SHAW CHIROPRACTIC

PLEASE PRINT AND COMPLETE ALL SECTIONS

PATIENT INFORMATION:

First Name_____ Middle Initial_____ Last Name_____

Preferred Name_____ Social Security Number _____

Home Phone Number_____ Cell Phone Number_____

Address_____City_____State____ Zip_____

Email Address** _____

****Would you like to receive appointment reminders via email? ☐ YES ☐ NO**

Sex ☐ Male ☐ Female Birthdate_____Age_____ ☐ Single ☐ Married ☐ Widowed ☐ Divorced

☐ Employed ☐ Retired ☐ Full-Time Student ☐ Part-Time Student ~ School _____

Employer _____Occupation_____Phone:_____

Business Address_____City_____State____ Zip_____

PRIMARY INSURED OR RESPONSIBLE PARTY: ☐ SAME AS ABOVE

First Name_____ Middle Initial_____ Last Name_____

Social Security Number _____ Birthdate _____

Home Phone Number_____ Cell Phone Number_____

Street Address_____City_____State____ Zip_____

Employer _____Occupation_____Phone:_____

Business Address_____City_____State____ Zip_____

Insurance Company_____Phone Number_____

Policy or ID Number_____ **Group Number**_____

Emergency Contact Person_____

Phone_____**Relationship to Patient**_____

Do we have permission to share your health information with this person? ☐ YES ☐ NO

(OVER)

1003 East Interstate Avenue, Suite 5 ◦ Bismarck, ND 58503 ◦ 701.221.2788

SURGERIES: (MAJOR & MINOR - DATE) _____

_____

_____

_____

_____

_____

LIST *ANY* TRAUMAS/ACCIDENTS *EVER EXPERIENCED DURING LIFETIME*: INCLUDE SLIPS, FALLS, SPORTS INJURIES, FARM INJURIES, ER VISITS, VEHICLE ACCIDENTS, ETC. ▪ When ▪ Where ▪ How

_____

_____

_____

_____

_____

_____

_____

_____

_____

WATER CONSUMPTION: _____ OUNCES / LITERS PER DAY

ALCOHOL CONSUMPTION: _____ SERVINGS PER ☐ DAY ☐ WEEK ☐ MONTH

TYPE(S) OF ALCOHOL CONSUMED: _____

TOBACCO USAGE: CIGARETTES _____ PACKS PER ☐ DAY ☐ WEEK ☐ MONTH

CHEW _____ CANS PER ☐ DAY ☐ WEEK ☐ MONTH

OTHER_____ PER ☐ DAY ☐ WEEK ☐ MONTH

How did you hear about our office? ** ☐ Friend/ family member_____

**☐ Professional referral_____ ☐Website ☐ Other _____

****Do we have your permission to thank this person for referring you?** ☐ **YES** ☐ **NO**

_____ Reviewed By: _____

PATIENT SIGNATURE DOCTOR

SHAW Chiropractic Health INST

Patient name_____ Date_____

Reason for visit_____

Have you been treated before for this problem? ☐No ☐Yes

If yes, by ☐ Physician ☐ Doctor of Chiropractic ☐ Physical Therapist ☐ Osteopath ☐ Other_____

What did they do and/or recommend?_____

When did your symptoms appear? _____ Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Is it constant or does it come and go?_____ Does it interfere with your ☐ Work ☐ Sleep ☐ Daily routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Walking ☐ Bending ☐ Lying down ☐ Twisting and/or turning

☐ Other_____

(Describe activities - stretching, lifting, etc.)

Have you ever had chiropractic care for other problems? ☐ No ☐ Yes ☐ When?_____

Do you take ☐ Muscle relaxers ☐ Pain killers ☐ Insulin ☐ Birth control pills ☐ Over-the-counter meds

☐ Other prescription drugs (Please list all medications in the space provided at bottom of page.)

