATIENT EXAM STANDARD \$60**

**NEW PATIENT EXAM DETAILED \$90**

**SELF-PAY ADJUSTMENT \$50**

**PROGRESS EXAM \$40**

**SELF-PAY REHAB \$20**

**EXTREMITY ADJUSTMENT \$15**

**ELECTRIC STIM THERAPY \$20**

**SHOCKWAVE \$60**

**FULL SPINE X-RAYS \$160**

**MASSAGE THERAPY \$45-\$115**

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**SIGNATURE**

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**DATE**