

Cornerstone Chiropractic & Wellness

507 N Nokomis St. Ste. B

Alexandria, MN 56308

(320)762-2639 phone

(320)762-2650 fax

contact@cornerstonealexandria.com

New Patient

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number(s) Main: _____ Cell: _____

Is it O.K. to contact you at work? Yes No (Work): _____

E-mail Address: _____

SSN _____ Birthdate: _____

Marital Status: Single Married Other

Emergency Contact Name: _____

Relationship: _____ Phone number(s): _____

Financial Responsibility

Who is responsible for payment? _____

How will you pay for your care? _____

Insurance Co.: _____ Group Policy # _____

Address: _____ Phone # _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Relation: _____ Policy Holder's Employer: _____

What brings you here?

Have you ever had chiropractic care before? Yes No

If yes, please tell us the doctor's name or facility: _____

How did you find out about our office? _____

Is this appointment related to: Work Sports Auto Personal Injury Other?

When did the pain occur? _____

Are you receiving care from other health professionals? Yes No

If yes, please name them and their specialty.

Please list any drugs or medications you are taking.

Please list any vitamins/herbs/homeopathic/others you are taking.

Are you pregnant? Yes No If yes, what month? _____

Current Health

What are your most pressing health concerns?

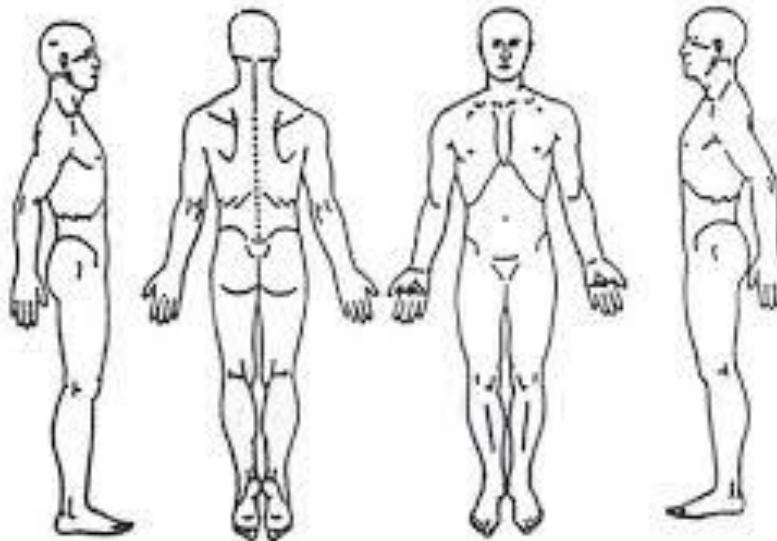
For how long? _____

Is it: Getting worse Improving Intermittent Constant Can't say

Where is the problem? Please use the illustrations and lines below to explain.

Front _____

Back _____



Ankle Swelling
Cold Extremities
Blurred Vision
Vision Problems

Breast Pain/Lump
Cramps
Painful Urination
Bladder Trouble

Dizziness
Loss of Sleep
Difficulty Hearing
Ear Pain

If applicable, date of last menstrual period: _____

Past injuries can affect present health. *(please circle all that apply)*

Fall/Accident	Head Injuries	Fights	Sports injuries	Broken Bones
Dislocations	Spinal Tap	Surgery	Traction	Use(d) Cane
Use(d) Walker	Extensive Dental Work	Dental Appliances	Knocked Unconscious	

If yes to any of the above, please describe.

Are there other health concerns or anything else you'd like us to know about you?

Yes No If yes, please tell us.

The above is accurate to the best of my knowledge.

(Signature)

(Date)

I, parent/guardian, give permission for minor's care.

(Signature)

(Date)

Credit Policy and Patient Responsibility

Thank you for choosing Cornerstone Chiropractic & Wellness. We are committed to your treatment being successful. Please understand that prompt payment of your bill is considered part of your treatment plan. We have put together the details of our Credit and Financial Policies below. Please read carefully and sign below to begin treatment.

All patients complete our information and insurance forms.

Copays are due at time of service.

For your convenience, we accept cash, check, Visa, MasterCard, and Discover.

