Intake Form

Information provided on this form is confidential. It is very important the information given is complete and accurate to assist you properly in your healing process.

RIVER FALLS CHIROPRACTIC, INC.

Dr. Barb Wasson, DAc (715) 425-6665

Today's Date ___/___/___

Name _____ Date of Birth ___/___/___ Age:_____ Sex:

Address_____

City/ State/ Zip _____ email _____

Telephone: (home)_____ (work)_____ (cell) _____

Emergency Contact Person/Relationship_____

Phone #_____

Who is your Primary Care Physician ? _____

Referrals are the best compliments. Whom may we thank for your referral ?

What are the concerns for which you are seeking care ? (symptoms, diagnosis and date of onset)

1. _____
2. _____
3. _____

What other treatments have you received for any of these conditions? _____

What makes your condition better ? (movement, rest, heat, cold, eating, sleeping, etc)

_____

What makes your condition worse ? (fatigue, stress, certain foods or times of day, heat, cold, hunger, etc)

_____

Medical Conditions

Please inform me if you have a bleeding disorder, high blood pressure and/or are on blood thinners or if you are pregnant. (Please include any other major medical condition you might have.)

_____

_____

Allergies

Are you hypersensitive or allergic to any foods, drugs, chemical or environmental substances ?

_____

Medications and Supplements

What medications (prescribed or over the counter) herbs, vitamins, supplements, etc. are you currently taking ?

_____

_____

_____

Muscles, Joints & Bones (Please fill this page out if the reason for your visit is for pain) :

Do you have pain or tightness? Where?_____

Recent injuries ? _____ Was this from an auto accident or work related?_____

The pain is (circle all that apply): Sharp Dull Aching Numb

Superficial Pain Deep Pain Burning Tingling Shooting

Pain worse/better with heat Pain worse/better with cold Pain worse/better with pressure

Pain worse in am/pm Pain worse/better with movement

I have (circle all that apply): Swollen joints Arthritis/joint pain Tendonitis

Bone pain Muscle cramping Muscle pain Repetitive Strain Injury

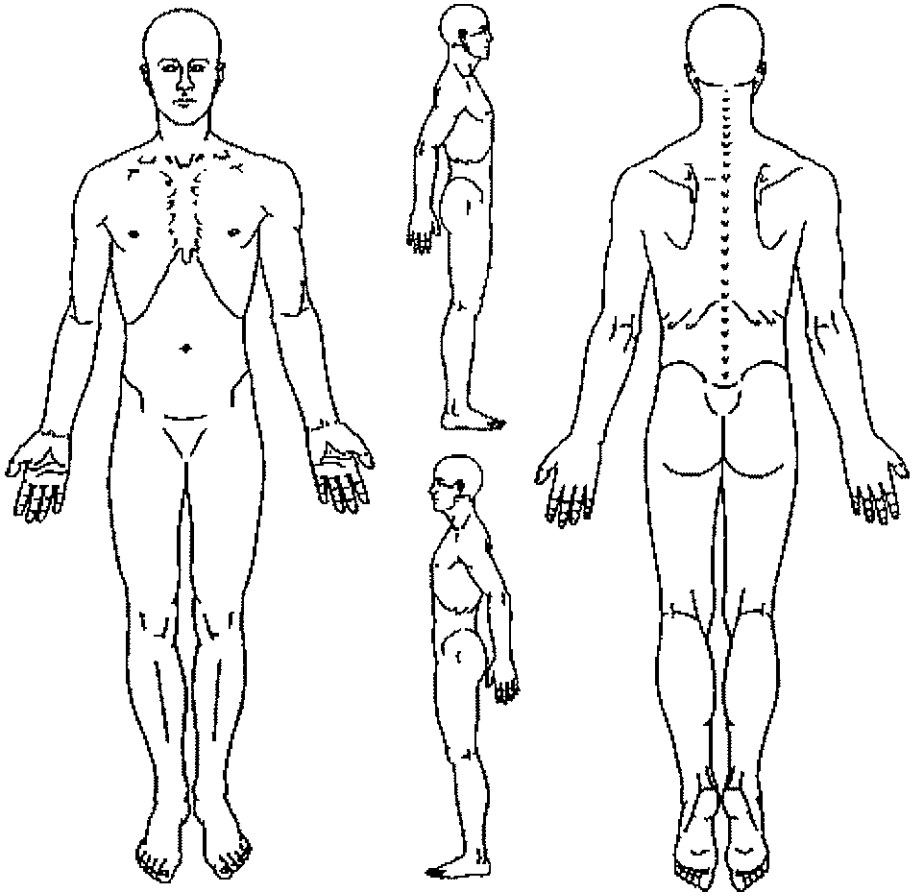
Fractured Bone(s) -- Where?_____

Other_____

Pain Diagram (please mark all areas of pain on diagram below)

A= aching B= burning N=numbness P= pins and needles

S= stabbing pain O= other type of sensation



HIPPA Notice
Privacy Disclosure and Policies

As a patient at this clinic, you have the right to know how your private, confidential healthcare and personal information is being protected. Below are the methods in which your information is secured confidentially in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA). This notice describes the policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

Safeguards in place include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Public Interaction

Should we see you socially, by coincidence or intent, we will not acknowledge how we are acquainted unless you infer consent through introduction, etc.. It is our preference to discuss your health in the office setting only to protect your privacy and ensure that important information is kept in your chart.

