Prairie Life Chiropractic
715 S Main Ave
Sioux Center, IA 51250

Patient Information

Name_____ **Birth Date**_____
Guardian's Name (If applicable)_____
Address_____
City_____ **State**_____ **Zip**_____
Home Phone (___)_____ **Cell (___)**_____
Email_____
Sex: □M □F **Age**_____ **SS#**_____
□ Single □ Married □ Widowed □ Separated □ Divorced
Race: □White □Am. Indian □Alaska Native □Asian
□Native Hawaiian □Black or African American
□Other Pacific Islander □Decline to State
Ethnicity: □Hispanic or Latino □Not Hispanic or Latino
Occupation_____ **Employer**_____
Employer City_____
Employer Phone(___)_____
Whom may we thank for referring you? _____

Emergency Contact

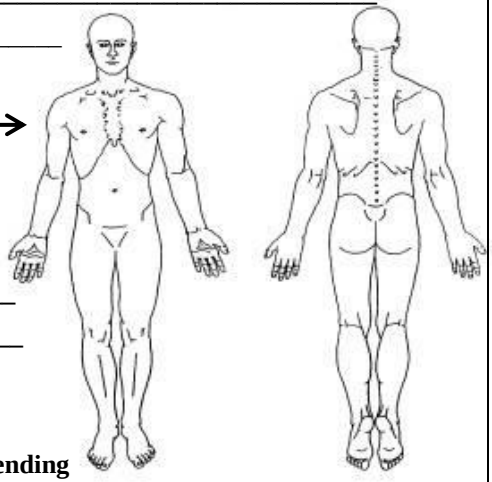
Name_____ **Relationship**_____
Home (___)_____ **Cell(___)**_____
Employer_____ **Work Phone (___)**_____

Accident Information

Is this condition due to an accident?
□ **Yes** □**No** **Date**_____
If so, please get the appropriate paperwork from the front desk.
Type of accident:
□ **Auto** □**Work** □**Home** □ **Other**
To whom have you made a report of your accident?
□ **Auto Insurance** □ **Employer** □ **Worker Comp.** □ **Other**
Attorney Name_____ □ **N/A**

Condition Information

In your own words, where is the problem? _____
When did your symptoms appear? _____
Is this condition getting: □ Better □ Worse □ Stays the same □ Unknown
Mark an X on the picture where you have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____
Type of pain: □ Aching □ Burning □ Dull □ Pulling □ Sharp □ Shooting □ Stabbing
□ Stinging □ Throbbing □ Cramping □ Stiffness □ Swelling
How often do you have pain? (Daily, Weekly, Monthly, ect.) _____
Is it constant or does it come and go throughout the day? _____
Does it interfere with your: □ Work □ Sleep □ Daily Routine
□ Getting comfortable at night □ Recreation
Activities or movements that are difficult to perform: □ Sitting □ Standing □ Walking □ Bending
□ Lying Down □ Coughing □ Sneezing □ Bowel movements
What makes your pain feel better? □ Ice □ Heat □ Medication □ Stretches □ Other _____

Treatment History

What treatment(s) have you received for this condition? □**Medical/Medications** □**Surgery** □**Physical Therapy** □**Chiropractic**
□ **Acupuncture** □**None** □**Other**_____
Name of the provider who gave previous services? _____

Other Symptoms

□**Neck Pain**	□**Neck Stiffness**	□**Tension**	□**Dizziness**	□**Abnormal Weight Gain**	□**Nausea**
□**Back Pain**	□**Back Stiffness**	□**Numbness**	□**Shortness of Breath**	□**Abnormal Weight Loss**	□**Vision Changes**
□**Shoulder Pain**	□**Headaches**	□**Weakness**	□**Change in Smell**	□**Abnormal Heart Rate/Rhythm**	□**Irritability**
□**Arm Pain**	□**Jaw Problems**	□**Sleep Difficulty**	□**Abnormal Bruising**	□**Change in Taste/Vision/Hearing**	□**Night Sweats**
□**Leg Pain**	□**Grip Problems**	□**Fatigue**	□**Memory Loss**	□**Blood in Stool/ Urine/ Sputum**	□**Chest Pressure**

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Health History

Please mark on "Current" or "Past" to indicate if you have or have had any of the following:

