

# 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: \_\_\_\_\_

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? \_\_\_\_\_

**HISTORY OF PRESENT INJURY** 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:

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

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## Health History

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

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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 :

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Last Menstrual Period: \_\_\_\_\_

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

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

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New Hope, MN 55427  
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