Woodbury Family Chiropractic

Today's Date ___/___/_____

Name_____ Age_____ Height _____ Weight _____ lbs.
Address_____ City_____ State_____ Zip_____
Cell#_____Home#_____Date of Birth ___/___/_____ Sex: M F
E-Mail Address: _____
How did you hear about us?_____
Occupation/Employer _____Phone (Work)_____
Insurance Company_____Phone_____
Insured's Name _____Insured's Date of Birth _____
Insured's Group # _____ Insured's address same? Y N
Spouse's Name _____Children's Names/Ages_____
Present condition due to an injury? __ Yes __ No __ On the Job __ Auto Accident __ Other
Has the accident been reported? __ Yes __ No __ To Employer __ Auto Carrier __ Other

HEALTH REPORT:
Reason for seeking care: _____
List any other doctors seen for this: _____
List any diagnosis and type of treatment: _____
Have you had similar accidents or injuries before? __ Yes __ No
If yes, explain: _____
List the names of any relatives that have or have had a similar problem:
_____
Have you or any relative received chiropractic treatment previously? __ Yes __ No
If yes, explain:_____
Have you been treated for any health condition by a physician in the last year? __ Yes __ No
If yes, explain:_____
Are you currently taking medication? __ Yes __ No
List medications:_____
Have you taken medication in the past? __ Yes __ No
List medications _____
List conditions you are taking medications for:
_____
List the approximate dates of any surgery or treated conditions:_____
_____
_____
Family History: Health conditions, age of death and cause of death.
Father: _____
Mother: _____
Brother/s & Sister/s: _____
Do you smoke Y/N ____ · Alcohol Y/N __Daily __Weekly __Social Occasions ·
Caffeinated drinks per day _____
Do you take Vitamins/Supplements Y/N If yes, type and how often _____

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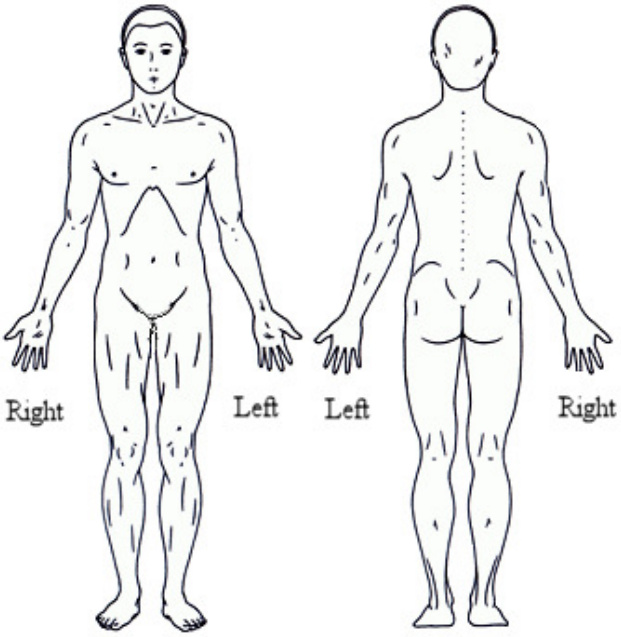
Using the symbols below, mark on the pictures where you feel discomfort:



Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Other _____	^ ^ ^

When did the current complaint begin? _____
How long have you had these symptoms?_____
What activities aggravate your condition/pain?_____
_____
What activities lessen your condition/pain?_____
_____
Is this condition worse during certain times of the day? Y/N
Is this condition interfering with Work?_____
Sleep?_____ Routine?_____
Is this condition progressively getting worse?_____

Please mark each item below for each sign or symptom you presently have or previously had:

GENERAL SYMPTOMS
__ Convulsions
__ Dizziness
__ Fainting
__ Headache
__ Nervousness
__ Numbness
__ Wheezing

MUSCLES & JOINTS
__ Low Back Problems
__ Pain between Shoulders
__ Neck Problems
__ Arm Problems
__ Leg Problems
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__ Sore Muscles
__ Weak Muscles
__ Walking Problems
__ Sprains/Strains
__ Broken Bones

RESPIRATORY
__ Asthma
__ Chronic Cough
__ Difficulty Breathing
__ Spitting Blood
__ Spitting Phlegm

CARDIO-VASCULAR
__ High Blood Pressure
__ Heart Attack
__ Pain over Heart
__ Poor Circulation
__ Heart Trouble
__ Rapid Heart
__ Slow Heart
__ Strokes
__ Swelling Ankles
__ Varicose Veins

