Accelerated Chiropractic & Natural Healing Center, LLC

Randy Hamling, D.C
717 Atlantic Ave.
Morris, MN 56267
(320) 585-7246
acceleratedchiro@gmail.com

Patient Information

(* Denotes Required Fields)

*Name:_____(Last Name), _____(First Name) (_____)(Preferred First Name) ____(MI) *Social Security #_____ *Birth Date: __/__/____ (MM DD YYYY)

*Gender: ❑ Male ❑ Female *Marital: ❑ Married ❑ Single ❑ Widowed ❑ Divorced

*Race: ❑Caucasian/White ❑African-American/Black ❑Asian
❑Central/South American ❑Native American ❑Pacific Islander

*Ethnicity ❑Hispanic or Latino ❑Not Hispanic or Latino ❑I Decline to Answer

*Mailing Address:_____ *City:_____ *State:_____ *Zip:_____

*Home Phone:_____ *Cell Phone:_____ *E-mail address:_____

*Occupation:_____ *Employer:_____

*Employer's Address:_____ *City, State, ZIP:_____ *Office Phone:_____

*Family Medical Doctor:_____ *Medical Facility:_____

*In Case of Emergency, who should we contact?_____ *Phone #:_____

*How would you like to receive appointment reminders? ❑Text Msg. (*Cell Carrier_____) ❑E-mail
❑Text No Appointment Reminders

*Smoking Status: ❑Every Day Smoker (#years___) ❑Former Smoker (#years___)
❑Occasional Smoker (#years___) ❑Never Smoker

Current Medications ❑None	Dosage and Frequency (i.e. 5mg once a day, etc)
Medication Allergies ❑None	**Reaction**

*Clinical Summary - We have to make available to you a list of your diagnoses, medications, and medication allergies which can be automatically e-mailed to you following each visit.
❑ I DO want to receive this (E-mail_____) ❑ I DO NOT want to receive this Clinical Summary

*How did you hear about us? (Check all that apply)
❑Family Member/Friend/Doctor (Who May We Thank?_____)
❑Fair/Event ❑Lecture/Business Appreciation
❑Our Website ❑Facebook ❑Clinic Sign/Driving By
❑White Pages ❑Yellow Pages
❑Online Directory (Which Directory?_____)
❑Other_____

*Patient's Signature:_____ *Date: __/__/____ (MM DD YYYY)

Guardian's Signature Authorizing Care:_____ *Date: __/__/____ (MM DD YYYY)

Form Edited 08/06/17

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CONSENT FOR TREATMENT, THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PURPOSES OF BILLING, TREATMENT AND FILE MAINTENANCE

NAME_____, _____

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 health care operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether or not to sign this consent. Our Notice provides a description of our treatment, payment activities and health care operations of the uses and disclosures we may make of you 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 you sign 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.

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 our Contact Person. Please understand that revocations of this consent will not affect any action we took in reliance on this consent before we received your revocations and that we may decline to treat you or to continue treating you if you revoke this consent.

Informed Consent: I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or "Spinal Adjustment". As the joints in your spine are moved you may experience a 'pop' call cavitation as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also know as Oculosympathetic Palsy), costovertebral strains and separations. Rare complications include, but are not limited to stroke. The most common complication or complaint following a spinal manipulation is an ache or stiffness at the site of adjustment.

I am aware of these complications and in order to minimize their occurrence I will take precautions. These precautions include but are not limited to my taking a detailed clinical history of you and examining you for any defect which could cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take your clinical history.

I 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 care information to carry out treatment, payment activities and health care operations.

Signature _____ Date_____/_____/_____

If this consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name _____

Relationship to Patient _____

You are entitled to a copy of this consent after you sign it

Authorization and Assignment of Benefits/Financial Policy

ACCELERATED CHIROPRACTIC & NATURAL HEALING CENTER, LLC
717 Atlantic Ave.
Morris, MN 56267
Tel: 320-585-7246 Fax: 320-585-7247

1. I hereby authorize **Accelerated Chiropractic & Natural Healing Center, LLC** to release any and all appropriate information concerning my health condition to any insurance company, adjuster, attorney requesting it in order to process any claim for re-imbursement of charges incurred by me.

