1740 Weir Drive, Suite 24 Woodbury, MN 55125 (ph) 651-232-6830 (fax) 651-702-2636 www.NaturalCareWoodbury.com

**NEW PATIENT INTAKE FORM**

**Patient Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date of Birth**:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

(Last, First, Middle Initial) Gender at Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Gender and Pronouns\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone:** (C):\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_(H):\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_(W):\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

**Email**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Social Security Number**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Healthcare Provider and/or Clinic:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By checking the box to the right you consent to us communicating with your PCP if needed.

Who referred you to our clinic?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is your reason for seeking care at our clinic?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

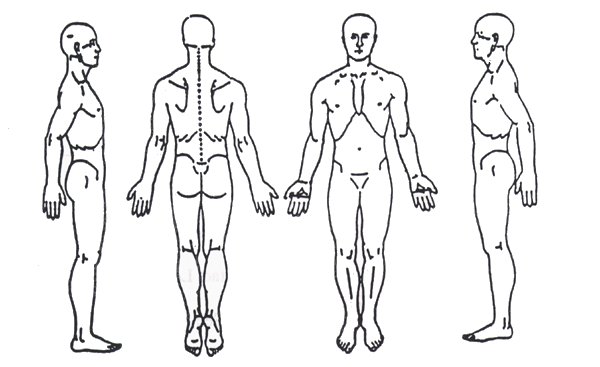
**When did your condition/symptoms begin?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How did your condition/symptom begin? \_\_\_\_\_\_**

**How often do you experience you symptoms?**

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day) ☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

**Indicate on the picture below where you have pain or other symptoms, as well as the nature of your symptoms:**

Use the symbols below:

Numbness

=========

Pins and Needles

000000000

Burning

XXXXXXXXX

Stabbing

////////////

Aching

+++++++++

Other

\*\*\*\*\*\*\*\*\*

1. **During the past 4 weeks:**
   1. How much has pain interfered with your normal work (including work outside the home and housework)

☐Not at all ☐A little bit ☐Moderately ☐Quite a bit ☐Extremely

* 1. How much of the time has your condition interfered with your social activities (like visiting with friends, relatives, etc.)

☐All of the time ☐Most of the time ☐Some of the time ☐A little of the time ☐None

1. **How are your symptoms changing?**

☐ Getting Better ☐Not Changing ☐Getting Worse

1. **In general, would you say your overall health right now is:**

☐ Excellent ☐Very Good ☐Good ☐Fair ☐Poor

1. **Who have you seen for your symptoms?**

☐No one ☐Chiropractor ☐Medical Doctor ☐Physical Therapist ☐Other

* 1. What treatment did you receive and when? \_\_\_\_\_\_\_\_
  2. What tests have you had for you symptoms and when were they performed?

☐X-rays date: \_\_\_\_\_\_\_\_ ☐CT Scan date: \_\_\_\_\_\_\_\_ ☐MRI date: \_\_\_\_\_\_\_\_ ☐Other date: \_\_\_\_\_\_\_\_

1. **Have you had similar symptoms in the past?** ☐Yes ☐No
   1. If you have received treatment in the past for the same or similar symptoms, whom did you see?

☐This office ☐Chiropractor ☐Medical Doctor ☐Physical Therapist ☐Other

**For each of the conditions listed below, place a check in the PAST column if you have had the condition in the past. If you presently have a condition listed below, place a check in the PRESENT column.**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Past | Present |  | Past | Present |  | Past | Present |  |
|  |  | Headaches |  |  | Heart Issues |  |  | Lung Disorder |
|  |  | Migraines |  |  | Stroke |  |  | Asthma |
|  |  | Dizziness |  |  | Chest Pain |  |  |  |
|  |  |  |  |  |  |  |  | Cancer |
|  |  | Spinal Pain |  |  | Kidney Disorders |  |  | Tumor(s) |
|  |  | Upper Extremity Pain |  |  | Bladder Disorders |  |  |  |
|  |  | Lower Extremity Pain |  |  | Bladder Incontinence |  |  | Allergies |
|  |  | Jaw Pain |  |  |  |  |  | Depression/Anxiety |
|  |  |  |  |  | Liver Disorders |  |  | Thyroid Disorders |
|  |  | Arthritis |  |  | Weight Gain/Loss |  |  | Epilepsy |
|  |  | RA |  |  | GI Disorders |  |  | HIV/AIDS |
|  |  | Autoimmune Disorder |  |  | Bowel Incontience |  |  | Hepatitis |
|  |  | Fatigue |  |  | Abdominal Pain |  |  | Skin Disorders |

