WELCOME

LYON COUNTY CHIROPRACTIC
909 S. Union St.
Rock Rapids, IA 51246

Dr. Cody Hoefert D.C.
Dr. Nicholas Weber D.C.

Phone: (712) 472-4732
Fax: (712) 472-4734

PATIENT INFORMATION

Date _____ Address: _____

Name: _____ _____

Birth Date: _____ Sex: ___M ___F Age _____

Patient SS#_____ Marital: __Single __Married __Widowed __Separated __Divorced

Occupation_____ Employer_____

Employer Address_____ Employer Phone_____

Spouse's Name_____ Spouse's Birth Date_____

Whom may we thank for referring you?_____

CONTACT INFORMATION

Home_____ Cell_____

Work _____Ext_____

Email address: _____

Best time and place to reach you_____

IN CASE OF EMERGENCY, CONTACT:

Name_____Relationship_____

Home Phone_____

Work Phone_____Ext_____

ACCIDENT INFORMATION

Is condition due to an accident? __ Yes __No Date_____

Type of accident __ Auto __ Work __ Home __ Other

To whom have you made a report of your accident?

___Auto Insurance ___Employer ___Worker Comp. __Other

Attorney Name (if applicable)_____

FOR OFFICE USE ONLY

Patient Height: _____ Patient Weight: _____

Patient BMI: _____

Patient Blood Pressure: _____/_____

RACE/ETHNICITY

Please circle one: Race:
White American Indian Alaska Native Asian Hawaiian Black or African American Other Pacific Islander Decline to state

Ethnicity:
Hispanic or Latino Not Hispanic or Latino Decline to State

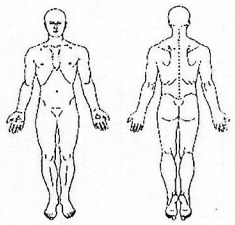
PATIENT CONDITION

In your own words, where is the problem?_____

When did your symptoms appear?_____

Is this condition getting: __Better __Worse __Stays the same __Unknown

Mark an **X** on the picture where you have pain, numbness, or tingling



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: __ Sharp __ Dull __Tingling __Numbness __Weakness __Aching __Shooting
__Burning __Throbbing __Cramping __Stiffness __Swelling __Other_____

How often do you have pain?_____

Is it constant or does it come and go?_____

Does it interfere with your: __Work __Sleep __Daily Routine __ Getting comfortable at night __Recreation

Activities or movements that are difficult to perform: __Sitting __Standing __Walking __Bending __Lying Down
__Coughing __Sneezing __ Bowel movements

What makes your pain feel better? __Ice __Heat __Medication __Stretches __Other_____

Please circle if you are experiencing any of the following symptoms:

Abnormal bruising	Blood in stool/urine/sputum	Double Vision	Leg cramps	Night sweats	Tension
Abnormal heart rate/rhythm	Blurry vision	Ear buzzing/ringing	Leg pain	Numb feet/toes	Weight gain
Abnormal weight loss	Change in smell	Fatigue	Memory loss	Numb hand/fingers	
Arm/shoulder pain	Change in taste/vision/hearing	Headaches	Nausea	Shortness of breath	
Back pain	Chest pressure	Irritability	Neck pain	Sleep difficulty	
Back stiffness	Dizziness	Jaw problems	Neck stiffness	Stomach upset	

PAST HEALTH HISTORY

What treatment(s) have you received for this condition? __ Medical/Medications __Surgery __Physical Therapy __Chiropractic __Acupuncture __None

__Other_____

Name of the provider who gave previous services?_____

Date of last: Physical Exam_____ Spinal Exam_____ Blood Test_____

Spinal X-ray_____ Chest X-ray_____ Urine Test_____

Dental X-ray_____ MRI/CT Scan_____ Bone Scan_____

Please circle "Yes" or "No" to indicate if you have or have had any of the following:

Acid Reflux	Yes	No	Diabetes	Yes	No	High Cholesterol	Yes	No	Psychiatric Care	Yes	No
AIDS/HIV	Yes	No	Drug Abuse	Yes	No	Migraine Headaches	Yes	No	Scarlet Fever	Yes	No
Alcoholism	Yes	No	Emphysema	Yes	No	Miscarriage	Yes	No	Stroke	Yes	No
Allergy Shots	Yes	No	Epilepsy	Yes	No	Mononucleosis	Yes	No	Suicide Try	Yes	No
Anemia	Yes	No	Fractures	Yes	No	Multiple Sclerosis	Yes	No	Thyroid Problems	Yes	No
Anorexia	Yes	No	Glaucoma	Yes	No	Mumps	Yes	No	Tonsillitis	Yes	No
Appendicitis	Yes	No	Goiter	Yes	No	Osteoporosis	Yes	No	Tuberculosis	Yes	No
Arthritis	Yes	No	Gonorrhea	Yes	No	Pacemaker	Yes	No	Tumors, Growths	Yes	No
Asthma	Yes	No	Gout	Yes	No	Parkinson's	Yes	No	Typhoid Fever	Yes	No
Bleeding Disorders	Yes	No	Heart Disease	Yes	No	Pinched nerve	Yes	No	Ulcers	Yes	No
Breast Lump	Yes	No	Hepatitis	Yes	No	Pneumonia	Yes	No	Vaginal Infections	Yes	No
Bronchitis	Yes	No	Hernia	Yes	No	Polio	Yes	No	Venereal Disease	Yes	No
Bulimia	Yes	No	Herniated Disk	Yes	No	Prostate Problem	Yes	No	Whooping Cough	Yes	No
Cancer	Yes	No	Herpes	Yes	No	Prosthesis	Yes	No			
Cataracts	Yes	No	High Blood Pressure	Yes	No	Rheumatoid Arthritis	Yes	No	Other_____		
Chicken Pox	Yes	No	Kidney Disease	Yes	No	Rheumatic Fever	Yes	No			

Please list any of the following you have had:

Falls_____ Date_____

Head Injuries_____ Date_____

Broken Bones_____ Date_____

Dislocations_____ Date_____

Surgeries_____ Date_____

FAMILY HISTORY

Please list any member of your family (parents, grandparents, brothers or sisters) who have had the following:

Cancer (type) _____ Stroke_____ High Blood Pressure_____

Rheumatoid Arthritis_____ Diabetes_____ Heart Disease_____

WORK ACTIVITY
__Sitting
__Standing
__Light Labor
__Heavy Labor

EXERCISE
__None __Moderate
__Daily __Heavy
__Cardiovascular
__Physical work

HABITS
__Smoking: Current: Start Date: _____ Packs/Day: _____
Former: End Date: _____
__Never Smoker
__Alcohol: Drinks/Week_____
__Coffee/Caffeine Drinks Cups/Day_____
Stress Level: __Low __Moderate __High Why?_____

ALLERGIES to medications or other
_____
_____

VITAMINS/MINERALS
_____
_____

MEDICATIONS_____

Functional Rating Index

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle which most closely describes your condition right now.

1. Pain Intensity

No pain	Mild pain	Moderate pain	Severe pain	Worse possible pain

2. Sleeping

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

No pain	Mild pain	Moderate pain	Moderate pain; need some assistance	Severe pain

4. Travel (driving, etc.)

No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

Can do usual work; plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7.Frequency of Pain

No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

No pain w/heavy weight	Increased pain w/heavy weight	Increased pain w/moderate weight	Increased pain w/light weight	Increased pain w/any weight

9. Walking

No pain; any distance	Increased pain after 1 mile	Increased pain after ½ mile	Increased pain after ¼ mile	Increased pain with all walking

10. Standing

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after ½ hour	Increased pain with any standing

Name: _____ Date: _____

HIPAA Notice of Privacy Practices

Lyon County Chiropractic
909 S. Union St.
Rock Rapids, IA 51246
Phone: (712) 472-4732
Fax: (712) 472-4734

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary to a home health agency that provides care to you. For example, our protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operation: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to your and when required by the Secretary of the department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

Your may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in a reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of you protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations, you may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care of for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is not in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

Your have the right to request to receive confidential communications from us by alternative means or at an alternative location.
You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____

Signature:_____ Date:_____

Lyon County Chiropractic Medical Release Form

I, _____, give Lyon County Chiropractic the consent to release my medical information to the person(s) listed below:

1)_____ Relationship:_____

2)_____ Relationship:_____

3)_____ Relationship:_____

4)_____ Relationship:_____

5)_____ Relationship: _____

By signing below, I authorize that I acknowledge that my information may be released to the person(s) listed above on my behalf. I am responsible to contact Lyon County Chiropractic if I ever want to change that names that I have authorized above.

Print Name: _____

Signature:_____

Lyon County Chiropractic

Financial Policy

Billing- Any outstanding balances are billed on the 1st of the month and considered past due 15 days after the invoice date or when special arrangements are not met. Bills will be sent for all covered services (after deductible has been met) after hearing from your insurance company. Billing is sent only after receiving an explanation of benefits on all covered services from your insurance company, regardless if your deductible has been met.

Cash Payment- Patient without insurance coverage may pay for care by cash, check, debit card, or credit card. Payment for service is due at the time the service is rendered. A time-of-service discount of 10% is available on all chiropractic services, if payment is made the same day as service. This discount does not apply to nutritional supplements, customized orthotics, or supplies.