EAR/NOSE/THROAT
__ Earache
__ Ear Noises
__ Enlarged Thyroid
__ Frequent Colds
__ Hay Fever
__ Nasal Blockage
__ Nose Bleeds
__ Pain Behind Eyes
__ Poor Vision
__ Sinusitis
__ Sore Throats
__ Tonsillitis

GASTRO-INTESTINAL
__ Belching/Gas
__ Colon Problems
__ Constipation
__ Diarrhea
__ Excessive Hunger
__ Excessive Thirst
__ Gall Bladder Trouble
__ Hemorrhoids
__ Liver/Gallbladder
__ Nausea
__ Abdominal Pain
__ Ulcer
__ Poor Appetite
__ Poor Digestion
__ Vomiting
__ Vomiting Blood
__ Black Stool
__ Bloody Stool
__ Weight Loss/Gain

GENITO-URINARY
__ Blood in Urine
__ Frequent Urination
__ Kidney Infection
__ Painful Urination
__ Prostate Problems
__ Loss of Bladder Control

SKIN OR ALLERGIES
__ Boils
__ Bruising Easily
__ Dryness
__
Eczema/Rash/Dermatitis
__ Hives
__ Itching
__ Sensitive Skin
__ Allergy_____

FOR WOMEN ONLY
__ Birth Control _____
__ Hormone Replacement
__ Cramps/Backaches
__ Excessive Flow
__ Hot Flashes
__ Irregular Cycle
__ Miscarriage
__ Painful Periods
__ Vaginal Discharge
__ Breast Pain
Pregnant at this time Y/N

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.

Patient Signature_____ Date_____

Woodbury Family Chiropractic

HIPAA Consent

I, _____ [Name of Individual] consent to Woodbury Family Chiropractic, “the Practice’s”, use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice’s general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice’s diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me. I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice. I understand I have a right to review the Practice’s Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice’s duties regarding the types of uses and disclosures of my Protected Health Information. I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

Signature or Personal Representative _____Date_____

Authorization for Treatment of a Minor

I hereby authorize Woodbury Family Chiropractic to administer care as they deem necessary to my minor child.

Signature of Parent/Legal Guardian_____Date_____

Do we have permission to leave a detailed voice or text message on your provided number?
__YES __ NO

Woodbury Family Chiropractic

Financial Policy

Thank you for choosing Woodbury Family Chiropractic! The following is a statement of our Financial Policy, which we require you to read and sign:

INSURANCE: As a courtesy, we may offer you an estimate for recommended treatment. All estimated patient portions and/or copays are due at the time of service. At any time, if you have questions regarding your insurance plan as it relates to your treatment, we will be happy to try and answer them to the best of our knowledge. However, we encourage you to refer to your benefits manual or policy customer service line if you have any questions about covered services. Please keep in mind your insurance is a contract between you and the insurance company. Your involvement in the process of providing us with proper information, and you being proactive in knowing your plan, will help to maximize your benefits to their full potential.

Our acceptance of insurance assignments does not absolve you of full responsibility for the treatment rendered. The estimate provided is to be considered a guideline until the final insurance payment is received and your account has been reconciled. The estimate is not a guarantee of insurance payment. If your plan has a reduced fee schedule or a provider network, it is your responsibility to be sure we are a participating (in-network) provider.

MINOR PATIENTS: Minors (under the age of 18) must be accompanied by a parent or legal guardian at their initial visit. The parent or legal guardian is responsible for the estimated patient portion and/or copays when treatment is rendered. The parent or legal guardian is required to notify our office of any changes in the minor's medical history prior to treatment.

DIVORCE DECREES: Our office is not party to divorce decrees. The parent or legal guardian who accompanies the minor at the appointment is responsible for payment of the estimated patient portion and/or copays.

COLLECTIONS AND RETURNED CHECKS: Accounts outstanding more than 90 days from treatment date will be transferred to a collections agency. A $30 service fee will be applied for checks that are returned for any reason.

MISSED APPOINTMENTS: We understand that at times it may be necessary to reschedule an appointment. If that need arises, we request that you call the practice on a business day, at least 2 hours in advance of the scheduled chiropractic appointment or you will be charged a $15 late cancellation fee. 24 hour notice is required for all massage therapy and acupuncture appointments. Unless canceled 24 hours in advance, a Late Cancel Appointment fee is charged to your account equal to 50% of the service fee. This fee is not covered by your insurance and will be your responsibility. Should a pattern of missed appointments be determined, future appointments may be impacted.

