cover sheet, this is yours to keep.

important information that was covered at the hope class. for those that didn't attend for themselves, please read over!

welcome to feeling better.

we are at our new location
4900 us highway 169 north, suite 301
new hope MN 55428

YOUR SCHEDULING CHECKLIST

- ☐ attend the hope class, or send a friend!
- ☐ for those that attend, book your first appointment and any and all additional appointments for your loved ones by friday at 5:00; **763.537.5555**

BRING THE FOLLOWING WITH TO YOUR FIRST APPOINTMENT

- ☐ this paperwork–it takes 45 minutes to fill out so do beforehand
- ☐ all supplements or medications you are currently taking, in their original bottles with contents in them
- ☐ any lab, medical records from the last 6 months
- —call us a full 48-hours in advance if you need to make a change to your appointment
- —arrive 10-minutes early to your appointments, this helps us run things smoothly!

HELP YOURSELF GET THE BEST RESULTS–YOU DESERVE IT!

1. have all you need to bring from the checklist, arriving 10-min early!
2. tell dr. brad all of your symptoms and complaints (bring a list/journal)
3. at your follow up appointments—tell dr. brad what's improving!
4. if appropriate, dr. brad may refer you to another practitioner as well
5. this is your time with dr. brad! keep this time focused on you
6. getting well is an investment, and we understand that. try the best you can to avoid commenting about cost during your appointment time, it can distract from the focus of recommendations and your treatment. the front desk is happy to fill you in on service fees.

KEEP YOUR APPOINTMENT TIME.

- —arriving in the lobby early is considered on-time
- —we will call to check in if you're ok at the start-time of your appointment if you have not arrived
- —as a rule, anything beyond a few-mintues late will be considered a missed appointment

IN THE CASE WE SOUND LIKE STICKLERS ABOUT THE CLOCK... HERE'S THE WHY:

–we want you to get the care you need!
–it is not realistic for dr. brad to treat a patient by rushing an appointment, this sacrifices the care you need and what you are investing in, dr. brad's unique case-by-case treatments and next step recommendations.

UT-OH, RUNNING LATE?

–please call (hands-free) if you become aware you will be late. the front desk works hard to make things work and has compassion for a patient who arrives late; yet typically dr. brad is booked and there will not be room to work someone in that has missed their appointment.
–if you miss a same-day appointment or cancel within the 24-hours policy, at this time we allow for a one-time of grace with no fee. for any additional missed appointments the charge will be the fee of the service.

SOMETHING COME UP IN BETWEEN APPOINTMENTS?

dr. brad offers phone consults for $4/minute. with his call backs he often gets voicemail, if you are comfortable tell the desk your question and provide the best phone number for him to leave a message with personal health information.

hopeclinicmn.com
763.537.5555

hope clinic
multiple specialists. one patient.

get some tips here!
@hopeclinicMN
@hopeclinicMN

Chiropractic Case History/Patient Information: Brad Molskness, DC

First Name _____ Middle _____ Last_____ Date: _____

Cell (____)_____ - _____ If there are any phone consults is it OK to leave personal health information on voicemail? ☐ yes ☐ no

Street_____City_____ State_____ Zip_____

Email_____@gmail.com @yahoo.com @comcast.net (other) @_____. _____

Age____ Birthdate _____ Under 18 ☐ Race_____ Marital: M S W D Home Ph (____) _____ - _____

Occupation:_____ Employer _____ Work Ph (____) _____ - _____

If Married Spouse_____ Occupation_____ Spouse Ph (____) _____ - _____

Is spouse your emergency contact? ☐ yes ☐ no Emegency contact _____ Ph (____)_____ - _____

Children ☐ 1. _____age_____2._____ age___ 3._____age 4._____ age ____

Who referred you to our clinic? _____ from BNI? ☐ Are you a member of BNI? ☐

CURRENT PRACTITIONERS Chiropractic Doctor:_____ *____Medical Doctor:_____ *_____

Dentist:_____ *___Therapist:_____ *____ Other:_____ *_____

If beneficial, do we have permission to update your practitioner regarding your care at this clinic? yes ☐ no ☐ *if you do permit please sign here: _____ *initial by those you authorize dr. brad's permission to discuss/consult with regarding your health care. dr. brad will discuss with you before communicating with them.

