CASE HISTORY

Bear Town Chiropractic Clinic, P.A.
Dr. Russell R. Heurung, D.C.
2186 3rd St.#104 White Bear Lake, MN 55110

Case #_____

Patient Name:_____Date:___/___/___

Address:_____City:_____State____ZIP_____

Home Phone:_____-_____-_____ Cell Phone: _____-_____-_____Work: _____-_____-_____

E-Mail_____

Date of Birth____/___/___ Age:_____ Sex: M F Marital Status: Single Married Divorced Widow

Employer_____ Occupation:_____

Employer Phone:_____ Work Status: O FT O PT O Student

Primary Insurance Company:_____Phone:_____

Who is Main Insured:_____ Their Date of Birth:_____

Secondary coverage?:_____Main Insured?:_____Date of Birth_____

If your present symptoms are due to an automobile **or *work related accident*** please fill out below:

Automobile accident ( ) Work Accident ( )

Date of Injury_____ What State did accident/injury occur in? _____
Auto or Work comp Insurance company name:_____
Adjusters Name:_____ Phone:_____
Claim #_____

Have you ever treated with another chiropractor? YES ( ) NO ( )

Habits:	**Exercise:**	**Family History:**
( ) Smoking packs/day____ ( ) Drinking alcohol_____ ( ) Caffeine per/day_____	( ) None ( ) Moderate ( ) Daily	( ) Mother □heart □cancer □spine ( ) Father □heart □cancer □spine ( ) brother # of__ □heart □cancer □spine ( ) sister # of __ □heart □cancer □spine

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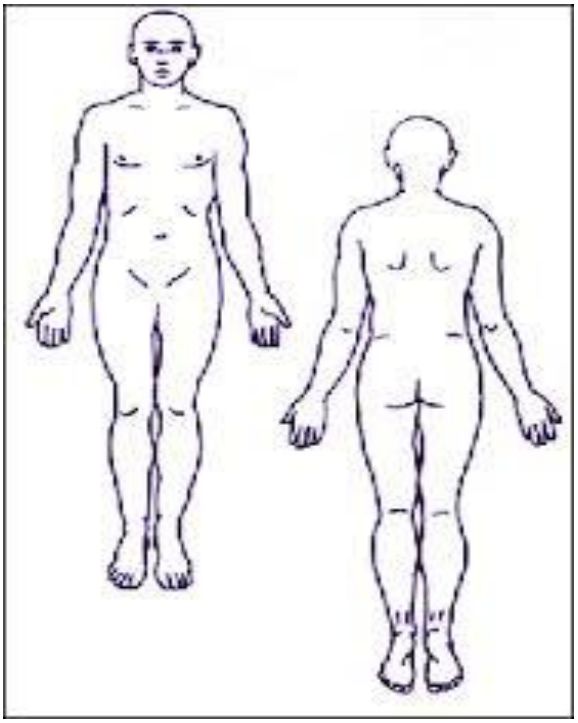
Place an "X" on the drawing on areas causing you pain and a letter describing the pain.

A= ACHE B=BURNING S=STABBING
N=NUMBNESS P=PINS & NEEDLES



PAIN SCALE

Please put a number 0-10 next to each "X" you have marked on the diagram to rate your pain.

0 1 2 3 4 5 6 7 8 9 10
None LITTLE MEDIUM SEVERE

What caused your symptoms:

_____

_____

_____

What makes the problem worse?

○ **Standing** ○ **Sitting** ○ **Lying down** ○ **Bending** ○ **Lifting** ○ **Twisting**

Have you found things to relieve your symptoms**?** ○ **YES** ○ **NO** If yes, please describe:

_____

_____

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Emergency Contact

Emergency Contact person 1. _____Relationship to patient_____

Home Phone (____) _____ Cell Phone: (____) _____Work Phone: (____)_____

Emergency Contact person 2. _____Relationship to patient_____

Home Phone (____) _____ Cell Phone: (____) _____Work Phone: (____)_____

Current Medications (Include all Prescriptions and over the counter meds including vitamins)

Name of Medication	Reason for taking Medication	Dose	Frequency

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Please enter: "2" for Previously and "3" for Presently in front of signs and symptoms. Leave blank if Never

