red river Chiropractic & WELLNESS

Welcome to Red River Chiropractic and Wellness!

Like our name says, we are both a chiropractic office and wellness center. In order to serve you best and help you reach your health goals; we want to understand your needs and wishes. We actually want to exceed your expectations! Your health is truly your greatest wealth. Because so many people today are struggling with a number of health problems and on medications they'd rather not be on, we've added personalized wellness and lifestyle programs to help people overcome and reverse a number of health issues such as:

- Excessive weight/belly fat
- Blood sugar problems/Type II Diabetes
- Fatigue
- Thyroid issues
- Inflammation
- Anxiety/depression
- Digestion/heartburn issues
- Hormonal issues

We actually offer a free weekly 60-minute talk entitled, "Stress, Hormones and Health" for people interested in learning more.

How can we best serve you? Please check the appropriate line.

_____ I'm here only for chiropractic care for my musculoskeletal complaint (neck, back, headaches, hip, shoulder, knees, etc.)

_____ I'm here to improve my overall health through a wellness program

_____ I'd like to learn more about how a wellness program could help me

_____ I'd like to hear what the doctor would recommend for me

Chiropractic Case History/Patient Information

Date: _____ Doctor: Jorgensen

Name: _____ Social Security # _____

Address: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

E-mail Address: _____

Age: _____ Birthdate: _____ Marital Status (circle): M S W D

Name of Nearest Relative: _____ Phone: _____

How were you referred to our office? _____

Family Medical Doctor: _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? _____

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

Patient's Name _____ **Date** _____

History of Present and Past Illness:

Purpose of Appointment/Chief Complaint _____

Date symptoms began/accident happened _____

Is this from an auto or work accident? If yes, please specify _____

If you ever had the same or similar condition before please describe _____

_____

If you have missed work how many days _____ Date of last physical exam _____

Do you have a history of strokes or hypertension? Yes No

List any major illnesses, injuries, falls, auto accidents and surgeries. If you are a woman please include childbirth information including dates: _____

_____

Medications you are currently taking _____

_____

If you have any allergies to medications please describe _____

Allergies you suffer from _____

Please describe any congenial condition(s) you have _____

_____

Women, are you currently pregnant? _____

Please list anything you would like the doctor aware of: _____

_____

_____

_____

DOCTOR _____

DATE OF VISIT ___/___/20___ Patient_____ Age_____

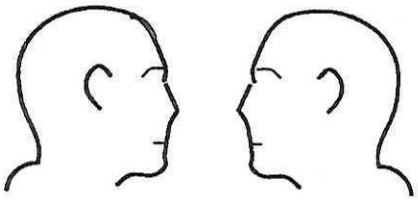
Check ONE: _____INITIAL EXAMINATION _____ RE-EVALUATION _____ NEW CONDITION

FOR INITIAL EXAMINATION OR NEW CONDITION, Please give first date you noticed symptoms _____

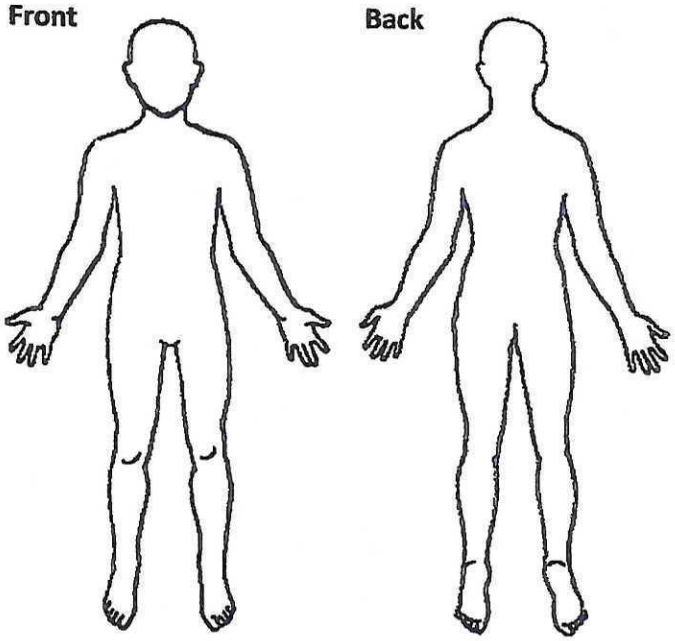
FOR INITIAL EXAMINATION OR NEW CONDITION, What is your major complaint? _____

