Craig Chiropractic and Kinesiology
506 Cedar St
Monticello, MN 55362
(763) 295-4301

www.drshauncraig.com

Patient Information:

Name:_____ DOB:___/___/___

Address:_____

City:_____ State:_____ Zip:_____

Cell phone#:_____ Home:_____ Work: _____

Email: _____

Sex: ☐Male ☐Female Occupation: _____

Who referred you or how did you hear about us? _____

Payment Information:

How do you plan on paying for your care? ☐ Health Insurance ☐ HSA Card

☐ Cash / Credit / Check ☐ Car Accident ☐ Work Injury

Name of Insurance Company:_____

Secondary Insurance: _____

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

Deductible: $_____ Copay: $_____ CoInsurance: _____%

Case # (If Applicable):_____

Payment is expected at the time of visit:

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that Craig Chiropractic and Kinesiology will prepare any necessary reports and forms to assist me in making collection from the insurance company and any amount authorized to be paid directly to Craig Chiropractic and Kinesiology. I clearly understand and agree that any services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered will be immediately due and payable.

Patient's signature: _____ Date: ___/ ___/ ___

Guardian's signature: _____Date: ___/___/___

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Consent to Treat:

In order to provide for the most effective healing environment, most effective application of chiropractic procedures and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum healing through chiropractic. To that end, we ask that you acknowledge the following points regarding chiropractic care and the services that are offered in this clinic:

1) **Chiropractic** is a licensed health care discipline which emphasizes the inherent recuperative power of the body to heal itself without the use of drugs or surgery.
2) **The Practice of Chiropractic** focuses on the relationship between structure and function (as coordinated by the nervous system) and how that relationship affects the preservation and restoration of health.
3) **Chiropractic Evaluation and Examination** is part of the standard chiropractic procedure. It is designed to identify health problems and chiropractic needs.
4) **Applied Kinesiology** is used by this clinic as an additional examination procedure which evaluates muscle function using manual muscle testing.
5) **Triad of Health** refers to structural, chemical, and emotional aspects of our health and well-being. Applied Kinesiology examination and treatment is used to identify which of these areas of health need to be addressed to enhance the body's recuperative powers to heal itself.
6) **Chiropractic Adjustment** is a very specific manipulation which is only performed by licensed chiropractors for the purpose of restoring joint motion and integrity, which helps improve the functioning of the nervous system.
7) **Neuro-Emotional Technique** is a technique used by chiropractors that uses muscle testing to identify and treat emotional stressors which may be contributing to nervous system imbalance.
8) **Nutritional Therapy** is used utilizing concentrated whole food supplementation, vitamins, minerals and traditional herbs to assist the body's recuperative powers to heal itself.
9) **Please speak frankly** to the doctor or staff on any matter related to your care at our office. We work to maintain a supporting and open environment.
10) We do not seek to replace or compete with medical, dental or other type(s) of health professionals, and will provide referral for another evaluation if the doctor feels it is in the best interest of the patient. Those providers retain responsibility for the care and management of medical conditions. We do not offer advice regarding treatment prescribed by other providers.
11) Chiropractic treatment is a safe and effective, being used millions of times per day. Significant adverse events are very rare, but have been reported. Occasionally patients may experience a temporary increase in soreness, and sometimes a temporary aggravation of symptoms during treatment. Please advise your chiropractor of any changes.

I understand all of the above information and give consent for the chiropractic and applied kinesiology evaluation and care to be performed by Shaun Craig DC, FIAMA.

Patient or Guardian's Signature _____ Date ___/___/___

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24 Hour Cancellation Policy

Our office schedule often fills up each day, and in many cases suffering patients have to wait to see us. We want you to understand that your scheduled appointment time is valuable, so in the event you cannot make your appointment, we do require **an advanced notice of appointment cancellation at least 24 hours before your scheduled appointment.** We understand that certain emergency circumstances arise and are willing to work with you in this regard. Text message appointment reminders are sent out the day before your appointment as a reminder. To encourage patients to make their scheduled appointments and / or reschedule their appointment with at least 24 hours' notice, the following fees apply:

1st offense: $25 fee

2nd offense: $50 fee

We appreciate your understanding in this regard. Please sign this form stating that you are aware of our 24 hour cancellation policy and understand that the above fees will be applied if we are not given 24 hours' notice of cancellation prior to your scheduled appointment time.

_____ ___/___/___

Signature of patient Today's Date

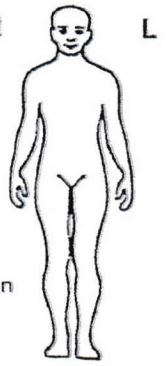
or parent / guardian

PATIENT INTAKE FORM

Patient Name: _____ Date:

1. Is today's problem caused by: ❑ Auto Accident ❑ Workman's Compensation ❑ Other

2. Indicate on the drawings to the right where you have pain/symptoms ⟶



3. How often do you experience your symptoms?

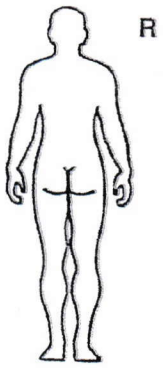
❑ Constantly (76-100% of the time) ❑ Occasionally (26-50% of the time)
❑ Frequently (51-75% of the time) ❑ Intermittently (1-25% of the time)

