

Patient Information

Patient Name: _____ Date of Birth: _____ Age: _____
 Address: _____ City: _____ State: _____
 Zip: _____ Home Phone: _____ Work Phone: _____
 Gender: _____ Occupation: _____ Employer: _____
 Emergency Contact: _____ Phone#: _____
 Have you seen a chiropractor in the past? _____
 Doctors Name: _____ Phone#: _____

Policy Holder Information

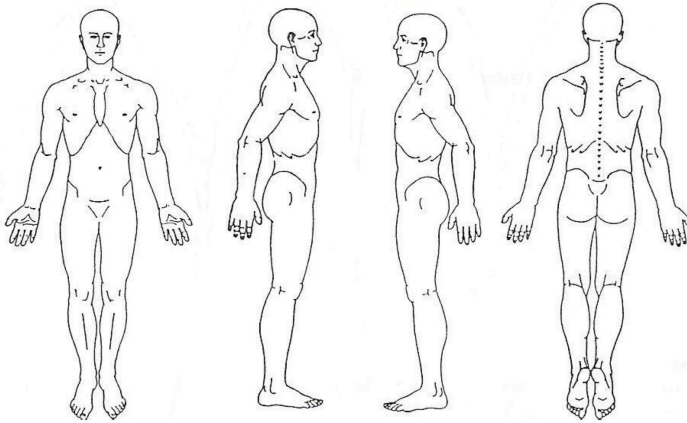
Policy Holder: _____ DOB: _____
 Relationship to Patient: _____
 Phone #: _____ Gender: _____
 Employer: _____ Work Phone#: _____

Referral Information

How did you hear about our clinic? _____
 Referred by(optional): _____

Patient History

Are your present problems due to an injury? _____ No _____ Yes
 On the Job Auto Accident Personal Injury Other _____
 Has the accident been reported? _____ Yes _____ No To employer Auto Carrier Other
 Have you seen anyone else for this problem? _____ No _____ Yes
 If yes, whom _____ Phone#: _____
 Are you now or have you ever been disabled? _____ No _____ Yes (Service or Work)
 If yes, when and how? _____

<p>Please mark the intensity of your pain 1=no pain and 10= most intense pain ever felt</p> <p>Example _____ <i>Neck</i> _____ 1 2 3 4 5 6 7 8 9 10</p> <p>Area#1: _____ 1 2 3 4 5 6 7 8 9 10</p> <p>Area#2: _____ 1 2 3 4 5 6 7 8 9 10</p> <p>Area#3: _____ 1 2 3 4 5 6 7 8 9 10</p>	<p>Please mark area & type of pain using the code below N= Numbness, P= Pain T= Tingling, A=Ache S=Soreness, ST=Stiffness</p> 
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Habits

Smoking Packs/Day _____
 Alcohol Drinks/Day _____
 Caffeine Cups/Day _____

Exercise

None
 Moderate
 Daily
 Type _____

Family History

	Diabetes	Heart	Kidney	Cancer	Other
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Describe _____

Have you had any of the following diseases? (Please circle all that apply)

Rheumatic Fever	Alcoholism	Tuberculosis	HIV/AIDS	Polio	Cancer
Pneumonia	Measles	Goiter	Epilepsy	Diabetes	Hepatitis
Venereal Disease	Chicken Pox	Lumbago	Whooping cough	Mental Disorder	Pleurisy

Please circle the appropriate letter for each item below. (C=currently, P=past)

