



NORTHERN LIFE

WELLNESS CHIROPRACTIC & PHYSICAL THERAPY

Dr: _____

File #: _____

Patient Name: _____ Birthday: ____/____/____

Age: _____ Sex: _____ Height: _____ ft. _____ in. Weight: _____ lbs.

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: Cell (____) _____ - _____ Home (____) _____ - _____ (Parent/Guardian if a minor)

Email: _____ (Parent/Guardian if a minor)

Occupation: _____ Employer: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed Spouse's Name: _____

Number of Children: _____ Were you referred in? Name: _____

Emergency Contact:

Name: _____ Relationship: _____ Phone: (____) _____ - _____

Are you a part of a team or club in need of sponsorship? ☐ Yes ☐ No

If yes, Team/Organization Name: _____

INSURANCE INFORMATION:

Company: _____ Policy Number: _____

Policy Holder's Name: _____ DOB: ____/____/____

HEALTH HISTORY:

Primary Care Physician: _____

Name of Clinic/Group: _____ Clinic Phone #: (____) _____ - _____

Have you ever received Chiropractic Care? ☐ Yes ☐ No

Physical Therapy Care? ☐ Yes ☐ No

Medications/supplements you are currently taking: _____

LIFESTYLE & STRESSORS:

☐ Coffee/Caffeine: _____ cups/day ☐ Smoking: _____ packs/day ☐ Alcohol: _____ drinks/week

☐ Exercise: _____ days/week Type: _____

☐ Stress Level: _____ (0-5) Reason(s): _____

HAVE YOU HAD ANY OF THE FOLLOWING (please provide any details and date of occurrence):

☐ Falls/Head Injuries: _____

☐ Broken Bones: _____

☐ Surgeries: _____

☐ Automobile Accidents: _____

PLEASE PROVIDE ANY SIGNIFICANT HEALTH HISTORY/CONDITIONS OF IMMEDIATE FAMILY MEMBERS & YOUR RELATION:

FEMALES: Are you pregnant? ☐ Yes ☐ No

My signature indicates: "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."

PRINT NAME

SIGNATURE

DATE

CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE HAD OR EXPERIENCED:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Digestion Issues | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Earache/Infections | <input type="checkbox"/> Irregular Cycle | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Arm/Shoulder Pain | <input type="checkbox"/> Ear Ringing | <input type="checkbox"/> Kidney Issues | <input type="checkbox"/> Sinus Infections |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Thyroid Issues |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Vertigo/Dizziness |
| <input type="checkbox"/> Deafness | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Prostate Issues | |
| <input type="checkbox"/> Other: _____ | | | |

CURRENT CONDITION:

What is your major symptom/issue? _____

When did your symptoms begin? _____

Have you had this problem before? ☐Yes ☐No Have you have previous treatment for this condition? ☐Yes ☐No

Other treatments you have had: ☐Chiropractic ☐Orthopedic ☐Neurologist ☐PT ☐Medication ☐Surgery

☐Other: _____

Is your condition getting progressively worse? ☐Yes ☐No Is this problem: ☐Constant ☐Comes & Goes

What does it feel like? ☐Burning ☐Sharp ☐Shooting ☐Dull ☐Stiff ☐Tingling ☐Throbbing ☐Swelling

☐Other: _____

Painful movements: ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down ☐Driving

