



Patient Registration Information

Please complete all that apply and circle your preferred communication:

DEMOGRAPHIC INFORMATION

Legal Name (First, Middle, Last): _____ Correct Name: _____

Correct Pronouns: _____ Sex at birth: _____ Gender: _____

D.O.B.: ____/____/____ Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Marital Status: _____ Spouse Name: _____ Spouse D.O.B. ____/____/____

Spouse/Partner Phone Number: _____ Authorized to discuss care? Y/N

How did you hear about us? _____

EMPLOYMENT

Employer: _____ Occupation: _____ Date of Hire: ____/____/____

EMERGENCY CONTACT

LAST NAME: _____ FIRST NAME: _____ M.I. _____

Phone: _____ D.O.B.: ____/____/____ Relationship: _____

Authorized to discuss care? Y/N Can we leave medical information on their voicemail? Y/N

MEDICAL INFORMATION

Primary Care Physician: _____ Referring Physician: _____

INSURANCE INFORMATION

PRIMARY Insurance Company Name: _____ Plan Name: _____

Plan #: _____ Group #: _____

Effective Date: _____ Phone Number: _____

Policy Holder: _____ Relationship: _____ D.O.B. _____

SECONDARY Insurance Company Name: _____ Plan Name: _____

Plan #: _____ Group #: _____

Effective Date: _____ Phone Number: _____

Policy Holder: _____ Relationship: _____ D.O.B. _____



INITIAL HISTORY

Name: _____ D.O.B. ____/____/____

Please provide the following information to the best of your ability.

Please describe your accident/injury or history of problem in detail:

When did your condition begin? _____ Have your symptoms gotten... Worse Better Same (circle only one)

Have you had these symptoms before? If so, how many times? _____

Your current symptoms are... Constant Intermittent Worse in the... A.M. P.M. Are you: Right-Handed Left-Handed

If intermittent, how long do the episodes last? _____ How frequent are the episodes? _____

What activities increase your pain? (circle those that apply)

Sitting - Standing - Walking - Lifting - Housework - Coughing/Sneezing - Lying flat on back - Lying flat on stomach

Anything else that aggravates the symptoms? _____

What activities decrease your pain? (circle those that apply)

Sitting - Standing - Walking - Lying flat on back - Lying flat on stomach

Anything else that aggravates the symptoms? _____

Do you have any pain going down your arm or leg? No Yes (if "yes" circle the area involved) R Arm - L Arm - R Leg - L Leg

Do you have numbness/tingling down your arm or leg? No Yes (if "yes" circle the area involved) R Arm - L Arm - R Leg - L Leg

Do you have weakness of your arm or leg? No Yes (if "yes" circle the area involved) R Arm - L Arm - R Leg - L Leg

Is the pain... sharp, dull, sore, deep, superficial, shooting, stabbing, gnawing, burning (circle all applicable)

Do you have difficulty sleeping because of pain? Yes No

Is there a specific time of day your symptoms are worse? Yes No If yes, please explain _____

Have any other health care providers evaluated you for this problem? Yes No

If yes, who/when? _____

Have you had any tests (x-rays, CT scan, MRI) to evaluate this problem? Yes No

If yes, please describe test and the facility performed: _____

What treatments have you received? Please describe (ex: PT, Chiro, Surgery)

_____ Made Better Worse No Change (Circle One)

_____ Made Better Worse No Change (Circle One)

_____ Made Better Worse No Change (Circle One)

Have you had any previous accident or injury? Yes No

If yes, please describe where and when _____

Please list all prescription medications, OTC meds and supplements you are taking.

Name	For how long?	Side effects?



INITIAL HISTORY

Name: _____ D.O.B. ____/____/____

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Past Medical History

Please circle the "Yes" or "No" box if you have any of the following illnesses

Diabetes	No	Yes	Thyroid problems	No	Yes
Hypertension/High Blood Pressure	No	Yes	Allergy problems	No	Yes
Heart Disease	No	Yes	High Cholesterol	No	Yes
Kidney/Bladder/Prostate problems	No	Yes	Neurological problems	No	Yes
Respiratory Issues	No	Yes	Addiction/Substance Abuse	No	Yes
Stomach/Intestinal	No	Yes	Mental Health/Psychiatric	No	Yes
Bleeding Disorder	No	Yes	Other medical diagnosis	No	Yes

For any yes answers, please explain _____

Please list all surgeries.

Type of Surgery	When & Name of Surgeon

Review of systems: Please check the "Yes" or "No" box if you have any of the following symptoms.