	Current	Past		Current	Past		Current	Past
Acid Reflux	☐	☐	Epilepsy	☐	☐	Parkinson's	☐	☐
AIDS/HIV	☐	☐	Glaucoma	☐	☐	Pinched Nerve	☐	☐
Alcoholism	☐	☐	Goiter	☐	☐	Prostate Problem	☐	☐
Allergy Shots	☐	☐	Gout	☐	☐	Prosthesis	☐	☐
Anemia	☐	☐	Heart Disease	☐	☐	Rheumatoid Arthritis	☐	☐
Anorexia	☐	☐	Hepatitis	☐	☐	Psychiatric Care	☐	☐
Appendicitis	☐	☐	Hernia	☐	☐	Stroke	☐	☐
Arthritis	☐	☐	Herniated Disc	☐	☐	Suicide Attempt	☐	☐
Asthma	☐	☐	Herpes	☐	☐	Thyroid Problems	☐	☐
Bleeding Disorders	☐	☐	Kidney Disease	☐	☐	Tonsillitis	☐	☐
Breast Lump	☐	☐	High Blood Pressure	☐	☐	Tuberculosis	☐	☐
Bronchitis	☐	☐	High Cholesterol	☐	☐	Tumors/Growths	☐	☐
Bulimia	☐	☐	Migraine Headaches	☐	☐	Ulcers	☐	☐
Cancer	☐	☐	Miscarriage	☐	☐	Venereal Disease	☐	☐
Chicken Pox	☐	☐	Mononucleosis	☐	☐			
Diabetes	☐	☐	Multiple Sclerosis	☐	☐	Other_____		
Drug Abuse	☐	☐	Osteoporosis	☐	☐			
Emphysema	☐	☐	Pacemaker	☐	☐	_____		

Please list any of the following you have had:

Falls_____ **Date**_____
Head Injuries_____ **Date**_____
Broken Bones_____ **Date**_____
Dislocations_____ **Date**_____
Surgeries_____ **Date**_____

Family History

Please list any member of your family (parents, grandparents, brothers or sisters) who have had the following:

Heart Disease_____ **Rheumatoid Arthritis** _____ **Stroke**_____
High Blood Pressure_____ **Diabetes**_____ **Cancer**_____

Exercise

Frequency	Type
☐None	☐Cardiovascular
☐Occasional	☐Light
☐Frequent	☐Heavy
☐Daily	

Social Habits

☐**Smoking** **Packs/Day**_____
☐**Alcohol** **Drinks/Week**_____
☐**Caffeine Drinks** **Cups/Day**_____
Stress Level (1-10) ____ **Why?** _____

Work Activity

☐**Sitting**
☐**Standing**
☐**Light Labor**
☐**Heavy Labor**

Allergies

_____
_____
_____
_____

Medications

_____
_____
_____
_____

Supplements

_____
_____
_____
_____

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Acupuncture Informed Consent for Diagnosis and Treatment

I (the signer of this document) freely choose to undergo acupuncture treatments, knowing that there are no guaranteed results, and I am free to stop acupuncture treatment at any time.

I understand that while acupuncture is generally a safe method of treatment, certain adverse effects may result from treatment. These may be, but are not limited to fainting, some local bruising, puffiness, redness, blood, and temporary pain or discomfort at the site of the needles during or following a treatment.

I understand the methods of treatment in the scope of Chinese medicine may include but are not limited to acupuncture, cupping, electro-acupuncture (electrical stimulation on the needles), and dry needling.

I understand the acupuncturist is not providing Western medical care, and I should look to my primary care physician for those services and routine checkups.

I understand all fees for services are due at the time of service.

I have read, or have had read to me, and completely understand the risks and benefits of acupuncture treatment, and I have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek acupuncture treatment.

● PATIENT PLEASE REVIEW ● PRINT & SIGN NAME ●

I have read or had read to me this informed consent document. I have discussed or been given the opportunity to discuss any questions or concerns with my chiropractor and have had these answered to my satisfaction prior to my signing this informed consent document. I have made my decision voluntarily and freely.

PATIENT'S NAME (Print) _____

_____ _____ _____ _____
(PATIENT / GUARDIAN SIGNATURE) (DATE) (TRANSLATOR / INTERPRETER SIGNATURE) (DATE)

CLINICIAN ONLY

Based on my personal observation and the patient's history, I conclude that throughout the informed consent process the patient was:

☐**Of Legal Age** ☐**Appears Unimpaired** ☐**Fluent in English**
☐**Consent Given Through Guardian** ☐**Oriented x3** ☐**Assisted with a Translator**

_____, D.C. _____
(CLINICIAN SIGNATURE) (DATE)

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HIPAA Notice of Privacy Practices

Prairie Life Chiropractic is committed to patient privacy and the confidentiality of personal health information entrusted to us.