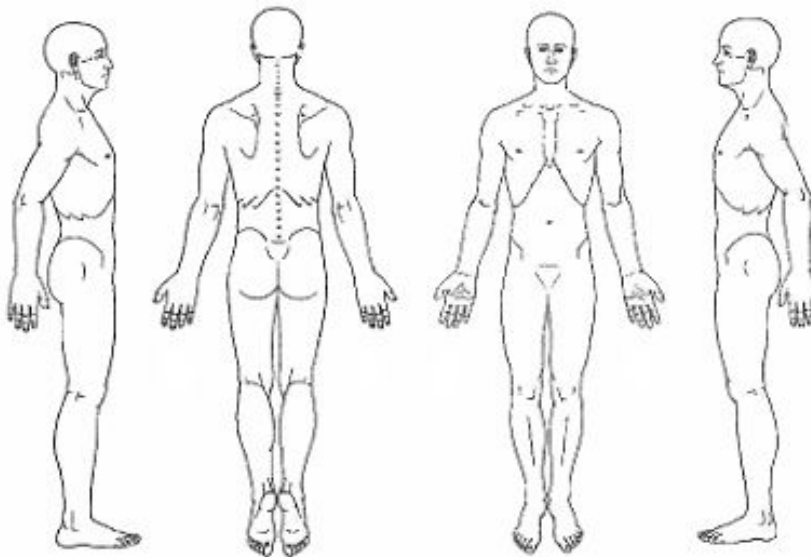
☐Other: _____

Does this interfere with any of the following: ☐Work ☐Sleep ☐Daily Life ☐Recreation ☐School/Studies

What makes this condition better? _____ Worse? _____

Please circle the severity of pain (current, best, & worse): 0 1 2 3 4 5 6 7 8 9 10

Using the diagram provided, mark the areas of concern:



☐ I HEREBY AUTHORIZE THIS OFFICE AND ITS DOCTORS TO ADMINISTER CARE TO MYSELF OR MY CHILD AS THEY DEEM NECESSARY

PRINT NAME

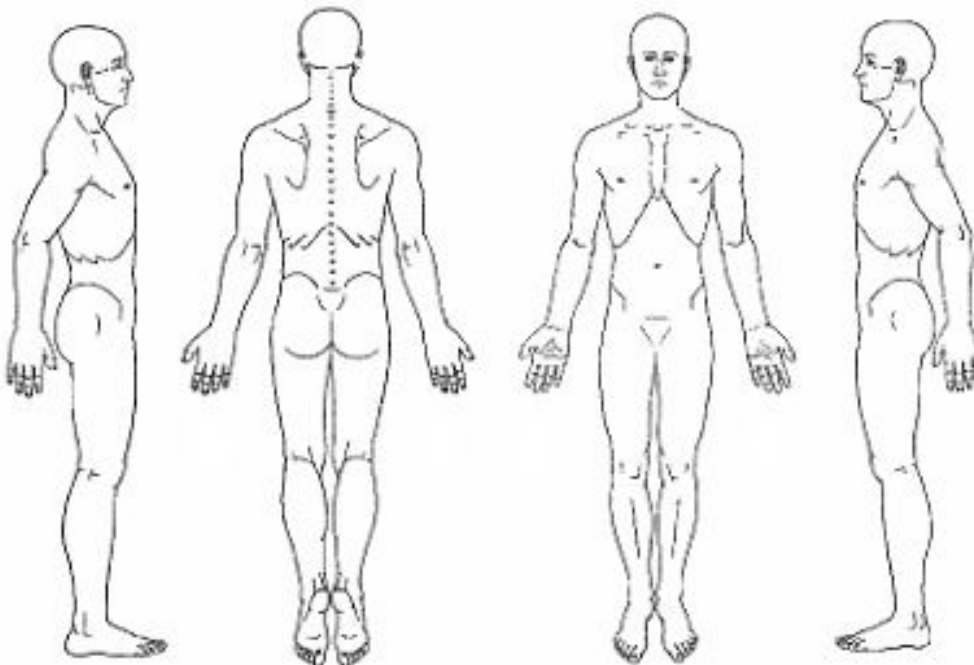
SIGNATURE (PARENT/GUARDIAN IF MINOR)