General Symptoms	Gastrointestinal	Eye/Ear/Nose/Throat	Respiratory
C P Allergy _____	C P Belching/Gas	C P Asthma	C P Chest Pain
C P Bronchitis	C P Colon Trouble	C P Crossed Eyes	C P Chronic Cough
C P Chills	C P Constipation	C P Deafness	C P Difficulty Breathing
C P Convulsions	C P Diarrhea	C P Earache	C P Wheezing
C P Dizziness	C P Excessive Hunger	C P Ear Discharge	C P Spitting Blood
C P Fainting	C P Gallbladder Trouble	C P Ear Noise	C P Spitting Phlegm
C P Fatigue	C P Hemorrhoids	C P Enlarged Thyroid	
C P Fever	C P Jaundice	C P Frequent Colds	Genitourinary
C P Headaches	C P Liver Trouble	C P Hay Fever	C P Bed Wetting
C P Loss of Sleep	C P Nausea	C P Hoarseness	C P Blood in Urine
C P Loss of Weight	C P Pain over Stomach	C P Nasal Obstruction	C P Frequent Urination
C P Nervousness	C P Poor Appetite	C P Nose Bleeding	C P Urinary Incontinence
C P Neuralgia	C P Poor Digestion	C P Pain in Eyes	C P Kidney Infection
C P Night Sweats	C P Vomiting	C P Poor Vision	C P Painful Urination
C P Numbness or Pain arms, legs, hands	C P Vomiting Blood	C P Sinusitis	C P Prostate Trouble
C P Been Unconscious When, _____		C P Tonsillitis	
C P Memory Lapse			
Muscles & Joints	Cardiovascular	Skin or Allergies	For Women Only
C P Backache	C P High Blood Pressure	C P Boils	C P Cramps/Backache
C P Foot Trouble	C P Low Blood Pressure	C P Bruising Easily	C P Excessive flow
C P Hernia	C P Pain over Heart	C P Dryness	C P Hot Flashes
C P Pain between Shoulders	C P Poor Circulation	C P Eczema	C P Irregular Cycle
C P Painful Tailbone	C P Heart Trouble	C P Hives	C P Miscarriage
C P Stiff Neck	C P Rapid Heart Rate	C P Itching	C P Painful Periods
C P Spinal Curvature	C P Slow Heart Rate	C P Sensitive Skin	C P Vaginal Discharge
C P Swollen Joints	C P Strokes	C P Skin Eruptions	Last Pap? _____
C P Tremors	C P Swelling Ankles		Are you Pregnant at this time? ___ Yes ___ No
C P Twitching	C P Varicose Veins		
C P Weakness	C P Anemia		
C P Arthritis			

Have you ever had x-rays taken? _____ Yes _____ No If yes, when? _____
 On what area? _____ At what location? _____

Operations and Procedures

DATE _____	Vaccinations	DATE _____	Tubes in Ears	DATE _____	Hernia
_____	Tonsillectomy	_____	Appendectomy	_____	Thyroid
_____	Gall Bladder	_____	Female Organs	_____	Stomach
_____	Back Operation	_____	Extremity Operation	_____	Cesarean

I have never had any operations/surgeries

Medications

Are you currently taking any medications or nutritional supplements, prescribed or over-the-counter (please list)

Drug _____	Dose/Frequency _____	For What? _____
Drug _____	Dose/Frequency _____	For What? _____
Drug _____	Dose/Frequency _____	For What? _____

Please read each section thoroughly, initial each section and sign at the bottom. Thank You

_____ I have received, read and understand how my Protected Health Information will be used in this office and I agree to these policies and procedures. If I have questions or concerns about how my Protected Health Information is/will be used I understand that I may contact the Compliance Officer at the back of the Notice of Privacy Practices at any time.

Authorization to Release Information

_____ I Authorize Lauderdale Wellness Center to release all information related to the care I receive to my HMO, insurance company, third party payor or their designee and other members of my healthcare team. Information may be shared with above-mentioned via mail, telephone or fax. I understand that this may be necessary for the payment of my bill, determining benefits or for utilization and quality review purposes.

Assignment of Benefits

_____ I assign all benefits payable to me for my care at Lauderdale Wellness Center. I understand that this health care facility will be paid directly by the insurance company or other payor. 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 understand and agree that health and accident insurance policies are an agreement between an insurance company and myself. Furthermore, I understand that Lauderdale Wellness Center will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid to Lauderdale Wellness Center will be credited to my account on receipt. I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of Lauderdale Wellness Center. If I fail to do so, I agree that I am liable to Lauderdale Wellness Center for the interest (at a rate of 18% per annum on the balance due more than 30 days), court costs, reasonable attorney fees, and any other necessary costs to enforce payment of any part of said account(s).

Consent for Treatment

_____ You have the right, as a patient to be informed about your condition and the recommended treatment to be used so that you may make an informed decision whether or not to undergo the procedure after knowing the risks and benefits involved. This disclosure is simply meant to give you all the information, even if the risk is very remote, so that you may give or with hold your consent for the treatment.

Doctors of Chiropractic, Medical Doctors and Physical Therapists using manual therapy treatment for patients with headaches and cervical spine complaints are required to explain that there have been rare cases of injury to a vertebral artery as a result of treatment. Such an injury has been known to cause a stroke, sometimes with serious neurological damage. The rare chance of this happening is estimated to be approximately from 1 per 400,000 treatments to 1 per 10 million treatments. Appropriate tests will be performed to help identify if you may be susceptible to this type of injury; you will be notified if that is the case. If you have any questions about this, please feel free to speak to your practitioner.