The ways in which we may use or disclose your health information are detailed in the Notice of Privacy Practices.

Your Right to Limit Uses or Disclosures: You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, we will provide you with a Limitation of Use and Disclosure of Protected Health Information Request form.

Your Right to Request that Your Patient Record be Amended: You have the right to request that we amend the information in your patient record. If you would like to amend any information in your record we will provide you with a Request to Amend Protected Health Information form.

Your Right to Revoke Your Authorization: You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

YOU HAVE A RIGHT TO REFUSE CONSENT FOR DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION. WITHOUT YOUR CONSENT, HOWEVER, PRAIRIE LIFE CHIROPRACTIC WILL NOT BE ABLE TO SUBMIT CLAIMS TO INSURANCE CARRIERS OR OTHER THIRD PARTY PAYERS AND MAY NOT ACCEPT YOU AS A PATIENT/CLIENT.

By signing below, I give consent to the Prairie Life Chiropractic clinicians or staff to use or disclose my personal health information as noted in the Notice of Privacy Practices.

_____

Printed Name

_____

Signature Date

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FINANCIAL POLICY

Acupuncture is not covered under most insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. We ask that you read and understand our policy as it applies to your particular situation.

Billing
Any outstanding balances are billed on the 1st of the month and considered past due 15 days after the invoice date or when special arrangements are not met. Bills will be sent for all covered services (after deductible has been met) after hearing from your insurance company.

Cash Payment
Patients without insurance coverage may pay for care by cash, check, debit card, or credit card. Payment for service is due at the time the service is rendered. A time of service discount is available on all chiropractic services. This discount does not apply to acupuncture, nutritional supplements, customized orthotics or supplies.

Group or Individual Insurance
We gladly accept insurance assignment if the insurance company 1) Verifies that the deductible has been met, 2) provides details of the available coverage, and 3) agrees to make payment directly to our office. Our office will file the necessary claim forms at no charge. Payment will be due by you at the time of service for any non-covered services, deductibles or co-payments.

Medicare
The doctor in this office is a Medicare provider. We will submit all claims to Medicare and secondary plans for you. The ***only*** chiropractic service Medicare reimburses for is manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. If you have a supplement plan, they will normally cover the other 20% of the allowable fee once the Medicare deductible has been met. You are responsible for payment in full for non-covered services at the time of service. This would include examinations, acupuncture, therapies, nutritional supplements and supports. If you do not have a supplement plan, you are responsible for the 20% that Medicare does not reimburse as well as any non-covered services listed above at the time of service.

Personal Injury/Automobile Accidents/Worker's Compensation
If you have been involved in a motor vehicle accident/injured on the job, it is important that you report the accident to your insurance agent/employer and request a claim number and the appropriate billing information. We will submit your claims at no charge. Although you as the patient are ultimately responsible for the bill, we will take assignment as long as you are under active care. Once the claim is settled, or if you suspend or terminate care, any fees for services are due immediately.

Special Arrangement
We have never denied anyone the benefits of chiropractic care because of their inability to pay our published fees. If financial hardship exists, it requires an Individual Consideration Contract. Please speak with the front desk staff for more information.

PATIENT AGREEMENT

I have read and understand the payment policy of Prairie Life Chiropractic. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Prairie Life Chiropractic and my insurance company. I request Prairie Life Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by Dr. Derek Kosters, that fees will be due and payable immediately. I also understand that all balances more than 30 days past due will be assessed a 1.5% finance charge, unless the balance is the responsibility of my insurance company. Once my insurance company has paid and a balance remains on my account, a 1.5% finance charge will be assessed monthly until the balance is paid in full. I understand that Prairie Life Chiropractic asks that I provide at least a 24 hour notice if I am unable to keep my scheduled appointment. Failure to provide at least a 24 hour notice may result in a penalty fee, at the discretion of Prairie Life Chiropractic. By signing this document, I assign directly to Dr. Derek Kosters all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the use of this signature on all insurance submissions.

_____ _____
Patient's signature (or guardian if a minor) Date

_____
Relationship to patient (If not the patient)