PRIOR LAKE NATURAL HEALTH CLINIC, P.A.

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Welcome to Our Clinic!

We are happy that you have chosen Prior Lake Natural Health Clinic, P.A. for your health care needs. By choosing this particular type of health care, you have the opportunity to understand the concepts of 'total person health' and obtain information concerning your personal needs for a healthy body. The Doctors of Chiropractic in this clinic have received education and training in the use of Applied Kinesiology, a method of diagnosis that involves the use of muscle testing as a supplemental procedure in diagnosis, treatment, and/or nutritional recommendation.

Payment Policy

Please note that payment is due at the time of each visit. We regret that we are unable to make exceptions to this policy. However, we do accept Visa, MasterCard, and Discover. If you wish to submit to insurance, your receipt is a suitable document to send to your insurance company for reimbursement.

Let us know at 24 hours in advance if you need to cancel your appointment. This time has been reserved for you. If you are unable to use it, please give us the opportunity to offer someone else our care. If sufficient notice is not provided a $40 late cancel / missed appointment fee will be charged.

What to Expect

Your initial appointment will include an examination and treatment. Additional treatments vary in frequency depending on the severity of the problems(s). Treatments are often scheduled once or twice the first few weeks, then once every other week or two for the next several weeks, and then continue to decrease as your health improves. Some patients will not need to come this frequently. The doctor will often recommend specific supplements for you to take. These would involve additional charges.

We will be happy to answer any questions you may have. Thank you!

Patient / Guardian Signature _____

CHILD HEALTH QUESTIONNAIRE

Parent / Guardian Name: _____
Child Name: _____
Sex: M _____ F _____
Date of Birth: _____
Address: _____
_____
_____
Phone: Home: _____
Cell: _____
Work: _____

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Has your child experienced the following:

Being accident prone _____
Falling down steps _____
Being labeled hyperactive _____
Broken bones or sprain injury _____
Scoliosis diagnosis _____
Being on medication _____
Falling from heights over 2 feet _____
Learning disorders _____
Involved in motor vehicle accident _____
Hospitalization or surgery _____
Showing signs of nervousness, twitching, or excessive talking to themselves _____

Please check all that apply to your child:

Headaches _____
Asthma _____
Sleeping disorders _____
Colic _____
Irritability _____
Frequent colds _____
Bloody Noses _____
Ear Problems _____
Constipation _____
Fatigue _____
Hyperactivity _____
Digestive Problems _____
Allergies _____
Diarrhea _____
Breathing Problems _____
Rashes _____
Bed Wetting _____
Flu _____
Milk or Lactose Intolerance _____
Other _____

Family Health History

Please check this list to see if any blood relatives to the patient had or do have any of the following conditions. If so, please mark next to each condition accordingly: M (Mother); F (Father); S (Sibling); PGM (Paternal Grandmother); MGM (Maternal Grandmother); PGF; or MGF.

Allergy	_____	Kidney Disease	_____
Asthma	_____	Migraine Headaches	_____
Eczema	_____	Liver Disease	_____
Cancer	_____	Mental Retardation	_____
Diabetes or Low Blood Sugar	_____	Mental Illness/Nervous Disorders	_____
Heart Trouble	_____	Scoliosis	_____
High Blood Pressure/Stroke	_____	Ulcers	_____
Other: _____		Please explain: _____	
		_____	
		_____	

Please check any area that applied to the patient's mother during the pregnancy:

Complications	_____	Bleeding	_____	Prenatal Classes	_____
Tobacco	_____	Toxic Exposures	_____	Chiropractic Care	_____
Recreational Drugs	_____	Allergic Reactions	_____	Carried to Full Term	_____
Alcohol	_____	Mental Trauma	_____	Premature Contractions	_____
Vitamins/Minerals	_____	Physical Injuries	_____	Back Pain	_____
Hospitalization	_____	Immunization	_____	Other Pain	_____
High Blood Pressure	_____	Prenatal Care	_____	Attitude: Happy (Usually)	_____

Medications: (please list) _____ Attitude: Depressed (Usually) _____

Any Diagnosed Illnesses (please explain)_____

Excessive Decrease in Weight _____ How Much? _____

Excessive Increase in Weight _____ How Much? _____

Caffeine (circle one: Cola, Coffee, Tea, Chocolate, other)

Prenatal History

Please check any problems the patient (child) had at birth:

