HEALTHWISE
CHIROPRACTIC

HealthWise Chiropractic
10731 W. Forest Home Ave
Hales Corners, WI 53130
p: 414.529.4600
f: 414.529.4689

New Patient Intake Form

Name | Age | Date of Birth

Address | City | State | Zip

Home Phone ( ) | Work Phone ( ) | Email

Sex ☐ Male ☐ Female

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Employment Status ☐ Full-time ☐ Part-time ☐ Retired ☐ None

Student ☐ Full-time ☐ Part-time

Employer Name | Occupation

Past History

Date of last physical exam ___ / ___ / ______

Serious Illnesses? When?

What operations have you had? When?

Have you ever suffered from:

☐ Allergies ☐ Anemia ☐ Arthritis ☐ Asthma ☐ Backaches
☐ Cancer ☐ Diabetes ☐ Digestive Disorder ☐ Dizziness ☐ Headaches
☐ Heart Trouble ☐ Nervousness ☐ Neuritis ☐ Numbness ☐ Rheumatic Fever
☐ Sinus Trouble ☐ Tuberculosis

Present History

Purpose of this appointment:

When did this condition begin? What caused it?

Have you ever had this problem before? If yes, please explain.

Have you ever received any treatments for this condition? If yes, what was the result?

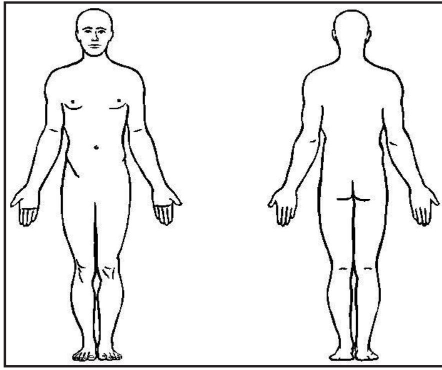
Has the problem been:
☐ Getting better ☐ Getting worse ☐ Staying the same (check one)

In what way has this condition affected your Home Life?

In what way has this condition affected your Occupational Life?

In what way has this condition affected your Recreational Life?

In what way has this condition affected your Rest and Sleep Life?



Please complete the diagram to the left by marking areas of pain.

Describe the areas of pain:

Insurance Information

Relationship to Insured

☐ Self ☐ Spouse ☐ Child/Dependent

Insured/Responsible Party (Fill out only if other than self)

Name	Date of Birth

Name of Employer

How did you find out about us?

Check all that apply

Internet
__ Google
__ Facebook
__ Healthwiseinfo.com

Print Advertisements
__ Boomers
__ Yellow Pages
__ Newspaper Ad

People
__ Friend or Family Member
Who? ___________________
__Doctor or Health Professional
Who? ____________________

Other
__ Saw the sign out front
__ Stan's Fit for your Feet

__ Health Festival or Event
Which Event? _______________________
__ Crossfit
__ My First Peekaboo
__ Insurance Listing
__ Church
Which Church? _____________________
__ Other ____________________________

Patient Responsibility Regarding Insurance Claim

"In some cases, HealthWise Chiropractic's fees are not covered, in full, by your insurance company. We want our patients to be aware of the fact that under any circumstance, the patient is personally responsible for any balance due after the insurance payment. HealthWise Chiropractic expects full payment within 30 days upon receipt of your statement. Any unpaid balance after 30 days will be charged 1.5% interest until all unpaid balances are paid in full. This balance due includes provisions set by your insurance company, such as: co-payments, co-insurance, deductibles, and "usual and customary" allowances. The policy held by you or your employer is a contract between the policyholder and the insurance company. HealthWise Chiropractic, S.C. does not accept insurance companies as patients. You are the patient!"

The above statement has been provided in the hope of minting good communication and understanding between the physician and the patient. If you have any questions regarding our fees, please feel free to contact our Business Manager at (414) 529-4600.

If you are not familiar with your insurance coverage, we ask that you discuss your policy with your employer or insurance company before charges are incurred. We will be happy to complete any insurance forms for you. If your insurance requires a specific claim form, please bring the form in so that we can submit the claim properly.

I, the undersigned, have read and fully understand the above statement. My signature authorizes release of medical information to my insurance company, as well as assignment of benefits to HealthWise Chiropractic, S.C.

