



New Patient Information

Name: _____ Date: _____
First Last MI

I prefer to be addressed as: _____ Birthdate: _____ Sex: M / F

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

Primary Phone: _____ Email: _____

Contact Preferences (circle): phone / e-mail / text How did you hear about us? _____

Occupation: _____ Employer: _____

Marital Status: Single / Married / Divorced / Widowed / Partnered Spouse/Partner Name: _____

Children? Yes / No How Many? _____ Preferred Language: _____

Insurance / Cash (Please Circle)

Insurance Name: _____ ID #: _____ Group #: _____ Copay? \$ _____

About Today's Visit

The reason for this visit: _____

Please describe pain and location: _____

When did it begin? _____ Is it getting worse? Yes / No / Constant / Inconsistent

Rate the pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (extreme) Nature: dull / achy / sharp / shooting / numb /

Does it interfere with your daily routine? Yes No If yes, please explain _____

Have you had similar symptoms in the past? Yes / No If yes, please explain _____

Have you been treated by a chiropractor previously? Yes / No How long ago? _____

Any additional information you would like to include? _____

Emergency Contact: _____ Phone: _____

Medical Doctor: _____ Phone: _____



ROOTED IN WELLNESS

CHIROPRACTIC

Health History

If you have had any of the following conditions, please circle:

- | | | | |
|--------------------|--------------------|--------------|-------------------------|
| Alcohol/Drug Abuse | Asthma | Epilepsy | High/Low Blood Pressure |
| Anemia | Cancer | Fainting | Psychiatric Issues |
| Arthritis | Cong. Heart Defect | Headaches | Seizures |
| Artificial Valves | Diabetes Type I/II | Heart Attack | Stroke |

Please list any medical conditions or surgeries you have had with dates: _____

Known Allergies: _____

Family Health History: _____

Please list medications and dosages: _____

Please list supplements/vitamins? _____

What is your typical exercise routine? _____

Are you on a special diet? Yes / No If so, what is it? _____

Do you smoke? Yes / No / Former smoker

For Women: Are you taking birth control? Yes / No

Are you having a regular cycle? Yes / No

Are you pregnant? Yes / No How far along? _____

Nursing? Yes / No

Birth Plan _____

Any complications with your pregnancy? _____

I understand the above information and have accurately completed it to the best of my knowledge. It is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ Date: _____

Records Release

Rooted In Wellness Chiropractic is authorized to release any information deemed appropriate concerning my physical condition, including diagnosis and records of treatment or examination, to my insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred.

Signature: _____ Date _____



Informed Consent for Chiropractic Care

PURPOSE OF CHIROPRACTIC CARE

Chiropractic care involves the science, art, and philosophy of detecting and correcting vertebral subluxations and other joint dysfunctions. The purpose is to restore proper alignment, reduce nerve interference, improve mobility, and promote the body's natural ability to heal.

NATURE OF CHIROPRACTIC PROCEDURES

The primary chiropractic technique utilized may include, but is not limited to, spinal adjustments, mobilization, manual therapy, physical modalities, rehabilitative exercises, and lifestyle recommendations. Chiropractic adjustments are usually performed by hand, but may also involve the use of instruments or specialized equipment.

RISKS ASSOCIATED WITH CHIROPRACTIC CARE

As with any healthcare procedure, there are potential risks. These may include but are not limited to:

Temporary soreness or discomfort, dizziness or nausea, aggravation of pre-existing symptoms, sprains/strains, rib fractures (rare), stroke or stroke-like symptoms (extremely rare).

Please inform your chiropractor immediately if you experience any unusual symptoms.

PATIENT RESPONSIBILITIES

It is important that you inform your chiropractor of any health conditions, medications, surgeries, or changes in your condition. You are encouraged to ask questions and seek clarification about any aspect of your care.

ALTERNATIVES TO CHIROPRACTIC CARE

Alternatives may include medical care, physical therapy, medications, or no care at all. You have the right to discuss these options with your chiropractor or seek a second opinion.