Patient Signature_____Date _____

Woodbury Family Chiropractic

Informed Consent for Chiropractic Care

I hereby give my consent to the performance of diagnostic tests and procedures and chiropractic treatment or management of my condition(s).
Chiropractic treatment or management of conditions almost always includes the chiropractic adjustment, a specific type of joint manipulation. Like most health care procedures, the chiropractic adjustment carries with it some risks. Unlike many such procedures, the serious risks associated with the chiropractic adjustment are extremely rare. Potential risks of chiropractic manipulation include:

- Temporary soreness or increased symptoms - It is not uncommon for patients to experience temporary soreness or increased symptoms or pain after the first few treatments.
- Dizziness, nausea, flushing - These symptoms are relatively rare. It is important to notify the chiropractor if you experience these symptoms during or after your care.
- Fractures - When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening disease or condition. If your chiropractor detects any such condition while you are under care, you will be informed and your treatment plan will be modified to minimize risk of fracture.
- Disc conditions - Spinal disc conditions like bulges or herniations may worsen even with treatment. It is important to notify your chiropractor if symptoms change or worsen.
- Stroke - According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care. A certain extremely rare type of stroke has been associated with chiropractic visits, though it is not caused by chiropractic care. While there is an association between this type of stroke and chiropractic visits, there is a greater association between this type of stroke and primary care medical visits. The increased occurrence of this type of stroke associated with both chiropractic and medical visits is likely explained by patients with neck pain and headache consulting both doctors of chiropractic and primary care medical doctors before or during their stroke.
- Burns - Other risks associated with chiropractic treatment include rare burns from physiotherapy devices that produce heat.
- Bruising - Instrument assisted soft tissue manipulation, such as Graston or cupping therapies, may result in temporary soreness or bruising.

• 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 chiropractor 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'S NAME (Print)_____ **DATE OF BIRTH**_____

_____ _____ _____ _____

(PATIENT | GUARDIAN SIGNATURE) **(DATE)** **(TRANSLATOR | INTERPRETER SIGNATURE)** (if applicable) **(DATE)**

CLINICIAN ONLY

Based on my personal observation and the patient's history, I conclude that throughout the informed consent process the patient was:

☐ OF LEGAL AGE ☐ APPEARS UNIMPAIRED ☐ CONSENT GIVEN THROUGH GUARDIAN ☐ INTERN PRESENT - INITIALS_____

☐ ORIENTED X3 ☐ FLUENT IN ENGLISH ☐ ASSISTED BY A TRANSLATOR OR INTERPRETER ☐ INTERN NOT PRESENT

_____, D.C. _____

(D.C. SIGNATURE) **(DATE)**

Woodbury Family Chiropractic

Non-Covered Services Form

While your policy covers some chiropractic services, there may be others that we feel would help the treatment of your condition and maintenance of good health, but are not covered or paid for by your health insurance policy. If you agree to receive these services, and they are later determined not eligible for reimbursement through your health insurance policy, your signature on this form signifies your agreement to pay for them in full.

Chiropractic services typically covered by health insurance policies include:

- Chiropractic manipulations for medically necessary care
- Treatment that has potential to significantly improve a clinical condition
- Limited treatment of symptom flare-ups or exacerbations where a permanent condition exists
- One unit of chiropractic therapeutic exercise or manual therapy in a region not also adjusted
- Ultrasound, decompression and acupuncture have variable coverage, policy depending

Your provider will only bill services to your insurance policy that they deem medically necessary to comply with network participation contracts. Services may <u>not</u> be eligible for reimbursement through your health insurance, or could be denied/retracted by your insurance provider. Unpaid insurance claims are your financial responsibility. Our reduced rates for non-covered services are outlined below. Patients will only be charged for services rendered.