**FAMILY HISTORY**

Please list any serious health conditions (cancer, diabetes, heart conditions, autoimmune disorders, etc.) within your immediate family (mother, father, grandparents, brothers, sisters, etc.):

**MEDICAL HISTORY**

Please list any surgeries and their date(s): Please list any trauma(s) or injuries and their date(s):

**List current medications and herbs/supplements you are taking:**

Medication/Supplement: Dose: Purpose: Prescribed By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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**Females only, please list:**

Number of pregnancies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of births:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Are you currently pregnant? Yes / No If yes, how many weeks?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PREVENTATIVE HEALTH HISTORY** (Please circle health screenings performed within the last year)

Blood Pressure Yes / No Fasting Blood glucose Yes / No

Breast Exam Yes / No Cholesterol Yes / No

Pap Smear Yes / No Dental Yes / No

Prostate Exam Yes / No Vision Yes / No

Colonoscopy Yes / No

**SOCIAL HISTORY**

**Alcohol Use Yes/No Drinks per week?\_\_\_\_\_ Caffeine Use Yes/No Drinks per day?\_\_\_\_\_ Tobacco Use Yes/No Type/Amount\_\_\_\_\_\_\_\_\_\_\_\_**

**Exercise Yes/No Times per week?\_\_\_\_\_ Recreational Drug Use Yes/No Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dietary Restrictions\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**QUADRUPLE VISUAL ANALOGUE SCALE**

Patient name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache neck low back

No pain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ worst possible pain

0 1 2 3 4 5 6 7 8 9 10

1 – What is your pain RIGHT NOW?

No pain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ worst possible pain

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ worst possible pain

0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?

No pain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ worst possible pain

0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?

No pain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ worst possible pain

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

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

Reprinted from *Spine,* 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

SCORE: \_\_\_\_\_\_\_\_\_\_\_

**NECK PAIN INDEX**

Patient name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This form is to be completed by patients being seen for neck pain. This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but please just circle the one choice which closely describes your problem right now.

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**SCORE (X2) \_\_\_\_\_\_\_\_\_**

**Pain Intensity**

1. I have no pain at the moment
2. The pain is very mild at the moment
3. The pain is moderate and does not vary much
4. The pain is fairly severe at the moment
5. The pain is severe but comes and goes
6. The pain is severe and does not vary much

**Personal care (washing, dressing, etc.)**

1. I can look after myself normally without causing extra pain
2. I can look after myself normally but it causes extra pain
3. It is painful to look after myself and I am slow and careful
4. I need some help but manage most of my personal care
5. I need help every day in most aspects of self care
6. I do not get dressed, wash with difficulty and stay in bed.

**Lifting**

1. I can lift heavy weights without extra pain
2. I can lift heavy weights, but it causes extra pain
3. Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g. on a table
4. Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
5. I can lift only very light weights
6. I cannot lift or carry anything at all

**Reading**

1. I can read as much as I want to with no pain in my neck
2. I can read as much as I want with slight pain in my neck
3. I can read as much as I want with moderate pain in my neck
4. I cannot read as much as I want because of moderate pain in my neck
5. I cannot read as much as I want because of severe pain in my neck
6. I cannot read at all

**Headache**

1. I have no headaches at all
2. I have slight headaches which come infrequently
3. I have moderate headaches which come infrequently
4. I have moderate headaches which come frequently
5. I have severe headaches which come frequently
6. I have headaches almost all the time

**Concentration**

1. I can concentrate fully when I want to with no difficulty
2. I can concentrate fully when I want to with slight difficulty
3. I have a fair degree of difficulty in concentrating when I want to
4. I have a lot of difficulty in concentrating when I want to
5. I have a great deal of difficulty concentrating when I want to
6. I cannot concentrate at all

**Work**

1. I can do as much work as I want to
2. I can only do my usual work, but no more
3. I can do most of my usual work, but no more
4. I cannot do my usual work
5. I can hardly do any work at all
6. I cannot do any work at all