CONSENT TO TREAT

I have read or have had read to me the above explanation of chiropractic care. I have discussed it with my chiropractor and have had all my questions answered to my satisfaction. I understand the risks involved and give my consent to receive chiropractic care and related procedures.

I understand that I may withdraw my consent and discontinue treatment at any time.

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

X _____ X _____ _____
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.

Signature: _____ Date: _____



Notice of Privacy Practices

This notice describes how your medical information may be used and disclosed and how you can access this information.

Our Responsibilities

Your chiropractic provider is required by law to:
Maintain the privacy of your health information
Provide you with this Notice of Privacy Practices
Abide by the terms of this notice

Permitted Uses and Disclosures

We may use or disclose your health information for purposes such as:

Treatment: To provide, coordinate, or manage your care and services.

Payment: To obtain payment for services rendered from you, an insurance company, or a third party.

Healthcare Operations: For quality assessment, licensing, audits, and staff training.

Other Permitted Uses

Your information may also be used or disclosed for public health purposes, law enforcement, or as required by law.

Other uses will require your written authorization.

Your Rights Regarding Your Health Information

You have the right to:

Inspect and obtain a copy of your health record

Request an amendment to your health record

Request a restriction on certain uses or disclosures

Request confidential communications

Receive a paper copy of this notice

We will not use or disclose your health information without your written authorization except as described in this notice.

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received, reviewed, and understand the Notice of Privacy Practices for chiropractic care provided by the office named above. I understand that this notice describes how my health information may be used and disclosed, and how I can access my information. Any changes made to this notice must be presented to you. Our privacy officer is Dr. Kelsey Lloyd and concerns can be presented to her at (651) 447-8988.

I have read, understand, and agree to the HIPAA policies at Rooted in Wellness Chiropractic.

Signature: _____

Date: _____

I am opting not to sign this agreement for the following reasons:

Signature: _____

Date: _____



Financial Agreement

1. Workers' Compensation ("On-the-Job" Injury)

Workers' compensation typically covers chiropractic care in full. Once care has concluded, you are allowed a 3-month period for the settlement of your claim. If a settlement has not been reached within this time, the full balance for services rendered becomes due immediately.

2. Personal Injury / Automobile Accidents

If you are receiving care due to a personal injury or motor vehicle accident please provide all auto insurance documentation as soon as possible. If you are working with an attorney, inform the front desk immediately. While you are ultimately responsible for your bill, our office will defer payment until settlement is received as long as you are actively receiving care. If care is suspended or terminated, any outstanding charges are due immediately.

3. Group or Individual Health Insurance

Please understand that your insurance policy is a contract between you and your insurance company, not between the insurer and our office. As a courtesy we will file claims and complete insurance paperwork at no additional charge. Patients are responsible for all charges not covered by insurance, including deductibles, co-insurance, and any services denied. Our billing system calculates your estimated responsibility, and any overpayments will be refunded once insurance payments are finalized. Because coverage varies by plan, you will be responsible for:

- Your deductible (if applicable)
- Your co-pay or co-insurance percentage
- Any non-covered services

4. Patients Without Insurance (Cash Patients)

We welcome patients without insurance. 100% of the first visit is due at the time of service.

5. Medicare

We are enrolled Medicare providers. Medicare **only covers spinal manual manipulation** when medically necessary.

- Once your annual deductible is met, Medicare covers 80% of the allowable fee.
- You are responsible for the remaining 20%, unless covered by a secondary insurance.
- Services not covered by Medicare (e.g., exams, therapies) are your responsibility.
- Our office will file all Medicare claims on your behalf at no charge.

Acknowledgment and Agreement

I have read and/or have had the above financial policy explained to me. I understand and agree to the terms and conditions as outlined. I authorize this chiropractic office to bill my insurance and release necessary health information for claim processing. I accept financial responsibility for any outstanding balances.

Signature: _____

Date: _____