HISTORY OF PRESENT ILLNESS Your main condition/symptoms you are wanting relief from: _____

_____

_____ Date symptoms started: _____ Related to work ☐ yes ☐ no Auto ☐ yes ☐ no

In the past, have you had the same or a similar condition? describe_____

PAST MEDICAL HISTORY — DATE OF YOUR LAST PHYSICAL EXAM _____

Have you ever been diagnosed as having or have suffered from? (Place a check by all that apply to you)

__Broken or Fractured Bones	__A Congenital Disease	__Epilepsy	__Ruptures	__Drug Addiction
__Circulatory Problems	__Excessive Bleeding	__Pace Maker	__Coughing Blood	__HIV Positive
__Rheumatoid Arthritis	__High/Low Blood Pressure	__Strokes	__Eating Disorder	__Gall Bladder
__Seizures/Convulsions	__Osteoarthritis	__Cancer	__Alcoholism	__Depression
__Ulcers				

__History of stroke or hypertension - if checked include date of incident: _____

Any major illnesses/injuries/falls/auto accidents or surgeries? Women–list childbirth dates and any issues _____

_____

Have you been treated for any health condition by a physician in the last year? ☐ yes ☐ no If so, any scans? ☐ Lab work? ☐

I went in for help with _____*the recommeded treatment was*_____

List all medications/drugs and reason for taking < ***please bring all medications (and supplements) with to your first appointment in the orginal bottles with product in them.***

1. Med_____ For_____ 3. Med_____ For_____

2. Med_____ For_____ 4. Med_____ For_____

Are you on disability or plan to apply for disability in the near future? ☐ yes ☐ no

Are you on Medicare? ☐ yes ☐ no if you are over 55 years old, include the date you will be on Medicare_____

Are you on a Medical/Government Assistance plan? ☐ yes ☐ no *we do not bill insurance.

Do you have any allergies to any medications? ☐ Yes ☐ No If yes, describe:_____

Do you have any allergies of any kind? ☐ Yes ☐ No If yes, describe:_____

Please list any other health problems you have, no matter how insignificant they may be:_____

_____

_____

_____

SOCIAL HISTORY

Do you drink alcoholic beverages?___ If so, how much per week?_____

Do you use any tobacco products?_____Do you smoke?____ If so, packs per day: _____

Do you take vitamin supplements?_____ If so, please list:_____

_____

Do you consume caffeine?____ If so, how much per day:_____

Do you exercise?_____ If yes, what is the frequency and type of exercise?_____

What are your hobbies?_____

What percentage of time during the day (at home or at your job away from home) do you spend:

lifting_____ sitting_____ bending_____working at a computer_____

FAMILY HISTORY

Father: living___ deceased____ Current age if still living:_____ Cause of death and age at death if deceased: _____

Mother: living___ deceased____ Current age if still living:_____ Cause of death and age at death if deceased:_____

Check if applicable to you: _____ As an adopted child, little is known of birth parents or family.

Do you have any family members who suffer from the same condition you do? If so, please list: _____

_____

FAMILY DISEASES (check if applicable and indicate whether family member is Father Mother, Sister, Brother, F, M, S, B)

Tuberculosis____	Cancer____	Mental Illness____
Diabetes ____	Asthma____	Heart Disease ____
Stroke ____	Kidney Disease___	Lung Disease____
Arthritis_____	Liver Disease ____	Other _____

Please check any and all insurance coverage that may be applicable in this case: WE DO NOT BILL INSURANCE, SEE FEE PAGE

☐ Major Medical ☐ Worker's Compensation ☐ Medicaid ☐ Medicare ☐ Auto Accident

☐ Medical Savings Account & Flex Plans ☐ Other

Health Care Companies you have coverage through:_____

Are you willing to make changes in your lifestyle? _____

Women Only: Are you pregnant or is there any possibility you may be pregnant? Yes ☐ No ☐ Uncertain ☐