Date of last: Physical exam_____ Spinal x-ray_____ Blood test_____

Spinal exam_____ Chest x-ray_____ Urine test_____

MRI, CT-scan, bone scan, other_____

Do you sleep on your ☐Back ☐Side ☐Stomach Sleep_____hours per night Non-job related exercise_____hours per week

Do you wear ☐ Heel lifts ☐ Shoe lifts ☐ Arch supports ☐ Orthotics, describe_____

CONDITIONS

Please check (√) conditions you have or have had in the past.

[] AIDS
[] Alcoholism
[] Anemia
[] Anorexia
[] Appendicitis
[] Arthritis
[] Asthma
[] Bleeding disorders
[] Breast lump
[] Bronchitis
[] Bulimia
[] Cancer
[] Cataracts
[] Chemical dependency
[] Chicken pox
[] Diabetes
[] Emphysema
[] Epilepsy
[] Fractures
[] Glaucoma
[] Goiter
[] Gonorrhea
[] Gout
[] Heart disease
[] Hepatitis
[] Hernia
[] Herpes
[] High cholesterol
[] HIV positive
[] Kidney disease
[] Liver disease
[] Measles
[] Migraine headaches
[] Miscarriage
[] Mononucleosis
[] Multiple sclerosis
[] Mumps
[] Osteoporosis
[] Pacemaker
[] Pneumonia
[] Polio
[] Prostate problem
[] Prosthesis
[] Psychiatric care
[] Rheumatoid arthritis
[] Rheumatic fever
[] Scarlet fever
[] Stroke
[] Suicide attempt
[] Thyroid problems
[] Tonsillitis
[] Tuberculosis
[] Tumors, growths
[] Typhoid fever
[] Ulcers
[] Vaginal infections
[] Venereal disease
[] Whooping cough
[] Other

MEDICATIONS

List medications you are currently taking

VITAMINS/HERBS/MINERALS

Allergies_____

Pharmacy Name_____Phone_____

(OVER)

1003 East Interstate Avenue, Suite 5 ◦ Bismarck, ND 58503 ◦ 701.221.2788

GENERAL SYMPTOMS

Please check (√) symptoms you currently have or have had in the past year

GENERAL

[] Chills
[] Dental problems
[] Depression
[] Difficulty sleeping
[] Dizziness
[] Fainting
[] Fever
[] Forgetfulness
[] Headache
[] Insomnia
[] Loss of weight
[] Nervousness
[] Numbness
[] Sweats
[] Tiredness
[] Weight gain

GENITO-URINARY

[] Blood in urine
[] Frequent urination
[] Lack of bladder control
[] Painful urination

_____
_____
_____

GASTROINTESTINAL

[] Bloating
[] Bowel changes
[] Constipation
[] Diarrhea
[] Excessive hunger
[] Excessive thirst
[] Gas
[] Heartburn
[] Hemorrhoids
[] Indigestion
[] Nausea
[] Rectal bleeding
[] Stomach pain
[] Vomiting
[] Vomiting blood

CARDIOVASCULAR

[] Chest pain
[] High blood pressure
[] Irregular heart beat
[] Low blood pressure
[] Poor circulation
[] Rapid heart beat
[] Swelling of ankles
[] Varicose veins

EYE, EAR, NOSE, THROAT

[] Bleeding gums
[] Blurred vision
[] Crossed eyes
[] Difficulty swallowing
[] Double vision
[] Earache
[] Ear discharge
[] Hay fever
[] Hoarseness
[] Loss of hearing
[] Nosebleeds
[] Persistent cough
[] Ringing in ears
[] Sinus problems
[] Vision - flashes
[] Vision - halos

SKIN

[] Bruise easily
[] Hives
[] Itching
[] Change in moles
[] Rash
[] Scars
[] Sore that won't heal

WOMEN only

[] Abnormal pap smear
[] Bleeding between periods
[] Breast lump
[] Extreme menstrual pain
[] Hot flashes

Date of last menstrual period_____

Are you pregnant?_____

Number of children_____

OTHER SYMPTOMS_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

NECK, BACK, EXTREMITIES

Please check (√) symptoms you currently have or have had in the past year

NECK

[] Pain in neck
[] Neck stiffness
[] Neck weakness
[] Pinched nerve in neck
[] Neck feels "out of place"
[] Muscle spasms in neck
[] Grinding/popping sounds in neck

