Welcome to our office...

Case # _____ Date _____

Our practice is based on the simple truth that if we satisfy and delight our patients, they will get well faster and be more likely to tell others about their chiropractic experience. This avoids costly advertising and helps keep our fees reasonable.

Since chiropractic results vary, we can't guarantee results, but we can promise your satisfaction.

Full Name _____ Nickname _____

Address _____ City _____ State _____ Zip _____

Sex: ( ) M ( ) F Age: _____ Birth date: _____/_____/_____ Marital Status: ( ) S ( ) M ( ) D ( ) W Children #:_____

SS#: _____-_____-_____ Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____)_____ E-mail address: _____

Occupation/Employer: _____

How did you hear about our clinic? _____

Name of person responsible for account: _____ Method of payment: _____

Emergency contact name: _____ Phone: (____) _____

Signatures & Authorizations

FEES PAYABLE WHEN SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS ARE MADE.
WE ARE REQUIRED TO MAINTAIN ORIGINAL X-RAYS AND RECORDS AS PROPERTY OF THIS CLINIC.

Consent for Treatment

I, the undersigned, hereby authorize Dr. Janine Bremer and whomever she may designate as her assistant(s) to perform diagnostic tests, including but not limited to radiographs, and to administer treatment as is necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained.
I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. Furthermore, I understand that this office 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 directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. **HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND I AM PERSONALLY RESPONSIBLE FOR PAYMENT.**

Patient's Signature _____ **Date** _____ **Witness** _____

X-Ray/Medical Records Release

I have requested the release of records of (patient's name) _____,

which are a part of the records at (clinic) _____

I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing by them, all copies of records and reports, including copies of x-rays and photostatted copies, abstracts or exerts of all records and any other information they may request relating to any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or may have in the future.

Please forward this to: **Gravon's Natural Chiropractic Clinic**
1024 Oxford Street
Worthington, MN 56187

Patient's Signature _____ **Date** _____ **Witness** _____

Consent for Treatment of Minor

I hereby authorize Dr. Janine Bremer, and whomever she may designate as her assistant(s), to perform diagnostic tests, including but not limited to radiography, and to administer treatment as she deems necessary to:

(Child's name) _____, my (Circle One) Son / Daughter.

Parent's or Guardian's Signature _____ **Date** _____ **Witness**_____

GRAVON'S NATURAL CHIROPRACTIC CLINIC *FINANCIAL INFORMATION*

The purpose of this information is to clarify your financial responsibilities.
We can then devote our efforts to helping you get the best results in the shortest amount of time.
These are the most common services we provide and when they are performed.

Procedure	Purpose	When Performed
Consultation	Tour the office, meet the doctor, discuss your health problem, and review your case history.	First visit.
Evaluation/Management [Examination(s)]	Ascertain the nature and severity of your health problem. Assess and evaluate your new or current health status and determine an appropriate course of action.	First visit, new conditions, Exacerbations, and re-examinations.
X-Rays	Visualize the location of spinal problems and confirm other examination findings.	If necessary, first visit, re-injuries, and at certain progress examinations.
Adjustment	Reduce the Vertebral Subluxation Complex and help stabilize your spinal or joint problem.	As indicated by examination or evaluation.
Therapy	Reduce inflammation and swelling, speed the healing process, and help provide relief.	As indicated by examination or evaluation.

- **Forms of Payment**

Patients are responsible for full payment at the time of service. We accept cash, personal checks, Visa and MasterCard. Any credit arrangements must be authorized in advance.

- **Insurance/Contract Services/Third Party**

Other options are available if group health insurance, worker's compensation, a managed care provider, Medicare, personal injury, or the result of an auto accident covers your care.

All professional services are rendered and charged to the patient receiving care and not to an insurance provider. We will supply you with statements, reports, or other documents to help you receive reimbursement from a third party. We will not become involved in disputes with your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information.

- **Billing**

Any outstanding balances are billed monthly and considered past due 10 days after the invoice date or when special arrangements are not met. Returned checks are subject to a $15.00 fee. Balances older than 30 days will accrue interest charges of 1.5% per month, plus any legal or collection fees.

Patient Agreement
I have read, understood, and agreed to this agreement.

Questions
Please ask if you have questions about this agreement or your ability to comply with its provisions. We are here to help.

_____ _____ _____ _____
Patient/Responsible Party Signature ***Date*** ***Office Representative*** ***Date***

Financial Information-MN rev. 9.20.06

Attorney Representation and Protection of Balance

I, the undersigned patient am directing my attorney, _____, to pay any outstanding bills out of my settlement and, in effect, protecting any such balance. I hereby make and declare the instructions contained to be irrevocable. I fully understand that I am directly responsible for all medical/chiropractic bills and this agreement is made solely for the doctor's additional protection and consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to make payment on a current status.