DATE

DOCTOR USE ONLY

Patient Information:		HR: _____	BP: _____
Cervical Spine Subjective Reporting:			
Thoracic Spine Subjective Reporting:			
Lumbar Spine Subjective Reporting:			
Extremity(s) Subjective Reporting:			
Cervical ROM		Thoracolumbar ROM	
Flexion:	Extension:	Flexion:	Extension:
Rt Rotation:	Lt Rotation:	Rt Rotation:	Lt Rotation:
Rt Lat. Flexion:	Lt Lat. Flexion:	Rt Lat. Flexion:	Lt Lat. Flexion:
Cervical Orthopedic Exams & Findings:		Compression: + -- Side: Rt Lt Radiation: Y N Lt Lat. Compression: + -- Side: Rt Lt Radiation: Y N Rt Lat. Compression: + -- Side: Rt Lt Radiation: Y N Distraction: + -- Side: Rt Lt Radiation: Y N	
Thoracic Orthopedic Exams & Findings:		Scheppelmann's: + -- Side: Rt Lt Slump Test: + -- Side: Rt Lt Radiation: Y N TOS Tests: + -- Side: Rt Lt Radiation: Y N Adams Flexion: + -- Side: Rt Lt	
Lumbar Orthopedic Exams & Findings:		Paraspinal Test: + -- Side: Rt Lt Kemps: + -- Side: Rt Lt Radiation: Y N Yeomans: + -- Side: Rt Lt Radiation: Y N Straight Leg Raise: + -- Side: Rt Lt Radiation: Y N Well Leg Raise: + -- Side: Rt Lt Radiation: Y N	
Extremity Orthopedic Exams & Findings:			

MOVEMENT SCREEN FINDINGS



DOCTOR USE ONLY

XRAY FINDINGS
CERVICAL SPINE:
THORACIC SPINE:
LUMBAR SPINE:
EXTREMITY(S):

ADJUSTING NOTES

RECOMMENDED POC:	3X/week for _____ months
	2X/week for _____ months
	1X/week for _____ months

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:

**PIFF Holdings, PC
DBA, Northern Life Wellness
13955 W. Preserve Blvd., Ste. 200
Burnsville, MN 55337
(952) 890-0804**



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.

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

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

PRINT NAME

SIGNATURE (PARENT/GUARDIAN IF MINOR)

DATE

PROFESSIONAL FEE SCHEDULE

Initial Visit and Standard Visits	Usual and Customary Physical Therapy Fees	
Consultation.....No Charge	Consultation...No Charge	Electronic Muscle Stimulation (per unit).....\$75
Examination (complexity/time based).....\$90-\$140	Evaluation.....\$170-\$210	Ultrasound (per unit).....\$75
X-Rays (per view).....\$70	Re-Evaluation.....\$97	Therapeutic Exercises (per unit).....\$75
Adjustment (depending on # of regions)...\$80-\$100	Ice/Hot Packs.....\$45	Neuromuscular Re-Education (per unit).....\$75
Extremity Adjustment.....\$75	Traction.....\$75	Manual Therapy Techniques (per unit).....\$75
Application of Ice/Hot Pack.....\$45		Therapeutic Activities (per unit).....\$80
Therapies (per unit).....\$45-\$80		

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 chiropractic or 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 PLAN

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

PRINT NAME

SIGNATURE (PARENT/GUARDIAN IF MINOR)

DATE

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.

PRINT NAME

SIGNATURE (PARENT/GUARDIAN IF MINOR)

DATE

PATIENT COMMUNICATION CONSENT FORM

I agree to allow Northern Life Wellness, PA and its staff to contact me using the following methods regarding my personal health, financial, billing information, and appointments. I authorize/do not authorize Northern Life Wellness, PA and staff to leave messages for me when I am unavailable as indicated below.

Check to Confirm Approval Method	Method	Number	Approval to Leave Messages
<input type="checkbox"/>	Cell Phone (Call/Text)	() -	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Home Phone	() -	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Work Phone	() -	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Email		<input type="checkbox"/> Yes <input type="checkbox"/> No

I authorize Northern Life Wellness, PA and staff to discuss my personal health, financial, billing information, and appointments with the individuals listed below. I understand that by leaving spaces blank, I am indicating my choice that I do not want my information shared with or released to anyone else.

Name	Relationship to Patient	Phone Number
		() -
		() -

By signing my signature below, I hereby acknowledge that I have read and understand the information provided on this Consent Form. I understand the risk associated with the different methods of communication, especially email, and consent to the communications outlined in this Consent Form.

_____	_____	_____
PRINT NAME	SIGNATURE (PARENT/GUARDIAN IF MINOR)	DATE