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations and coordination of care. We want you to know your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

SYMPTOM SURVEY FORM

Patient _____ Date _____

Birth Date ___/___/___ Approx Weight _____ Sex: Male ☐ Female ☐

Vegetarian: Yes ☐ No ☐

INSTRUCTIONS: Fill in only the circles which apply to you.
● ○ ○ MILD symptoms (occurred once or twice last 6 months).
○ ● ○ MODERATE symptoms (occurred once or twice last month).
○ ○ ● SEVERE symptoms (chronic, occurred once or twice last week).
○ ○ ○ **Leave circles BLANK if they don't apply to you!**

mild - **1 2 3** - *severe*

1 ○ ○ ○ Acid foods upset
2 ○ ○ ○ Get chilled often
3 ○ ○ ○ "Lump" in throat
4 ○ ○ ○ Dry mouth-eyes-nose
5 ○ ○ ○ Pulse speeds after meal
6 ○ ○ ○ Keyed up - fail to calm
7 ○ ○ ○ Cut heals slowly
8 ○ ○ ○ Gag easily
9 ○ ○ ○ Unable to relax; startles easily
10 ○ ○ ○ Extremities cold, clammy
11 ○ ○ ○ Strong light irritates
12 ○ ○ ○ Urine amount reduced
13 ○ ○ ○ Heart pounds after retiring
14 ○ ○ ○ "Nervous" stomach
15 ○ ○ ○ Appetite reduced
16 ○ ○ ○ Cold sweats often
17 ○ ○ ○ Fever easily raised
18 ○ ○ ○ Neuralgia-like pains
19 ○ ○ ○ Staring, blinks little
20 ○ ○ ○ Sour stomach often

GROUP 2

21 ○ ○ ○ Joint stiffness on arising
22 ○ ○ ○ Muscle-leg-toe cramps at night
23 ○ ○ ○ "Butterfly" stomach, cramps
24 ○ ○ ○ Eyes or nose watery
25 ○ ○ ○ Eyes blink often
26 ○ ○ ○ Eyelids swollen, puffy
27 ○ ○ ○ Indigestion soon after meals
28 ○ ○ ○ Always seems hungry; feels "lightheaded" often
29 ○ ○ ○ Digestion rapid
30 ○ ○ ○ Vomiting frequent
31 ○ ○ ○ Hoarseness frequent
32 ○ ○ ○ Breathing irregular
33 ○ ○ ○ Pulse slow; feels "irregular"
34 ○ ○ ○ Gagging reflex slow
35 ○ ○ ○ Difficulty swallowing
36 ○ ○ ○ Constipation, diarrhea alternating
37 ○ ○ ○ "Slow starter"
38 ○ ○ ○ Get "chilled" infrequently
39 ○ ○ ○ Perspire easily
40 ○ ○ ○ Circulation poor, sensitive to cold
41 ○ ○ ○ Subject to colds, asthma, bronchitis

GROUP 3

42 ○ ○ ○ Eat when nervous
43 ○ ○ ○ Excessive appetite
44 ○ ○ ○ Hungry between meals
45 ○ ○ ○ Irritable before meals
46 ○ ○ ○ Get "shaky" if hungry
47 ○ ○ ○ Fatigue, eating relieves
48 ○ ○ ○ "Lightheaded" if meals delayed
49 ○ ○ ○ Heart palpitates if meals missed or delayed
50 ○ ○ ○ Afternoon headaches
51 ○ ○ ○ Overeating sweets upsets

1 2 3

52 ○ ○ ○ Awaken after few hours sleep - hard to get back to sleep
53 ○ ○ ○ Crave candy or coffee in afternoons
54 ○ ○ ○ Moods of depression - "blues" or melancholy
55 ○ ○ ○ Abnormal craving for sweets or snacks

