

# Z Spine and Joint Center

## Confidential Patient Information

P.O. BOX 44130, Eden Prairie, MN 55344

Phone (952) 491-0577

Website: www.zspineandjoint.com

Office Use Only:  
Patient ID Number: \_\_\_\_\_  
DX: \_\_\_\_\_  
Payment Per Visit: \$ \_\_\_\_\_

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

Patient's Full Name \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Male  Female Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Married  Single  Widowed  Separated  Divorced Number of Children \_\_\_\_\_

Occupation: \_\_\_\_\_ Hours/Week \_\_\_\_\_ Employer: \_\_\_\_\_ Business Phone \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Employer: \_\_\_\_\_ Business Phone \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Family Physician: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Phone \_\_\_\_\_

May our office inform your family physician of presenting condition/s, exam findings, diagnosis, and treatment plan?  Yes  No

Do You Have Health Insurance? \_\_\_\_\_ Company Name \_\_\_\_\_

Previous Chiropractic Care:  Yes  No If Yes, for what Problem: \_\_\_\_\_

Doctor's Name \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Referred By (Friend, Relative, or Physician) : \_\_\_\_\_

Is Today's Visit Due To A Work Related Injury:  Yes  No

Is Today's Visit Due To A Personal Injury or Auto Accident:  Yes  No

(If yes to either questions above, please check with receptionist, additional information is needed)

### PAIN CHART

**\*\* Mark Your Areas of Pain on the Picture**

Chief Complaint: \_\_\_\_\_

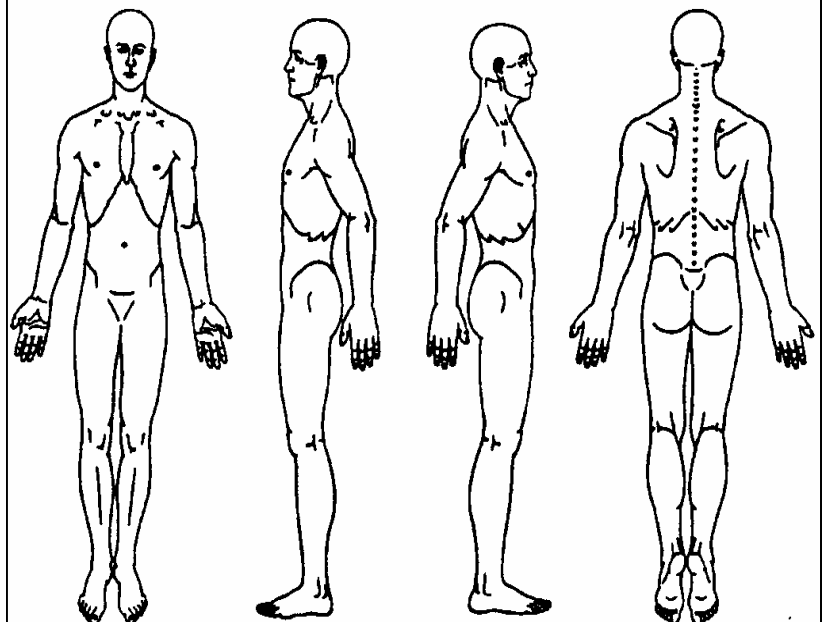
0 1 2 3 4 5 6 7 8 9 10  
←—————→  
no pain unbearable

#2 Complaint: \_\_\_\_\_

0 1 2 3 4 5 6 7 8 9 10  
←—————→  
no pain unbearable

#3 Complaint: \_\_\_\_\_

0 1 2 3 4 5 6 7 8 9 10  
←—————→  
no pain unbearable



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Chief complaint \_\_\_\_\_

Secondary or related complaint(s) if any: \_\_\_\_\_

Date of Onset: \_\_\_\_\_ Was the Onset  Gradual  Sudden Since onset, has it gotten:  Worse  Better

Describe what caused the pain: \_\_\_\_\_

PLEASE ANSWER THE FOLLOWING QUESTIONS TO HELP EXPLAIN YOUR **CHIEF COMPLAINT**:

Describe the quality of the complaint/pain:

- sharp
- dull/ache
- throbbing
- tingling/numbness
- other: \_\_\_\_\_

Does any of the following make the pain worse:

