door county
HEALING CENTER
HEALTH COMES FROM WITHIN

PERSONAL HISTORY

Name:_____ Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Date of Birth: _____ Gender: _____

Cell Phone: _____ Email: _____

Social Security Number: _____ Marital Status: _____

Spouse's Name: _____ Spouse's Contact Number: _____

Business Employer:_____ Business Phone: _____

Name and Number of Emergency Contact: _____

I was referred to The Door County Healing Center by: _____

Are you Medicare Eligible? _____ Do you have a Supplement: _____

Name of Supplement Company: _____ Do you have a Replacement Plan: _____

Name of Replacement Plan Company: _____

Please present all copies of your insurance cards at the front desk before the doctor sees you. Thank you.

Is your condition a current personal injury or workers compensation case? _____

Date of Injury: _____Claim #_____Employer's Name: _____

Employer's Address and Contact Information: _____

Name of Insurance Company and Contact information_____

HEALTH HISTORY

Describe the reason for this visit: _____

Date of onset: _____ Have you seen anyone else for this condition: ____

Who: _____ Type of treatment: _____

On a scale of 0-10, 10 being the WORST, rate your pain currently: _____

Please list any prescription drugs you are currently taking: _____

Please list any nutritional supplements you are currently taking: _____

Please list current or past diagnosis/major health concerns _____

_____

Please list and date any surgeries you have had: _____

Previous Chiropractic Care? _____ Doctor's name and date of last visit: _____

Please circle any health conditions you are suffering from:

Headaches or migraines	Asthma	Menstrual Problems
Heart conditions	Acid Reflux	High Cholesterol
Dizziness/Vertigo	Gastrointestinal Upset	Nausea
Vision Problems	Kidney Infections/ UTI	Unexplained Weight Loss
Radiating arm pain	Constipation	Arthritis
Hand/finger numbness	Diarrhea	Cancer
High Blood Pressure	IBS/Crohn's	Radiating leg pain/numbness
Stroke	Other: _____	

FINANCIAL STATEMENT

Payment is due at the time of service for all services provided by Door County Healing Center.

All patients will pay in full, at the desk, at each visit, at the time of service. Door County Healing Center is an *"out of network"* provider. Upon request, we will provide receipts and statements for patients to submit to their insurance companies if they have coverage. Patients will conduct all communication and follow up needed for their claims directly with the insurance company. Door County Healing Center will submit Medicare claims for Medicare patients. Services may be only partially covered, or not covered at all by Medicare (due to deductible; non covered service; limits of care, etc.). The Healing Center can provide additional information and support for the claims, but patients will have the primary responsibility for any needed follow up with Medicare or insurance providers.
Payment must be made in the form of cash, check, and credit card (subject to a fee of 3%). Post-dated checks are not accepted. If a patient's check incurs insufficient funds upon deposit they will be subject to a $25 fee that is to be paid before time of next service. I agree that I will be subject to a fee of $25 if I do not give at least a 24 hour notice of cancellation of my appointment. I may also be subject to a discretionary fee if I miss my appointment.

Printed Name: _____ Signature: _____

Date: _____

TERMS OF ACCEPTANCE

Our practice objective is to optimize musculoskeletal and nervous system function within the scope of chiropractic and clinical nutrition. If during the course of a chiropractic evaluation we encounter findings that necessitate co-management or referral, we reserve the right to do so. I hereby authorize the doctor to work with my condition through the use of adjustments to my spine and nutrition as they deem appropriate. I agree that the doctor will not be held responsible for any pre-existing medically diagnosed conditions that I may or may not report as a patient of The Door County Healing Center.

Printed Name: _____ Signature: _____

Date: _____

PRIVACY POLICY

I understand under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan, and direct my treatment and follow up with a multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment front third party payers and conduct normal healthcare operations such as quality assessments and physician's certifications. I can request a full copy of the HIPAA act for my review at the front desk.

Printed Name: _____ Signature:_____

Date: _____