General Symptoms	**Gastro-intestinal**	**Eye/Ear/Nose/Throat**	**Respiratory**
____ Headache	____ Poor Appetite	____ Poor Vision	____ Chronic Cough
____ Fever	____ Poor digestion	____ Crossed Eyes	____ Spitting Blood
____ Chills	____ Excessive Hunger	____ Pain in Eyes	____ Spitting Phlegm
____ Night Sweats	____ Belching or Gas	____ Deafness	____ Chest Pain
____ Fainting	____ Nausea	____ Earache	____ Difficulty Breathing
____ Dizziness	____ Vomiting	____ Ear Noises	
____ Convulsions	____ Vomiting Blood	____ Ear Discharges	**Gentio-Urinary**
____ Loss of Sleep	____ Pain over Stomach	____ Nasal Obstruction	____ Frequent Urination
____ Loss of weight	____Constipation	____ Nose Bleeds	____ Painful Urination
____ Fatigue	____ Diarrhea	____ Sore Throat	____ Blood in Urine
____ Numbness or pain	____ Colon Trouble	____ Hoarseness	____ Kidney Infection
In arms/legs/hands	____ Hemorrhoids	____ Hay Fever	____ Bed Wetting
____ Allergy (what?)	____ Liver Trouble	____ Asthma	____ Unable to Control Urine
____ Wheezing	____ Jaundice	____ Frequent Colds	____ Prostate Trouble
____ Neuralgia	____ Gall Bladder	____ Enlarged Thyroid	
		____ Tonsillitis	**For Women Only**
Muscle & Joints	**Cardio-Vascular**	____ Sinus Trouble	____ Painful Periods
____ Weakness	____ Rapid Heart		____ Excessive Flow
____ Twitching	____ Slow Heart	**Skin or Allergies**	____ Irregular Cycle
____ Stiff Neck	____ High Blood Pressure	____ Skin Eruptions	____ Hot Flashes
____ Backache	____ Low Blood Pressure	____ Itching	____ Cramps
____ Swollen Joints	____ Pain over Heart	____ Bruising Easily	____ Breast Implants/Surgery
____ Tremors	____Previous Heart Issue	____ Dryness	____ Miscarriage
____ Foot Trouble	____ Swelling Ankles	____ Boils	____ Vaginal Discharge
____ Painful Tail Bone	____ Poor Circulation	____ Sensitive Skin	____ Pregnant at this time
____ Pain Bet Shoulders	____ Varicose Veins	____ Hives or Allergy	____ Last Pap
____ Hernia	____ Strokes	____ Eczema	
____ Spinal Curvature		____ Medicines	By whom_____
		_____	Other_____

Operations and Procedures

Date	Date	Date
_____ Vaccinations	_____ Tubes in Ears	_____ Sinus
_____ Tonsillectomy	_____ Appendectomy	_____ Hernia
_____ Gall Bladder	_____ Female Organs	_____ Thyroid
_____ Back Operation	_____ Rectal Surgery	_____ Stomach
_____ Other	_____ Other	_____ Other

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Patient Name:_____ Date:_____/_____/_____ Case #_____

List any accidents or falls and date: O Car O Sports O Other

Please describe_____

List any broken bones or dislocations (fractures)_____

Have you ever had any spinal taps or spinal injections? ○ Yes ○ No

If yes, when:_____

Were you ever knocked unconscious? ○ Yes ○ No

If yes, when:_____

Have you ever had a lapse of memory? ○ Yes ○ No

If yes, when:_____

Have you ever had x-rays taken? ○ Yes ○ No When?_____

By Whom:_____

For what ailments were these picture made? _____

Do you suffer from any condition other than that for which you are now consulting us?

_____

_____

_____

_____

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Patient Name:_____ Date:_____/_____/_____ Case #_____

Informed Consent Authorization for Chiropractic Treatment

I the undersigned, hereby authorize Dr. Russell R. Heurung, D.C. (and whomever he may designate as his assistants) to administer treatment consisting of: Chiropractic adjustments,(eitiher through the use of his hands or mechanical device), therapy (ie: manual muscle massage, trigger point therapy, intersegmental traction, application of cold packes, etc.), x-rays, diagnostic tests, or procedures that are considered therapeutically necessary on the basis of examination history findings and other test findings and clinical judgement during the course of my treatment.

As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include: fractures, disc injury, dislocations, and muscle strain, Homer's syndrome, diaphragmatic parallysis, cervical myelopathy, and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious comoplications including stroke, Some patients will feel some stiffness and soreness following the first few days of treatment.

Fractures are rare occurences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and x-ray. Stroke has been the subject of tremendous disagreement within and without the profession with oned authority, (Scott Haldeman, D.C. M.D.) saying that such an outcome is extremely unlikely. Since even that risk should be avoided if possible, we employe tests in our examination which are designed to identify if you may be susceptible to that kind of inijury. The other complications are also generally described as "rare".

I hereby certify that I have read and fully understand the above informed consent/authorization for chiropractic treatments, the reasons why the treatment is considered necessary, its advantages and possible complications, if any, as well as possible alternative modes of treatment which were explained to me by Dr. Russell R. Heurung and/or his staff.

