zenchiropractic
HEALING FROM WITHIN

WELCOME!

zenhealingcenter
LONGEVITY AND WELLNESS

Name: _____ Today's Date: _____

Address: _____City/State/ZIP:_____

Home Phone: _____Work Phone: _____ Cell Phone: _____

E-mail: _____

Birthday: _____ Age: _____ Marital Status:_____ M W D S __

Employer: _____Occupation: _____

Emergency Contact/ Relation/ Phone:

_____

#of Children & Ages: _____

Favorite Hobbies or Interests: _____

History

Current Health Complaints/ Reasons for Consulting Our Clinic

1. _____
2. _____
3. _____
4. _____

Injury Occurred: ☐ Automobile ☐ Work ☐ Other: _____

Injury Date: _____Injury Origin: _____

Discomfort Frequency: ☐ Always ☐ Hourly ☐ Daily ☐ Occasionally

Missed Work: Yes No

Does it worsen: Yes No

Aggravates Condition: _____

Improves Condition: _____

Have you had the same or similar problem(s) before? If so, for how long?

_____

Other doctors you have seen for this problem: _____

Interferes w/ Activities: Yes No Affected Sleep: Yes No

Previous Chiro care: Yes No Date: _____ Explain: _____

Surgeries you have had: _____

Medication you currently take: _____

Is Chance Pregnant: Yes No Planning: Yes No

Have you ever been diagnosed with cancer?_____If so what kind? _____

Broken Bones: Yes No Treatment: Yes No Explain: _____

Sprains/Strains: Yes No Treatment: Yes No Explain: _____

Hospitalized: Yes No Treatment: Yes No Explain: _____

Surgery: Yes No Treatment: Yes No Explain: _____

Eating Disorder: Yes No Treatment: Yes No Explain: _____

Stroke: Yes No Treatment: Yes No Explain: _____

Family Health Hist: _____

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Patient Social

Alcohol:	Daily	Weekly	Occasion	Never
Homemade Food:	Daily	Weekly	Occasion	Never
Exercise:	Daily	Weekly	Occasion	Never
Processed Food:	Daily	Weekly	Occasion	Never
Tobacco:	Daily	Weekly	Occasion	Never

Interest in Additional Services

Chiropractic Care Plans:	Yes	No
Massage Therapy:	Yes	No
Acupuncture:	Yes	No
Workshops:	Yes	No

How did you hear about us?

☐ Internet Search

☐ Friend/Family/Co-worker (Name): _____

☐ Zen Healing Center Coupon

☐ Outside ADD

Appointment Reminders

It is okay to leave me a message on:

☐ Home phone ☐ Work phone ☐ Mobile Phone

If unable to reach me:

☐ you may leave a detailed message

☐ leave a message asking me to return your call

☐ do not leave a message

Is it okay to send you a text message or e-mail about your appointment?: Yes No

If yes, please provide the following information:

☐ Mobile Phone Number: _____

Select your cell phone carrier: ☐ AT&T ☐ Sprint ☐ T-Mobile ☐Verizon ☐ Other:_____

☐ Email: _____

Patient Name: _____ Date: _____

Signature: _____

Address: 4570 West 77th Street, Ste. 140, Edina, MN 55435 ***Phone:*** 952-500-8733 ***Website:*** www.zenhealingcentermn.com

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

By signing this document, I acknowledge that you have provided me with a copy of your *Notice of Privacy Practices*. The *Notice of Privacy Practices* contains a more complete description of the use and disclosure of my health information.

I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound by such restrictions.

Patient Name:_____
Relationship to Patient: _____
Signature:_____
Date: _____

These forms are provided as a service to subscribers to www.hhs.gov and do not constitute legal advice. We try to provide quality information, but all forms should be reviewed by competent counsel to ensure that they apply correctly to the laws and regulations in your locale.

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FINANCIAL POLICY

Thank you for choosing Zen Chiropractic Inc. for your care. We ask that all patients read and sign our Financial Policy as well as complete our patient information forms prior to seeing the doctor.

Patient's portion of payment, as well as any past due balances, are due at the time services are rendered. We accept cash, personal checks, and credit cards for payment. We do our best to inform you of an estimated cost of services prior to your visit. We are in-network with some insurance companies such as Blue Cross, Humana, Medicare, Medicaid, Workers Compensation, and Auto Insurance). Please understand that:

1. Your insurance policy is a contract between you, your employer, and the insurance company. We cannot guarantee any payments coming from your health insurance.
2. All charges are your responsibility whether your insurance company pays or not. Our company will accept financial responsibility for claims not filed correctly or in a timely manner. You are responsible for providing our company with correct and current demographic and insurance information in order for us to bill your insurance.
3. Fees for services, along with unpaid deductibles and co-payments, are due at the time of treatment.
4. If the insurance company does not pay your balance within 45 days we ask that you contact the carrier to request prompt payment. Please inform our company of the carrier's response.
5. Returned checks will be subject to a $30.00 collection charge. If the check is not picked up and payment made within 10 days, we will turn the check over to law enforcement.
6. Unpaid balances over 90 days will be sent to collections via small claims court, attorney, and/or collection agency with applicable collection fees.

Authorization to Release and Assign Insurance Benefits

I authorize release of any information required to act on any insurance claim and permit photographic or other facsimile reproduction of this authorization to be used in place of the original assignment. I hereby assign to Zen Chiropractic Inc. benefits I am entitled from my insurance company and/or Medicare. This authorization is in effect for all future claims, until I choose to revoke it in writing. At such point I will become responsible for filing my insurance claims.

I, the undersigned, understand and agree to the above Financial Policy. I understand that I am financially responsible for all charges incurred for my treatment at Zen Chiropractic Inc.

Patient Name:_____
Relationship to Patient:_____
Signature:_____
Date: _____

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TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective. Chiropractic has only one goal. It is important that each patient understands both the objective and method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual finding, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the diseases are called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____(Print name) have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.
I therefore accept chiropractic care on this basis.

Patient Name:_____
Relationship to Patient: _____
Signature:_____
Date: _____