Non-Covered Services	Cost Per Visit	Initials on ALL:
New Patient Exam 99201-99205/ Re-Exam 99211-99215	$50.90/$25.45	
Chiropractic Manipulation 12+ 98940/98941/98943	$59.04	
Chiropractic Manipulation under 12 98940/98941/98943	$48.86	
Chiropractic Manual or Exercise Therapy 97110/97140	$12.22	
Add-on 10-15min Custom Chiropractic Therapy	$45.81	
Add-on 8-10min Ultrasound Therapy 97135	$15.27	
Add-on 20min Acupuncture Spot or Cupping	$45.81	
Add-on Class IV Laser Therapy	$35.63/region	
Add-on Decompression Therapy 97012	$10.18	
Acupuncture Sessions 30/60/90	$50/$75/$115	
Massage Therapy Sessions 30/60/90	$50/$80/$115	
Cancellation fees (Acu/Massage, Chiropractic)	50% of service fee, $15/chiro visit	

- Patients billed amount may not, and will not, exceed the provider's usual and customary amount.
- All services & charges rendered are subject to MN Sales or Provider tax.
- Patients reserve the right to refuse services recommended at any point.
- Electing to attend services offered serves as agreement to this signed policy.

I acknowledge that I am signing this statement voluntarily, and that it is not being signed after the services have already been provided. I have had ample opportunity to ask questions about my liability and the provider/staff has answered them to my satisfaction. I understand that I have the right to refuse this care and that by signing this form, I will be fully responsible for the total billed charge(s) related to non-covered services.

Patient Name:_____ Signature:_____Date:_____

Guardian Name:_____Signature:_____Date:_____

Witness Name:_____Signature:_____Date:_____

Woodbury Family Chiropractic

Medical Necessity Policy

The following is a statement of our Medical Necessity Policy, which we require you to read and sign.

Insurance payers only cover care they deem 'medically necessary' and this can best be understood as coverage for a series of consecutive visits for rehabilitation of acute musculoskeletal pain or dysfunction conditions. They do not cover care that is intended for maintenance or wellness conditions. This is why it is important to follow the treatment plan your provider recommends so that you may get the insurance benefit and result you are covered for.

Insurance companies can and have selectively retracted payment for years of visits from our clinic when retrospectively deeming the care does not meet their standard of 'medical necessity'. As ethical practitioners, we would only bill insurance if we believed patient care was medically necessary. Unfortunately, insurance companies have the final say.

In an effort to continue to provide care to patients, without surprise bills on either side of the arrangement, we will no longer submit more than 20 chiropractic visits per year to an insurance policy. We have been told that billing beyond 20 visits, no matter the visit limit told to members, will result in our clinic being flagged and potentially audited. This is a risk we do not have the bandwidth to take on.

We do offer SELF-PAY rates for wellness and maintenance care that allow you to continue treatment at an affordable, discounted rate. We have pay as you go rates, as well as wellness memberships with member perks for these non-medically necessary visit types.

Please ask our staff or providers for more information on how you can save money on chiropractic care with our wellness care options. These visit types often can be submitted for reimbursement by HSA or flex spending accounts, though they are not billed with the same coding as medically necessary insurance visits.

Patient Signature_____Date _____

Woodbury Family Chiropractic

2025 Self Pay Price List

Chiropractic Focused Exam - $50

Chiropractic Adjustment (1-5 regions) - $58 (12+), $48 (under 12)

Adjustment Add-Ons:
+ Chiropractic Manual Therapy* (adds appointment time) + $45
+ Ultrasound Therapy +$15 per region
+ Laser Therapy +$35 first region, $20 additional regions
+ Decompression +$10
+ Spot Acu +$45

*Chiropractic manual therapy may include graston technique, kinesiotaping, active release technique (ART)/ muscle release technique, myofascial or craniosacral techniques, chiropractic massage and manipulation techniques

Chiropractic Re-Exam Intake Fee - $25 (applies after 6 months without a chiropractic visit)

Wellness Memberships

MOVE-WELL (Level 1) $89/mo (2 adjustments/month)
MOVE-FREE (Level 2) $159/mo (4 adjustments/month)

Membership Perks -
$5 OFF all therapy options (manual therapy, ultrasound, laser, massage (per 30min), acupuncture (per 30min)
10% OFF products
Bring family member add-on - $40/adjustment (all ages)

Massage Pricing:
$80/ 60min
$50/ 30min
$115/ 90min

Acupuncture Pricing:
$115 New Patient
$75 Full Session
$50 Spot Acu or Cupping
$45 Add Spot Acu to Chiropractic Visit
$115 Acupuncture & Bodywork

All prices subject to Mn Care Tax.

Woodbury Family Chiropractic
Custom Adjustments. Amazing Results