Kettle Moraine Health Center

Patient Registration Form

Patient Information:

Full Name (F, MI, L): _____Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
I prefer to receive calls at (Circle): Home Work Cell
Email Address: _____Would you like to receive our e-newsletter? Yes No
Age: _____ Date of Birth: _____
I am (Circle one): Under Age 18 Single Married Divorced Widowed Separated Partnered
Spouse Name _____ Employer _____ Occupation_____
Language (Circle One): English Spanish Other _____

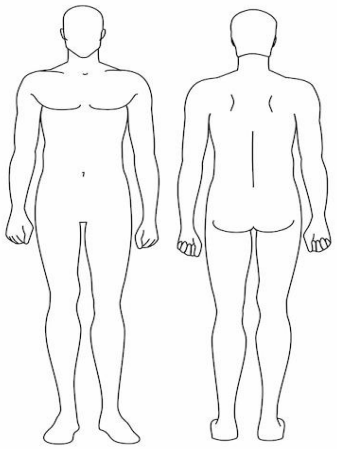
Payment Information:

Person Responsible for Payment: _____ Relationship: _____
Phone: _____
Insurance Plan_____ Subscriber's Name and Date of Birth_____
Member ID/Subscriber ID #_____ Group #_____
Emergency Contact: _____ Emergency Contact Phone Number: _____
Whom may we thank for referring you? _____

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

Numbness (n)_____
Pins & 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 **CIRCLE 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? (circle 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 (circle one) 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 (circle one): Auto Insurance Employer

Workers Compensation Carrier and Claim #_____

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? (Circle 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? (Circle 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? (Circle One) YES NO
If YES, please list medication name and dosage:
_____
_____
_____
_____
Pharmacy Name: _____ Pharmacy Phone Number: _____

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

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

Please check 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	Migraines ☐Yes ☐No	STD ☐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 Press ☐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 for last 2-3 years_____

Kettle Moraine Health Center

Dr. Richard Venske and Associates

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.

Per our policy, there is a separate financial policy form for a patient who is being treated under a motor vehicle accident/personal injury case.

Our policy for a patient who is being treated under a workers 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 can offer a "pay as you go" plan or "pay at the time of service" 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 $60.

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

Dr. Richard Venske and Associates

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 your 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