2. This office agrees to assist me in determining what Chiropractic benefits are available under my insurance policy.

3. I understand the benefits quoted to **Accelerated Chiropractic & Natural Healing Center, LLC** by my insurance company are **NOT** a guarantee of payment. This is done by **Accelerated Chiropractic & Natural Healing Center, LLC** as a courtesy and is ultimately my responsibility to know, or find out, what my specific policy covers at this clinic.

4. This office does not file insurance for all secondary carriers, but will support you with paperwork so you can submit your claims.

5. I hereby authorize and assign direct payment to **Accelerated Chiropractic & Natural Healing Center, LLC** for any and all sums owed now or hereafter by any insurance company, which covers the services provided to me by **Accelerated Chiropractic & Natural Healing Center, LLC.**

6. I understand that my insurance carrier most likely does not cover maintenance care. Therefore, once **Accelerated Chiropractic & Natural Healing Center, LLC** informs me that care may be determined to be not Medically necessary, it is my responsibility to pay for such treatments at the time they are rendered or participate in their discounted wellness program.

7. I understand that **Accelerated Chiropractic & Natural Healing Center, LLC** does not own my insurance policy and I agree to take an active role in collecting payment from my insurance company. As a courtesy to me, **Accelerated Chiropractic & Natural Healing Center, LLC** will bill my insurance company and wait up to 90 days for payment. If after 90 days my insurance carrier has not paid a claim, I agree to pay for the outstanding charges. I understand **Accelerated Chiropractic & Natural Healing Center, LLC** will send me a payment receipt. Any payments made on these claims thereafter will be refunded to me.

8. I understand and agree to pay a 1.5% monthly (18% annually) service charge on any **outstanding balance** over 90 days old. I understand any and all outstanding balances may be turned over to a collection agency.

9. I understand that **Accelerated Chiropractic & Natural Healing Center, LLC** does have the capability to securely store credit card information within a 3rd party payment system. I ☐ would / ☐ would NOT like to provide a card to put on file and receive a 5% convenience discount and allow payments up to $_____ any time my insurance assigns deductibles/co-insurance fees as patient responsibility as per my subscriber agreement with my insurance company (deductibles and co-insurance only, not co-pays, products, etc. that is to be paid each visit). I also agree to allow ACNHC to e-mail a statement reflecting my insurance assigned patient responsibility charges and payments to:_____

10. I understand that this insurance assignment is offered as a courtesy to me, and may be terminated at any time. I accept full financial responsibility for any and all charges I incur.

11. I agree to pay any and all amounts not paid by the insurance company. If any action must be taken by **Accelerated Chiropractic & Natural Healing Center, LLC** to enforce its rights under this authorization and assignment of benefits, I understand that I may be held responsible for any reasonable costs incurred by taking such action.

I have read and understand the payment policy of Accelerated Chiropractic & Natural Healing Center, LLC. I understand that deductibles, co-payments, or payments for cash services are due at the time of service or at the end of each week and I agree that my balance will not exceed $150.00 at any time. If I fail to follow any part of this agreement Accelerated Chiropractic & Natural Healing Center, LLC has the right to terminate their professional services and I agree my balance will be due in full at that time.

_____ / / _____
Signature of Patient/Guardian Date MM DD YYYY

_____
Printed Name
Form Edited 08/06/2017

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OFFICE POLICY FOR MEDICARE PATIENTS

In Accordance with current Medicare regulations, please be advised that you are required to pay a yearly deductible of $150.00 toward your Part B medical expenses.

COVERAGE AND TREATMENT LIMITATIONS

For most conditions, Medicare will consider 36 chiropractic manipulations per year as Medicare's maximum allowed chiropractic benefit annually. Of these 36 visits, Medicare will pay 80% of their allowable amount after the deductible is met each year for chiropractic manipulation only.

X-RAYS, EXAMINATIONS AND MODALITIES

Medicare will **only** cover spinal manipulations. An examination and/or current x-rays (less than 12 months old) are required in order for Medicare to pay for your chiropractic manipulations, **however**, Medicare will not pay for examinations or x-rays. You will be required to pay for these services yourself. Medicare will not pay for manipulation of anything other than the spine, meaning Medicare will not pay for manipulation of extremities (arms, legs, knees, shoulders, etc.). Medicare will also not pay for modalities such as electric muscle stimulation, ultrasound, traction and hot or cold packs. Accelerated Chiropractic & Natural Healing Center, LLC offers a **Pre-paid Senior Plan (PSP)** to help make these services affordable for you.