We offer massage therapy and chiropractic cash plans. **Payment is due at time of service.**

We offer a time of service discount which must be paid at time of treatment, if no payment is made you will be billed insurance prices per law.

We offer payment plans with prior credit approval and signed agreement.

Patient with Insurance coverage

We may accept assignment of insurance benefits at first visit. However, we do require your copayments be paid at the time of the service. The balance incurred is your personal responsibility whether your insurance company pays or not. Coverage amounts vary from policy to policy. You understand that your insurance policy is a contract between you and your insurance company. This office holds no party to that contract and will not be held responsible in the event that your insurance denied any claim. *If no insurance is presented at the first visit or you do not keep the office updated, we are not responsible for keeping track for you and we are not responsible for resubmission.*

Usual and customary rates

Our practice is committed to providing the best treatment for our patients. We charge what is usual and customary for our area. You are responsible for all usual and customary charges, regardless of what your insurance company's arbitrary discrimination of usual and customary rates.

Delinquency

In the event your account becomes past due and is referred to an outside collection agency or attorney you will be responsible for the collection costs, along with reasonable attorney fees and court costs incurred by this office.

I have read and understand Cornerstone Chiropractic & Wellness credit and financial policy with the respect to payment on my account.

Patient Signature _____ Date _____

Patient Consent

TO OUR PATIENTS: Please read and sign the form below. Ask questions if there is something you do not understand. **Please check to indicate approval:**

____ RELEASE OF MEDICAL RECORDS FOR MY MEDICAL CARE OR AS REQUIRED BY LAW:

- To healthcare providers directly involved in my care.
- To State, Federal and accrediting bodies for required reporting data and/or surveys for compliance.
- For purposes of my care and for business operations.

NOTE: records are not automatically sent to your physician. They must be requested.

____ ASSIGNMENT OF BENEFITS/BILL MY INSURANCE:

- I authorize Cornerstone Chiropractic & Wellness to send my bills for my medical care and treatment to my insurance company and/or Medicaid for payment, to extent my insurance company and/or Medicare or Medicaid ID required to pay the bill under terms of my insurance policy or by law.
- I request that my insurance company and/or Medicare or Medicaid pay Cornerstone Chiropractic & Wellness and the providers who are involved in my treatment.
- I consent to the release of my medical records by Cornerstone Chiropractic & Wellness to my insurance company and/or Medicare or Medicaid (and organizations working on their behalf) if necessary I order for my bills to be paid.
- I agree to pay for charges not covered by my insurance.
- **I understand that if I do not check this box Cornerstone Chiropractic & Wellness will send a bill directly to me for payment.**

____ RELEASE OF MEDICAL RECORDS FOR MEDICAL OR SCIENTIFIC RESEARCH:

- I agree that my records may be used by Cornerstone Chiropractic & Wellness for medical scientific study.
- No information which can identify me as a patient or participant in any such study will be shared.
- I may revoke this in writing at any time.

By signing this form, I consent and authorize my medical health provider to assess and treat me. I understand that my provider is available to explain the purpose or treatment, and that I have the right to refuse recommended treatment. I understand I have the right to revoke this consent, in writing, at any time except where Cornerstone chiropractic & Wellness had already made disclosures in reliance to the consent.

I consent to the treatment(s) provided by this clinic. I understand that my condition may necessitate medications from time to time due to the type of treatment(s) rendered and the portions of my body that may need to be examined. I understand and consent to clinic staff providing me with verbal descriptions, when there are changes to my exam(s) and treatment(s), consent to the clinic staff providing said treatment(s) and exam(s) and hereby consent to any similar subsequent treatment(s) or exam(s). If I do not consent, I will immediately inform clinic staff. There are times when individuals other than staff may see me receiving treatment at the clinic or overhear discussions of my conditions or insurance. I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff.

Patient Name: _____ Date: _____

Patient/guardian Signature: _____ Date: _____

If applicable, patient's relationship to guardian: _____

Check only if applicable (one-time acknowledgment)

____ I acknowledge that I have been offered a copy of Cornerstone Chiropractic & Wellness Privacy Practices Information. If I would like a copy in the future, I will ask for one.