HEALTHWISE
CHIROPRACTIC

Steps for your appointment:

1) Please fill out all New Patient forms in their entirety.
2) Please arrive on time.
3) We require a 24-hour notice to change or cancel your appointment.
4) All consultation deposits, exam fees, re-exams fees, and services rendered by HealthWise Chiropractic are non-refundable. Administrative fees maybe applied for the use of staff and physician time.

HEALTHWISE CHIRORACTIC
10731 W. Forest Home Ave.
Hales Corners, WI 53130
414.529.4600

Note: *If these steps are not followed it may compromise the full value of your consultation and therefore we will kindly reschedule your appointment.*

I understand and agree that, by completing and signing the new patient paperwork, that the consultation deposits, exam fees, re-exam fees, and services rendered by HealthWise staff and physicians are non-refundable. I understand that administrative fees may be applied for the use of staff and physician time.

Patient, Guardian, or Responsible Party's Signature: _____

Print Patient Name: _____ Date: _____/_____/_____

HEALTHWISE
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CONTACT INFORMATION

Legal Name: _____

Address: _____ City: _____ State_____ ZIP _____

Cell Phone: (_____)_____ Home/Work Phone: (_____)_____

Email: _____ Date of Birth: _____/_____/_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

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

Occupation: _____ Employer: _____

Referred to our practice by: _____

PERSONAL HISTORY

Date of last physical exam _____/_____/_____

Present MD: _____

City, State: _____

What accidents or recent trauma have you experienced? When did these occur?

_____

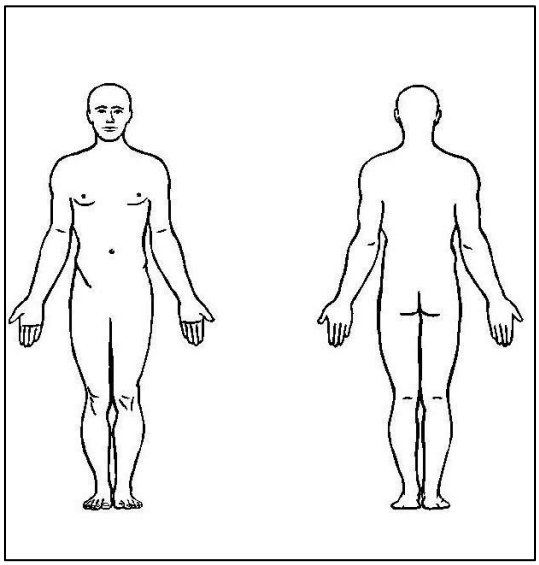
_____

_____

What surgeries have you had? When? _____

_____

_____



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

Describe the area(s) of pain or discomfort:

1)_____

_____

2)_____

_____

3)_____

_____

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 hear about us? (Check all that apply)
Internet: ☐ Google ☐ Facebook ☐ Healthwiseinfo.com ☐ Other: _____
Print Advertisement: ☐ Boomers ☐ Yellow Pages ☐ Newspaper Ad
People: ☐ Friend ☐ Family Member ☐ Doctor or Health Professional
Name of the individual who referred you: _____
Other: ☐ Saw the sign out front ☐ Stan's Fit for your Feet ☐ Health Festival or 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 and 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 maintaining 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)

INITIAL CONSULTATION

Name: _____ **Date:** _____/_____/_____

How long have you suffered with this problem? _____

Would you like improvement with any of the following?
☐ Digestion: Reflux, Gas, Constipation
☐ Sleep: Falling asleep or staying asleep
☐ Sense of Well Being
☐ Energy

What have you tried doing to resolve this problem that DID NOT work?

_____

_____

Have you seen other doctors for this condition? ☐ Yes ☐ No

Explain: _____

Is your condition due to an Employment Related Injury? ☐ Yes ☐ No

Is your condition due to an automobile accident? ☐ Yes ☐ No

How does this problem interfere with the following areas in your life?

Work: _____

Family: _____

Hobbies: _____

Life: _____

Do you know how this problem may have started? _____

_____

What is the purpose of your visit?
☐ Resolve my immediate problem
☐ Improve my lifestyle
☐ Both
☐ Other: _____

How have you taken care of your health in the past?
☐ Medication
☐ Routine medical
☐ Exercise
☐ Diet and Nutrition
☐ Holistic
☐ Vitamins
☐ Chiropractic
☐ Other: _____

HEALTHWISE CHIROPRACTIC

HealthWise Chiropractic
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: ☐ Email ☐ Phone ☐ Text

DOB: ____/____/_____ **Gender:** ☐ Male ☐ Female **Preferred Language:** _____

Smoking Status: ☐ Every Day Smoker ☐ Occasional Smoker ☐ Former Smoker ☐ Never Smoked

Smoking Start Date (Optional): _____

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

Ethnicity (Check one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I Decline to Answer

Are you currently taking any medication? (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: _____/_____

FAMILY HISTORY

Name: _____ **Date:** _____/_____/_____

Please review the conditions listed below and indicate those that are current health problems of a family member by the designation “C” under his or her column. The designation “P” should be used to indicate a past problem. Leave blank the spaces that do not apply.

Condition	You	Father	Mother	Spouse	Children	
	Age	Age	Age	Age	Age	Age
Allergies						
Anxiety						
Asthma						
ADHD						
Back trouble						
Bed wetting						
Cancer						
Colic						
Constipation						
Depression						
Diabetes						
Disc problems						
Ear infections						
Emotional issues						
Emphysema						
Epilepsy						
Headaches						
Heart trouble						
Heart burn						
High BP						
IBS						
Indigestion						
Infertility						
Insomnia						
Kidney trouble						
Neck pain						
Nervousness						
Obesity						
Pacemaker						
Pinched nerve						
Prenancy						
Scoliosis						
Sinus trouble						
Other:						

Do you have any metal implants in the body, including joint replacements, plates, screws, or rods?
☐ Yes ☐ No If yes, where? _____

Additional Comments: _____

_____

HEALTHWISE CHIROPRACTIC, S.C.
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.

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

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 we 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 your 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. Such billing and collection activities may include disclosure of PHI (personal health information) to a healthcare clearinghouse in connection with processing claims.
- **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 Vicki Greggs 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 about 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 Workers' 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 Sate 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

How We Use or Disclose Information

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 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 of your health information. *HWC 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 anytime. Even if you have agreed to receive this notice electronically, you are still entitled to a hard 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 Vicki Greggs, 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.*
- **HWC will not sell you 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 Vicki Greggs 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 Chiropractor, S.C.
Attn: Privacy Officer, Vicki Greggs
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 April 15, 2010

HEALTHWISE
CHIROPRACTIC

Acknowledgement & Consents
Marketing Authorization

I acknowledge that I have received a copy of the HealthWise Chiropractic, S.C. Notice of Privacy Practices and have been 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 HWC with respect to my protected Health information.

_____ _____/_____/_____
Patient or Representative Signature Date

I consent to allowing HealthWIse Chiropractic, S.C. 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): _____

_____ _____/_____/_____
Patient or Representative Signature Date

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

_____ _____/_____/_____
Patient or Representative Signature Date

I authorize HealthWise Chiropractic, S.C. to use my health information (name, address, date of birth, etc.) for direct mail marketing purposes. I am willing to receive mail and email 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.

_____ _____/_____/_____
Patient or Representative Signature Date

HEALTHWISE
CHIROPRACTIC

Informed Patient Consent

I understand that if I am 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- Please Print

_____ _____/_____/_____
Patient or Representative Signature Date