WELCOME

Date: ______________________

Patient Information

Name: ____
Last First MI

Email Address: ____

Mailing Address: ____
Street Street 2 / Apt #

____
City State Zip

Phone #: (C)____________________ (H)____________________ (Other) ______________

Date of Birth: ____________________ Sex: ❑ Male ❑ Female SS#: ________________

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Occupation: ________________________ Employer: ________________________

Employer Address: ________________________________ Phone: ________________

How did you hear about our practice? ______________________________________

Emergency Contact: Name: ________________________ Relation: ____________________

Emergency Phone #: (C) ________________________ (Other) ________________________

Accident Information

Is this visit due to an accident? ❑ Yes ❑ No If yes, what type? ❑ Auto ❑ Work ❑ Other ________

Has it been reported? ❑ Yes ❑ No If yes, to whom? ________________________

Financial Information

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: ____________ ID #: ____________

Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: ____________ ID #: ____________

Name of policy holder: ____

If other than self: Relationship to patient____________ Date of Birth________ SS#________________

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY(IES) TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, Affinity Medical Group, PA, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) ________________________________ **DATE** ____________________

Patient Name: ___________________________________ DOB: _____________________

Current Health Information

What is the main complaint you would like us to help with today? ________________________

Are there any other complaints you would like us to evaluate today? ______________________

<u>HISTORY OF PRESENT INJURY</u> Approximate date of onset: _____________ (Intensity key: 0-10 scale is used with 0 being no pain and 10 being the most severe pain)	
Do you know what may have brought the pain/problem on? ☐ Unknown ☐ YES If yes, explain:	
What does it feel like? ☐Sharp ☐Dull ☐Achy ☐Shooting ☐Burning ☐Stabbing ☐Numb ☐Tingly ☐Other:	
Rate the pain from 0-10, with 0 being no pain and 10 being the absolute worst possible pain. ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10	
Does the pain move/radiate anywhere else (such as the ☐Arm ☐Hand ☐Leg ☐Foot)? ☐NO ☐YES Other:	
Does the pain increase when you cough or sneeze? ☐NO ☐YES	
Is the pain constant? ☐NO ☐YES If not constant, how often do you have the pain/problem?	
What makes this pain worse? ☐Sit ☐Walk ☐Stand ☐Drive ☐Computer ☐Work ☐Sleep ☐Lift ☐Bend ☐Twist Other:	
What makes this pain better? ☐Ice ☐Heat ☐Rest ☐OTC’s ☐Rx’s ☐PT ☐Chiro Other:	
Because of the pain, have you noticed a loss or change in sleep? ☐NO ☐YES	Does it affect your mood? ☐NO ☐YES
Do find it difficult to complete any daily tasks or activities? ☐NO ☐YES If yes, explain:	
Other ways this has affected your life: ☐Being less social ☐Not able to play with children ☐Affecting sex life Other:	
If this problem didn’t exist, either partially or totally, what would you like to be doing again? ☐Hobbies ☐Work ☐Social Other:	
Is there anything else you’d like us to know?	

Please check to indicate if you are also currently experiencing any of the following conditions:

❑ Neck Pain/Stiffness	❑ Pins/Needles in Arms	❑ Light Bothers Eyes	❑ Sudden Weight Loss	❑ Nausea
❑ Back Pain/Stiffness	❑ Pins/Needles in Legs	❑ Depression	❑ Loss of Taste	❑ Cold Feet
❑ Arm/Hand Pain	❑ Fatigue	❑ Nervousness	❑ Loss of Memory	❑ Chest Pain
❑ Leg/Knee Pain	❑ Sleeping Difficulties	❑ Tension	❑ Jaw Problems	❑ Fever
❑ Headaches	❑ Loss of Smell	❑ Cold Sweats	❑ Constipation	❑ Fainting
❑ Dizziness	❑ Allergies	❑ Stomach Problems	❑ Shortness of Breath	
❑ Asthma	❑ Blurred Vision	❑ Night Pain	❑ Bowel/Bladder Changes	

Patient Name: ______________________________________ DOB: ______________________

Health History

Please list any MAJOR MEDICAL EVENTS, SURGERIES, AND/OR HOSPITALIZATIONS you have had (type & date):

