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 make your pain worse? (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 make your pain better? (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 <u>pain</u> 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 <u>numbness/tingling</u> down your arm or leg? No Yes (if "yes" circle the area involved) **R** Arm - **L** Arm - **R** Leg - **L** Leg

Do you have <u>weakness</u> 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 <u>any</u> 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.____/_____/______

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.

		Yes	No		Yes	No
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/LYMPTH	Swollen glands	( )	( )	Sweating at night	( )	( )
	Bleeding	( )	( )	Easy Bruising	( )	( )
ENDOCRINE	Feel warmer	( )	( )	Feel cooler than others	( )	( )
MUSCOLOSKEL	Joint pain	( )	( )	Cramps	( )	( )
	Muscle Ache	( )	( )	Weakness	( )	( )
	Loss of mobility	( )	( )			
DERM-	Rash	( )	( )	Hives	( )	( )
ATOLOGIC	Itching	( )	( )	Skin or Hair changes	( )	( )
MENTAL HEALTH	Nervousness	( )	( )	Tension	( )	( )
	Mood changes	( )	( )	Depression	( )	( )
	Anxiety/Panic	( )	( )			

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INITIAL HISTORY

Name: ____D.O.B.____/_____/______

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

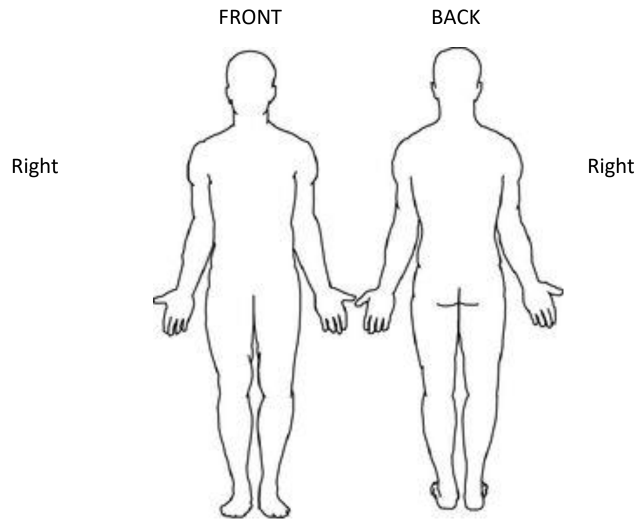
Occupation and job duties: (ex: sitting at a computer, lifting, bending, twisting, etc.) ______________________________

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)

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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**

SS 2/16/19

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

MN Spine and Sport is committed to providing exceptional care. Unfortunately, when one patient cancels without giving enough notice, they prevent another patient from being seen. **Please call us at (651) 459-3171 by 2:00 p.m. on the day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 2:00 p.m. on Friday.** If prior notification is not given, our no-show/late cancellation policy is as follows:

1) **I understand that if I miss a scheduled appointment or not call our office by 2:00 p.m. on the day prior to your scheduled appointment, you will be reminded that you need by 2:00 p.m. the day before.**
2) **I understand that if I miss a second appointment without calling and rescheduling by 2:00 p.m. on the day prior to your scheduled appointment, 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, office by 2:00 p.m. on the day prior to your scheduled appointment, I will be billed directly for the appointment. 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 multiple services on a given day a therapy service, including, but not limited to, acupuncture, exercise, laser, PEMF, or decompression and elect not to have a given treatment the day of, I will be charged full price 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 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 an additional courtesy, you will receive a text message or email reminder at approximately 2:00PM the day before. If you cancel after you receive this message and it is after 2:00 PM window, **you still are subject to the policy.**
- **This policy supersedes any other previous cancellation 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: _____________________

7/6/2021 SS

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: __________________________