NUTRITIONAL SUPPLEMENTS AND SUPPORTS/BRACES

Medicare does not cover orthotics, nutritional supplements, pillows or other supports or durable medical equipment. The Doctor may recommend these items to you, but Medicare **will not** pay for these items.

MEDICARE FINANCIAL POLICY ACKOWLEDEMENT

I agree to pay for each day's services until my deductible has been met each year. I understand that I am responsible for my 20% Medicare co-insurance at the time of each visit unless I have supplemental insurance that covers my deductible and 20% co-insurance.

I understand that if I have more than 36 visits in a year that I will be responsible for all visits not allowed by Medicare.

I understand the policy of this office and agree that charges not covered by Medicare as explained in this office policy will be paid by me personally at the time of service unless other arrangements have been previously made with the Business Office.

Patient's Signature _____ **Date** MM / DD / YYYY

Patient Name (please print) _____ , _____
Last Name First Name MI

Form Edited 08/06/2017

A. Notifier:

B. Patient Name: , **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** CMT below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** CMT below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Chiropractic Manipulative Treatment (CMT is the only chiropractic service covered by Medicare)	Medicare may determine care is not Medically necessary at any time without warning.	$45 - $65 $36 - $52 TOS Discount

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** CMT listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** CMT listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** CMT listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.** CMT listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date: / / MM DD YYYY

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

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ACKNOWLEDGEMENT OF NON-CONTRACTUAL SERVICES
ACKNOWLEDGEMENT OF NON-COVERED SERVICES

I have been advised that my insurance company may deny the services rendered by Accelerated Chiropractic & Natural Healing Center, LLC. Therefore, I acknowledge and accept liability for payment of those services.

Accelerated Chiropractic & Natural Healing Center, LLC, will not be bound to the contractual agreement with my insurance company in regards to non-contractual services. Therefore, I agree to pay the balance due on these services after my insurance company processes the claim. This includes what the insurance company may put in "provider reduction," "contractual agreement," etc.

Some insurance carriers do not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your insurance carrier may not pay for the services and healthcare products below.

Services	Applicable Insurance Carrier	Reason Insurance May Not Pay:	Cost of Service	Time of Service 20% Discount
Initial Exam/Progress Exams	Medicare	Non-covered service	Varies	(-20%)
X-Rays	Medicare	Non-covered service	Varies	(-20%)
Extremity Adjustment	Medicare, MN Healthcare Programs	Non-covered service / Wellness visit	$30	$24
Therapeutic Modalities:				
- Intersegmental Traction	Medicare, MN Healthcare Programs	Non-covered service / Wellness visit	$25	$20
- Electrical Muscle Stim.- Supervised	Medicare, MN Healthcare Programs	Non-covered service / Wellness visit	$25	$20
- Electrical Muscle Stim.- Attended	Medicare, MN Healthcare Programs	Non-covered service / Wellness visit	$30/$15	$24 / $12
- Ultrasound	Medicare, MN Healthcare Programs	Non-covered service / Wellness visit	$20/$10	$16 / $8
- Manual Therapy	Medicare, MN Healthcare Programs	Non-covered service / Wellness visit	$40/$20	$32 / $16
- Strapping	Medicare, MN Healthcare Programs	Non-covered service / Wellness visit	$25	$20
- Pelvic Stabilizers (Shoe Orthotics)	Most Insurance Carriers	Non-contractural service	Varies	No Discount
- Supplements/Retail Products	Most Insurance Carriers	Non-contractural service	Varies	No Discount
Other:				

We do our best to advise you when we recommend a service that will benefit your treatment if that service is covered by your insurance or not. This advisory is to let you know these non-covered services. With this information, it is your responsibility to recognize when a recommended therapy or other non-covered service is about to begin, to advise the doctor if you would choose to decline such a procedure at that time. This is an acknowledgement that you understand the above services are not covered by my insurance and should you choose to still receive the therapy you agree to pay for them the day they are rendered to receive the time of service discount.

SIGNATURE _____ DATE _____ / / _____
MM DD YYYY

_____ /
PRINTED NAME

Form Edited 08/06/2017

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Name: Birthdate: / /

History of Present Condition / What Brings You In Today?