SHOULDERS

	Right	Left
[] Pain in shoulder joint	[]R	[]L
[] Pain across shoulders		
[] Can't raise arm	[]R	[]L
[] Above shoulder level		
[] Over head		
[] Tension in shoulders		
[] Pinched nerve in shoulder	[] R	[] L

MID-BACK

[] Mid-back pain
[] Mid-back stiffness
[] Pain between shoulder blades
[] Pain from front to back
[] Muscle spasms in mid-back

ARMS & HANDS

	Right	Left
[] Pain in upper arm	[] R	[] L
[] Pain in elbow	[] R	[] L
[] Pain in forearm	[] R	[] L
[] Pain in hand	[] R	[] L
[] Pain in fingers	[] R	[] L
[] Pins & needles in arm	[] R	[] L
[] Pins & needles in fingers	[]R	[]L
[] Numbness in arm	[] R	[] L
[] Numbness in fingers	[]R	[]L
[] Weakness of arm	[] R	[] L
[] Weakness of hand	[] R	[] L
[] Hands cold	[] R	[] L

LOW BACK

[] Low back pain
[] Low back stiffness
[] Low back weakness
[] Pinched nerve in low back
[] Low back feels "out of place"
[] Muscle spasms in low back

HIPS, LEGS & FEET

	Right	Left
[] Pain in buttocks	[] R	[] L
[] Pain in hip joint	[] R	[] L
[] Pain down leg	[] R	[] L
[] Pain in knee	[] R	[] L
[] Pain in ankle	[] R	[] L
[] Pain in foot	[] R	[] L
[] Weakness of leg	[]R	[]L
[] Weakness of knee	[] R	[] L
[] Leg cramps	[]R	[]L

OTHER SYMPTOMS_____
_____
_____
_____
_____
_____
_____
_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Patient Signature Date

Reviewed by_____ _____
Doctor Date

1003 East Interstate Avenue, Suite 5 ◦ Bismarck, ND 58503 ◦ 701.221.2788

SHAW CHIROPRACTIC

FINANCIAL POLICY

☐ **PRIVATE PAY** (WITHOUT INSURANCE) - I have no insurance coverage or third party liable for my health care expenses. **I will bring my account current on each visit.**

☐ **BLUECROSS BLUESHIELD** - Shaw Chiropractic Health Institute, PC is a *PREFERRED PROVIDER* (including the Federal Employee Program and Blue Card PPO) **COPAYS ARE DUE AT TIME OF SERVICE.** Statements for any coinsurance due and/or non-covered charges will be emailed on a regular basis and prompt payment of owed amount is expected. My signature below authorizes payment of benefits directly to Dr. Robert D. Shaw and/or Shaw Chiropractic Health Institute, PC for services rendered.

☐ **SANFORD HEALTH PLAN** - Shaw Chiropractic Health Institute, PC is a *PARTICIPATING PROVIDER* including the North Dakota Public Employees Retirement System Health Plan (NDPERS). **COPAYS ARE DUE AT TIME OF SERVICE.** Statements for any coinsurance due and/or non-covered charges will be emailed on a regular basis and prompt payment of owed amount is expected. My signature below authorizes payment of benefits directly to Dr. Robert D. Shaw and/or Shaw Chiropractic Health Institute, PC for services rendered.

☐ **INSURANCE (OTHER)** - Shaw Chiropractic Health Institute, PC will file all primary claims to help you receive the maximum reimbursements your policy will allow. Insurance is a contract between you and your insurance company. We are not a party to this contract. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary. Any questions concerning your coverage should be directed to your insurance company. **My signature further indicates that I accept the responsibility for payment of my care at Shaw Chiropractic Health Institute, PC and I will bring my account current on each visit.**

☐ **MEDICARE** - Dr. Shaw is a Non-Participating Provider and he **does not accept assignment.** Shaw Chiropractic Health Institute, PC will file all primary claims so you can receive an official Medicare denial if a signed Advanced Beneficiary Notice (ABN) directs us to do so.

