DR. USE ONLY
H.R.:_____
B.P.:___/___
Weight:_____

Northern Life Wellness
Automobile Accident Questionnaire

File #_____
Date: _____
DR._____

Patient Name:_____ S.S.# _____
Birthday: _____/_____/_____ Age: _____ Sex: _____ Height: _____ Weight: _____
Referred By? _____

Contact Information
Address:_____ City: _____ State: ____ Zip:_____
Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated Spouse's name: _____
Phone Number (h) (_____)_____-_____ (c) (_____)_____-_____ (w) (_____)_____-_____
Parents Name & Cell Phone (if patient is a minor): (_____)_____-_____
Email: _____
In case of emergency please contact:
Name: _____ Relationship: _____ Phone #: _____

Insurance Information

1. **Your** Auto Ins company_____Claim#_____
   Policy#:_____ Adjuster's Name & Phone #_____
   Driver of other vehicle, if any: _____
   Other Driver's Ins. Co:_____ Phone #_____
   Policy #:_____Claim#_____
   Have you retained an attorney? □ Yes □ No □ Not Yet □ Other: _____
   If so, attorney's name, address and phone:_____
   _____
   _____
2. Your Health Insurance company:_____
   ID/Policy#_____Group#:_____

Accident Information
Time and Date present injury occurred: ____:____ □ AM □ PM **on** _____/_____/_____ *(mm/dd/yy)*
You were heading? □North □South □East □West **on** _____ *(street/highway)*
Number of people in your vehicle? _____ Were police notified? □ Yes □ No
Were you knocked unconscious? □ Yes □ No Did head strike the windshield or object? □ Yes □ No
You were struck from? □ Behind □ Front □ Left Side □ Right Side □ Other_____
You were? □Driver □Passenger □Front Seat □Back Seat □Using Seat Belts □Other Protective Devices
Were you treated after the accident? _____
Was treatment given? □ Yes □ No Was any Doctor consulted after the accident? □ Yes □ No
If so, give Doctor's name: _____ □ D.C. □ M.D. □ D.O. □ D.D.S

Please explain, in detail, how your accident happened: _____
_____
_____
_____
_____

Before the injury, were you capable of working on an equal basis with others your age? □ Yes □ No
Are your work activities restricted as a result of this accident? □ Yes □ No

Current Condition

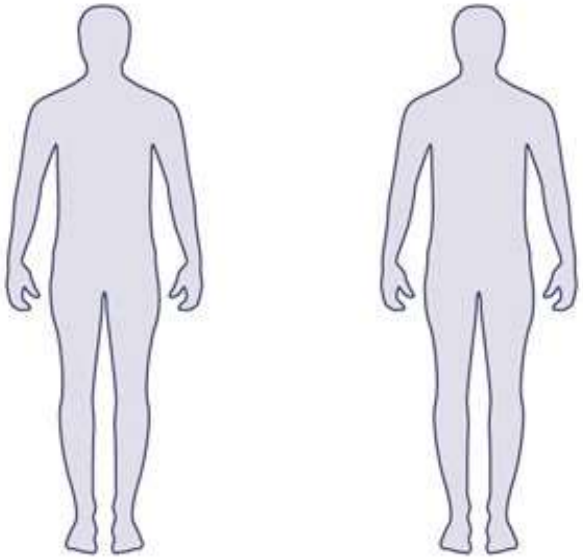
Did you feel pain immediately after the accident? □ Yes □ No □ Later that day □ Next day □ Other
If other, when? _____
Where did you feel pain immediately after the accident? _____

Since the injury, are your symptoms: □ Improving? □ Getting Worse? □ Staying the Same?
Is this problem: □Constant □Comes and goes
Does it feel □ Burning □ Sharp □ Shooting □ Dull □ Aching □ Stiff □ Tingling □ Throbbing □ Swelling □ Other
What makes the condition better? _____ Worse? _____

Does it interfere with: □ Work □ Sleep □ Daily Routine □ Recreation?
Painful movements/activities: □ Sitting □ Standing □ Walking
□ Bending □ Lying down □ Driving