**Driving**

1. I can drive my care without neck pain
2. I can drive my car as long as I want with slight pain in my neck
3. I can drive my car as long as I want with moderate pain in my neck
4. I cannot drive my car as long as I want because of moderate pain in my neck
5. I can hardly drive my car at all because of severe pain in my neck
6. I have no social life because of pain

**Sleeping**

1. My sleep is never disturbed by pain
2. My sleep is occasionally disturbed by pain
3. Because of pain I have less than 6 hours sleep
4. Because of pain I have less than 4 hours sleep
5. Because of pain I have less than 2 hours sleep
6. Pain prevents me from sleeping at all

**Recreation**

1. I am able to engage in all recreational activities with no pain in my neck at all
2. I am able to engage in all recreational activities with some pain in my neck
3. I am able to engage in most, but not all recreational activities because of pain in my neck
4. I am able to engage in a few of my usual recreational activities because of pain in my neck
5. Pain restricts me to short necessary journeys under 30 minutes
6. I cannot do any recreational activities at all
7. I cannot concentrate at all

**LOW BACK OSWESTRY 2.1A**

Patient name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This form is to be completed for patients being seen for back pain. This questionnaire is designed to give us information as to how your back (or leg) trouble affects your ability to manage in everyday life. Please answer every section. Mark one number only in each section that most closely describes you today.

**Standing**

1. I can stand as long as I want without extra pain
2. I can stand as long as I want but it gives me extra pain
3. Pain prevents me from standing for more than 1 hour
4. Pain prevents me from standing for more than half an hour
5. Pain prevents me from standing for more than 10 minutes
6. Pain prevents me from standing at all

**Sleeping**

1. My sleep is never disturbed by pain
2. My sleep is occasionally disturbed by pain
3. Because of pain I have less than 6 hours sleep
4. Because of pain I have less than 4 hours sleep
5. Because of pain I have less than 2 hours sleep
6. Pain prevents me from sleeping at all

**Sex life (if applicable)**

1. My sex life is normal and causes no extra pain
2. My sex life is normal but causes some extra pain
3. My sex life is nearly normal but is very painful
4. My sex life is severely restricted by pain
5. My sex life is nearly absent because of pain
6. Pain prevents any sex life at all

**Social Life**

1. My social life is normal and causes me no extra pain
2. My social life is normal but increases the degree of pain
3. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sport, etc.
4. Pain has restricted my social life and I do not go out as often
5. Pain has restricted social life to my home
6. I have no social life because of pain

**Travelling**

1. I can travel anywhere without pain
2. I can travel anywhere but it gives extra pain
3. Pain is bad but I manage journeys over two hours
4. Pain restricts me to journeys of less than one hour
5. Pain restricts me to short necessary journeys under 30 minutes
6. Pain prevents me from travelling except to receive treatment

**Pain Intensity**

1. I have no pain at the moment
2. The pain is very mild at the moment
3. The pain is moderate at the moment
4. The pain is fairly severe at the moment
5. The pain is very severe at the moment
6. The pain is the worst imaginable at the moment

**Personal care (washing, dressing, etc.)**

1. I can look after myself normally without causing extra pain
2. I can look after myself normally but it is very painful
3. It is painful to look after myself and I am slow and careful
4. I need some help but manage most of my personal care
5. I need help every day in most aspects of self care
6. I do not get dressed, wash with difficulty and stay in bed.

**Lifting**

1. I can lift heavy weights without extra pain
2. I can lift heavy weights, but it causes extra pain
3. Pain prevents me from lifting heavy weights off the floor but

I can manage if they are conveniently positioned, e.g. on a table

1. Pain prevents me from lifting heavy weights but I can manage

light to medium weights if they are conveniently positioned

1. I can lift only very light weights
2. I cannot lift or carry anything at all

**Walking**

1. Pain does not prevent me walking any distance
2. Pain prevents me walking more than one mile
3. Pain prevents me walking more than a quarter of a mile
4. Pain prevents me walking more than 100 yards
5. I can only walk using a stick or crutches
6. I am in bed most of the time and have to crawl to the toilet

**Sitting**

1. I can sit in any chair as long as I like
2. I can sit in my favorite chair as long as I like
3. Pain prevents me from sitting for more than 1 hour
4. Pain prevents me from sitting for more than half an hour
5. Pain prevents me from sitting for more than 10 minutes
6. Pain prevents me from sitting at all