- lifting/bending/pushing/pulling
- cough/sneeze/bowel movement
- driving/riding/sitting
- walking/running/standing
- other: \_\_\_\_\_

Describe if pain is in a single spot or does is spread out:

- radiating dull, deep ache
- pin point
- burning, sharp stabbing, tingling, numb
- other: \_\_\_\_\_

Does any of the following make it better:

- rest/laying down
- sitting
- walking/exercise
- other: \_\_\_\_\_

How often are you aware of the pain:

- intermittent (less than 25% of time when awake)
- occasional (25-50% of time when awake)
- frequent (50-75% of time when awake)
- constant (75-100% of time when awake)

Does it interfere with your daily activities:

- minimal (annoyance, no impairment)
- slight (tolerated, some impairment)
- moderate (marked impairment)
- marked (preclude any activity)

Have you detected any possible relationship of your current complaint with any of the following:

- Muscle Weakness  Bowel/Bladder problems  Digestion  Cardiac/Respiratory  Other: \_\_\_\_\_

Have you tried any self-treatment or taken any medication (over the counter or prescription):  Yes  No

If yes, explain: \_\_\_\_\_ Results: \_\_\_\_\_

Are you currently pregnant?  Yes  No Are you currently taking anti-coagulant or blood thinning medication?  Yes  No

What type of care are you interested in:  Pain relief only  Healing of current condition  Performance Enhancement  All three

What is your long-term goal for treatment (eg. Play a round of golf without pain)? \_\_\_\_\_

OFFICE NOTES \_\_\_\_\_

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

In general, would you say your health is (check one):  Excellent  Very good  Good  Fair  Poor

**PAST HEALTH HISTORY:**

1. Have you ever experienced your present problem before for which you are consulting us:  Yes  No If yes, When: \_\_\_\_\_

Was treatment provided:  Yes  No If yes, By whom: \_\_\_\_\_ Outcome: \_\_\_\_\_

2. Have you **ever** had a **stroke** or issues with **blood clotting**?  Yes  No

3. Have you **ever** had any **major illnesses, injuries, broken bones, hospitalizations, accidents, or surgeries**?  Yes  No

3. Are you presently taking any **prescription drugs**, over-the-counter drugs, vitamins, or supplements?  Yes  No

**SYSTEMS REVIEW QUESTIONS:**

Date	Injury/Fracture/Illness/Surgeries	Treatment	Results

Do you or have you ever had any problems with the following areas? (Please mark **Y** for yes or **N** for no in each of the following:)

Product/Drug	Reason	Dosage	Frequency

- 1. \_\_\_ Eyes
- 2. \_\_\_ Ears, Nose, Mouth, Throat
- 3. \_\_\_ Heart
- 4. \_\_\_ Lungs/ Breathing
- 5. \_\_\_ Intestines/Bowels
- 6. \_\_\_ Urinary

- 7. \_\_\_ Muscles
- 8. \_\_\_ Nerves
- 9. \_\_\_ Joints/Bones
- 10. \_\_\_ Skin
- 11. \_\_\_ Internal Organs
- 12. \_\_\_ Blood

- 13. \_\_\_ Allergies
- 14. \_\_\_ Psychological/Emotional
- Females only:**
- 15. \_\_\_ Gynecological/Menstrual/Breast
- Males Only:**
- 17. \_\_\_ Prostate/Testicular/Penile

Please explain any above **Yes** answers: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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## SOCIAL HISTORY:

Office use only:  
Patient ID Number: \_\_\_\_\_

Recreational Activities (Hobbies): \_\_\_\_\_  
\_\_\_\_\_

Your education level:  Highschool  Some college  College Graduate  Post Graduate  Other: \_\_\_\_\_

- |                          |                          |                                     |  |
|--------------------------|--------------------------|-------------------------------------|--|
| Yes                      | No                       |                                     |  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you exercise? _____              | times per week                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you smoke? _____                 | packs per day                                      |
|                          |                          |                                     | If you have quit smoking, when did you quit? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you use other forms of tobacco?  | What/How much per day? _____                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you consume alcohol?             | How many drinks per week? _____                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you eat a balanced low fat diet? | If no, explain: _____                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you get adequate sleep?          | If no, explain: _____                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Is work stressful to you?           | If yes, explain: _____                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Is family life stressful to you?    | If yes, explain: _____                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you use recreational drugs?      | If yes, explain: _____                             |