____

____

Please list any ALLERGIES: ____

Are you currently being treated for any medical conditions? ❑ Yes ❑ No If yes, explain ___________________________

Who is your primary care physician? (doctor and/or practice) ____

❑ I have provided a copy of my medications **or** Please list any medications you are currently taking :

____

____

Last Menstrual Period: ___________________

Please check to indicate if you have ever had any of the following:

❑ Aids/HIV	❑ Cancer	❑ Hepatitis	❑ Osteoporosis	❑ Stroke
❑ Alcoholism	❑ Cataracts	❑ Hernia	❑ Pacemaker	❑ Suicide Attempt
❑ Allergy Shots	❑ Chemical Dependency	❑ Herniated Disc	❑ Parkinson's Disease	❑ Thyroid Problems
❑ Anemia	❑ Chicken Pox	❑ Herpes	❑ Pinched Nerve	❑ Tonsillitis
❑ Anorexia	❑ Diabetes	❑ High Cholesterol	❑ Pneumonia	❑ Tuberculosis
❑ Appendicitis	❑ Emphysema	❑ Kidney Disease	❑ Polio	❑ Tumors/Growths
❑ Arthritis	❑ Epilepsy	❑ Liver Disease	❑ Prostate Problems	❑ Typhoid Fever
❑ Asthma	❑ Fractures	❑ Measles	❑ Prosthesis	❑ Ulcers
❑ Bleeding Disorders	❑ Glaucoma	❑ Migraines	❑ Psychiatric Care	❑ Vaginal Infections
❑ Breast Lump	❑ Goiter	❑ Miscarriage	❑ Rheumatoid Arthritis	❑ Venereal Disease
❑ Bronchitis	❑ Gonorrhea	❑ Mononucleosis	❑ Rheumatic Fever	❑ Whooping Cough
❑ Bulimia	❑ Gout	❑ Multiple Sclerosis	❑ Scarlet Fever	
	❑ Heart Disease	❑ Mumps	❑ Other ______________________	

Is there a FAMILY HISTORY of any of the following conditions? (indicate family member including parents, grandparents & siblings)

❑ Heart Disease ____________________ ❑ Diabetes ____________________

❑ Cancer ____________________ ❑ Arthritis ____________________ ❑ Other ______________________________

SOCIAL HISTORY

Do you exercise: ❑ Frequently ❑ Moderately ❑ Occasionally ❑ None

Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

Caffeine _______ cups/day Alcohol_____ drinks/week Cigarettes_______ packs/day

NUTRITIONAL HISTORY

Please list any supplements you are currently taking (vitamins/herbs/minerals): ______________________________________

Please list any special considerations or restrictions to your diet: ____

DEVELOPMENTAL HISTORY

Please list any congenital diseases, illnesses, or malformations: ____

Please list any psychological/psychiatric illness____

Patient Name: ___________________________________ DOB: _____________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPPA)

I acknowledge that I have reviewed the Notice of Privacy Practices of Affinity Medical Group.

Please initial one of the following options.

__________ I wish to receive a paper copy of Privacy Notice.

OR

__________ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please initial both lines and sign below.

__________ I acknowledge that it is the policy of Affinity Medical Group to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

__________ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer, Dr. Kyle Hagel, about my concerns.

______________________________________ _______________________

Signature of Patient/Guardian Date

______________________________________ _______________________

Witness (Office Staff) Date

Patient Name: ____ DOB: ________________________

CONSENT TO TREATMENT

This form is intended to inform our patients of the risks associated with the different services we offer and to obtain consent to proceed with treatment recommendations and/or procedures.

Please initial each space below indicating that you have read and understand each of the following.

________By consenting to treatment by our providers you, as the patient, give our providers permission and authority to care for you in accordance with current standards of care. Our recommendations to you depend on full disclosure of your medical history and current symptoms. It is the responsibility of the patient to communicate to our providers: current or latent pathology, illnesses, or deformities, which would otherwise not come to the attention of the physician.

