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):

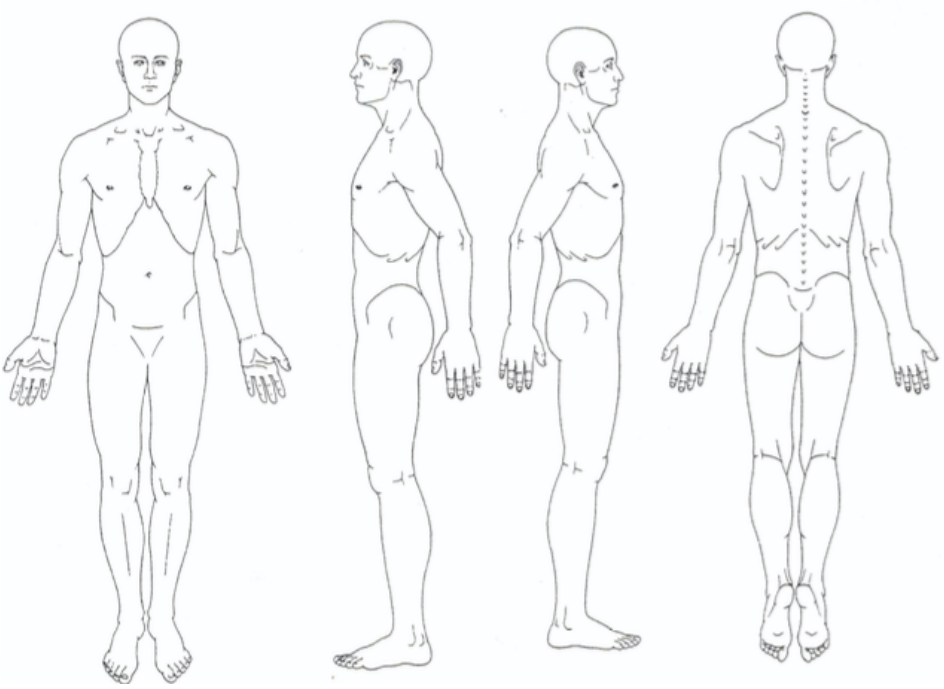
0 1 2 3 4 5 6 7 8 9 10

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**
☐ None	☐ Sitting	_____	
☐ Moderate	☐ Standing	_____	
☐ Daily	☐ Light Labor	_____	
☐ Heavy	☐ 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:_____

NOTICE:

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 $19.00. As the patient, you are responsible for this fee.

Signature _____ Date_____