



HELVIG HEALTH, LLC
CHIROPRACTIC PHYSICIAN

ALAN J. HELVIG, D.C.

Patient Information

Last Name _____ First Name _____

Address (Primary) _____

City _____

State _____ Zip Code _____

Address (Secondary) _____

City _____

State _____ Zip Code _____

E-mail _____

Home Phone _____ Cell Phone _____

Sex M F Age _____

Date of Birth _____

Marital Status

Married Single Widowed

Separated Divorced Partnered for _____ years

Occupation _____

Patient Employer _____

Spouse's Name _____

Whom may we thank for referring you? _____

Emergency Contact

In case of emergency, contact:

Name _____

Relationship to patient _____ Contact phone number _____

Patient Conditions

Reason for Visit _____

First day symptoms appeared _____

Rate the severity of your pain (circle, 0-no pain, 10-extreme pain):

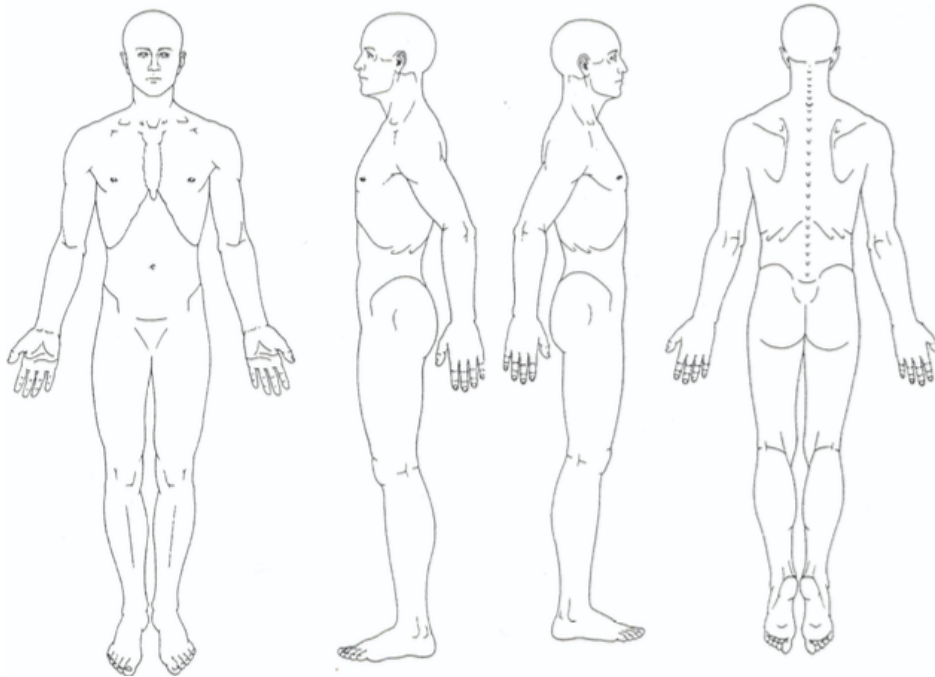
0 1 2 3 4 5 6 7 8 9 10

How often do you have this pain?

- Occasionally (less than 50% of the time)
- Intermittently (50% of the time or more)
- Constantly (approximately 100% of the time)

Please mark off the areas of your complaint on the diagram below. Please use the following symbols on the pain diagram to accurately describe your condition.

- PPP Where you experience Pain BBB Where you experience Burning
- NNN Where you experience Numbness CCC Where you experience Cramping
- TTT Where you experience Tingling



- Does it interfere with Work Sleep Daily Routine Recreation
- Movements that are difficult to perform Sitting Standing Walking Bending
- Lying Down

Health History

What treatment have you already received for your condition? Medication Surgery
 Physical Therapy Chiropractic Care Other _____

Date of Last:

Physical Exam _____ Spinal X-Ray _____

Spinal Exam _____ MRI, CT-Scan, Bone Scan _____

Please circle to indicate if you have had any of the following:

- | | | | |
|---------------------|----------------|--------------------|----------------------|
| AIDS/HIV | Diabetes | High Cholesterol | Prostate Problems |
| Alcoholism | Emphysema | Kidney Disease | Prosthesis |
| Anemia | Epilepsy | Liver Disease | Rheumatoid Arthritis |
| Arthritis | Fractures | Migraine Headaches | Stroke |
| Asthma | Heart Disease | Multiple Sclerosis | Thyroid Problems |
| Bleeding Disorders | Hernia | Osteoporosis | Tumors, Growths |
| Cancer | Herniated Disk | Pacemaker | Ulcers |
| Chemical Dependency | Herpes | Pinched Nerve | Other _____ |

Exercise

Work Activity

Injuries/Surgeries

Date

- | | | | |
|-----------------------------------|--------------------------------------|-------|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Sitting | _____ | |
| <input type="checkbox"/> Moderate | <input type="checkbox"/> Standing | _____ | |
| <input type="checkbox"/> Daily | <input type="checkbox"/> Light Labor | _____ | |
| <input type="checkbox"/> Heavy | <input type="checkbox"/> Heavy Labor | _____ | |

Medications

Condition Medication is Taken For

Patient Signature _____ **Today's Date** _____

Consent to Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by Alan J. Helvig, D.C., and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed.

I have had an opportunity to discuss with Dr. Helvig and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand the results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Notice of Privacy Practices Patient Acknowledgment of Receipts

This healthcare practice recognizes that every patient has the Right to Privacy concerning their personal health information. We make every effort to protect and preserve patient records in a manner that secures this information.

By signing this acknowledgment: You are only confirming that you have received a copy of our PRIVACY PRACTICES.

You do not give up any of your rights and you may choose at some point in the future to provide more specific instructions for us to follow regarding your personal health information.

I have received a copy of this office's Notice of Privacy Practices:

Printed Name: _____ Signature: _____

Today's Date: _____

TO MEDICARE AND MEDICARE ADVANTAGE PATIENTS:

REASONS FOR DENIAL:

Excluded Services: An excluded service from Medicare coverage is any service other than manual manipulation for treatment of subluxation of the spine. The chiropractor is not required to bill excluded services; however the provider may bill these services to Medicare in order to obtain a denial for secondary insurance purposes. The following are examples (not an all-inclusive list) of services that, when performed or ordered by the chiropractor, are excluded from Medicare coverage and for which the beneficiary is responsible for payment:

- Treatment/Adjustments for a **chronic** condition that does not meet the definition as described in the “indications and limitations” section of this policy.
- Maintenance Therapy
- Laboratory tests
- X-Rays

Coverage will be denied for lack of reasonable expectation that the continuation of treatment would result in “significant long term improvement of the patient’s condition”. Continued repetitive treatment without an achievable and clearly defined goal is considered maintenance therapy and is not covered.

(MEDICARE PART B SPECIAL ISSUE)

Medicare will only cover spinal manipulation. Because of this, most secondary insurances will not cover the Therapy charge of \$16.00. As the patient, you are responsible for this fee.

Signature _____ Date _____