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**Score (X2)\_\_\_\_\_\_\_\_\_\_\_**

**The Keele STarT Back Screening Tool**

Patient name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thinking about the **last 2 weeks** tick your response to the following questions:

**Disagree Agree**

**0 1**

1. My back pain has **spread down my leg(s)** at some time in the last 2 weeks
2. I have had pain in the **shoulder** or neck at some time in the last 2 weeks
3. I have only **walked short distances** because of my back pain
4. In the last 2 weeks, I have **dressed more slowly** than usual because of back pain
5. It’s not really safe for a person with a condition like mine to be physically active
6. **Worrying thoughts** have been going through my mind a lot of the time
7. I feel that **my back pain is terrible** and **it’s never going to get any better**
8. In general I have **not enjoyed** all the things I used to enjoy
9. Overall, how **bothersome** has your back pain been in the **last 2 weeks**?

Not at all Slightly Moderately Very Much Extremely

0 0 0 1 1

**Total Score (all 9): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sub Score (Q5-9): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Text

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1740 Weir Drive, Suite 24 Woodbury, MN 55125 (ph) 651-232-6830 (fax) 651-702-2636 www.NaturalCareWoodbury.com

**PATIENT FINANCIAL ACKNOWLEDGEMENT**

**Please read thoroughly. Initial your acknowledgements, then sign and print your name and the date. Thank you.**

VERIFICATION OF BENEFITS

If you have medical insurance and would like to receive the maximum benefits available to you from your insurance company, it is important that **YOU** contact your insurance company **PRIOR to your first visit in our office**. We are happy to answer any insurance questions you may have, but please understand, The Natural Care Center can only assist you and **CANNOT** guarantee payment from your insurance company. Please note that it is your responsibility to understand your insurance benefits and coverage. Giving the Natural Care Center all of your insurance information, including any secondary insurances, will help us to **estimate** your benefits to the best of our ability.

ASSIGNMENT OF BENEFITS

I assign all benefits payable to me for my care at the Natural Care Center of Woodbury. I understand that this health care facility will be paid directly by the insurance company or other payer. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

GUARANTEE OF PAYMENT

I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of this health care facility. I acknowledge that any exams not covered by insurance are due in full at the time of service. Your initials are a guarantee of payment for all charges incurred for treatment in accordance with the rates and terms of this health care facility. In the event that you have insurance coverage for chiropractic care and your diagnosis, but have an unmet deductible, the clinic may use the insurer’s provided fee schedule to calculate your owed amount and collect a portion, or all, of your fee up front. In the event that payment cannot be made on the account and it is sent to collections, a 35% fee will be added to cover the cost of the collections agency. In the event that the clinic must take legal action against any persons with an outstanding debt, the patient is responsible for all legal and attorney fees.

APPOINTMENT FEES AND CANCELLATION POLICY

We require a $50 deposit on all new patient appointments to secure the time. This will be applied to your appointment/account or refunded if insurance pays in full for services. **We require a 24-hour cancellation notification** for our Acupuncture/Oriental Medicine, Massage, and Graston Therapy appointments. Please note**: a $50 fee will be assessed for acupuncture and massage, and a $25 fee for Graston cancellations made with less-than 24-hour notice**. Monday appointments must be cancelled on the Friday prior to your scheduled visit.

ACUPUNCTURE COVERAGE

Your initial Acupuncture exam may, or may not, be covered. Please check with your insurance carrier about your specific plan and condition to ensure coverage. Even if your health plan covers general Acupuncture, your specific diagnosis may not be covered for treatment. If this is the case, you must pay out-of-pocket, but at a discounted rate for Acupuncture.

FOR ACUPUNCTURE AND CHIROPRACTIC **MEDICARE** PATIENTS

**Acupuncture is not a covered** service since licensed Acupuncturists are not able to credential with Medicare. We are not able to submit claims to them at any time. Also, **Chiropractic examinations and re-examinations are never covered** by Medicare. Your provider must do these to provide you with safe, accurate care even though they are not covered by the insurance. Medicare also **does not cover therapies such as electric muscle stimulation, ultrasound, or traction.** **Please note:** Medicare is your primary insurance carrier, this means that your supplement plan or secondary coverage will not pay the cost of these services even though they cover them. They only pay any additional costs after your primary insurance pays its portion.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

**SIGNATURE (PATIENT/GUARDIAN) PRINT NAME DATE**

Text

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1740 Weir Drive, Suite 24 Woodbury, MN 55125 (ph) 651-232-6830 (fax) 651-702-2636 www.NaturalCareWoodbury.com

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT**

The Natural Care Center of Woodbury is committed to patient privacy and the confidentiality of the patient information/personal health information that is entrusted to us.