GROUP 4

56 ○ ○ ○ Hands and feet go to sleep easily, numbness
57 ○ ○ ○ Sigh frequently, "air hunger"
58 ○ ○ ○ Aware of "breathing heavily"
59 ○ ○ ○ High altitude discomfort
60 ○ ○ ○ Opens windows in closed rooms
61 ○ ○ ○ Susceptible to colds and fevers
62 ○ ○ ○ Afternoon "yawner"
63 ○ ○ ○ Get "drowsy" often
64 ○ ○ ○ Swollen ankles, worse at night
65 ○ ○ ○ Muscle cramps, worse during exercise; get "charley horses"
66 ○ ○ ○ Shortness of breath on exertion
67 ○ ○ ○ Dull pain in chest or radiating into left arm, worse on exertion
68 ○ ○ ○ Bruise easily, "black and blue" spots
69 ○ ○ ○ Tendency to anemia
70 ○ ○ ○ "Nose bleeds" frequent
71 ○ ○ ○ Noises in head, or "ringing in ears"
72 ○ ○ ○ Tension under the breastbone, or feeling of "tightness", worse on exertion

GROUP 5

73 ○ ○ ○ Dizziness
74 ○ ○ ○ Dry skin
75 ○ ○ ○ Burning feet
76 ○ ○ ○ Blurred vision
77 ○ ○ ○ Itching skin and feet
78 ○ ○ ○ Excessive falling hair
79 ○ ○ ○ Frequent skin rashes
80 ○ ○ ○ Bitter, metallic taste in mouth in mornings
81 ○ ○ ○ Bowel movements painful or difficult
82 ○ ○ ○ Worrier, feels insecure
83 ○ ○ ○ Feeling queasy; headache over eyes
84 ○ ○ ○ Greasy foods upset
85 ○ ○ ○ Stools light colored
86 ○ ○ ○ Skin peels on foot soles
87 ○ ○ ○ Pain between shoulder blades
88 ○ ○ ○ Use laxatives
89 ○ ○ ○ Stools alternate from soft to watery
90 ○ ○ ○ History of gallbladder attacks or gallstones
91 ○ ○ ○ Sneezing attacks
92 ○ ○ ○ Dreaming, nightmare type bad dreams
93 ○ ○ ○ Bad breath (halitosis)
94 ○ ○ ○ Milk products cause distress
95 ○ ○ ○ Sensitive to hot weather
96 ○ ○ ○ Burning or itching anus
97 ○ ○ ○ Crave sweets

GROUP 6

98 ○ ○ ○ Loss of taste for meat
99 ○ ○ ○ Lower bowel gas several hours after eating
100 ○ ○ ○ Burning stomach sensations, eating relieves
101 ○ ○ ○ Coated tongue
102 ○ ○ ○ Pass large amounts of foul-smelling gas
103 ○ ○ ○ Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
104 ○ ○ ○ Mucous colitis or "irritable bowel"
105 ○ ○ ○ Gas shortly after eating
106 ○ ○ ○ Stomach "bloating" after eating

