Mankato Chiropractic
& Mankato's
Healing Touch

31 Navaho Ave, Mankato, MN 56001 507-345-4035

Please print all information Date: _____

Name _____
(First Name) (MI) (Last Name)

Address: _____

City: _____ State: _____ Zip: _____

Phone: Home: _____ Cell: _____ Birth Date: _____/_____/_____

Sex: M or F Marital Status: M S W D

Email: _____ Occupation: _____

Employed by: _____ Work Phone: _____
(Business name)

Emergency contact: _____ Phone: _____

Referred by: _____

General & Medical Information

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptom, massage/bodywork may not be appropriate A referral from your primary care provider may be required prior to service being provided.

___Yes ___No Have you ever experienced a professional massage or bodywork session?
If yes, how recently? _____

If you answer "yes" to any of the following questions, please explain as clearly as possible.

___Yes ___No Do you frequently suffer from stress?
___Yes ___No Do you have Diabetes?
___Yes ___No Do you experience frequent headaches?
___Yes ___No Are you pregnant?
___Yes ___No Do you suffer from arthritis?
___Yes ___No Are you wearing contact lenses?
___Yes ___No Do you have high blood pressure?
___Yes ___No Do you suffer from epilepsy or seizures?
___Yes ___No Do you suffer from joint swelling?
___Yes ___No Do you have varicose veins?
___Yes ___No Do you have any contagious disease?
___Yes ___No Do you have Osteoporosis?
___Yes ___No Do you have any allergies?
___Yes ___No Do you bruise easily?
___Yes ___No Have you ever been diagnosed with cancer?

Over ⇨

General & Medical Information continued

If you answer "yes" to any of the following questions, please explain as clearly as possible.

___Yes ___No Have you had any broken bones in the past two years?
___Yes ___No Have you been in an accident or suffered any injuries in the past two years?
___Yes ___No Do you have fibromyalgia?
___Yes ___No Do you have cardiac or circulatory problems?
___Yes ___No Do you suffer from back pain?
___Yes ___No Do you have numbness or stabbing pains anywhere?
___Yes ___No Are you very sensitive to touch or pressure in any specific area?
___Yes ___No Do you have any other medical condition we should be aware of?
___Yes ___No Are you on any medications?

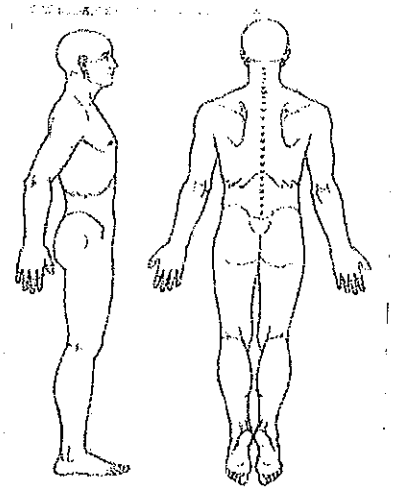
If yes, list medication and illness _____

_____

Additional comments: _____

_____

Are you experiencing any pain at the current time?
If so, indicate where on the body charts below



I understand that the massage/ bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediatley inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort.

I further understand that massage or bodywork should not be construed as a substitue for medical examination, diagnosis, or treatment and that I should see a chiropractor, physician or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage/ bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I forget to do so.

I agree to pay for services provided to me in this office at the time and date performed. I realize if I am late for an appointment I may not get the entire time originally scheduled. I will have to pay only for the amount of my actual session. In the future, if I schedule an appointment and cannot make that scheduled time, I will call and cancel my appointment. It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the entire schedule appointment.

Patient's signature: _____

Parent's or Guardian's signature: _____

Mankato Chiropractic Center and Mankato's Healing Touch
Consent for Purposes of Treatment, Payment and Healthcare Operations

I, _____ [Name of Individual] consent to Mankato Chiropractic Center, Mankato Chiropractic Center and Mankato's Healing Touch's ("the Practice's") use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, [patient's name] acknowledge that I have received and agree to the Notice of Privacy Practices of Mankato Chiropractic Center and Mankato's Healing Touch, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practice.

_____ _____

Date Signature

_____

Print Name

FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO PATIENT

The Practice has made a good-faith effort to obtain an acknowledgement of _____ [patient's name]'s receipt of our Notice of Privacy Practices. In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

- ☐ Patient Unavailable
- ☐ Patient Physically Unable
- ☐ Patient Unwilling

In an effort to obtain the patients acknowledgement, the Practice has attempted to provide patient with a Notice of Privacy Practices in the following manner (check all that apply) :

☐ Personally ☐ Mail ☐ Phone Follow Up

☐ Other: _____

_____ _____

Date Signature

_____

Print Name of Physician

Mankato Chiropractic Center and Mankato's Healing Touch, Mankato, Minnesota