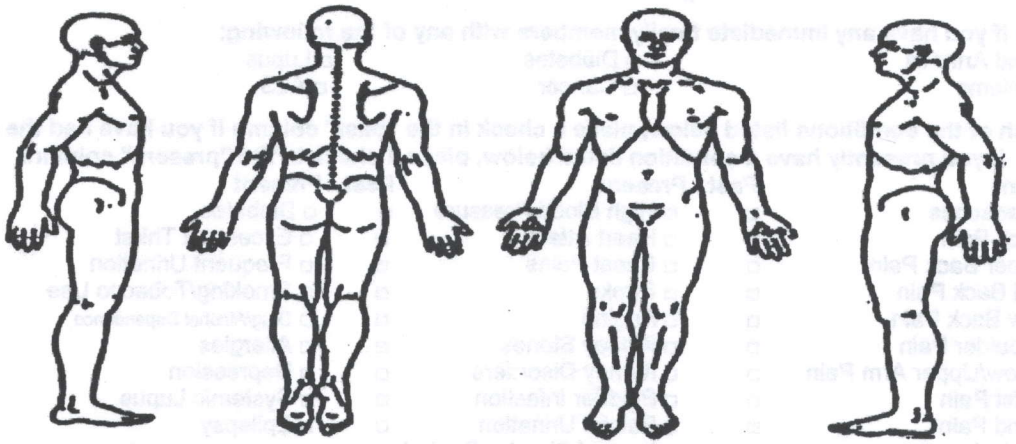
Patient's Signature _____ **Date** _____ **Witness** _____

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: ◻ Auto Accident ◻ Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

◻ Constantly (76-100% of the time) ◻ Occasionally (26-50% of the time)
◻ Frequently (51-75% of the time) ◻ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

◻ Sharp ◻ Numb
◻ Dull ◻ Tingly
◻ Diffuse ◻ Sharp with motion
◻ Achy ◻ Shooting with motion
◻ Burning ◻ Stabbing with motion
◻ Shooting ◻ Electric like with motion
◻ Stiff ◻ Other:_____

5. How are your symptoms changing with time?

◻ Getting Worse ◻ Staying the Same ◻ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?

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

8. How much has the problem interfered with your social activities?

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

9. Who else have you seen for your problem?

◻ Chiropractor ◻ Neurologist ◻ Primary Care Physician
◻ ER physician ◻ Orthopedist ◻ Other:_____
◻ Massage Therapist ◻ Physical Therapist ◻ No one

10. How long have you had this problem? _____

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe?

◻ Yes ◻ Yes, at times ◻ No

13. What aggravates your problem?

_____

14. What concerns you the most about your problem; what does it prevent you from doing?

_____

15. What is your: Height_____ **Weight** _____ **Date of Birth** _____

Occupation _____

16. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?
□ Stenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

19. 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	□	□	High Blood Pressure	□	□	Diabetes
□	□	Neck Pain	□	□	Heart Attack	□	□	Excessive Thirst
□	□	Upper Back Pain	□	□	Chest Pains	□	□	Frequent Urination
□	□	Mid Back Pain	□	□	Stroke	□	□	Smoking/Tobacco Use
□	□	Low Back Pain	□	□	Angina	□	□	Drug/Alcohol Dependance
□	□	Shoulder Pain	□	□	Kidney Stones	□	□	Allergies
□	□	Elbow/Upper Arm Pain	□	□	Kidney Disorders	□	□	Depression
□	□	Wrist Pain	□	□	Bladder Infection	□	□	Systemic Lupus
□	□	Hand Pain	□	□	Painful Urination	□	□	Epilepsy
□	□	Hip Pain	□	□	Loss of Bladder Control	□	□	Dermatitis/Eczema/Rash
□	□	Upper Leg Pain	□	□	Prostate Problems	□	□	HIV/AIDS
□	□	Knee Pain	□	□	Abnormal Weight Gain/Loss			
□	□	Ankle/Foot Pain	□	□	Loss of Appetite		**For Females Only**	
□	□	Jaw Pain	□	□	Abdominal Pain	□	□	Birth Control Pills
□	□	Joint Pain/Stiffness	□	□	Ulcer	□	□	Hormonal Replacement
□	□	Arthritis	□	□	Hepatitis	□	□	Pregnancy
□	□	Rheumatoid Arthritis	□	□	Liver/Gall Bladder Disorder			
□	□	Cancer	□	□	General Fatigue			
□	□	Tumor	□	□	Muscular Incoordination			
□	□	Asthma	□	□	Visual Disturbances			
□	□	Chronic Sinusitis	□	□	Dizziness			
□	□	Other:_____						

20. List all prescription medications you are currently taking:
_____

21. List all of the over-the-counter medications you are currently taking:
_____

22. List all surgical procedures you have had:
_____

23. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

24. What activities do you do outside of work?
_____

25. Have you ever been hospitalized? □ No □ Yes
if yes, why _____

26. Have you had significant past trauma? □ No □ Yes

27. Anything else pertinent to your visit today?_____

Patient Signature_____ **Date:**_____