	1	2	3	
				GROUP 7A
107	O	O	O	Insomnia
108	O	O	O	Nervousness
109	O	O	O	Can't gain weight
110	O	O	O	Intolerance to heat
111	O	O	O	Highly emotional
112	O	O	O	Flush easily
113	O	O	O	Night sweats
114	O	O	O	Thin, moist skin
115	O	O	O	Inward trembling
116	O	O	O	Heart palpitates
117	O	O	O	Increased appetite without weight gain
118	O	O	O	Pulse fast at rest
119	O	O	O	Eyelids and face twitch
120	O	O	O	Irritable and restless
121	O	O	O	Can't work under pressure
				GROUP 7B
122	O	O	O	Increase in weight
123	O	O	O	Decrease in appetite
124	O	O	O	Fatigue easily
125	O	O	O	Ringing in ears
126	O	O	O	Sleepy during day
127	O	O	O	Sensitive to cold
128	O	O	O	Dry or scaly skin
129	O	O	O	Constipation
130	O	O	O	Mental sluggishness
131	O	O	O	Hair coarse, falls out
132	O	O	O	Headaches upon arising, wear off during day
133	O	O	O	Slow pulse, below 65
134	O	O	O	Frequency of urination
135	O	O	O	Impaired hearing
136	O	O	O	Reduced initiative
				GROUP 7C
137	O	O	O	Failing memory
138	O	O	O	Low blood pressure
139	O	O	O	Increased sex drive
140	O	O	O	Headaches, "splitting or rending" type
141	O	O	O	Decreased sugar tolerance
				GROUP 7D
142	O	O	O	Abnormal thirst
143	O	O	O	Bloating of abdomen
144	O	O	O	Weight gain around hips or waist
145	O	O	O	Sex drive reduced or lacking
146	O	O	O	Tendency to ulcers, colitis
147	O	O	O	Increased sugar tolerance
148	O	O	O	Women: menstrual disorders
149	O	O	O	Young girls: lack of menstrual function
				GROUP 7E
150	O	O	O	Dizziness
151	O	O	O	Headaches
152	O	O	O	Hot flashes
153	O	O	O	Increased blood pressure
154	O	O	O	Hair growth on face or body (female)
155	O	O	O	Sugar in urine (not diabetes)
156	O	O	O	Masculine tendencies (female)
				GROUP 7F
157	O	O	O	Weakness, dizziness
158	O	O	O	Chronic fatigue
159	O	O	O	Low blood pressure
160	O	O	O	Nails weak, ridged
161	O	O	O	Tendency to hives
162	O	O	O	Arthritic tendencies
163	O	O	O	Perspiration increase
164	O	O	O	Bowel disorders
165	O	O	O	Poor circulation
166	O	O	O	Swollen ankles
167	O	O	O	Crave salt
168	O	O	O	Brown spots or bronzing of skin
169	O	O	O	Allergies - tendency to asthma

	1	2	3	
170	O	O	O	Weakness after colds, influenza
171	O	O	O	Exhaustion - muscular and nervous
172	O	O	O	Respiratory disorders
				GROUP 8
173	O	O	O	Apprehension
174	O	O	O	Irritability
175	O	O	O	Morbid fears
176	O	O	O	Never seems to get well
177	O	O	O	Forgetfulness
178	O	O	O	Indigestion
179	O	O	O	Poor appetite
180	O	O	O	Craving for sweets
181	O	O	O	Muscular soreness
182	O	O	O	Depression; feelings of dread
183	O	O	O	Noise sensitivity
184	O	O	O	Acoustic hallucinations
185	O	O	O	Tendency to cry without reason
186	O	O	O	Hair is coarse and/or thinning
187	O	O	O	Weakness
188	O	O	O	Fatigue
189	O	O	O	Skin sensitive to touch
190	O	O	O	Tendency toward hives
191	O	O	O	Nervousness
192	O	O	O	Headache
193	O	O	O	Insomnia
194	O	O	O	Anxiety
195	O	O	O	Anorexia
196	O	O	O	Inability to concentrate; confusion
197	O	O	O	Frequent stuffy nose; sinus infections
198	O	O	O	Allergy to some foods
199	O	O	O	Loose joints
				FEMALE ONLY
200	O	O	O	Very easily fatigued
201	O	O	O	Premenstrual tension
202	O	O	O	Painful menses
203	O	O	O	Depressed feelings before menstruation
204	O	O	O	Menstruation excessive and prolonged
205	O	O	O	Painful breasts
206	O	O	O	Menstruate too frequently
207	O	O	O	Vaginal discharge
208			O	Hysterectomy / ovaries removed
209	O	O	O	Menopausal hot flashes
210	O	O	O	Menses scanty or missed
211	O	O	O	Acne, worse at menses
212	O	O	O	Depression of long standing
				MALE ONLY
213	O	O	O	Prostate trouble
214	O	O	O	Urination difficult or dribbling
215	O	O	O	Night urination frequent
216	O	O	O	Depression
217	O	O	O	Pain on inside of legs or heels
218	O	O	O	Feeling of incomplete bowel evacuation
219	O	O	O	Lack of energy
220	O	O	O	Migrating aches and pains
221	O	O	O	Tire too easily
222	O	O	O	Avoids activity
223	O	O	O	Leg nervousness at night
224	O	O	O	Diminished sex drive