Circle below the severity of your pain:
(No pain) **0 1 2 3 4 5 6 7 8 9 10** (Severe pain)

Please mark your areas of pain and/or dysfunction on the figures to the right:



Please indicate your current health issues:

- □ Arm pain
- □ Back pain
- □ Bladder trouble
- □ Chest pain
- □ Confusion
- □ Coughing blood
- □ Difficult breathing
- □ Difficult chewing
- □ Difficult speech
- □ Difficulty swallowing
- □ Dizziness
- □ Ear pain
- □ Fainting
- □ Forgetfulness
- □ Headaches
- □ Hearing loss
- □ Leg pain
- □ Loss of feeling
- □ Muscle jerking
- □ Nausea
- □ Neck pain
- □ Nose pain
- □ Numbness
- □ Painful joints
- □ Paralysis
- □ Shoulder blade pain
- □ Sore muscles
- □ Stiff joins
- □ Swollen joints
- □ Vision problems
- □ Weak muscles

Females: Are you pregnant: □Yes □No

My signature indicates that, "This is to certify, to the best of my knowledge that I am not pregnant at this time. I hereby authorize the Wellness Clinic to take X-Rays as necessary to determine the status of my spine. I will assume all responsibility for any effects on a fetus potentially present"

Printed name:_____

Signature:_____Date:_____

Health History

Primary Care Physician:_____Clinic Phone #:_____

Name & Location of Clinic:_____

Previous Chiropractic care? □No □Yes Previous Physical Therapy? □No □Yes

List any Medications/Supplements you are taking: _____

Check any of the following conditions you have had:

- □ Aids/HIV
- □ Allergies
- □ Anxiety/Depression
- □ Arthritis
- □ Asthma
- □ Bladder problems
- □ Cancer
- □ Chronic fatigue
- □ Deafness
- □ Diabetes
- □ Digestion problems
- □ Earache
- □ Ear ringing
- □ Epilepsy
- □ Headaches
- □ Migraine
- □ Heart disease
- □ Hemorrhoids
- □ Herniated disk
- □ High blood pressure
- □ Insomnia
- □ Irregular cycle
- □ Kidney problem
- □ Osteoporosis
- □ Poor circulation
- □ Prostate problems
- □ Rheumatoid Arthritis
- □ Sciatica
- □ Shingles
- □ Sinus infection
- □ Stroke
- □ Thyroid problems
- □ TMJ
- □ Venereal disease
- □ Vertigo

Stressors

- □ Smoking Packs/day: _____
- □ Alcohol Drinks/week: _____
- □ Coffee/Caffeine Cups/day: _____
- □ High Stress Level Reason: _____
- □ Exercise: ☐ None ☐ Moderate ☐ Daily ☐ Heavy

Have you had any:	**Description**	**Date**
Surgeries: □No □Yes	_____	_____
Broken bones: □No □Yes	_____	
Falls/Head injuries: □No □Yes	_____	

Significant Family Histoy:_____

_____

X I hereby authorize this office and its doctors to administer care to myself or my child as they deem necessary.

Date:_____Signature_____ Parent (if minor)_____

The Health Care Information Rights of Our Patients and Clients Include:

Your Right to Revoke Consent: You may revoke consent to use or disclose your health information 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) Your health information was released prior to receipt of your request to revoke your consent; and 2) Were you required to give your authorization as a condition for 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: You have a right to limit the use or disclosure of your personal health information. To do so you must inform us, in writing, of any health care providers, hospitals, employers, insurers or other individuals or organizations that you do not want us to disclose your health information to. We are not required to agree to your restrictions; however, if we agree with your restrictions, the restriction is binding on us.

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 services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable, written request if you would like to receive information about your health or the services we provide at a place other than your home or if you would like the information in a different form.

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; such requests must be in writing. We may refuse your request, and charge you for retrieval and copying costs, only in accordance with Minnesota law.

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 that the record was created or as long as the information remains in our files. Amendment requests must be in writing and give us reason to support the change you are asking us to make; however, the clinic is not obligated to comply with your request if it is judged to be unreasonable.

