Wisconsin Center for Integrative Health

3814 Oakwood Hills Parkway Eau Claire, WI 54701

Name_____ Date: _____
(First) (Middle initial) (Last)

☐ **Same as before**. Make changes below, if any.

Phone: Home_____ Cell _____ Single/ Married / Divorced / Widowed

Email: _____ Work status: full / part / retired / unemployed

Patient's Address _____City _____ State_____ Zip_____

Employer Name: _____Occupation:_____

Person to contact in case of an emergency_____ Phone_____

If the patient is a minor: I give consent to treat. Yes/ No _____ _____
Parent or Guardian signature *Date*

Responsible Party ☐ same as above Is this a Work injury? Yes/No Is this related to an Auto Accident? Yes/No

Person responsible for this account _____Relationship to Patient: self/ spouse/parent/_____

Address _____Home Phone _____

Date of Birth: _____E-Mail _____Cell Phone _____

Do you have any Medical insurance? Yes / No ☐ Subscriber is the same as the patient / responsible party. (circle one)

Name of the Subscriber_____ Relationship to patient: self/spouse/parent/_____

Birthdate_____ Name of Employer_____ Work Phone _____

Insurance Company_____ Group #_____ ID # _____

Ins. Co. Address _____ City _____ State _____ Zip_____

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Wisconsin Center for Integrative Health and/or Tenold Chiropractic, LLC** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been* or *will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 ____. X_____
(Patient signature)

X_____ (signature of Guardian if applicable) X_____(print patient name)

Complaint **:** _____

Location of pain: _____**Right/Left/Bilateral/Central**

Severity: 0-1-2-3-4-5-6-7-8-9-10 **Frequency**: 76-100% Constant / 51-75% Frequent / 26-50% Occasional / 0-25% Intermittent
(No pain) (Worst pain)

Duration: _____ **Onset:** _____
How long have you had this pain/ problem? When did it start? (What were you doing when this pain/problem began?)

What activities make this worse?

Complaint**:** _____

Location of pain: _____**Right/Left/Bilateral/Central**

Severity: 0-1-2-3-4-5-6-7-8-9-10 **Frequency**: 76-100% Constant / 51-75% Frequent / 26-50% Occasional / 0-25% Intermittent
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Complaint**:** _____

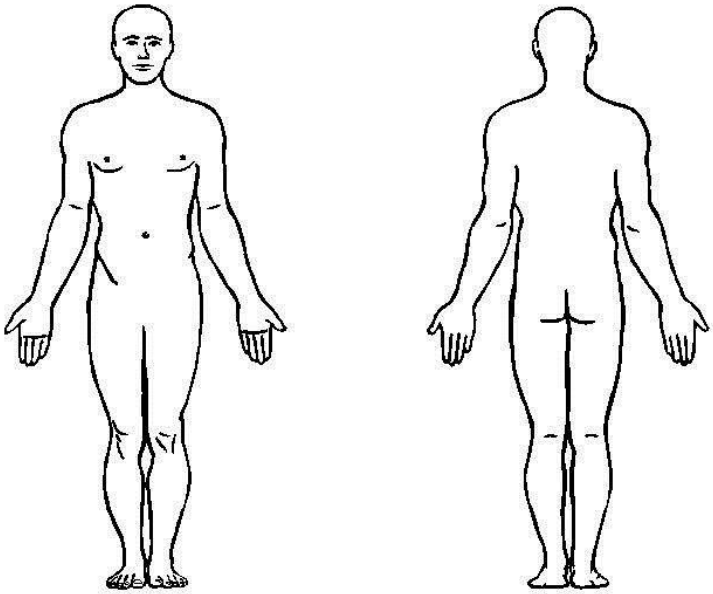
Location of pain: _____**Right/Left/Bilateral/Central**

Severity: 0-1-2-3-4-5-6-7-8-9-10 **Frequency**: 76-100% Constant / 51-75% Frequent / 26-50% Occasional / 0-25% Intermittent
(No pain) (Worst pain)

Duration: _____ **Onset:** _____
How long have you had this pain/ problem? When did it start? (What were you doing when this pain/problem began?)

What activities make this worse?

Mark the appropriate sensation…



Numbness >>>>

Pins & Needles 0000

Burning XXXX

Stabbing ////

Aching ((((

Changes in Medical History since last visit at our office, including Hospitalizations/Surgeries/Serious Illnesses (including date)_____

_____

Medication: ☐ None. _____

_____

(Note what each medication is treating)

Medication Allergies: ☐ None. _____

Vitamins/supplements: _____

Are you currently pregnant? Yes / No If yes, under care of:_____

Surgical Implants: Yes / No Breast implants, knee replacement, knee replacement, pacemaker, spinal stimulator, scoliosis rods, etc.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of Patient, Parent or Guardian **Date**