As with any health care procedures, complications may arise during or after treatment. These complications may include soreness, muscle or ligament sprain, dislocations, fractures, disk injury or physiotherapy burn. These are extremely rare occurrences.

Authorization to Treat a Minor (under the age of 18)

_____ I hereby request and authorize Dr. Brian Malzer to perform diagnostic tests and render chiropractic adjustment and other treatments to my minor son/daughter. This authorization is intended to include radiographic examination at the doctor's discretion. As of this date, I have legal right to select and authorize health care services for the minor child. Under the terms and conditions of my divorce (if applicable) separation or other authorization, the consent of a spouse/former spouse or other parent is not required. If my authorization to select and authorize this care should be revoked or modified in anyway, I will immediately notify Lauderdale Wellness Center.

Signature of Patient or Responsible Party

Date

Relationship to Patient

Lauderdale Wellness Center's

Notice of Privacy Practices

Effective April 14, 2003

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Lauderdale Wellness Center is dedicated to maintaining the privacy of your protected health information. "Protected Health Information" is information that identifies you and relates to your past, present or future physical or mental health conditions, the provisions of health care to you, and payment for health care services you receive.

Our Legal Duty:

- ❖ We are required by applicable federal and state law to maintain the privacy of our health information.
- ❖ We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information.
- ❖ We must follow the privacy practices that are described in this Notice while it is in effect, and continue until we replace it.
- ❖ You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.
- ❖ We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law.
- ❖ We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain: including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new Notice available upon request.

Use and Disclosures of Health information:

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

- ❖ *Treatment:* We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
- ❖ *Payment:* We may use and disclose your health information to obtain payment for services we provide to you.
- ❖ *Healthcare Operations:* We may use and disclose your health information in connection with our healthcare operations. Health care operations include quality assessment and improvement activities, reviewing the competencies or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
- ❖ *Appointment Scheduling and Reminders:* We may contact you to obtain registration information or remind you of an appointment (such as voicemail messages, postcards, or letters).
- ❖ *Your Friends and Family:* We must disclose your health information to you, as described in the Patient's Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so. You may limit the information given to your friend or family member if you wish.
- ❖ *Persons Involved in Your Care:* We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care of your location, your general condition, or death. If you are present, prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inference of your best interest in allowing a person to pick up medical supplies, x-rays or other similar forms of health information.
- ❖ *Marketing Health Related Services:* We will not use your health information for marketing communications without your written authorization.
- ❖ *Required by law:* We may use or disclose your health information when we are required to do so by federal, state or local law.
- ❖ *Public Health Activities:* We may use and disclose your health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. For Example, we may disclose your health

information to public health authorities for prevent or control disease, injury or disability or to notify people about recalls of products they may be using.

- ❖ *Abuse or Neglect:* We may disclose your health information to appropriate authorities if we believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
- ❖ *National Security:* We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected information of inmate or patient under certain circumstances.
- ❖ *Other Uses and Disclosure of Health Information:* Any other uses and disclosures not described in this Notice will be made only with your written authorization. If you give us authorization to use or disclose your health information for other purposes not described in this Notice, you may revoke that authorization, in writing, at any time. Except to the extent that action has already been taken, we will stop using and disclosing your health information for the reasons covered by your written authorization.

Patient Rights:

- **Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using that contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending a letter to the address at the end of this Notice. If you request copies, we will charge you \$1.05 per page and \$13.79 fee for staff time to locate and copy your health information in that format. Tax will be in addition to that price. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using that information listed at the end of this Notice for a full explanation of our fee structure.
- **Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
- **Restrictions:** You may request restrictions on who has access to your health information. While Lauderdale Wellness Center will consider your request, we are not required to agree to your requested restrictions, but if we do agree, we will abide by our agreement (except in an emergency).
- **Amendment:** You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.
- **Alternative Communications:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make this request in writing. Your request must specify the alternative means or location and provide satisfactory explanation how payment will be handled under the alternative means or location you request.
- **Electronic Notice:** If you receive this Notice electronically, you have the right to a paper copy. To obtain a paper copy of this Notice, and your request in writing to the address listed at the end of this Notice.

Questions and Complaints: If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information, or in response to a request you made to amend or restrict the use or disclosure of your health information, or to have us communicated with you by alternative means or locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U. S Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Service upon request. You will not be retaliated against for filing a complaint.

Compliance Officer: Dana Malzer Telephone #: (651) 917-9800 Fax #: (651) 917-9801
Email: Dana@LauderdaleWellnessCenter.com
Address: 2443 Larpenteur Ave. W. Lauderdale, MN 55113