Purpose of Consultation? ☐New Patient/New Injury ☐Existing Patient/New Injury ☐Wellness Checkup

Chief Complaint:_____

Location:_____

When did it start?_____ Is this your first time experiencing this? ☐Y ☐N

Prior injury to this area? ☐Y ☐N Details:_____

What were you doing when it started? (Cause?)_____

On a Scale of 0-10, how would you rate your pain/symptom. 0 = None, 10 = Worst Imaginable
On AVERAGE:_____/10 At Its WORST:_____/10 At Its BEST:_____/10

What words would you use to describe your pain/symptom?_____
What particular part of the day does it bothers more?_____During Activity Only?_____

How often do you experience the pain/symptom?
Constantly (75%-100%)☐ Frequently (50%-75%)☐ Occasionally (25%-50%)☐ Intermittently (0%-25%)☐

Since its onset, has it been getting: Worse☐ Better☐ Staying the Same☐

What seems to make it worse:_____

What seems to relieve it:_____

Numbness/pain seem to radiate away from primary area? ☐Y ☐N Where to?_____

On a Scale of 0-10, how would you rate your **radiating** discomfort. 0 = None, 10 = Worst Imaginable
On AVERAGE:_____/10 At Its WORST:_____/10 At Its BEST:_____/10

What words would you use to describe your **radiating** discomfort?_____

How often do you experience the **radiating** discomfort?
Constantly (75%-100%)☐ Frequently (50%-75%)☐ Occasionally (25%-50%)☐ Intermittently (0%-25%)☐

Have you seen another healthcare practitioner for this condition? ☐Y ☐N (If Yes, please proceed below)

Who/What Facility_____ Dates of Treatment/How Long Ago?_____

What was the treatment?_____Was it Effective?_____

Any Other Comments about your PRIMARY complaint that the Doctor should know about before treatment?

Treatment Goal (Check all that apply): ☐Pain Relief Only ☐Pain Relief & Manage Regularly ☐Wellness Only
☐Help me get back to_____more comfortably ☐Pain Relief and Keep My Body at its BEST with Wellness

Have you ever seen a chiropractor in the past?_____ Are you pregnant?_____

Do you have a pacemaker?_____ Do you think you may be pregnant?_____

Patient Signature_____ Date_____/_____/_____

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Name: Birthdate: / /

Secondary Condition

Secondary Complaint:_____

Location:_____

When did it start?_____ Is this your first time experiencing this? ☐Y ☐N

Prior injury to this area? ☐Y ☐N Details:_____

What were you doing when it started? (Cause?)_____

On a Scale of 0-10, how would you rate your pain/symptom. 0 = None, 10 = Worst Imaginable
On AVERAGE:_____/10 At Its WORST:_____/10 At Its BEST:_____/10

What words would you use to describe your pain/symptom?_____

What particular part of the day does it bothers more?_____During Activity Only?_____

How often do you experience the pain/symptom?
Constantly (75%-100%)☐ Frequently (50%-75%)☐ Occasionally (25%-50%)☐ Intermittently (0%-25%)☐

Since its onset, has it been getting: Worse☐ Better☐ Staying the Same☐

What seems to make it worse:_____

What seems to relieve it:_____

Numbness/pain seem to radiate away from primary area? ☐Y ☐N Where to?_____

On a Scale of 0-10, how would you rate your **radiating** discomfort. 0 = None, 10 = Worst Imaginable
On AVERAGE:_____/10 At Its WORST:_____/10 At Its BEST:_____/10

What words would you use to describe your **radiating** discomfort?_____

How often do you experience the **radiating** discomfort?
Constantly (75%-100%)☐ Frequently (50%-75%)☐ Occasionally (25%-50%)☐ Intermittently (0%-25%)☐

Have you seen another healthcare practitioner for this condition? ☐Y ☐N (If Yes, please proceed below)

Who/What Facility_____ Dates of Treatment/How Long Ago?_____

What was the treatment?_____Was it Effective?_____

Any Other Comments about your SECONDARY complaint that the Doctor should know about before treatment?

Patient Signature_____ Date_____/_____/_____

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Name: Birthdate: / /

Systems Review

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you **NOW** have these conditions or **P** if you have **PREVIOUSLY** had these conditions. Also, please indicate with the letter **F** if you have a **FAMILY MEMBER** who has suffered from the condition. Any details you can provide would be beneficial and should be mentioned below.

