

CURRENT CONCERNS:

REASON(S) FOR SEEKING TREATMENT: _____

HISTORY OF INJURY TO THE AREA? Y N

IF YES, PLEASE EXPLAIN: _____

DATE OF INJURY/ONSET OF SYMPTOMS: ___/___/___

CURRENT PAIN LEVEL: (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST PAIN IMAGINABLE)

DESCRIPTION OF PAIN: ACHING SHARP BURNING NUMBNESS TINGLING

SELF-CARE: ICE HEAT OTHER _____

OTHER HEALTHCARE PROVIDERS SEEN FOR THIS CONCERN: Y N

IF YES, NAME OF PRACTITIONER _____ APPROXIMATE DATE OF TREATMENT ___/___/___

HAVE YOU EVER BEEN TREATED BY A CHIROPRACTOR? Y N IF YES, APPROX DATE ___/___/___

ARE YOU PREGNANT Y N IF YES, DUE DATE ___/___/___ OB PHYSICIAN _____

GENERAL HEALTH HISTORY:

CURRENT HEIGHT: _____ CURRENT WEIGHT: _____

PLEASE CHECK ALL THAT APPLY TO YOUR HEALTH HISTORY..

CONGENITAL HEART DEFECT

CANCER

DIABETES

KIDNEY PROBLEMS

SCOLIOSIS

ASTHMA

NECK PAIN

BACK PAIN

HEADACHES

CONSTIPATION

DIARRHEA

DIGESTIVE PROBLEMS

EAR ACHES/INFECTIONS

COLIC/FUSSINESS

SLEEPING PROBLEMS

BED WETTING

ACID REFLUX

SKIN IRRITATION

OTHER CONDITIONS _____

ALLERGIES/SENSITIVITIES _____

MEDICATIONS _____

VITAMINS/SUPPLEMENTS _____

ACCIDENTS/INJURIES _____

PEDIATRICIAN/FAMILY PHYSICIAN _____



PATIENT NAME: _____

ASSIGNMENT OF BENEFITS AND RELEASES:

- I AUTHORIZE AND DIRECT THAT PAYMENT BE MADE DIRECTLY TO A L WAGNER FAMILY CHIROPRACTIC PC, DR. ASHLEY L. WAGNER, FOR ANY AND ALL INSURANCE BENEFITS OR REIMBURSEMENT FOR SERVICES RENDERED, WHICH AMOUNTS WOULD OTHERWISE BE PAYABLE TO ME UNDER ANY INSURANCE OR PRE-PAID HEALTHCARE PLAN.
- I AUTHORIZE THE RELEASE OF ANY INFORMATION CONCERNING MY HEALTH AND HEALTHCARE SERVICES TO ANY INSURANCE COMPANY, ADJUSTER, PRE-PAID HEALTH PLAN, DOCTOR OR ATTORNEY INVOLVED IN THIS CASE.
- I UNDERSTAND THAT THERE IS NO GUARANTEE THAT MY INSURANCE COMPANIES OR PRE-PAID HEALTHCARE PLAN WILL COVER OR PAY FOR ALL OF MY CHARGES. NOTWITHSTANDING DENIAL, REDUCTION OF BENEFITS OR FAILURE TO PAY FOR ANY REASON, I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL REMAINING CHARGES.

I AUTHORIZE DR. ASHLEY L. WAGNER TO DISCUSS MY CASE WITH ANY OTHER HEALTHCARE PROFESSIONAL AT HIS/HER DISCRETION.

DATE

PATIENT SIGNATURE

WITNESS:

I REVIEWED THIS AUTHORIZATION FORM VERBALLY WITH THE PATIENT AND HE/SHE APPEARS TO UNDERSTAND IT FULLY.

DATE

WITNESS SIGNATURE



CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME: _____

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

PURPOSE OF CONSENT: BY SIGNING THIS FORM, YOU WILL CONSENT TO OUR USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT ACTIVITIES, AND HEALTHCARE OPERATIONS.

NOTICE OF PRIVACY PRACTICES: YOU HAVE THE RIGHT TO READ OUR NOTICE OF PRIVACY PRACTICES BEFORE YOU DECIDE WHETHER TO SIGN THIS CONSENT. OUR NOTICE PROVIDES A DESCRIPTION OF OUR TREATMENT, PAYMENT ACTIVITIES, AND HEALTHCARE OPERATIONS, OF THE USES AND DISCLOSURES WE MAY MAKE OF YOUR PROTECTED HEALTH INFORMATION, AND OF OTHER IMPORTANT MATTERS ABOUT YOUR PROTECTED HEALTH INFORMATION. A COPY OF OUR NOTICE ACCOMPANIES THIS CONSENT. WE ENCOURAGE YOU TO READ IT CAREFULLY AND COMPLETELY BEFORE SIGNING THIS CONSENT.

WE RESERVE THE RIGHT TO CHANGE OUR PRIVACY PRACTICES AS DESCRIBED IN OUR NOTICE OF PRIVACY PRACTICES. IF WE CHANGE OUR PRIVACY PRACTICES, WE WILL ISSUE A REVISED NOTICE OF PRIVACY PRACTICES, WHICH WILL CONTAIN THE CHANGES. THOSE CHANGES MAY APPLY TO ANY OF YOUR PROTECTED HEALTH INFORMATION THAT WE MAINTAIN. YOU MAY OBTAIN A COPY OF OUR NOTICE OF PRIVACY PRACTICES, INCLUDING ANY REVISIONS OF OUR NOTICE, AT ANY TIME BY CONTACTING: ROCHELLE TELEPHONE: 701-751-2020

RIGHT TO REVOKE: YOU WILL HAVE THE RIGHT TO REVOKE THIS CONSENT AT ANY TIME BY GIVING US WRITTEN NOTICE OF YOUR REVOCATION SUBMITTED TO THE CONTACT PERSON LISTED ABOVE. PLEASE UNDERSTAND THAT REVOCATION OF THIS CONSENT WILL NOT AFFECT ANY ACTION WE TOOK IN RELIANCE ON THIS CONSENT BEFORE WE RECEIVED YOUR REVOCATION, AND THAT WE MAY DECLINE TO TREAT YOU OR TO CONTINUE TREATING YOU IF YOU REVOKE THIS CONSENT.

SIGNATURE

I, _____ (PRINT), HAVE HAD FULL OPPORTUNITY TO READ AND CONSIDER THE CONTENTS OF THIS CONSENT FORM AND YOUR NOTICE OF PRIVACY PRACTICES. I UNDERSTAND THAT, BY SIGNING THIS CONSENT FORM, I AM GIVING MY CONSENT TO YOUR USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT ACTIVITIES AND HEALTH CARE OPERATIONS.

SIGNATURE: _____ DATE: _____

RELATIONSHIP TO PATIENT (IF APPLICABLE): _____

AUTHORIZED PROVIDER REPRESENTATIVE SIGNATURE: _____