This portion is necessary <u>ONLY</u> if the patient is a minor

I hereby authorize the above named doctor of chiropractic, chirporoactic assistant and/or employee of the above doctor of chiropractic to administer care as deemed necessary to my:

Son_____ Daughter _____ Minor under my guardianship_____

_____ _____

Patient or Guardian Signature Date

_____ _____

Witness Signature Date

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Patient Name:_____ Date:_____/_____/_____ Case #_____

Records Release, Assignment of Benefits, Limited Power of Attorney For this Case and Payment Agreement

For Value received, I hereby assign to Dr. Russell R. Heurung, D.C., hereinafter referred to as doctor, to the extent of my bill for health care services, any and all claims which I may have

(a) For benefits provided under any policy of insurance or other health care plan
(b) Against any other party whose negligence may have caused my injuries or who may be legally responsible for my injuries, illnesses, or health care costs

I further assign to doctor a lien in the amount of my bill for health care services against the proceeds of any insurance policy, or health care plan, and against any claim which I may have against any other party whose negligence may have caused my injuries, or who may be legally responsible for my injuries, illness, or health care costs.

I hereby direct payment be made directly to my doctor. I hereby appoint as my true and lawful attorney, irrevocable, and with full power of substitution for and in my name, to ask, demand, sure for, collect, endorse, sign, and receive any such insurance or other benefits or claims against other parties for my injuries. Although doctor shall be granted such powers contained herein, doctor is not obligated or compelled to exercise such powers but may do so at doctor's discretion. I agree to cooperate with doctor in collecting any such amounts, including appearing in court if necessary. Doctor is further empowered to plan any and all information and documents pertaining to my policies including a copy of such policy and any information of supporting documentation concerning or touching upon the handling, calculation, processing or payment of any claim.

In the event that I fail to make payment in full for any sums due and owing not covered by my insurance policies or health care plans, the prevailing party in any litigation shall be entitled to collect a reasonable attorney fee together with court costs.

I recognize that payment for services rendered by doctor is due upon receipt of the services but that doctor has agreed to accept this assignment as an accommodation to me and that doctor may revoke this assignment at any time. I hereby waive any applicable statute of limitations which may affect doctor's right to collect for services. (continued next page)

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(continuation)

In the event that I receive directly any check, draft, or other benefits subject to this assignment at a time when there is still a balance due doctor, I agree to deliver such check, draft, or benefit to doctor immediately upon receipt, and the proceeds thereof shall be applied to my bill.

In accordance with Minnesota Statues; I hereby authorize doctor to release and to permit the examination or copying of any of my medical records, X-rays, laboratory reports, and the results of any type or character to such persons as the doctor deems appropriate.

In the event that any provision of this agreement is determined to be invalid or unenforceable, all other provisions of this agreement shall remain enforceable.

In witness thereof, this agreement has been entered the day and year set forth below.

_____ _____
Signature of patient or guardian Date

_____ _____
Witness Signature Date

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Bear Town Chiropractic Clinic Financial Policy

We are committed to providing you with the best possible chiropractic care, and we are open to discussion of our professional fees with you at any time. Your clear understanding of our Financial Policy is an important aspect of our professional relationship.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept check or cash.

We will accept insurance if and only if all pertinent insurance information has been supplied (including signed claim form if necessary), and coverage verified by a member of our staff. Any deductible amount or co-pay amount must be paid at the time of each visit.

We file insurance claims as a courtesy to our patients. You must realize however, that:

1) Your insurance policy is a contract between you, your employer, and your insurance company. We are not a party to that contract.
2) We will not become involved in disputes between you and your insurance company regarding deductible, co-payments, covered charges, secondary insurance, usual and customary charges, etc., other than to supply factual information as necessary.
3) You are ultimately responsible for any and all unpaid balances on your account.

Medica, Medicaid, Champus, Medical Assistance, Worker's Compensation:

If you are covered by any of these or any other government sponsored program, please discuss your payment situation with our office staff prior to your date of service.

Balances older than 60 days are subject to a service charge of 1.5% per month. We realize that temporary financial problems may affect timely payment of your account. If such problems should arise, we encourage you to contact us promptly for assistance in the management of your account.

If you should have any questions regarding the information above or any uncertainty involving insurance coverage, PLEASE don't hesitate to ask us. WE ARE HERE TO HELP.

_____ _____

Responsible Party Signature Date

Bear Town Chiropractic Clinic, P.A.
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Acknowledgment of our Notice of Privacy Practices

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of the **Bear Town Chiropractic Clinic, P.A**. Notice of Privacy Practices. By signing below I am "only" giving acknowledgement that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

_____ _____
Patient Name (Print) Patient's Date of Birth

_____ _____
Signature of Patient or Parent/Legal Guardian Date

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