4. How would you describe the time of pain?

❑ Sharp ❑ Dull ❑ Diffuse ❑ Achy
❑ Achy ❑ Burning ❑ Shooting ❑ Stiff
❑ Numb ❑ Tingly ❑ Sharp with motion ❑ Shooting with motion
❑ Electric-like with motion ❑ Other: _____

5. How are your symptoms changing with time?

❑ Getting Worse ❑ Staying the Same ❑ Getting Better



6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

1 2 3 4 5 6 7 8 9 10 *(please circle)*

7. How much has the problem interfered with your work?

❑ Not at all ❑ A little bit ❑ Moderately ❑ Quite a bit ❑ Extremely

8. How much has the problem interfered with your social activities?

❑ Not at all ❑ A little bit ❑ Moderately ❑ Quite a bit ❑ Extremely

9. Who else have you seen for your problem?

❑ Chiropractor ❑ Neurologist ❑ Primary Care Physician
❑ ER Physician ❑ Orthopedist ❑ No one
❑ Massage Therapist ❑ Physical Therapist ❑ Other:_____

10. How long have you had this problem?_____

11. How do you think your problem began?_____

_____

12. Do you consider this problem to be severe?

❑ Yes ❑ Yes, at times ❑ No

13. What aggravates your problem?_____

14. What alleviates your problem? _____

15. What concerns you the most about your problem; what does it prevent you from doing? _____

_____

16. What is your: Height_____ Weight_____ Date Birth_____

17. Occupation _____ Have you missed work?_____

18. How would you rate your overall Health?

❑ Excellent ❑ Very Good ❑ Good ❑ Poor

19. What type of exercise do you do?

❑ Strenuous ❑ Moderate ❑ Light ❑ None

20. Indicate if you have any immediate family members with any of the following:

❑ Rheumatoid Arthritis ❑ Diabetes ❑ Lupus
❑ Heart Problems ❑ Cancer ❑ ALS

20. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have the condition listed below, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	High Blood Pressure	❑	❑	Diabetes
❑	❑	Neck Pain	❑	❑	Heart Attack	❑	❑	Excessive Thirst
❑	❑	Upper Back Pain	❑	❑	Chest Pains	❑	❑	Frequent Urination
❑	❑	Mid Back Pain	❑	❑	Stroke	❑	❑	Smoking/Tobacco Use
❑	❑	Low Back Pain	❑	❑	Angina	❑	❑	Drug/Alcohol Dependence
❑	❑	Shoulder Pain	❑	❑	Kidney Stones	❑	❑	Allergies
❑	❑	Elbow/Upper Arm Pain	❑	❑	Kidney Disorders	❑	❑	Depression
❑	❑	Wrist Pain	❑	❑	Bladder Infection	❑	❑	Systemic Lupus
❑	❑	Hand Pain	❑	❑	Painful Urination	❑	❑	Epilepsy
❑	❑	Hip Pain	❑	❑	Loss of Bladder Control	❑	❑	Dermatitis/Eczema/Rash
❑	❑	Upper Leg Pain	❑	❑	Prostate Problems	❑	❑	HIV/AIDS
❑	❑	Knee Pain	❑	❑	Abnormal Weight Gain/Loss			
❑	❑	Ankle/Foot Pain	❑	❑	Loss of Appetite	For Females Only		
❑	❑	Jaw Pain	❑	❑	Abdominal Pain	❑	❑	Birth Control Pills
❑	❑	Join Pain/Stiffness	❑	❑	Ulcer	❑	❑	Hormonal Replacement
❑	❑	Arthritis	❑	❑	Hepatitis	❑	❑	Pregnancy
❑	❑	Rheumatoid Arthritis	❑	❑	Liver/Gall Bladder Disorder			
❑	❑	Cancer	❑	❑	General Fatigue			
❑	❑	Tumor	❑	❑	Muscular Incoordination			
❑	❑	Asthma	❑	❑	Visual Disturbances			
❑	❑	Chronic Sinusitis	❑	❑	Dizziness			
❑	❑	Other:_____						

21. List all prescription medications you are currently taking:

_____

22. List all of the over-the-counter medications you are currently taking:

_____

23. List all surgical procedures you have had:

_____

24 What activities do you do outside of work?

_____

25. Have you ever been hospitalized? ❑ No ❑ Yes

If yes, why _____

27. Have you had significant past trauma? ❑ No ❑ Yes

28. Have you previously seen a chiropractor? ❑ No ❑ Yes

If yes, what were the results? ❑ Great ❑ Good ❑ Fair ❑ Mixed ❑ Poor ❑ Other

28. Anything else pertinent to your visit today? _____

Patient Signature_____ Date:_____

Medicare Patients Only!

A. Notifier: Craig Chiropractic and Kinesiology, 506 Cedar St, Monticello, MN 763-295-4301

B. Patient Name: **C. Identification Number: Leave Blank**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D. Exam, supplements, AK** below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D. Exam, supple, AK** below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
1) Initial Examination (initial visit)	-Required, but not covered	$70.00
2) Nutritional Supplementation, taping, etc	-Not covered by Medicare. If needed.	Variable
3) Acupuncture	-Non-covered service. If needed / requested.	$45.00
4) AK: Muscle & Nutritional Testing, Neuro-emotional tech, myofascial release, meridian tx.	-Non covered service. Done with every patient, every visit. Added to any co-pay.	$10.00 / Visit

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D. Exam, supplements** listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D. Exam, supplements** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D. Exam, supplem** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D. Exam, supplem** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

*****Examination Fee ($70), supplements ($variable), AK ($10) need to be paid at time of service.**

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.