Your Right to Receive an Accounting of the Disclosures We Have Made of Your Records: You have the right to submit a written request for an accounting of the disclosures we have made of your health information for the last six years before the date of your request. By law, such accounting requests will include all disclosures made except for those that: 1) Are required for your treatment, to obtain payment for your services or to operate our practice; 2) Were made to you; 3) We are required or permitted to make without our consent or authorization; 4) Were disclosed with your written consent; 5) Were necessary to maintain a facility directory of individuals involved with your care; 6) Were disclosed for national security or intelligence purpose; 7) Were made to correctional or law enforcement officers; or 8) Were made prior to April 14, 2003.

We will provide the first accounting within any 12-month period without charge. Retrieval and copying fees complying with Minnesota law may be charged for any additional accounting requests during the same 12-month period. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

Your Right to Obtain a Paper Copy of This Notice: You may request a copy of this notice at any time.

Your Right to Complain: You may complain to us if you feel that we have violated your privacy rights. We respect your right to do so and will not take any action against you if you do file a complaint. For further information about our privacy policies and practices, to express a concern or to file a complaint, please contact the Compliance/Privacy Officer at:

Jeffrey W. Danielson, D.C.
Northern Life Wellness
13955 W. Preserve Blvd., Ste. 200
Burnsville, MN 55337
(952) 890-0804

Northern Life Wellness

CONSENT/AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

OUR PRIVACY PLEDGE: Northern Life Wellness is concerned with and committed to the protection of our patients' privacy and ensuring the confidentiality of personal health information entrusted to us.

Ways in which the clinic may use or disclose your health care information include, but are not limited to:

- Another provider or facility for the purpose of diagnosis, assessment or treatment of your health condition.
- Another party, such as insurance carrier, HMO or employer for the purpose of receiving payment for services rendered to you.
- The use of that information within our practice for quality control or other operational purposes.
- The use of that information to contact you by telephone, mail or e-mail with appointment reminders, information about the clinic, treatment alternatives or other health-related information that may be of interest to you.

Along with this consent form, you will be given a copy of our privacy notice that describes our privacy policies in detail. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. The current notice, including the effective date, will be posted in the clinic and will be given to you when you come in for treatment.

Your Right to Limit Uses or Disclosures: You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions; however, if we agree with your restrictions, the restriction is binding on us.

Your Right to Revoke Your Authorization: You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. 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.

YOU HAVE A RIGHT TO REFUSE CONSENT FOR DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION. WITHOUT YOUR CONSENT, HOWEVER, NORTHERN LIFE WELLNESS WILL NOT BE ABLE TO SUBMIT CLAIMS TO INSURANCE CARRIERS OR OTHER THIRD PARTY PAYERS AND MAY NOT ACCEPT YOU AS A PATIENT/CLIENT.

Initial Here

[ ] **I acknowledge receipt of Northern Life Wellness's Notice of Privacy Practices**

By signing below, I give consent to Northern Life Wellness clinicians or staff to disclose my personal health information.

_____	_____
Printed Name	**Parent or Guardian (if a minor)**
_____	_____
Signature	**Date**
_____	
Date	

PROFESSIONAL FEE SCHEDULE

INITIAL VISIT AND STANDARD VISITS

Consultation	No Charge
Examination (complexity/time based)	$90 - $140
X-rays (**per view**)	$60
Adjustment (depending on # of regions)	$60 - $80
Extremity Adjustment	$65
Application of Ice/Hot Pack	$35
Therapies (per unit)	$40 - $70

USUAL AND CUSTOMARY PHYSICAL THRAPY FEES

Consultation	No Charge	Electronic Muscle Stimulation (per unit)	$40
Evaluation	$170-210	Ultrasound (per unit)	$40
Re-evaluation	$97	Therapeutic Exercises (per unit)	$70
Hot/cold packs	$35	Neuromuscular Re-education (per unit)	$70
Traction	$40	Manual Therapy Techniques (per unit)	$55
		Therapeutic Activities (per unit)	$58

Our experience has shown that it is wise to have an understanding with our patients as to our office policies and fees. This form has been prepared for your convenience and information. We offer several methods of payment for your needs. This information will enable us to better serve you and help to avoid misunderstandings in the future. Our main concern is your health and well-being, and we will do our best to help you in any way we can. A detailed outline of services charges can be provided upon request.