________**Rehabilitation:** Stretches and exercises may be used during your treatment in our office. We have done our best to evaluate the safety and necessity of these exercises for you prior to having you perform them. However, you may have pain in your muscles or joints are we are making changes to them. You must perform the stretches and exercises EXACTLY as given to you by our staff. Any variation of them, either in the office or outside the office, will increase your risk of injury.

________**Chiropractic Care:** There are inherent risks with spinal manipulation. You may have increased pain in the area of complaint, or other areas. This may happen because we are changing the structure of your body and changing the muscles that are used as a result. There have also been reports of Cerebrovascular Accidents (CVA) following spinal manipulation. The most recent research shows that spinal manipulation is very safe and does NOT increase your risk for CVA appreciably.

________**Durable Medical Equipment:** If you are prescribed any equipment by our office you agree to use the equipment EXACTLY as instructed. You also agree not to allow any friend or family member to use it. Any unintended use of prescribed equipment puts the user at risk of injury.

________**Injections, Blood Draws for Lab Testing, Acupuncture, Special Testing:** There are several therapies and procedures performed in the office that require the piercing or puncturing of the skin. There are several risks you should be aware of with these services. Pain, bleeding, bruising, and infection at the site of puncture are all possible risks associated with puncturing the skin, regardless of the reason for puncture. Sterile technique is used in all punctures to reduce risk of infection.

________**No Guarantee of Results:** Our providers make their best recommendations based on their knowledge and experience. We only recommend treatments we believe will be of benefit to the patient. We CANNOT guarantee results. There are too many variables that are out of our control to do so.

________**Reports of Complications/Injury:** Should you have any of the listed complications, or other symptoms, following a therapy or treatment let a staff member know as soon as possible. Also, if you have any subsequent injuries outside of our office let our staff know BEFORE you receive your next treatment.

________I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I have read and understand each of the above items and give my consent to the treatment recommendations of the providers of Affinity Medical Group, PA.

____ ________________________

Patient Signature Date

____ ________________________

Staff Witness Date

Patient Name: ________________________________ DOB: ____________________

Financial Office Policies

1. All patients are on a cash basis until our staff can verify all insurance coverage(s).
2. Your insurance will be verified promptly and will be reviewed with you if applicable.
3. After coverage and deductible are verified, this office may accept assignment on most policies provided the insured/patient signs an appropriate statement of benefits and/or a lien authorizing payment to be sent to the doctor.
4. Waiting for the insurance payment is a courtesy and it may be withdrawn under certain circumstances.
5. As a patient, it is your responsibility to take care of the co-payment (usually a percent or fixed dollar amount) and any non-covered services on a monthly basis. This office may make payment arrangements on an individual basis. Any such plan or arrangements will be discussed during your report of findings.
6. This office does not warrant or guarantee that your insurance company will pay, nor does this office promise that an insurance company will or should pay the fees charged. Insurance policies are an arrangement between the insurance carrier and the patient/insured.
7. Any service not covered or coverage reductions by your insurance carrier will be the patient's responsibility.
8. This office will submit an insurance claim for you. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly with your insurance adjuster or agent. Any denied or disputed claims will be treated as uncovered.
9. If your account should go to collections for any reason, it will be the patient's responsibility for any court costs, attorney's fees, and or collection costs incurred in collecting the account balance.
10. I authorize the release of any medical or other records or information from my health record. I authorize release of records or information necessary to process any claims.
11. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due. This means refunds are made only after your balance is completed and cleared with this office.
12. If you receive correspondence of checks from your insurance company, you agree to bring these into our department so that we may determine if any action needs to be taken or if the check is on assignment to this office.
13. If you change insurance companies or employers, you agree to provide this office with the current information immediately.
14. If this office gives you any professional or accounting discount for treatment and you decide to drop out of care then our standard fees will apply.
15. This office accepts MasterCard, Visa, American Express, Discover Card, personal checks and cash.
16. 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.
17. If you stop care and have a financial agreement signed with our office, you will be responsible for any/all charges that you have incurred at our office.

Thank you for your cooperation in this matter.
I have read and fully understand the financial office policy and agree to abide by these terms.

________________________________ ______/______/______

Patient Signature or Responsible Party Date

Affinity Medical Group
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New Hope, MN 55427
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