Major Medical Insurance- The doctors in this office are providers for **most** major medical insurance companies. We will call to verify benefits as each individual and group plans may have different benefits, coverages, and deductibles. We gladly accept insurance assignment if the insurance company 1) Verifies that the deductible has been met, 2) Provides details of the available coverage, and 3) Agrees to make payment directly to our office. Our office will file the necessary claim forms at no charge. Patients are responsible for all co-payments and non-covered services. Payments for non-covered services and co-payments will be collected at the time of service and can be paid for by cash, check, debit card, or credit card.

Medicare- The doctors in this office are Medicare providers. We will submit all claims to Medicare and secondary plans for you. The only chiropractic services Medicare reimburses for is manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. If you have a supplement plan, they will normally cover the other 20% of the allowable fee once the Medicare deductible has been met. You are responsible for the payment in full for non-covered services at the time of service. This would include X-rays, examinations, therapies, nutritional supplements and supports. If you do not have a supplement plan, you are responsible for the 20% that Medicare does not reimburse as well as any non-covered serves listed above at the time of service. The 10% discount will be applied for all non-covered chiropractic services when paid the same day of service (excluding nutritional supplements, customized orthotics and supplies.)

Medicaid- The doctors in the office are providers for Iowa Medicaid and their manage care organizations. We will file claims at no extra fee. Medicaid requires anyone over the age of 18, and not pregnant, to have X-rays done once a year to show medical necessity. If x-rays are refused by the patient, the patient will be responsible for future visits until X-rays are completed. This is a covered service by Medicaid. You are responsible for all non-covered items, such as supplements or supports.

Personal Injury/Automobile Accidents/Workers Compensation- If you have been involved in a motor vehicle accident/injured on the job, it is important that you report to your insurance agent/employer and request a claim number and the appropriate billing information. We will submit your claims at no charge. Although you as the patient are ultimately responsible for the bill, we will take assignment as long as you are under active care. Once the claim is settled, or if you suspend or terminate care, any fees for services are due immediately.

Special Arrangement- We rarely deny anyone the benefits of chiropractic care because of the inability to pay our published fees; However, we reserve the right to refuse treatment in non-emergency situations until your account is in good standing. If financial hardship exists, it requires an Individual Consideration Contract. Please speak with the front desk staff for more information.

Missed Appointments- You are responsible for calling in prior to your scheduled appointment if you are unable to make it. All no-show appointments will be subject to the fee's listed below:

*Any missed appointment without notice will be subject to paying a flat rate fee of $20. This fee is a personal responsibility, not the responsibility of your insurance company.

*Any missed DOT Physicals will be charged the full amount. Any DOT Physicals that are scheduled to be completed on a Saturday will need to be pre-paid at the time the appointment is scheduled. The fee is not transferable or refundable if the appointment is missed.

Card Processing Fee: When using any type of card to make a payment, you will now be responsible for a 3% processing fee. This fee will be added to the balance being paid.

Patient Agreement

I have read and understand the payment policy of Lyon County Chiropractic. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Lyon County Chiropractic and my insurance company. I request that Lyon County Chiropractic prepare customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by Dr. Cody Hoefert and/or Dr. Nick Weber that fees will be due and paid immediately. I also understand that all balances more than 30 days past due will be assessed a 1.5% finance charge unless the balance is the responsibility of my insurance company. Once my insurance company has paid and a balance remains on my account, a 1.5% finance charge will be assessed until the balance is paid in full.

_____ _____

Patient's Signature (or guardian if a minor) Date

Lyon County Chiropractic

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent confusion and disappointment.

Chiropractic Adjustment- An adjustment is the specific applications of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health- A state of optimal physical, mental, and social wellbeing, Health is not merely the absence of infirmity or pain.

Vertical Subluxation Complex- A misalignment of one or more of the 24 vertebrae in the spinal column, causes alteration of the nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than the Vertebral Subluxation Complex. However, if, during the course of a chiropractic examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Chiropractic doctors choose not to prescribe drugs or perform surgery, but instead are concerned with eliminating vertebral subluxation through non-invasive and natural methods only.

Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. Our only practice objection is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation. Adjunctive therapies will be used only as needed to reduce swelling, increase circulation and to provide pain relief, not to reduce vertebral subluxations.

All questions regarding the doctor's objective pertaining to my care in the office have been answered to my complete satisfaction.

I have read and fully understand the above statement and, therefore, accept chiropractic care on this basis.

_____ _____

Patient's Signature Date

I consent to evaluate and adjust a minor child.

I, _____, being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.