Kettle Moraine Health Center

Patient Registration Form

Patient Information:

Full Name: _____ Date: _____
First MI Last

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____
I prefer to receive calls at (Circle): Home Work Cell

Email Address: _____ Social Security Number: _____

Age: _____ Date of Birth: _____ Sex (Check): ☐Female ☐ Male

I am (Check One): ☐Under Age 18 ☐Single ☐ Married ☐Divorced ☐Widowed ☐ Separated ☐Partnered

I am (Check One): Spouse Name _____ Employer _____ Occupation _____ SS# _____

Ethnicity (Check): ☐White / Caucasian ☐Black / African American ☐ Hispanic / Latino / Spanish Origin ☐Asian
☐ American Indian ☐Native Hawaiian

Language (Check): ☐English ☐Spanish ☐Chinese ☐ Other _____

Payment Information:

Person Responsible for Payment: _____ Relationship: _____

Phone: _____

Health Plan _____ Subscriber's Name _____ ID# _____ Group # _____

Emergency Contact: _____ Emergency Contact Phone Number: _____

Whom may we thank for referring you? _____

□Internet □Insurance Company □Ad in Community □Physician □Other:_____

DESCRIBE your symptoms today including **HOW & WHEN** your symptoms started :
Please mark areas of injury or discomfort

Numbness (n) _____

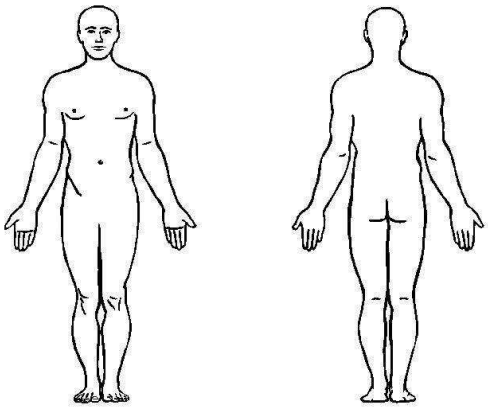
Pins and needles (p) _____

Burning (b) _____

Aching (a) _____

Stabbing (s) _____

Indicate where you have pain or other symptoms:



LIST EACH Complaint in order of **PRIORITY / SEVERITY**.
Circle PAIN LEVEL and **Check All TYPES of PAIN** you are experiencing for each one:

None Unbearable

1. _____ 0 1 2 3 4 5 6 7 8 9 10
☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramping ☐ Stiffness ☐ Swelling

2. _____ 0 1 2 3 4 5 6 7 8 9 10
☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramping ☐ Stiffness ☐ Swelling

3. _____ 0 1 2 3 4 5 6 7 8 9 10
☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramping ☐ Stiffness ☐ Swelling

4. _____ 0 1 2 3 4 5 6 7 8 9 10
☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramping ☐ Stiffness ☐ Swelling

How often do you experience your symptoms? (Check One)
□ Constantly (76-100% of the day) □ Frequently (51 – 75% of the day) ☒ Occasionally (26 – 50 % of the day) □ Intermittently (0 – 25% of the day)

Since it began, is your problem □ Improving ☒ Getting worse ☒ No change

How much have your symptoms interfered with your normal daily activities (including work outside the home and housework, home, social activities)?
□ Not at all □ A little bit □ Sometimes □ Quite a bit □ All the time

Activities or movements that are painful to perform: □ Sitting □ Standing □ Walking □ Bending □ Lying Down
What makes the problem better? □ Sitting □ Standing □ Walking □ Bending □ Lying Down

What treatment have you already received for your complaint? □ Medications □ Surgery □ Physical Therapy □ Chiropractic Services
□ Epidural Injection □ X-Ray □ MRI □ Other _____
If you checked any of the above treatments, please indicate name and address of other doctor: _____

Is this condition / complaint is due to an accident:
□ No □ Yes, Date of Injury/accident _____ Type of Accident: □ Auto □ Work □ Home □ Other _____

Has this accident / injury been reported to: □ Auto Insurance □ Employer □ □ Other _____
Work Activity: □ Sitting □ Standing □ Light Labor □ Heavy Labor

In general, would you say your overall health right now is: □ Excellent □ Very Good □ Good □ Fair □ Poor

Are you a smoker? (Check One) □ YES □ NO If YES, would you like information on quitting smoking? (Check One) □ YES □ NO

Habits:
Exercise: □ None □ Moderate □ Daily □ Heavy
Alcohol: Number of Drinks _____ per □ day □ week □ month
Coffee / Caffeine Drinks: Number of Cups _____ per □ day □ week □ month

What is your current stress level? □ Low □ Average □ High

For female patients: Are you pregnant? (Check One) □ YES □ NO If YES, what is your due date: _____

Date of Last: Physical Exam _____ Chest X-ray _____ Blood Test _____

Spinal Exam _____ Spinal X-ray _____ Urine Test _____

MRI _____ CT Scan _____ Bone Scan _____

Do you take any medications, vitamins, herbs, minerals? (Check One) ☒ YES ☒ NO
If YES, please list medication name and dosage:

_____

_____

_____

Pharmacy Name: _____ Pharmacy Phone Number: _____

Do you have any allergies? (Check One) ☒ YES ☒ NO
If YES, please list:

_____

_____

_____

Have you had any surgeries (Include procedure / description / date)? (Check One) ☒ YES ☒ NO
If YES, please list:

_____

_____

_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Other _____	
Chemical Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No	_____	
Chicken Pox	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		

