A. L. WAGNER
FAMILY CHIROPRACTIC
DR. ASHLEY L. WAGNER

MEDICARE (65 YEARS +)

TODAY'S DATE:____/____/____

PATIENT INFORMATION:

FULL NAME:____ DATE OF BIRTH:___/___/___ AGE:____

GENDER: ☐M ☐F HOME PHONE:____________________ MOBILE PHONE:________________________

ADDRESS:____
STREET ADDRESS CITY STATE ZIP + 4

E-MAIL ADDRESS:____

REFERRED BY: ☐ PHYSICIAN________________________ ☐ FAMILY/FRIEND__________________________

☐ TV COMMERCIAL ☐ PHONE BOOK ☐ OTHER_______________________________

INSURANCE INFORMATION:

PLEASE PRESENT CURRENT INSURANCE CARD

COMPANY NAME:____ EFFECTIVE DATE:_____/_____/_____

INSURED'S NAME:___________________________________ INSURED'S DATE OF BIRTH:____/____/_____

☐ CURRENTLY UNINSURED, AND WILL BE PAYING OUT OF POCKET FOR SERVICES PROVIDED

ASSIGNMENT OF BENEFITS / INFORMATION RELEASE:

I AUTHORIZE AND DIRECT THAT PAYMENT BE MADE DIRECTLY TO A L WAGNER FAMILY CHIROPRACTIC FOR ANY AND ALL INSURANCE BENEFITS OR REIMBURSEMENT FOR SERVICES RENDERED BY THE PROVIDER, 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.
****ATTENTION MEDICARE CHIROPRACTIC PATIENTS:** I UNDERSTAND THAT MEDICARE REQUIRES DOCTORS OF CHIROPRACTIC TO PERFORM A HEALTH HISTORY AND EXAMINATION PRIOR TO TREATMENT OF ANY PATIENT NEW TO THE CLINIC, HOWEVER, MEDICARE WILL NOT COVER THE EXPENSES ASSOCIATED WITH THIS REQUIREMENT. I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYING THIS FEE.

SIGNATURE:____ DATE:_____________

WITNESS SIGNATURE:______________________________________ DATE:_____________

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, APPROXIMATE DATE OF LAST TREATMENT _____/_____/______

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

☐ARTHRITIS ☐HIGH BLOOD PRESSURE ☐ARTIFICIAL JOINTS

☐CONSTIPATION ☐DIARRHEA ☐DIGESTIVE PROBLEMS

☐SLEEPING PROBLEMS

☐OTHER CONDITIONS____

☐ALLERGIES/SENSITIVITIES____

☐MEDICATIONS____

☐VITAMINS/SUPPLEMENTS____

☐ACCIDENTS/INJURIES____

____

PRIMARY CARE PHYSICIAN____

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:____