The ways in which we may use or disclose your health information are detailed in our Privacy Practices.

**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, we will provide you with a Limitation of Use and Disclosure of Protected Health Information Request form.

**Your Right to Request that Your Patient Record be Amended:**

You have the right to request that we amend the information in your patient record. If you would like to amend any information in your record, we will provide you with a Request to Amend Protected Health Information form.

**Your Right to Revoke 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 received your request to revoke 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 THE RIGHT TO REFUSE CONSENT FOR DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION. WITHOUR YOUR CONSENT, HOWEVER, THE NATURAL CARE CENTER OF WOODBURY WILL NOT BE ABLE TO SUBMIT YOUR CLAIMS TO INSURANCE CARRIERS OR OTHER THIRD PARTY PAYERS FOR PAYMENT, AND YOU WILL BE REQUIRED TO PAY CASH AT THE TIME OF SERVICE FOR ANY SERVICES RENDERED.

By signing below, I give consent to the Natural Care Center of Woodbury’s clinicians or staff to use or disclose my personal health information as stated in the Notice of Privacy Practices. I may request the full Notice of Privacy Practices at any time for review.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

(Signature of Patient) (Print Name) (Date)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

(Signature of Authorized Representative) (Date

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**ACUPUNCTURE AND ORIENTAL MEDICINE INFORMED CONSENT**

**Consent** I hereby authorize my Licensed Acupuncturist (L.Ac.) to evaluate and treat according to the principles of Oriental Medicine; this authority shall extend to remedying any unforeseen conditions or reactions to treatment procedures.

**Practitioner Qualifications** All Licensed Acupuncturists (L.Ac.) possess at least a masters degree from an Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM) accredited educational institution or program and are certified by the National Certification Commission of Acupuncture and Oriental Medicine (NCCAOM).

**Scope of Practice** Minnesota Law (Minnesota Statute 147B.06) defines Acupuncture practice as including, but not limited to, the following:

* Using Oriental medical theory to assess, diagnose and develop a plan to treat a patient in an attempt to improve overall body function and/or relieve pain
* Using treatment techniques that may include:
* Insertion of sterile acupuncture needles through the skin
* Acupuncture stimulation including, but not limited to, electrical stimulation or the application of heat with moxibustion or heat lamps
* Cupping
* Dermal friction
* Acupressure
* Herbal therapies
* Dietary counseling based on traditional Chinese medical principles
* Breath techniques or exercise according to Oriental medical principles

**Possible Side Effects** I understand that there are possible side effects to my treatment that may include the following:

* Broken needles
* Minor pain or soreness in the treatment area
* Transient bruising
* Infection
* Needle sickness (dizziness, nausea, fainting)
* Sensation of heat, cold, tingling or numbness
* Skin irritation or slight bleeding at needle sight
* Generalized fatigue
* Gastrointestinal disturbances from herbal remedies
* Minor burns from moxibustion (heat stimulation)

**Treatment Outcomes** I understand that no promises or guarantees can be made regarding the outcome of treatment and that reasonable efforts will be made to give me information so that I might make educated decisions regarding the duration and appropriateness of continued care. I understand that I may stop treatment at any time.

**Western Biomedical Diagnosis** I understand that it is not within the scope of practice for acupuncturists to offer Western medical (biomedical) diagnosis and that it is my responsibility to seek such diagnosis elsewhere if I have not already done so.

**I Do / Do Not have a pacemaker.** **I Do / Do Not have a bleeding disorder.**

**\*PATIENT PLEASE REVIEW \* PRINT & SIGN NAME\***

I have read or had read to me this informed consent document. I have discussed or been given the opportunity to discuss any questions or concerns with my Licensed Acupuncturist and have had these answered to my satisfaction prior to my signing this informed consent document. I have made my decision voluntarily and freely.

Patient Name (print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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(Patient/Guardian Signature) (Date) (Translator/Interpreter Signature) (Date)

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(L.Ac. Signature) (Date)