______________________	__________	______________________	__________
(Patient's Signature)	(Date)	(Guardian or Responsible Party's Signature)	(Date)

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10731 W Forest Home Ave
Hales Corners, WI 53130

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:____________________________ **Last Name:**____________________________

Email address: ___________________@___________________

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** ______________

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): ___________________

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Family Medical History (Record one diagnosis in your family history and the affected)

Diagnosis	Father	Mother	Sibling (i.e. Sister)	Offspring
Example: Heart Disease		*X*		

Are you currently taking any medications? (Please include regularly used over the counter medications)***(NOTE: If you do not know the name, dose AND frequency of your medications, please leave this area blank until you can report complete information.)***

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: ____ Date: __________________

For office use only

Height: __________ Weight:_____________ Blood Pressure:_______ /_______

Informed Patient Consent

I understand that, if accepted as a patient of:

HealthWise Chiropractic, S.C.

I am authorizing them to:

- Proceed with any further treatment that may be necessary.
- Provide treatment in an open concept room where I acknowledge that information regarding my personal health may inadvertently be overheard or seen by other staff and patients.

I understand that I may make the following requests:

- To have any risks involving my treatment explained to me
- To have an appointment for a private consultation.

____
(Patient Name – Print)

______________________________________ ________________
(Patient or Representative Signature) (Date)

HealthWise Chiropractic

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We* are required by law to protect the privacy of any health information we collect about you. We are also required to give you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights about your health information that are described in this notice.

The terms "information" or "health information" in this notice include any personal information that is created or received by a health care provider that relates to your physical or mental health or condition, the provision of health care to you, or the payment for such health care.

We have the right to change our privacy practices. If we do, we will provide the revised notice to you within 60 days by direct mail or post it on our website: www.healthwiseinfo.com

How we Use or Disclose Information

We must use and disclose your health information to provide information:

- To you or someone who has the legal right to act for you (your personal representative);
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure you privacy is protected; and
- Where required by law.

We have the right to use and disclose health information to pay for your health care and operate our business. For example, we may use your health information:

- **For Payments** due us and to process claims for health care services you receive.
- **For Treatment**. We may disclose health information to our staff and other health providers to help them provide health care to you. For example, your chiropractor may share treatment notes with your physical therapist.
- **For Health Care Operations**. We may use or disclose health information as necessary to operate and manage our business, and to help manage your health coverage. For example, we might use your personal health information for staff training, administrative monitoring of our systems, to collect insurance payments or to call you to remind you of an appointment.
- **To Provide You With Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health related products and services.
- **To Plan Sponsors**. If your coverage is through an employer group health plan, we may share the summary health information and enrollment and disenrollment information with the plan sponsor.

In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restriction on its use and disclosure of the information.

- **Appointment Reminders**. We may use health information to contact you for appointment reminders.

- **Provider Schedule**. We may use personal information to identify where you are located in the facility. We may disclose this information to persons asking for you by name. If you do not want this information disclosed you must notify Carol Carpenter at 414-529-4600.

We may use or disclose your health information for the following purposes under limited circumstances:

- **To Persons involved with your care**. We may use or disclose your health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when permitted by law.
- **For Public Health Activities** such as reporting disease outbreaks.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities, including a social service or protective service agency.
- **For Health Oversight Activities** such as governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes** such as providing limited information to locate a missing person.

- **To Avoid a Serious Threat to Health or Safety** by, for example, disclosing information to public health agencies.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Worker's Compensation** including disclosures required by state workers' compensation laws of job-related injuries.
- **For Research Purposes** such as research related to the prevention of disease or disability, if the research study meets all privacy law requirements.
- **To Provide Information Regarding Decedents**. We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.

If none of the above reasons applies, **then we must get your written authorization to use or disclose your health information**.

In compliance with Wisconsin State Law that is more stringent than the federal Health Insurance Portability and Accountability Act (HIPAA) we will get your written authorization:

- To disclose any alcohol and drug abuse information
- To disclose any HIV/AIDS related information
- To disclose any mental health information
- To disclose any abuse related information.

What Are Your Rights

The following are your rights with respect to your health information.

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your care**. Please note that we will try to honor your request however we are not required to agree to any restriction**.

- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. box instead of your home address).
- **You have the right to see and obtain a copy** of health information that may be used to make decisions about you such as claims and health records. You may also receive a summary of this health information. You must make a written request to inspect and/or obtain a copy your health information. In certain limited circumstances, we may deny your request to inspect and copy your health information.
  HealthWise Chiropractic Charges a reasonable cost for the provision of the requested information.
- **You have the right to ask to amend** information we maintain about you if you believe the health information about you is wrong or incomplete. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to a paper copy of this notice**. You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website: www.healthwiseinfo.com
- **You have the right to receive an accounting** of disclosures of your information made by us during the six years prior to your request. The request for an accounting must be made in writing to Carol Carpenter, 10731 W. Forest Home Ave., Hales Corners, WI 53130. The request must specify the time period for the accounting not prior to April 14, 2003 and not to exceed the past six (6) years. Accounting requests will be subject to a reasonable cost -based fee. This accounting will not include disclosures of information: (i) made prior to April 14, 2003; (ii) for treatment, payment, and health care operations purposes; (iii) to you or pursuant to your authorization; and (iv) to correctional institutions or law enforcement officials; and (v) other disclosures that federal law does not require us to provide an accounting.

- **HealthWise Chiropractic will not sell your Personal Health Information.**

Exercising Your Rights

- **Contacting your Health Provider**. If you have any questions about this notice or want to exercise any of your rights, please call Carol Carpenter at: 414-529-4600.
- **Filing a Complaint**. If you believe your privacy rights have been violated, you may file a complaint in writing with our privacy officer at the following address:
  HealthWise Chiropractic
  Attn: Privacy Officer, Carol Carpenter
  10731 W. Forest Home Ave.
  Hales Corners, WI 53130

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.

Effective April 14, 2003
Revised February 28, 2014

**For purposes of this Notice of Privacy Practices, "we" or "us" refers to HealthWise Chiropractic.*

HEALTHWISE
CHIROPRACTIC

Acknowledgement & Consents
Marketing Authorization

I acknowledge that I have received a copy of the HealthWise Chiropractic Notice of Privacy Practices and hav given an opportunity to review and understand it. The notice brochure describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of health care operations. The notice brochure also describes my rights and the duties of HealthWise with respect to my protected health information.

X ____ Date_______________
Patient or Representative Signature

I **consent** to allowing HealthWise Chiropractic to use and or disclose my Protected Health Information in compliance with their policies as indicated in their Notice of Patient Privacy Practices.

Print Patient Name:____

Print Name of Personal Representative (if applicable): ____

X ____ Date:_____________
Patient or Representative Signature

I give permission for my personal health information TO BE RELEASED to my immediate family (spouse, children, and/or parents) upon their request.

X____ Date:_____________
Patient or Representative Signature

I **authorize** HealthWise Chiropractic to use my health information (name, address, date of birth, etc) for direct mail marketing purposes. I am willing to receive mail from HealthWise such as birthday cards, patient newsletters, and information on upcoming events and promotions. I am willing to have my name on the referral board when I refer new patients to HealthWise.

I understand that I am under no obligation to sign this form and that HealthWise may not condition my treatment or payment eligibility for health care services based on my decision to sign this authorization. I know that I may withdraw this authorization at any time by notifying the front desk receptionist.

X____ Date:_____________
Patient or Representative Signature

For Office Use Only

If a patient refuses to sign the **acknowledgement** that they received the Privacy Notice:

1. Complete the following:

We attempted to obtain written acknowledgement of receipt of our Notice of Health Information Privacy Practices, but acknowledgement could not be obtained because of the following reason(s):

Individual refused to sign ______ (front desk initials) ________________________________ (doctor signature)
Communication barriers prohibited us from obtaining acknowledgement
An emergency situation prevented us from obtaining acknowledgement
Other; (please specify) ____

2. Notify the provider prior to the patient being seen and give the provider this form
3. Flag the patient computer file "XDENIED" month/year in the driver's license field.

For Office Use Only

If a patient refuses to sign the **consent** to use and or disclose PHI:

1. Complete the following:

We attempted to obtain written consent to use and disclose PHI in accordance with our Privacy Policies but the consent could not be obtained because of the following reason(s):

Individual refused to sign ______ (front desk initials) ________________________________ (doctor signature)
Communication barriers prohibited us from obtaining consent
An emergency situation prevented us from obtaining consent
Other; (please specify) ____

2. Notify the provider prior to the patient being seen and give the provider this form
3. Flag the patient computer file "XDENIED" month/year in the driver's license field.

For Office Use Only

- If a patient signs the HIPAA **acknowledgement, consent and marketing authorization** then flag the patient computer file **"MHIPAA"** month/year in the patient computer file.

- If a patient signs the HIPAA **acknowledgement and consent but not the marketing authorization** then flag the patient computer file **"XHIPAA"** month/year in order to prevent any marketing communications being sent to the patient.