N = Now P = Previously F=Family Member

☐N☐P☐F	Loss of Coordination	☐N☐P☐F	Headache
☐N☐P☐F	Weak Grip/Pinching	☐N☐P☐F	Buzzing/Ringing in Ears
☐N☐P☐F	Muscle Pain/Weakness/Cramps	☐N☐P☐F	Weakness/Fatigue
☐N☐P☐F	Shoulder/Neck/Arm Pain	☐N☐P☐F	Fever/Chills
☐N☐P☐F	Stiff Neck	☐N☐P☐F	Allergies
☐N☐P☐F	Neck/Mid-Back/Low Back Pain	☐N☐P☐F	Diabetes
☐N☐P☐F	Sinus Problems	☐N☐P☐F	Night Sweats
☐N☐P☐F	Joint Stiffness/Arthritis	☐N☐P☐F	Thyroid Dysfunction
☐N☐P☐F	Spinal Curvature	☐N☐P☐F	Weight Gain/Loss
☐N☐P☐F	Joint Pain/Swelling	☐N☐P☐F	Blood Pressure High/Low
☐N☐P☐F	Broken Bones	☐N☐P☐F	Cold Feet/Hands
☐N☐P☐F	Osteoporosis	☐N☐P☐F	Heart Disease/Irregular Heartbeat
☐N☐P☐F	Seizures/Tremors	☐N☐P☐F	Irritable Bowel/Constipation/Diarrhea
☐N☐P☐F	Stroke	☐N☐P☐F	Ulcers
☐N☐P☐F	Numbness/Tingling/Sensation Loss	☐N☐P☐F	Chest Pains/Tightness
☐N☐P☐F	Paralysis	☐N☐P☐F	Breathing Problems
☐N☐P☐F	Difficulty Speaking	☐N☐P☐F	Chronic Swelling/Edema
☐N☐P☐F	Dizzy Spells/Loss of Balance	☐N☐P☐F	Irregular Menstruation
☐N☐P☐F	Loss of Smell/Taste	☐N☐P☐F	Groin Pain
☐N☐P☐F	Fainting/Nervousness	☐N☐P☐F	Difficult or Frequent Urination
☐N☐P☐F	Loss of Concentration/Memory	☐N☐P☐F	Increased Thirst
☐N☐P☐F	Depression	☐N☐P☐F	Cancer/Lumps
☐N☐P☐F	Loss of Sleep	☐N☐P☐F	Alcohol/Drug Addiction

Details of those marked:_____

_____

_____

Other concerns the doctor should know about:_____

_____

Other Family History_____

_____

Patient Signature_____ Date_____/_____/_____

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Name: Birthdate: / /

Detailed Medical History

Past Surgeries	Reason	Dates

Medications	For What Condition?	Dates

Hospitalizations	Reason	Dates

Vitamins/Supplements

Major Injuries	Date	Treatment Given?

Allergies	Substance?	Reaction?

Have You Ever Taken…	
☐Y ☐N	Insulin
☐Y ☐N	Birth Control
☐Y ☐N	Blood Pressure Meds
☐Y ☐N	Cholesterol Meds
☐Y ☐N	Cortisone
☐Y ☐N	Thyroid Medications
☐Y ☐N	Recreational Drugs
☐Y ☐N	Hormone Replacement
OTHER?	_____

Social History

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed Number of Children_____

Usual # Hours of Sleep Per Night_____ **Do You Still Feel Tired Throughout the Day?** ☐Y ☐N

How Often Do You Exercise? ☐Regularly ☐Frequently ☐Sometimes ☐Never

Exercise Intensity ☐Low ☐Medium ☐High **Type?** ☐Cardio ☐Build Muscle ☐Muscle Toning

Diet? ☐Well Balanced ☐Vegetarian ☐Frequent Fast Food ☐Specific Diet?_____

Caffeinated Beverages Consumed Per Day? ☐0-12 oz. ☐12-32 oz. ☐32-64 oz. ☐64-128 oz

Water Consumed Per Day? ☐0-12 oz. ☐12-32 oz. ☐32-64 oz. ☐64-128 oz ☐More

Alcoholic Beverage Consumption ☐None ☐1-2/Wk ☐3-4/Wk ☐5+/Wk ☐Occasional Binge Drinking ☐Daily

Tobacco Products? ☐Y ☐N If Yes… Type:_____ How much?_____per_____

What Do You Enjoy to Do During Your Free Time?_____

What Do You Feel You Lost Due to Your Condition Today?_____

Patient Signature_____ Date_____/_____/_____