		<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
GENERAL	Chills	()	()	Weight Loss or Gain	()	()
	Fatigue	()	()	Daytime Sleepiness	()	()
ALLERGY	Environmental	()	()	Sneezing fits	()	()
NEURO	Passing out	()	()	Seizures	()	()
	Weakness	()	()	Numbness/tingling	()	()
	Memory Loss	()	()	Abnormal ache	()	()
EYES	Eye pain	()	()	Vision Changes	()	()
ENT	Ringing in ears	()	()	Dizziness	()	()
	Hearing loss	()	()	Sinus pain	()	()
	Snoring	()	()	Sore throat	()	()
RESPIRATORY	Cough	()	()	Coughing Blood	()	()
	Wheezing	()	()	Shortness of Breath	()	()
CARDIAC	Chest Pain	()	()	Palpitations	()	()
	Wake short of breath	()	()	Ankle Swelling	()	()
GASTROINTESTINAL	Trouble swallowing	()	()	Heartburn	()	()
	Abdominal Pain	()	()	Nausea/Vomiting	()	()
	Bowel Irritability	()	()	Rectal Bleeding	()	()
GENITOURINARY	Frequent Urination	()	()	Painful Urination	()	()
	Blood in urine	()	()	Prostate Problems	()	()
	Loss of bladder	()	()	Could you be pregnant?	()	()
HEME/LYMPH	Swollen glands	()	()	Sweating at night	()	()
	Bleeding	()	()	Easy Bruising	()	()
ENDOCRINE	Feel warmer	()	()	Feel cooler than others	()	()
MUSCOLOSKELE	Joint pain	()	()	Cramps	()	()
	Muscle Ache	()	()	Weakness	()	()
	Loss of mobility	()	()			
DERM-ATOLOGIC	Rash	()	()	Hives	()	()
	Itching	()	()	Skin or Hair changes	()	()
MENTAL HEALTH	Nervousness	()	()	Tension	()	()
	Mood changes	()	()	Depression	()	()

INITIAL HISTORY

Name: _____ D.O.B. ____/____/____

Anxiety/Panic () ()

Family History: Please check the "Yes" or "No" box if any relatives have/had any of the following illnesses. If yes, please indicate which relative(s) have/had the problem.

	No	Yes	
Back Problems	()	()	_____
Rheumatoid Arthritis	()	()	_____
Heart problems/murmurs	()	()	_____
Diabetes	()	()	_____
Cancer	()	()	_____
Bleeding Disorder	()	()	_____

Are you currently: (Circle One) Single Married Widowed Divorced Separate

How many children do you have? _____ **Ages?** _____ **How many live with you?** _____

Do you smoke cigarettes? Yes No **Packs per day:** _____

Do you drink alcoholic beverages? Yes No **How many drinks per day?** _____

Do you take or have you ever used any street drugs (ex-marijuana, cocaine, etc.)? Yes No

Are you working? Yes No Full-Time Part-Time

When did you last work? Date: _____ **Is there light duty available at work?** Yes No

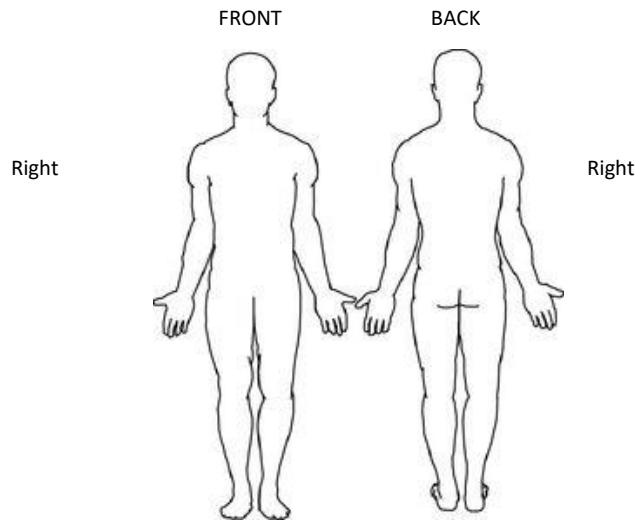
Occupation and job duties: (ex: sitting at a computer, lifting, bending, twisting, etc.) _____

Do you enjoy your work? Yes No **Do you like your co-workers?** Yes No

What hobbies or activities (work, sports, and hobbies) do you hope to return? _____

PAIN DRAWING

INSTRUCTIONS: Mark these drawings according to where you hurt (if the back of your neck hurts, make the drawing on the back of the neck, etc.). If you feel any of the following symptoms, please indicate which sensations you feel by placing the marks shown below.



PAIN LEVEL: (Circle one)

0	1 2 3	4 5 6	7 8	9 10
(No Pain)	(tolerate pain w/o meds)	(requires medication)	(go to ER)	(severe pain-go to the hospital)



MN SPINE AND SPORT
MOVE BETTER. FEEL BETTER. LIVE BETTER.

Consent for Examination and Treatment

I hereby request and consent to an examination and treatment. I understand that the treatment may include, but are not limited to therapeutic exercises, forms of manipulation, acupuncture, manual therapy, ice, heat, electric stimulation, therapeutic laser, PEMF, spinal decompression and ultrasound.

While the chances of experiencing complications are small, there have been case reports including, but not limited to soreness, inflammation, soft tissue injury, dizziness, burns, strains, separations, and temporary increase in symptoms. Very rare reports include disc injury, fractures, vertebral artery dissection and stroke. Some patients may feel sore following the first few days of treatment.

I do not expect Dr. Schreiber to anticipate all risks and complications and wish to rely on his best judgment during the procedures that are in my best interests based on the facts known at that time. Dr. Schreiber will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to Dr. Schreiber's attention, it is your responsibility to inform the Doctor.

