Welcome to our office

Schupp Chiropractic & Sports Injury
2110 Fordem Ave.
Madison, WI. 53704
(608) 244-7447

Patient Information

Name: ____ Today's Date:______/________/_______
First M.I. Last

Address:______________________________ City____________________ State_______ Zip___________

Sex: ❑F ❑ M Marital Status : ❑Married ❑Single ❑Widow ❑Divorced ❑Partner Number of children_____

Birth date:_____/______/_______ Age:________ Phone(_______)_________________________

Email Address:____@_____________________

Your employer: ________________________________ Occupation:______________________________

Work address:____

Spouse/ Partner / Parent name:_________________ Employer:_____________________ Work phone:______________

Person to contact in an emergency:____________________________ Phone: (_____)___________________

How did you select our clinic? ❑ Newspaper ❑Phone book ❑ Location ❑TV ❑ Insurance Plan Provider ❑ Mailer

❑ Attorney Referral ❑Family/friend/co-worker referral ____

Financial arrangements

This visit is due to: ❑Auto accident ❑Work accident ❑Other injury ❑Unknown cause ❑Sports Injury

Who is responsible for your bill: (Several may apply) ❑Self ❑Workers-Comp. ❑Medical assistance ❑Medicare

❑Auto Accident □Other insurance____

Your health insurance company:____

Address____

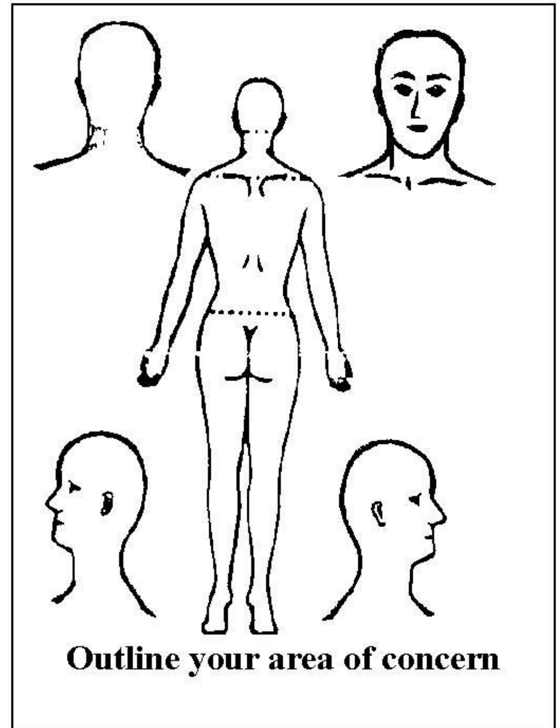
ID # ___________________________Group #__________________

Current Symptoms

Patient Name: ______________ Date: ______________

Reason for visit:____

____



Date of accident/injury:______/______/_______

When did you first notice symptoms? _________________

Is the problem: ❑Improving ❑ Constant ❑ Getting worse?

Is the problem: ❑ Mild ❑Moderate ❑Severe?

Have you seen other doctors for this condition? ❑ Yes ❑ No
Name and address of other doctors seen for this **current** condition:

____

____

Type of treatment: ________________________________

Results: ____________________________________

Have you ever had this condition before? ❑ Yes ❑ No When? ______________________________

List other conditions and doctors that have treated you in the **past**:______________________________

____

Have you ever received previous chiropractic care? ❑ Yes ❑ No When?________________________

Doctors Name?____

Health History

List all Surgery/Operation dates____

____

Accidents and injuries in the past:____

Hospitalizations:____

List all medications you are currently taking: ❑Pain killers' ❑ Antibiotics ❑ Insulin ❑ High blood pressure

❑ Anti-depressants ❑ Muscle relaxants ❑ Birth control pills ❑ Other______________________

(Women) Are you currently pregnant? ❑ Yes ❑ No Is there any possibility that you may be pregnant? ❑ Yes ❑ No