List the five main complaints you have in the order of their importance:

1. _____
2. _____
3. _____
4. _____
5. _____

daily food diary: include all food and drink in a typical day

Name _____ Today's Date_____

As a baby, did you breastfeed? ☐yes ☐no If so, for how long? _____

At what age were you given baby formula? _____

At what age was your first food introduced?_____

breakfast:

snack:

lunch:

snack:

dinner:

snack:

REMINDER: PLEASE BRING ALL CURRENT MEDICATIONS, SUPPLEMENTS AND VITAMINS TO YOUR APPOINTMENT, IN THEIR ORIGINAL BOTTLES WITH PRODUCT IN THEM.

 # Informed Consent Document (vs 11.04.2019)

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. If anything is unclear you are welcome to ask questions before signing.

The nature of the chiropractic adjustment: The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy and/or therapies supporting chiropractic manipulation. If I use chiropractic manipulation to treat you, I may use my hands or mechanical instrument upon your body in such a way as to move your joints. This may cause an audible "pop" or "click," much as you have experienced when you crack your knuckles. You may feel a sense of movement.

The nature of natural healing: Our goal in natural care is to remove hindrances to healing, and remind your body what it needs to do to heal itself. Sometimes, a patient may experience a Herring's law response or what some people call a healing crisis. This could take the form of symptoms from old illnesses returning for a while as your body now has the tools to get through the entire course of healing. Another example is a cleansing response in which the body will clear out toxins through the bowels, lungs or skin. We will do our best to let you know if we believe you may experience this type of response.

Analysis/examination/treatment: By signing this page you consent to including but not limited to: chiropractic, orthopedic, kinesiologic and general physical examination, a thorough health history, chiropractic treatment, soft tissue and nutritional therapy.

The material risk inherent to chiropractic adjustment: As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and other therapies. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myopathy, costovertebral strains and separations, and burns.

The probability of those risks occurring: Fractures are rare occurrences and in general a result of some underlying weakness of the bone which I check for during the taking of your history and during examination. If there is a concern I will order medical imaging which may include an x-ray. Stroke has been the subject of tremendous disagreement. The incidences of a stroke is exceedingly rare and according to research estimated to occur between one in one million to five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options: Other treatment options for your condition may include
—self-administered, over the counter analgesics and rest —hospitalization — surgery
—medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers

The risks and dangers attendant to remaining untreated: Remaining untreated may allow the formation of adhesions and reduce mobility. Over time, this process may complicate treatment making treatment more difficult and less effective the longer it is postponed.

Do not sign until you have read and understand the above. Please check the appropriate block and sign below.

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. If I so choose, I have the option to discuss this with dr. brad and have my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated _____ Patients Name _____

Signature of Patient or Parent/Guardian _____

Dated _____Dr. Brad Molskness, DC _____

 # Patient Health Information Consent Form

dr. brad's appointment healthcare notes are for his use for the benefit of your patient care. They are not formatted to the medical record industry standard required by insurance companies, as we do not bill insurance and use notes based on multiple disciplines containing language outside of Allopathic care (traditional medical care). If we were to invest the time and resources to take the medical billing notes that would double the time of each appointment and therefore double the fee.

At times patients will list us as a provider of care when applying for Social Security Administration or Disability Benefits. This is your right. Be aware they will require dr. brad's appointment healthcare notes. Due to the nature and language of dr. brad's Multiple Discipline Care these healthcare notes may confuse your case and cause delays.

The patient has the right to examine and obtain a copy of his or her appointment healthcare notes at any time and request corrections. We can make copies of your notes and provide to you by mail or in person, we ask for a 48-hour notice to prepare those and will mail to you at no fee.

