Application For Admission To Wisconsin Spinal Rehabilitation Center

Today's Date _____ Name_____

Age _____ Birthday _____Sex_____

Address_____

Email_____City_____
State _____ Zip _____Home Phone _____

Work Phone _____ Cell Phone _____

Occupation_____ Marital Status S M W D

SS# _____

How did you hear about Wisconsin Spinal Rehabilitation Center?

_____

1. Please explain in detail your main problem/symptom prompting your request for a consultation with Dr. Friedrichs?

_____

_____

2. When did this symptom begin _____/_____/_____ Did it begin:

Gradual Sudden Progressive over time

3. Is this related to an auto accident/ work injury? _____ If yes, please explain:

_____

4. Circle type of pain: Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting

5. Circle the intensity of your pain with 10 being the worst pain: 1 2 3 4 5 6 7 8 9 10

6. How often do you experience this symptom throughout the day: 100% 75% 50% 25%

7. Is there anything you can do that makes the it feel better?

_____

8. What activities/movements are guaranteed to make it worse?

9. Have you ever experienced this condition before? _____ If yes, please explain:

_____

10. Do you believe that your weight may be a contributing factor to your concern?

Yes_____ No_____

11. List any other problems/ symptoms you would like to address today?

_____

Please list all past surgeries:

Type:_____

Date:_____

Type:_____

Date:_____

Please list all previous auto accidents, accidents and falls (even if you sought no treatment for it):

What:_____

Date:_____

What:_____

Date:_____

Please list any medications or vitamins you are currently taking:

Have you seen a Doctor of Chiropractic before? _____ If so, when and why?

Have you had an MRI or x-rays recently?_____ If so, when and where?

Do you have insurance? _____ Please be sure we have a copy of your insurance card

PATIENT CONSENT FORM

Regarding the Use & Disclosure of Protected Health Information

("HIPAA Release Form")

For the purposes of this Consent Form, "Office" shall refer to: WISCONSIN SPINAL REHABILITATION CENTER S.C.

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment, or health care operations, and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior signing this form. I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy. I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment, or health care operations, and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing. I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

Patient Name (please print):_____

Signature:_____

Date:____/____/____

Terms of Agreement:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office may prepare the necessary reports and forms to assist me in making collection from my insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-insured remittances for the conveyance of credit to my account. However, I clearly understand and agree that I am personally responsible for payment. I also understand if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be due immediately. I understand that a 1.5% monthly interest charge will be applied to all accounts over 30 days past due. I understand that Wisconsin Spinal Rehabilitation Center, S.C. is responsible for subluxation identification and reduction only. Wisconsin Spinal Rehabilitation Center, S.C. is not responsible for any past, present or future medical illnesses or diagnosis treatment or identification. Dr. Friedrichs is not my primary physician. I also understand that insurance does not pay for spinal decompression and if decompression is deemed necessary in my particular case I will pre-pay for decompression services provided to me by Dr. Friedrichs. I understand that decompression or any other services provided to me does not guarantee cure or healing and that the Dr. may need to refer me to another doctor or facility to assist me in my health care.

Signature:_____
Date:_____

I authorize release of information necessary to process this claim and request payment be made directly to Wisconsin Spinal Rehabilitation Center, S.C. and the attending Doctor.

Signature:_____
Date:_____

Females Only

Upon completion of the patient history and examination, Dr. Friedrichs will decide if X-rays will be taken for your specific condition or illness. If you are pregnant, X-rays cannot and will not be taken. Therefore, I am NOT pregnant and Dr. Friedrichs is hereby authorized and directed to complete a radiographic examination to treat my present specific condition or illness.

Signature:_____
Date:_____

Medicare Only - Explanation of Medicare Benefits for Chiropractic Care

Medicare may reimburse for Chiropractic adjustments coded 98940-98943 on your insurance claim. Medicare may only cover these adjustments if current X-rays are taken, unfortunately Medicare will not cover the cost of these X-rays. Medicare sets a limit of 24 adjustments per year, depending on the patient's condition. Additional items not covered by Medicare are examinations, therapies and support charges.

Therefore you will be responsible for all charges. We will gladly submit all claims for your Medicare reimbursement. Medicare will then send you a check for the services that they cover.

I further agree that by signing below, I have been notified by Wisconsin Spinal Rehabilitation Center, S.C. that they believe, in my case, Medicare is likely to deny payment for services identified above, for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

Signature:_____
Date:_____

Consent for Treatment

Every type of health care is associated with some risk of a potential problem. This includes Chiropractic health care. We want you to be informed about potential problems associated with Chiropractic health care before consenting to treatment. This is called informed consent. Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of a machine. Usually those movements result in a “pop” or “click” sound and/or sensation in the area being adjusted. In this office we may use trained staff personnel to assist the doctor with portions of you consultation, examination, X-ray taking, traction, massage therapy, exercise instruction, or other services. Occasionally, when your doctor is unavailable, another doctor will adjust you on that day.

STROKE: Stroke is the most serious potential problem associated with Chiropractic adjustments. Stroke means that a portion of the brain does not receive enough oxygen for the bloodstream. The result can be temporary or permanent dysfunction of the brain, or even death. Chiropractic adjustments have been associated with strokes that arise from the vertebral artery only. This is because the vertebral artery is actually found inside the neck vertebrae. The adjustment that is related to the vertebral artery stroke is called the “Extension-rotation thrust atlas adjustment”. Fortunately, we do not perform this type of adjustment on patients. Other types of neck adjustment may also potentially be related to vertebral artery strokes, but no one is certain. The most recent studies (Journal of the CCA. Vol. 37. No. 2 June, 1993) estimate that the incident of this type of stroke is 1 per every 3, 000,000 upper neck adjustments. This means that an average Chiropractor would have to be in practice for hundreds of years before he or she would statistically be associated with a single patient stroke.

SOFT TISSUE INJURY: Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely a chiropractic adjustment, traction, massage therapy, and/ or therapeutic exercise may damage some muscle or ligament fibers. The result is a temporary increase in pain which may necessitate extra visits for resolution, but there are no long-term effects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

RIB FRACTURES: The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely does a chiropractic adjustment crack a rib bone, and this is referred to as a fracture. This occurs only in patients who have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients very carefully, and especially those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

SORENESS: It is common for Chiropractic adjustments, spinal decompression,

massage therapy, and or/ therapeutic exercise to result in an increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while you body is undergoing therapeutic change. It is not dangerous, and may vary according to your general health.

SPINAL DECOMPRESSION: The AxiomWorldwide DRX9000 is a vertebral decompression device which has been cleared for marketing by the FDA for temporary relief of pain. The DRX9000 has not been approved by the FDA. The FDA has never tested the efficacy of safety of the DRX9000.

OTHER PROBLEMS: There may be other problems or complications that can arise from Chiropractic care other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment. Chiropractic is a system of health care delivery, and therefore, as with any health care delivery system, we can not and do not promise a cure for any symptom, disease, or condition as a result of treatment in this office.

We will always give you our best care, and if results are not acceptable, we will refer you to another provider who may be better able to fulfill your needs. If you have any questions of the above, please ask you doctor. When you have full understanding, please sign and date below.

_____ _____

Patient's Printed Name Patient's Signature (or Guardian)

Date_____

Thank you for choosing Wisconsin Spinal Rehabilitation Center, S.C.

Brookfield, WI East Troy, WI