SUBJECTIVE PAIN ASSESSMENT

Right **Left**



Front **Back**



RATE YOUR PAIN

Place an "X" on the drawings to the left wherever you have pain. Beside the "X" indicate the type of pain you are experiencing:

A=Ache
B=Burning
ST=Stabbing
SP=Spasm
N=Numbness
P=Pins and Needles
T=Throbbing

(Example: XST between your shoulders mean you have stabbing pain between your shoulders)

PAIN SCALE: Please circle the number that best describes your overall pain:

0 1 2 3 4 5 6 7 8 9 10 10+

NONE LITTLE MEDIUM SEVERE EXCRUCIATING

PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE **DATE**

_____

Patient's Name _____ **Date** _____

If you currently have any of the following mark with the letter "N"

If you had any of the following in the past mark with the letter "P"

Headaches		Loss of Balance		Breathing Problems	
Neck Pain		Fainting		Fatigue	
Stiff Neck		Loss of Smell		Lights Bother Eyes	
Back Pain		Loss of Taste		Ears Ringing	
Sleeping Problems		Unusual Bowel Patterns		Broken Bones/Fractures	
Nervousness		Cold Hands		Rheumatoid Arthritis	
Tension		Cold Feet		Excessive Bleeding	
Irritability		Arthritis		Osteoarthritis	
Chest Pains/Tightness		Muscle Spasms		Pacemaker	
Dizziness		Frequent Colds		Stroke	
Shoulder/Neck/Arm Pain		Fever		Ruptures	
Numbness in Fingers		Sinus Problems		Eating Disorder	
Numbness in Toes		Diabetes		Drug Addiction	
High Blood Pressure		Indigestion Problem		Gall Bladder Problems	
Difficulty Urinating		Joint Pain/Swelling		Ulcers	
Weakness in Extremities		Menstrual Difficulties		Weight Loss/Gain	
Depression		Loss of Memory		Coughing Blood	
Circulation Problems		Seizures/Epilepsy		Low Blood Pressure	
Osteoporosis		Heart Disease		Cancer	
Alcoholism		HIV Positive			

Please indicate beside each activity whether you engage in it by:

Often – "O" Sometimes – "S" Never – "N"

Vigorous Exercise		Family Pressures	
Moderate Exercise		Financial Pressures	
Alcohol Use		Mental Stresses	
Drug Use			
Caffeine Use			

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Preauthorization: Some insurance companies require a preauthorization prior to treatment. Failure to obtain preauthorization may result in your insurance company refusing to pay said claim. Any refusal of payment by insurance for this reason is the patient's responsibility.

Medical Assistance (Medicaid): Presentation of member ID card must be made at time of service and any changes in the benefits must be provided prior to further services being rendered. If the patient is not eligible at the time of service, he/she will be responsible for the charges at the time of service. It is the patient's responsibility to know any/all limits of their insurance benefits. We file Medicaid claims for the state of North Dakota only. Medical Assistance issued from any other state must be filed by the patient. The patient will also be responsible for payment of services to Red River Chiropractic and Wellness.

Self-Pay: All self-pay patients will be responsible for any/all charges for services rendered at the time of service unless prior payment arrangements have been made.

Statements: Statements will be emailed and/or mailed out monthly. You will then have 10 business days to make a payment or contact Red River Chiropractic and Wellness about setting up payment arrangements.

Attestation Statement:

I have read, understand and agree to the above Red River Chiropractic and Wellness payment policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles are my responsibility. I acknowledge that these policies do not obligate Red River Chiropractic and Wellness. I authorize my insurance benefits to be paid directly to Red River Chiropractic and Wellness.

I authorize Red River Chiropractic and Wellness to release pertinent medical information to my insurance company when/if requested or to facilitate payment of claim.

_____ _____ _____

Name (Print) Signature Date

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Notice for Medicare Patients

Medicare and Medicare supplement insurance will **Not** pay for your initial exam or any x-rays. They will pay for spinal adjustments only.

Our policy requires payment at the time of service. Below are the charges to be expected:

-Initial Exam Fee: $77.00

-Cervical X-Ray: $72.00

-Lumbar X-Ray: $78.00

_____

Print Name of Patient

_____ _____

Patient Signature Date