For PHI release of information requests (from a lawyer, life insurance or other) we will review the document to look for a signature from the patient, and call the patient to confirm verbal consent before releasing PHI. We limit what PHI is released to what is necessary. Our office is not obligated to agree to those restrictions as we can be obligated to release PHI to government agencies for requests that come to the clinic (for example, requests for records that come from The Social Security Administration or other Government Agency).

The patient may provide a written request to revoke consent at any time during care (except for the use of care). This would not affect use of those records for the care given prior to the written request but would apply to any care given after the request has been presented.

For your security and privacy, all staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our clinic. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

Patients have the right to file a formal complaint with our privacy officer about any possible violations of these policies and procedures.

If the patient refuses to sign this consent for the purpose of treatment, or health care operations and care, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient Name_____ Signature_____ Date_____

 # Fee Structure (vs 11.04.2019)

We require immediate payment at the time of any fees for services or product purchases. At this time, we accept payment in the form of cash, check or credit/debit card. At any time, the fee structure at Hope Clinic can change without notice.

WE DO NOT BILL INSURANCE

We are a unique place. We use Multiple Disciplines which means you have many options. Our goal is to provide the most appropriate care for your specific case. We base our treatment recommendations completely on appropriateness for you, this may include more than one chiropractic therapy, technique or treatment within the same service time; this falls outside the scope of what insurance companies would cover.

We do not take insurance; we are not in contract (network) with any insurance company, and we do not bill any insurance companies. We can provide a superbill and a receipt at the time of payment if you so choose. We cannot guarantee any reimbursement from insurance for the products or services we provide. Insurance reimbursement of any kind is a matter completely between you and your insurance company.

HEALTH SAVINGS ACCOUNTS

We cannot answer questions or guarantee that any service or product falls within any specific Health Savings Account, or other Flexible or Benefit Spending Plan. At this time, we will simply collect payment with the debit or credit card you provide. It is common for patients to use HSA and Benefit Plan cards as payment, at times the plan will request documentation. We can provide you with a letter of Medical Necessity if any benefit plan requests it as necessary.

FOR AUTO ACCIDENT OR WORK COMPENSATION CLAIMS

If you are seeking chiropractic care reimbursement for a workers' compensation claim or auto accident incident dr. brad will do his best to refer you out to the appropriate practitioner based on your exam and symptoms that will provide the appropriate health care records and documentation for your insurance coverage.

RESULTS ARE NOT GUARANTEED

We are a healthcare clinic and because there are many factors which we cannot control including but not limited to your lifestyle, we cannot guarantee any results. We are completely dependent on clear communication with you to help you make appropriate healthcare decisions.

We charge according to the timeslot that was reserved for you. **There are no refunds for appointments or services rendered.** And your appointment time has been reserved specifically for you.

We reserve the right to charge the full value of the appointment time reserved if we are not given **24-hours notice of cancellation** for follow up appointments, and a full **48-hours** for any 30 minute or first-time appointments.

Schedule your appointments carefully to allow for **arriving at least 5-minutes early** for each appointment. Time is necessary for proper care. Arriving late does not allow us to provide appropriate care and therefore will be considered a same-day missed appointment. **Please call (hands-free) right away if you find you are going to be at all late.** Our patient services staff will try our best to pursue if there are any options to get you in, but know we are often booked back-to-back and if nothing can be worked out this may be a missed appointment with a fee; and the cancellation policy will apply.

We charge by the amount of time scheduled for each patient. This allows us to give the best possible care for your specific case. This also allows you to choose the amount of time spent directly with your practitioner. You'll be aware of the fee for your appointment regardless of whether the care provided includes chiropractic adjustments, muscle testing, nutrition therapy, muscle release techniques, exercise therapy, lifestyle education or other services.

Please note that all practitioners at Hope Clinic are independent contractors and may charge different fees for their services. Our front desk patient services staff are happy to help answer questions about any services we provide.

I understand and agree to abide by the fee structure and cancellation policies of Hope Clinic.

Patient Name_____ Signature_____ Date_____