PLAN 1: GROUP INSURANCE

If you have insurance which covers physical therapy, we will bill your insurance directly. Please present your card on your first visit. Until we have the completed necessary information to verify coverage, you will be required to pay for your care. This includes any deductible or co-pay at the time of your service. In the event the insurance check should come to you, you are expected to bring the check in to us. Remember, insurance companies do not guarantee payment. Please know that we will bill the insurance company for all the services provided including but not limited to extremity adjustment, traction, neurological re-education, and soft tissue therapies. If you have questions regarding any of your billing please ask.

PLAN 2: HEALTH CARE MADE AFFORDABLE (HCMA)/CASH

For those patients who qualify, we offer discounted cash agreements on a monthly block basis. Please ask for details separate to this professional fee schedule. Fees are to be paid at the time services are rendered, unless special arrangements have been made in advance. Discontinuing care before completing the agreed upon corrective or wellness care plan will cause your plan to be prorated at our regular rates for all visits from the beginning of care.

PLAN 3: WORKERS COMPENSATION INJURY

You need to report your injury to your employer and bring in insurance information. Payment for services is required until insurance information is verified. We will bill the insurance company directly.

PLAN 5: AUTO/PERSONAL INJURY

You need to report the accident and present your auto insurance card to us on your first visit. Payment will be required until your coverage can be verified. We will bill the insurance company directly.

Insurance verification and authorization is not a guarantee of payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee. I understand that I may be responsible for any balance that is not paid by insurance. I authorize the Clinic to release any information regarding my treatment to any insurance company in effort to receive reimbursement for services provided. I authorize the use of this signature on all insurance submissions.

I have read and understand all of the options available to me.

_____ _____ _____

Date Signature Parent or Guardian (if a minor)

INFORMED CONSENT WAIVER & AUTHORIZATION TO TREAT

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

> ***Adjustment****:* An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method of correction is by specific adjustments of the spine and joints of the body.
> ***Health****:* A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.
> ***Vertebral Subluxation****:* A subluxation is a complex of functional and/or structural and/or pathological articular changes that compromise neural integrity and may influence organ system function and general health..

We obtain the necessary clinical information to establish an accurate impression of the person's health status by utilizing diagnostic and treatment procedures that are supported by the best available evidence, clinical experience or consensus-driven guidelines and are in accordance with legal standards of care. We do not offer advice regarding treatment prescribed by others. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we follow a cooperative patient management with referral to communication and collaboration with other health care providers to ultimately benefit the patient.

Practice Objective
Our office recognizes and places particular attention on the adjustment, correction and prevention of the subluxation complex by facilitating neurological and biomechanical integrity in the preservation and restoration of your health and wellness.

The material risks inherent in chiropractic adjustments
As with any healthcare procedure, there are certain complications which may arise during chiropractic adjustments and therapy. These complications include but are not limited to: costovertebral strains and separations, fractures, muscle strain, cervical myelopathy, and although rare, various vascular injuries. Some patients will feel stiffness and soreness following the first few days of treatment. We 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 our attention, it is your responsibility to inform us.

Informed Consent and Authorization
I, the undersigned, have been informed by the participating treating doctor of Chiropractic (D.C.) that he/she is/are a licensed chiropractor, and having been informed by such Doctor as to the benefits and potential risks of chiropractic and radiological treatment, hereby consent to such treatment. All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I, therefore, accept chiropractic care on this basis.

This document is binding and the parties hereto intend this Informed Consent Waiver and Authorization to Treat to be binding and insure the benefit of their respective principals, heirs, executors, administrators, successors, and assigns; includes any and all my successors and/or heirs. I further state that should complication arise from such agreed treatment with treating Doctor of Chiropractic that such individual and myself will be the only parties to engage in any and all recourse should that need arise foregoing any and all others.

_____	_____	_____
Date	Signature	Parent or Guardian (if a minor)