Consultations

We consult with other healthcare practitioners and clinical specialists while working on patient cases and treatment plans. These conversations and transfers of information by phone, in person, by fax, or email are confidential, and names are not used unless necessary.
In administering your health care, we may gather and maintain information that may include these examples of non-public personal information

- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, worker's comp and your employer, and other third party administrators (e.g. requests for medical records, claim payment information)

Please note that this is an integrated clinic and our practitioners do discuss individual cases so that we may better serve you. All information shared is kept confidential as all of our practitioners are in accordance with HIPPA. Please notify River Falls Chiropractic in writing if you do not want your case discussed with the other practitioners within the clinic.

Records Release

Your confidential healthcare information is private and cannot be copied and shared with anyone else without your written, signed consent. In some cases, if time does not permit, your verbal approval may be accepted after proper identification is acquired. Copies of released records are sent by mail or fax, and are accompanied by a Confidential Patient Information Cover Sheet if faxed.

Definition and Penalties to Comply

Protected health information is any information, whether oral or recorded, in any form or medium that: 1) is created or received by a healthcare provider, health plan, public health authority, employer, life insurer, school or university, or healthcare clearing house in the normal course of business, and 2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual. This information may reside in any medium: tape, paper, disc, fax, email, and/or digital voice message.

I have read and understand my right to privacy, as stated above, and agree to have Dr. Barb Wasson, Licensed Acupuncturist maintain my records confidentially in accordance with the law. I agree to inform Dr. Barb Wasson, Licensed Acupuncturist if I need any special arrangements pertaining to this issue.

signature	date
print name	

FINANCIAL POLICIES

River Falls Chiropractic requests payment for your treatment at the time of service. Cash, check and all major credit cards are accepted.

Returned Checks. If your check is returned for insufficient funds, there will be a $25.00 Returned Check fee added to your account, in addition to the amount the check was for. Initial _____

Nonpayment. If your account is over 90 days past due from our first billing sent to you, it will be referred to a collection agency for payment. By signing this agreement you will also authorize the office to release information needed to secure payment. Initial _____

Missed Appointments. If you miss your appointment or cancel with less than 24 hours notice, you will be charged for the appointment after the second occurrence. Initial _____

I have read and understand the policies and agree to abide by the guidelines.

_____ Date _____

Signature of patient or responsible party

Insurance Policy Information

Auto, Personal Injury, and Workers Comp Insurance companies recognize the effectiveness of acupuncture treatment for related injuries and in the state of Wisconsin acupuncture is covered by auto and worker's compensation insurance. (In some cases you may need a referral from a physician.)

We can contact your auto or worker's comp insurance to see if acupuncture may be a covered service for you. Please provide the following information so that we may submit claims on your behalf.

Insurance Agent _____ Phone _____

Claim Number _____ Date of Accident _____

State in which injury occured: _____

Referred by a Physician ? Please provide a copy of the prescription or referral letter

Thank you for understanding our policies. Please let us know if you have any questions.

River Falls Chiropractic 215 N 2nd St. River Falls, WI 54022 715-425-6665

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

(Date)

OFFICE SIGNATURE **X**

ALSO **SIGN** THE **INFORMED CONSENT** ON **REVERSE** SIDE

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and 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 treatment.

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

MISSED APPOINTMENT POLICY

Out of respect and consideration for our practice members, we kindly ask you to honor your scheduled appointment time. Please note that appointment space is limited daily and both of our doctors have waiting lists.

We understand unanticipated events occasionally occur. In our desire to be effective and fair to all of our clients' time, we ask you to give a minimum 24 hour advance notice when cancelling an appointment. This allows the opportunity for someone else to schedule and utilize your valuable appointment space.

We are happy to excuse one missed chiropractic appointment without charge. If there is a second missed appointment, you will be charged a $40 cancellation fee which is applied to your account. Insurance will not be billed for these charges. Cancellation fees are the responsibility of the patient and must be paid in full before the next visit.

Missed Clinical Nutrition appointments will be billed at $45 for every 15 minutes scheduled. For missed massage appointments, patients will be billed at $70 for an hour.

I have read and understand the River Falls Chiropractic Appointment Cancellation Policy. I am aware that I will be charged for the missed appointment, and I agree to these terms.

I, _____, have received a copy of The Cancellation Policy.

_____ _____

Signature of Patient Date