Other available treatment options include: over-the-counter analgesics and rest; medical care and prescription drugs, such as anti-inflammatory, muscle relaxers and pain-killers; hospitalization; and surgery. If you choose one of the aforementioned options, there are risks and benefits that you may wish to discuss with your primary care physician.

I have been informed that I have the right to refuse any portion of treatment and been given the opportunity to ask questions that pertain to my treatment. I have read, or been read to, the above consent and by signing below, I agree to the above-named procedures. I understand that there always may be an unexpected complication and no guarantee can be made concerning the outcome of treatment. I intend that this consent form to cover the entire course of treatment and for any other condition(s) that I seek future treatment.

Name

Date

Parent of a minor

Date

Dr. Scott Schreiber

Date

Witness

Date



OFFICE FINANCIAL POLICY

Effective January 1, 2021

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care.

- We will verify your insurance benefits prior to treatment, however, this is not a guarantee of payment. You are ultimately responsible for payment of treatment received. We request that you have read and understand your own insurance policy. MN Spine and Sport cannot discount or reduce fees. The fees are set by YOUR insurance company as reasonable and necessary. _____initial
- We mail patient statements around the 15th of the month. Payment for any insurance deductibles and/or coinsurance is required at that time. You may pay by check, cash or credit card. You also have the option of paying online at www.mnspineandsport.com. _____initial
- If a check is returned for any reason, you are responsible for the payment, bank fees and a \$50 processing fee. _____initial
- You are considered a cash patient until you bring in your current insurance card, and we qualify and accept your insurance coverage. If you choose to use your insurance for treatment, we cannot reverse claim submissions. _____initial
- If you have a copay, you must pay at the time of service. There are no exceptions. _____initial
- If your carrier has not paid a claim in forty-five (45) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment. If you have a deductible and/or co-insurance, we require a credit card on file. If you do not have a credit card on file, your balance will be forwarded to a collection agency. _____initial
- Once we receive your insurance company's explanation of benefits, we will charge the card on file within 30 days, unless you have previously paid the balance _____initial
- If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted. _____initial
- I understand that MN Spine and Sport does not offer initial consultations at no charge, nor do we discount or negotiate fees after services are rendered. _____initial

Patient Printed Name: _____

Signature: _____ Date: _____

Please provide your HSA, FSA, or credit card information below.

Card #: _____ Exp. Date: _____ CVV#: _____

Name as it appears on the card: _____

Cardholder's Signature: _____



Missed Appointments and Late Cancellation Policy

Due to the busy nature of our practice, a scheduled appointment means that time is specifically **reserved only for you**. We understand that sometimes it is necessary to reschedule appointments, therefore, we request that you kindly give us at least **24 hours notice** and we will gladly reschedule your appointment. Due to the comprehensive nature of our practice, appointments are in high demand, especially given the amount of time that has to be allotted for cleaning and sanitizing between patients, and your early cancellation will give another patient the opportunity to have access to timely care. Our no-show/late cancellation policy is as follows:

- 1) I understand that if I miss a scheduled appointment or cancel less than 24 hours before the appointment for the **first time**, you will be reminded that you need to call at least 24 hours in advance.
 - 2) I understand that if I miss a second appointment without calling and rescheduling less than 24 hours, for the **second time**, I will be charged \$50 for the missed appointment and must pay the fee prior to being rescheduled. If you have a cash package, that amount will be deducted from that account.
 - 3) I understand that on the **third time** I miss a chiropractic appointment or therapy session, without calling and/or rescheduling my appointment less than 24 hours in advance, I will be billed directly according to the scheduled fee or according to the rules of your healthcare plan. Your health plan does not cover payment for missed appointments; therefore, you are responsible for the full payment.
 - 4) I understand that if I am scheduled for a therapy service, including, but not limited to, acupuncture, exercise, laser, PEMF, or decompression and elect not to have treatment without calling with 24 hours, I will be charged for that visit.
- We DO understand that life's unexpected occurrences do come up and sometimes you cannot plan for the unforeseen. Situations such as this will be handled on an individual basis.
 - To cancel appointments please call **651-459-3171**. If you do not reach the receptionist, you may leave a detailed message on our voice mail system 24 hours a day. We will call you to reschedule your appointment as soon as possible.
 - As a courtesy, you will receive a text message or email reminder at approximately 6:00PM. If you cancel after you receive this message and it is within the 24-hour window, you are still subject to the policy.

To better serve our patients, we appreciate your understanding and are available to answer any questions you may have.

Patient Name (Please Print): _____

Patient Signature: _____ Date: _____



NOTICE OF PRIVACY PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you would like to review a detailed version of our privacy policy, it is available on our website (.pdf), as well as at the office (print).

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restriction on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager.

MN Spine and Sport
8360 City Centre Dr. Ste. 120
Woodbury, MN 55125
651-459-3171

My signature below confirms that I have been made aware of the **Notice of Privacy Practices** and can be provided a copy upon request.

Signature: _____ Date: _____