## FAMILY HISTORY AND HEALTH STATUS: list any diseases, disorders, or major illnesses. If deceased, from what?

1. Mother: \_\_\_\_\_
2. Father: \_\_\_\_\_
3. Sisters: \_\_\_\_\_ How many? \_\_\_\_\_
4. Brothers: \_\_\_\_\_ How many? \_\_\_\_\_
5. Other: \_\_\_\_\_

## OTHER INFORMATION:

How do you sleep  Back  Side  Stomach Do you use a pillow :  Yes  No

Do you wear orthotics or arch supports  Yes  No

**Females:** Date of last gynecological and breast exam: \_\_\_\_\_

For Purposes of X-Ray: Possible pregnancy?  Yes  No

Date of last menstrual cycle: \_\_\_\_\_

## Please read and sign:

I hereby state that all information that I have provided Z Spine and Joint Center is complete and truthful and that I fully disclosed my health history.

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

# INFORMED CONSENT

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I \_\_\_\_\_, Do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used.

Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasionally bruising in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor.

Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

## TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

## ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including, rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

**I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.**

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

_____ Signature of Patient	Date _____
_____ Signature of Parent or Guardian (if a minor)	Date _____
_____ Signature of Witness	Date _____

## AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release **any information** you deem appropriate concerning my physical or emotional condition and/or health history to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the **direct payment to you** of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services **refuses to make such payment** upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. However, it is understood that all reasonable efforts have been made to collect the sums due from the insurance company, or companies, contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what was due, I personally owe you.
4. In addition to the above, I hereby waive any statute of limitations on collection and/or recovery in this state of Minnesota.
5. I further agree that this Authorization and Assignment is irrevocable until all moneys owed Z Spine & Joint Center are paid in full.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

### Financial/Privacy Policy and Disclaimer

- **Insurance verification is not a guarantee of payment.** Verification is only a quote of patient benefits. Insurance companies review charges individually and make payment accordingly. **Charges not covered by insurance are the patient's responsibility and due within 30 days of billing.**

#### Deductible Payments

Once we receive an "Explanation of Benefits" from your insurance company, we will bill or credit the account for the remaining balance. Reimbursement checks can be issued upon request.

#### Collection of Patient Balance

Co-payments and Co-insurance is the patient's responsibility and may be collected at the time of service.

If the "Explanation of Benefits" report shows the patient has an outstanding balance from services not covered by the individual insurance company, patients will receive a bill outlining these outstanding charges. **Upon receipt, payment is due within 30 days. After 30 days, it is the clinic's policy to turn unpaid accounts over to a collections agency.**

Legal fees incurred from the collections process are the responsibility of the patient in addition to the previous balance.

#### Returned Checks

It is our policy to collect \$25.00 for checks that are returned to us. This is to cover any fees that apply from the transaction

#### Appointments

If unable to keep an appointment, as a courtesy to our staff and other patients please give 24-hour notice. If it is a continual problem there will be a **\$20 charge** added towards your account each visit that is missed. The patient will be responsible for payment.

#### Financial Policy Questions

We are happy to address questions regarding your account at any time. Please direct accounting questions to our billing administrator.

#### HIPPA Privacy Policy

Attached to the patient information packet at the back of these forms is the HIPPA Notice of Privacy Practices Policy for you.

By signing below, the patient acknowledges that he/she has received the HIPPA Privacy Policy and that he/she understands and will comply with our financial policies.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

# HIPAA Notice of Privacy Practices

Z Spine and Joint Center  
1121 Town Centre Drive  
Suite 105  
Eagan, MN 55123  
Phone: (952) 491-0577

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

**Uses and Disclosures of Protected Health Information:** Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purposes of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

## **Payment**

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

## **Healthcare Operations**

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to chiropractic school patients that may see patients at your office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Disease: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Require Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other Permitted and Required Uses and Disclosures** Will be made only with your consent, authorization or opportunity to object unless required by law.

**You may revoke this authorization,** at any time, in writing, except to the extent that your physician or the physicians practice has taken an action in reliance on the use or disclosure indicated in the authorization.

## **Your Rights**

Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information not be disclosed to family members or friends who may be involved in your care for notification purposes as described in this Notice of Privacy Practices, Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, or your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

#### **Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your **complaint. We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before April 14, 2003.