Do you have any allergies? ❑Yes ❑ No To what:______________________________

Please check any of the diseases you have had

Patient Name ___________________________

- ❑Diphtheria
- ❑ Polio
- ❑ Measles
- ❑Mumps
- ❑ Small Pox
- ❑ Chicken Pox
- ❑ Whooping cough
- ❑ Anemia
- ❑ Migraine headache
- ❑Stomach ulcers
- ❑AIDS/HIV
- ❑Scarlet fever
- ❑Appendicitis
- ❑Pneumonia
- ❑Rheumatic fever
- ❑Malaria
- ❑Tuberculosis
- ❑Diabetes
- ❑Cancer
- ❑Multiple sclerosis
- ❑Heartburn
- ❑Venereal disease
- ❑Heart Disease
- ❑Pacemaker
- ❑Gout
- ❑Alcoholism
- ❑Bronchitis
- ❑Depression
- ❑Epilepsy
- ❑Stroke
- ❑Osteoporosis
- ❑Mental disorder
- ❑Tumors/Growths
- ❑Asthma
- ❑Hepatitis
- ❑Hernia
- ❑Herniated disc
- ❑High cholesterol
- ❑Kidney disease
- ❑Liver disease
- ❑Tumors/growths
- ❑Parkinson’s
- ❑Covid-19

Other:____

Have you received the full dose of vaccination for COVID-19? ❑Yes ❑ No

If yes, when? ______/______/_________

Which brand of vaccine was administered? ❑Pfizer ❑Moderna ❑Johnson & Johnson

Please note each condition you below with an “X” for currently have and color-in previously have had:

Musculoskeletal conditions

- ❑Low back pain
- ❑Pain between shoulders
- ❑Paralysis
- ❑Neck pain
- ❑Arm pain
- ❑Joint pain/stiffness
- ❑Difficulty walking
- ❑Hip pain
- ❑Headaches

Nervous System

- ❑Numbness
- ❑Ears ringing
- ❑Dizziness
- ❑Forgetfulness
- ❑Confusion/Depression
- ❑Fainting
- ❑Convulsions
- ❑Stress Work/Home
- ❑Epilepsy

Eyes, ears, nose ,throat

- ❑Vision problems
- ❑Ear aches
- ❑Hearing difficulty
- ❑Sinus problems
- ❑Dental problems
- ❑Sore throat
- ❑Difficulty chewing/clicking jaw

Gastro-Intestinal

- ❑Poor /excessive appetite
- ❑Excessive thirst
- ❑Frequent nausea
- ❑Vomiting
- ❑Diarrhea
- ❑Hemorrhoids
- ❑Liver trouble
- ❑Gall bladder problems
- ❑Recent weight loss/gain
- ❑Heartburn
- ❑Gas or bloating after meals

Cardiovascular

- ❑Chest pain
- ❑Pain over heart
- ❑Heart problems
- ❑Persistent cough at night
- ❑Difficulty breathing
- ❑Lung problems
- ❑Ankle swelling
- ❑Varicose veins
- ❑High blood pressure
- ❑Rapid heartbeat

Male / Female

- ❑Bladder Problems
- ❑Painful urination
- ❑Excessive urination
- ❑Discolored urine
- ❑Vaginal pain / Infections
- ❑Breast pain
- ❑Prostate / Sexual dysfunction

Other:_______________________

Health Habits

Patient Name ________________________

Do you smoke? ❑ Yes ❑ No Packs/Day____________________

Do you drink alcohol? ❑Yes ❑ No Drinks/week________________

Do you drink coffee or soda? ❑ Yes ❑ No Serving /week____________________

How often do you exercise and what do you do? ▯ None Times/week____________ Activity________________

On a Scale from 1-10 (10 being extreme stress) how stressful would you rate,

Your job? _______________________

Home life?______________________

Family History

(*Please describe your family's health and if they are deceased please state the cause)*

Father's health?____

Mother's health?____

Sibling's health?____

Chiropractic care consists of maintaining optimal health through spinal adjustments. Some patients see doctors of chiropractic for ***Relief*** care. This type of care is for temporary symptom relief. Other patients wish to have the cause and symptoms corrected, this would be ***Corrective*** care. Yet, other patients recognize the value of chiropractic for preventing problems and maintaining their bodies at an optimal level of health. This is ***Preventative*** care similar to your regular dental visits or yearly check-up with your medical doctor.

