WISCONSIN CHIROPRACTIC CENTER, LLC

5050 West Rawson Avenue
Franklin, WI 53132

(414) 377-8584
(414) 377-8588
info@wichiropracticcenter.com

# NEW PATIENT PAPERWORK

## *Personal Information*

Legal Name: _____ Preferred Name: _____

Date of Birth: _____ Gender: Male Female Social Security #: _____

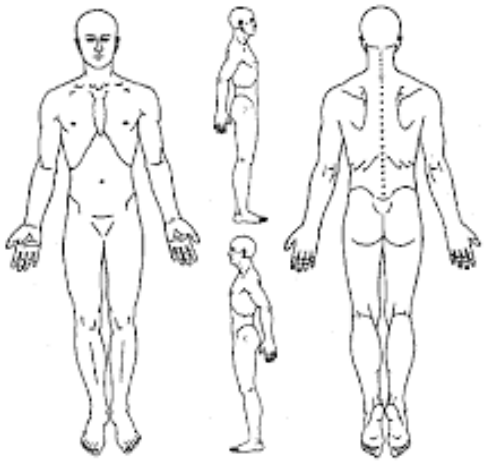
Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ ( Cell / Home ) Email: _____

Height: _____ Weight: _____ Age: _____ Marital Status: Single Married Divorced Other

Emergency Contact (name and relation to patient): _____ Phone #: _____

Occupation: Full Time Part Time Unemployed Student Retired Referred by: _____



## *Pain Diagram*

- On the diagram to the left please mark the areas of complaint you would like us to address / help with.
- Please **NUMBER** your complaints starting with **#1** (being the most severe, bothersome, painful, etc.) and continuing numbering from there.

What are the goals/activities you hope to improve with chiropractic care:

_____

_____

## *Chief Complaint #1 (from the diagram above):*

Describe this issue: _____

When did the issue start: _____ Did it start (circle one): Suddenly / Gradually over time / It comes and goes

Do you know what caused the issue / how it started: _____

Has the issue been (Circle One): Improving since it started / Worsening since it started / Staying the same

Is the issue now (Circle One): Constant / Frequent / Occasional / Intermittent / Other: _____

What does it feel like (Circle Any): Tight / Achy / Sharp / Shooting / Numb / Tingly / Other: _____

Does the pain radiate anywhere (Circle One): No / Yes, if yes, where: _____

How intense is the pain (on a scale from 0 to 10, if means none all and 10 is “emergency room level”): _____/10

What helps relieve pain: _____ What makes it worse: _____

Have you tried anything else for this pain: No / Other Chiropractor / Primary Care / PT / Massage / ER or Urgent Care

Patient Chart Number: _____

*If you have **a 2nd complaint** complete the box below, otherwise circle: NONE*

Describe this issue: _____

When did the issue start: _____ Did it start (circle one): Suddenly / Gradually over time / It comes and goes

Do you know what caused the issue / how it started: _____

Has the issue been (Circle One): Improving since it started / Worsening since it started / Staying the same

Is the issue now (Circle One): Constant / Frequent / Occasional / Intermittent / Other: _____

What does it feel like (Circle Any): Tight / Achy / Sharp / Shooting / Numb / Tingly / Other: _____

Does the pain radiate anywhere (Circle One): No / Yes, if yes, where: _____

How intense is the pain (on a scale from 0 to 10, if means none all and 10 is "emergency room level"): _____/10

What helps relieve pain: _____ What makes it worse: _____

Have you tried anything else for this pain: No / Other Chiropractor / Primary Care / PT / Massage / ER or Urgent Care

**If you have **more than two complaints**, please ask the front desk for an additional complaint sheet.*

***Review of Systems** Circle any of the following you currently have or have had in your past or circle **NONE***

**Neurological:** Anxiety / Depression / Headaches / Stroke / Dizziness / Numbness & Tingling / Other:_____

**ENT:** Ear Issues / Tinnitus / Eye Problems / Vision Changes / Sinus Issues / Sore Throat / Other: _____

**Cardiovascular:** Chest Pain / Shortness of Breath / Sweating / High Blood Pressure / Cholesterol / Heart Attack / Clots

**Respiratory:** Asthma / Sleep Apnea / Frequent Snoring / Allergies: _____

**Gastrointestinal:** Constipation / Diarrhea / Colitis / Acid Reflux / Ulcer / Hernia / Other: _____

**Miscellaneous:** Cancer / Diabetes / Thyroid Issues / Kidney Stones / Incontinence / Bladder Issues / Prostate Issues

**Musculoskeletal:** Arthritis / Disc Issues / Fibromyalgia / Muscle Spasms / Other: _____

Other Medical Issues not listed above: _____

***Medical History / Family History / Social History** Please complete the following:*

Please list any medications you take: _____

Please list any supplements you take: _____

Please list any surgeries you have had: _____

Do you: Drink alcohol ( Yes / No ) Smoke ( Yes / No ) Exercise ( Yes / No ) Use seatbelts ( Yes / No )

For Women Only: Are you currently pregnant ( No / Yes, if yes, how far along: _____weeks) . # Prior Pregnancies: _____

Do you have a family history of (circle any): Diabetes / Cancer / Heart Disease / Spinal Issues / Other: _____

☐ I would like my primary care physician to receive a copy of the initial report explaining the chiropractic care I am receiving. Primary Care Physician Name: _____ Location: _____

☐ I do not have a primary care physician at this time.