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ALL CARE I RECEIVE AT SHAW CHIROPRACTIC.

My signature further indicates that I accept the responsibility for payment of my care at Shaw Chiropractic Health Institute, PC and I will bring my account current on each visit.

1003 East Interstate Avenue, Suite 5 ◦ Bismarck, ND 58503 ◦ 701.221.2788

FINANCIAL POLICY continued
CLINIC POLICIES

1. PAYMENT / COPAY IS DUE AT TIME OF SERVICE. (A $ 1.00 Statement Fee will apply for those who choose to be billed by mail.)

2. A 3.5% fee is automatically added to all credit card transactions.

3. Any fees for services rendered will be immediately due and payable for patients suspending or terminating care.

4. A $5.00 past due fee will be added monthly to all delinquent accounts.

5. Any fees resulting from an account being sent to collections are the patient's responsibility.

6. A $25.00 service charge will be assessed for any check returned for any reason.

7. A $25.00 fee can be charged for failure to give at least 24 hours advance notice of a missed appointment. ($40.00 fee for the Wishek clinic)

8. It is understood and agreed that any amount paid to Shaw Chiropractic Health Institute, PC for X-RAYS is for evaluation purposes only and the **films will remain the permanent property of Shaw Chiropractic Health Institute, PC.**

9. If you want to file an AFLAC or Combined claim you MUST give Dr. Shaw your COMPLETED form on the first visit following your accident. We charge a $20.00 fee for claims not managed in this manner.

I understand and agree that Shaw Chiropractic Health Institute, PC has the right to refuse to accept me at any time before chiropractic care begins. A consultation and the conducting of a physical evaluation are not considered chiropractic care.

MY SIGNATURE IS AN ACKNOWLEDGMENT THAT I UNDERSTAND AND AGREE TO ABIDE BY THE POLICIES STATED ABOVE. My signature also authorizes the release of any information concerning my health and health care services to my insurance companies or health plan.

_____ _____

Patient / Guardian Signature Date

_____ _____

Witness Date

SHAW CHIROPRACTIC

INFORMED CONSENT FOR CHIROPRACTIC CARE

When a patient seeks chiropractic health care, and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are only done by hand.

If, during your care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____	_____	_____
Print Name	Signature	Date

CONSENT TO EVALUATE AND ADJUST A MINOR CHILD:

I, _____ being the parent or legal guardian of _____ _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

1003 East Interstate Avenue, Suite 5 ◦ Bismarck, ND 58503 ◦ 701.221.2788

SHAW CHIROPRACTIC

HIPAA Compliance Concerning Your Protected Health Information

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.

The covered entity is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information;

For purposes of this notice, the term "**covered entity**" refers to Shaw Chiropractic Health Institute, PC and Dr. Robert D. Shaw.

Dear Patient, you have rights concerning your private health information, your access to this information and to know how this information is used by our office. You also have rights related to our ability to contact you concerning your activity in our practice, such as recall reminders, billing and other matters related to how we communicate with you and others on your behalf. Please understand that this office and all its employees and associates make every effort possible to always keep confidential your private medical information and only with your consent will such information ever be shared with others.

A. The covered entity may contact the individual to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual.

B. Your Personal Health Information (PHI) will not be shared with any third party without your express written consent. Your PHI is under lock and key and will not be available to anyone other than the covered entities authorized personnel.

C. Your records are available to you for review, copying or corrections by appointment and you will not be denied access to your PHI. Any changes you request to your PHI must be supplied to this office in writing and you will be advised within 30 days of any objection to the correction, or that the correction has been made.

D. With respect to other providers requesting your PHI, we will require a written authorization for the release of medical records signed by you, detailing the name, address, and phone number of the requesting physician. Under no circumstances will we discuss your PHI with anyone without your express written permission. (This will of course exclude any office staff that has necessary access to your records.)

_____ _____ _____

Print Name Signature Date

1003 East Interstate Avenue, Suite 5 ◦ Bismarck, ND 58503 ◦ 701.221.2788