Our clinic's goal is to educate the patients about chiropractic and their health. Please feel free to ask questions, in fact we encourage it. We know you are interested in your health and staying well.

Please check the type of care you wish, so that we may be guided by your wishes.

❑***Relief care*** ❑***Corrective care*** ❑***Preventative care*** ❑***I wish for the doctor to determine the type of care necessary***

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my minor child during the period of such chiropractic care to third party payers and /or health practitioners. I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my or my dependent's behalf.

Patient's signature:____ Date_____/_______/______

(If patient is a minor, signature of parent, guardian or legal custodian)

Informed Consent to Chiropractic Treatment

The Nature of Chiropractic Treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop" similar to the noise produced when a knuckle is "cracked," and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, deep soft tissue techniques, or traction may also be used.

Possible Risks: As with any health care procedures, complications are possible following a chiropractic manipulation. Complications could conceivably include fracture of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, or other minor complications. There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote.

Probability of Risks Occurring: The risks of complications due to chiropractic treatment have been described as "rare" to "extremely rare", statistically less often than complications from taking a single aspirin tablet.. There has not been a single reported injury in our clinic since its inception in 1954.

Other treatment options which could be considered may include the following:

1. *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver, and kidneys, and other side effects in a significant number of cases.
2. *Medical care*, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
3. *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
4. *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of Remaining Untreated: Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual Risks: I have had the following unusual risks of my case explained to me:

I have read the above explanation of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

________________________ ________________________ ________________

Printed Name Signature Date

To request an accounting of disclosures, you must make your request, in writing, to Dr. Andrew Schupp.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Dr. Andrew Schupp. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to Dr. Andrew Schupp. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you 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. To obtain a paper copy of this notice, make a written request to Dr. Andrew Schupp.

CHANGES TO THIS NOTICE: We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Dr. Andrew Schupp. All complaints must be made in writing. **You will not be penalized for filing a complaint**.

Printed name: ____

Signature: ____

Date:____

Office Financial Policy

Purpose: To provide a clear explanation of our financial policies in advance so that we may better serve you, the patient, and to prevent any upsets over financial concerns.

Cash

- All patients are on a cash basis until their insurance coverage and deductible is verified by our staff.
- This office may make payment plan arrangements on an individual basis. Any such plan or arrangement can be discussed during your report of findings.

Insurance

If you have insurance, we will gladly take assignment in most cases with the following exceptions and regulations, provided that we have prior certification from your insurance company. There are additional guidelines that apply to patients on Medicare or other federally reimbursed programs.

- We accept assignment as a **courtesy** to you; you are responsible for your entire bill if your insurance company doesn't pay any of the anticipated charges for any reason. We are not a mediator between you and your insurance company and will not enter into any dispute with said company. ***It is your responsibility to understand your insurance policy***.
- All co-pays are due at time of service.
- Whenever you receive any worksheets from your insurance company or explanation of benefits (EOB), please bring this information into this office as soon as possible. We must have a copy of this to if determine proper payment has been made. **If you receive a check from your insurance for services rendered by this clinic, you must bring it into the office upon receipt.** If any over-payment exists after all insurance billing has been done, we will issue you an over-payment check – it will not come from your insurance company. All insurance payments, regardless of which company issues a check first, are applied to your account as long as a balance is due.
- Any remaining balance and/or services not covered or coverage reductions by your insurance company will be the patient's responsibility.
- This office will submit a claim **ONE TIME**. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist in dealing directly with your insurance company, adjustor, or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges in a timely basis.
- If you discontinue care, any outstanding balance is due and payable in full immediately.
- Interest of 12% per year will be charged on any unpaid balances.

If you have any questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the doctor.

I have read and understand the financial policies above and agree to abide by these terms.

____

Printed name of patient or responsible party

____ ________________

Signature of patient or responsible party Date