Immunizations_____
Dates & places last 2-3 years_____

Kettle Moraine Health Center

Financial Policy

It is vital for you and your family to have access to quality health and wellness care. Every attempt will be made to make this care affordable to you and your family. We would advise an insurance policy that allows you and your family to choose your own physician, not allowing managed care to undermine the quality and standards you deserve. **Our office will file claims and facilitate payment from your insurance company (or third party payer), but please understand that your insurance policy is a contract between you, your employer, and the insurance company. If you have specific questions regarding your insurance coverage, please contact the member services number for the plan. We will submit claims for services rendered to your insurance company unless other payment arrangements are made within 24 hours of your initial visit.**

Our financial policy will require that everyone make a payment at the time of treatment. We accept cash, check pr credit card. This may only be your deductible and/or estimated coinsurance, or office visit co-payment, but it is necessary for us to collect payments toward your portion at the time of service. If your insurance company should pay more than anticipated, then we will be happy to refund you any overpayment. If your insurance company should pay less than anticipated, then you may be billed for an additional amount.

Our policy for a patient whose insurance company pays them directly, we will bill you for any outstanding balance after receiving your pre-set payment amounts.

Our policy for a patient, who is being treated under a motor vehicle accident/personal injury case, there is a separate financial policy form. – See _____

Our policy for a patient who is being treated under a worker's compensation case will be required to provide us with your workers compensation claim/case number and carrier information within 1 week of the initial visit for this condition. If your workers compensation claim is denied, you agree to work with our billing department to make payment arrangements until the balance is paid in full. Our policy for a patient who does not have insurance or does not have a current card will be required to pay at the time of the visit.

We offer reasonable rates and payment plans for anyone uninsured. We offer a "pay as you go" plan or "Pay-At-Time-Of-Service" plan which incorporates discounted rates when you pay the same day as the service is rendered. *We can offer our 'Pay At the Time of Service' rates to visits because they involve minimal paperwork, which means that a bill or statement cannot be submitted to insurance companies or to you by our office without additional fees.* If payment is not made at the time of service, our normal billed rate will apply to any statement sent to you requesting payment.

We reserve the right to charge for appointments cancelled without 24 hours advance notice. This includes appointments made for chiropractic services, massage, acupuncture or personal training. The fee charged will be $45.

If any special or unusual financial considerations are necessary, please communicate these special needs to anyone on our staff who will be happy to direct to the director of patient accounts.

We look forward to providing you with the finest in personalized care. Thank you.

I authorize the release of medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party Listed above accepts assignment. I also authorize payment of medical benefits to the physician or supplier for services listed above.

Signature _____ Date _____

Kettle Moraine Health Center

Treatment and Care Informed Consent for Chiropractic

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures; including various modes of physiological therapy, diagnostic X-rays, exercises, massage therapy, acupuncture and nutritional supplements/dietary recommendations which may be used for me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other authorized licensed doctors of chiropractic or persons who might now or in the future treat me while working or associated with, or serving as back-up for Dr. Richard Venske at the clinic or office listed below or any other office or clinic.

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

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment. This includes but is not limited to: soreness, dizziness, fractures, disc 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 or her, is in my best interest. I understand that I am responsible for monitoring my own condition throughout the treatments and will inform the doctor of any unusual symptoms that might occur.

I have read, or have 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.

_____ _____

Name (Printed) Date

_____

Signature: Patient or Legal Representative (Attorney, Guardian, Parent)

_____

Witness

Kettle Moraine Health Center

Dr. Richard Venske and Associates

Consent for Use and Disclosure of Health Information

This notice describes how chiropractic and medical information about you may be used and disclosed, your rights as a patient, and ways for you to get additional information on our policies.

Our clinic has always been very protective and respectful of your personal information. Under new federal regulations (the HIPAA Privacy Act), we have adopted additional guidelines to ensure the proper use, confidentiality and disclosure of your health information.

We May Release or Disclose Your Health Information:
- For treatment purposes to another health care provider or clinic if we refer you, or to providers or staff within our clinic that are taking part in your care.
- For billing and collection purposes, we may release records of you health care and information that you have provided to your insurance carrier or other financially responsible parties.
- For operational purposes within our clinic for quality control, office administration, record keeping, staff or provider training.

Specifically, you authorize the release of any information pertinent to your case to any insurance company, adjuster, or attorney involved in this case for the purpose of obtaining payment on your health claims.

We may also use your personal health information to contact you regarding your appointments, to send you information about our clinic or office events, or to share treatment options. We will not disclose information about you to anyone outside our office without your written approval.

You have the right to inspect or obtain a copy of the information we will use for these purposes. You have the right to amend your records at this office. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provide to you or the reimbursement avenues associated with your care. Requests to inspect, copy or amend your health related information should be provided to the Front Desk in writing.

We normally provide information about your health to you in person at the time you receive care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form, please advise us in writing as to your preferences.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint in writing to the Clinic Director.

If you would like further information about our privacy policies and practices please see the “NOTICE OF PRIVACY PRACTICES” binder in reception or ask for a copy at the Front desk.

_____	_____	_____
Name (Printed please)	Signature	Date

If you are a minor or if you are being represented by another party:

_____	_____	_____
Personal Representative (Printed)	Signature	Date

ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

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 appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: 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 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. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

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, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). 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.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm 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 agree with the current or future recommendations for care. 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 NAME:

ACUPUNCTURIST NAME: Michael J Aehl LMT. LAc. Kettle Moraine Health Ctr

(Date)

PATIENT SIGNATURE X

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