# Estimated Benefit Information

Listed below are payment options for services based on information provided when appointments are scheduled.
Please notify us if any changes have occurred since then.

☐ ***Self-Pay / No Insurance***

| Estimated Cost of Care | |
|---|---|
| Examination and X-Rays if needed | |
| Adjustments | |
| Therapies Recommended | |

☐ ***Personal Health Insurance***

| Deductible | Copay | Co-Insurance | Out of Pocket | Limits |
|---|---|---|---|---|
| | | | | |

-Secondary policies, if present and provided, will be billed after the primary policy has processed.

☐ ***Medicaid***

-Your policy has a $_____ copay for each visit and you are allowed 20 visits per "spell of illness."
-Your policy covers spinal adjustments.

☐ ***Medicare with/without Supplemental Policy***

-MEDICARE: Medicare pays 80% of the SPINAL ADJUSTMENT after the 2023 annual deductible of $226.00 has been met. Medicare DOES NOT cover exams, x-rays, therapies of Maintenance adjustments. The cost for these services along with any co-insurance is the responsibility of the patient.
-SUPPLEMENTAL CROSSOVER: Any co-insurance or non-covered service will then be billed to the supplement if one is present and provided. Most follow the Wisconsin Mandate and will cover the cost of care.

☐ ***Medicare Advantage Plan***

-We will bill your adjustment to your Advantage Plan, your policy has a $_____ copay per visit.
-MOST advantage plans follow Medicare guidelines and will only cover services Medicare covers; therefore exams, x-rays, therapies, and maintenance care are not covered and will be the patient's responsibility.

☐ ***VA Community Care***

-The VA provides an authorization for 12 visits over a 4 month period of time.
-If additional visits are required a new authorization can be requested.

☐ ***Personal Injury (Auto Accident)***

-We will bill either your auto-insurance or the liable parties auto insurance for payment.
-If no auto policies are present or available your primary medical insurance will be billed.
-If you have retained an attorney and the balance is held on account an attorney's lien will be required.

☐ ***Work Injury (Workers Compensation)***

-Your employers workers compensation policy will be billed for payment.

**STATEMENT OPTIONS (Select One):**

☐ I choose to receive monthly *paper statements* via US Mail for outstanding balances to be paid.
☐ I choose to enroll in monthly *E-Pay Statements* via text/email to my contact information provided. A link will be provided to access e-statement with secure online payment options available.

See Reverse

## Please read the following and initial to indicate request and consent to each statement:

***Informed Consent for Chiropractic Services:***

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures; physical examination, tests, diagnostic x-rays, physical therapy procedures, etc. on me by Jacqueline A. Stencel, DC and/or any assistant or other licensed practitioners at Wisconsin Chiropractic Center. I understand, as with any health procedure, there are certain complications which may arise during chiropractic treatments. Those complications include but are not limited to: fracture, disc injury, nerve injury, dislocations, muscle strains and ligament sprains. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and wish to rely on the doctor to exercise judgment during the course of care as to what is in my best interest. I have had time to discuss the nature, purpose and risks of chiropractic treatments and recommended procedures and had any and all questions answered. I understand specific results are not guaranteed. I have been informed and weighted the risks involved in chiropractic treatment at this office and have decided it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment and intend this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment. **Initial: _____**

***HIPAA :***

Wisconsin Chiropractic Center's HIPAA Policies and Procedures are posted in the office and I have been offered time to review them for any updates and/or changes and have had questions answered. **Initial: _____**

In accordance with current HIPAA Policies and Procedures, the following individual(s), if any, have my permission to access my medical records and billing/payment information: ☐ No One ☐ _____,
Relationship(s) to patient: _____ **Initial: _____**

***Correspondence:***

I authorize Wisconsin Chiropractic Center to send text message and/or email communication to me. I understand that I may reply with various commands to receive office, location, account and appointment alerts. I agree that individuals associated with my account may receive alerts referencing the account holder and/or dependents. Initial: _____

***Financial Policy:***

I understand it is the policy of Wisconsin Chiropractic Center that payment is due at the time of service. If payment cannot be made in full payment plans are available. Failure to pay on balances regularly may necessitate automatic payment plan. If payment plan defaults, is refused or alternate arrangements are discussed account may be referred to an outside collection agency. **Initial: _____**

***Insurance Authorizations (if self pay skip to signature):***

My estimated benefits have been reviewed with me. I understand all benefits quoted are not guaranteed. I understand I am financially responsible for any and all charges left to me by my insurance company in accordance to my policy guidelines at the time claims are processed even if they differ from what was quoted to me by my insurance company.
**Initial: _____**

I authorize Wisconsin Chiropractic Center to bill my insurance company directly for services rendered. My initials, noted here, serve as permission for Wisconsin Chiropractic Center to use my signature as provided below on any and all claim forms submitted to my insurance company on my behalf as well as authorize Wisconsin Chiropractic Center to release medical information to my insurance company for claims processing. I authorize payment of my insurance benefits directly to Wisconsin Chiropractic Center. **Initial: _____**

**I acknowledge the information provided on the above pages (current complaints, medical issues, insurance information and initialed sections) is true and accurate to the best of my knowledge at the time of completion.**

_____ _____ _____

Patient or Representative Signature | Relationship to Patient | Date

Patient Chart Number: _____