_____ Breathing	_____ Nursing	_____ Coloring	_____ Crying
_____ Sleeping	_____ Jaundice	_____ Choking	_____ other

Please explain:_____

_____

Please Check If These Items Applied To The Patient At Birth:

_____ Medication	_____ Surgery	_____ Artificial Feeding
_____ Silver Nitrate	_____ Vitamin K	_____ Circumcision
_____ Other	Please explain _____	

_____

Nutrition

Please check if the patient has received any of the following:

_____ Breast Milk _____ Cow's Milk _____ Goat's Milk _____ Soy Milk
_____ Commercial Formula Brand (s) _____
_____ Solid Foods _____ Sweets _____ Juice: Fruit _____ Juice: Vegetable
_____ Vitamins Brand (s) _____
_____ Medications Please list: _____
_____ other Please explain: _____

Previous Health Care

Name of Pediatrician : _____ Date of last exam _____
Please list any conditions or illnesses that have already been diagnosed. Include any serious mental or physical traumas for which treatment was recommended and/or received:

_____
_____
_____

Please list the immunizations the patient has received and any reactions observed:

Date	Immunization (s)	Reactions

REQUEST FOR PAYMENT OF BENEFITS TO PROVIDER OF CARE

I hereby authorize _____ Insurance Company/Insurance Administrator to pay by check and for it to be mailed directly to Prior Lake Natural Health Clinic, P.A., the expense benefits allowable, and otherwise payable to me under my current policy, as payment toward the total charge for professional services rendered, and I have agreed to pay, in a current manner, any balance of said professional charges, I agree that this office be given power of attorney and endorse/sign my name on any drafts for payment of my bill.

Patient Signature _____ Date _____ Witness_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize the release of any medical information necessary to process my insurance claims(s) and also certify that all insurance information given to this clinic is correct and complete.

Patient Signature _____ Date _____

CONSENT FOR TREATMENT OF A MINOR

I hereby authorize Tammy T. Nyhus, DC,DICCP/Tara L. Roman, DC and whomever they may designate as their assistants to administer chiropractic care as they deem necessary to (Child's name) _____ (Relationship to Child) _____

Parent/Guardian Signature _____ Date _____

LEGAL REPRESENTATION AND PROTECTION OF BALANCE

I, the undersigned patient, am directing my Attorney _____ to pay any outstanding bills out of my settlement, and, in effect, protecting any such balance. I fully understand that I am directly responsible for any medical bills and this agreement is made solely for the doctor's additional protection and consideration of the awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will await payment but will require me to make payment on a current status.

Patient Signature _____ Date _____

PATIENT INFORMATION AND INFORMED CONSENT

I hereby acknowledge that I have read the following statement and agree to the following conditions concerning chiropractic care, nutritional or homeopathic program/consultation, Applied Kinesiology examination/findings, acupuncture, and any supplemental reports.

It is understood that these examinations, programs, and finding are NOT TO TREAT OR DIAGNOSE ANY DISEASE. No guarantees have been made to me that the testing and/or consultation will affect a cure of the symptoms and complaints from which I presently suffer. It is also understood that these procedures are not represented as a practice of medicine.

I agree that any information given from these procedures is for guidance and recommendation only and is not to be regarded as medical advice. At no time will there be any implied and/or stated indications for any patient to discontinue taking any medications as prescribed by his/her physician. At no time will there by any implied and/or stated indication to any patient to discontinue care under the direction of any other physician.

It has been found that complete patient compliance to the natural health care recommendation usually results in greater and more consistent changes towards better health. If you, the patient, wish to decline participation in this program, you may do so at any time. This office reserves the right to dismiss any patient at any time due to poor compliance to the program.

The undersigned agrees that he/she is not an investigator or representative of any state or federal investigatory agency, the American Medical Association, or any media.

Patient Signature _____ Date _____

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a 'click' or 'pop', such as the noise when a knuckle is 'cracked', and you may feel movement of the joint. Various ancillary procedures, such as hot or cold pack, electrical stimulation, therapeutic ultrasound or traction may also be used.

Possible risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous stain, dislocation of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury, or stroke, could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or other minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as 'rare', about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury, or stroke, has been estimated at one in one million to one in ten million, and can be further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered 'rare'.

Other treatment options that could be considered may include the following:

- **Over the counter analgesics.** The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- **Medical care,** typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- **Hospitalization** in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- **Surgery** in conjunction with medical care adds risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate and make future rehabilitation more difficult.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

Patient Signature _____ Date _____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. 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.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. 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.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, 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.

Print Patient Name Date

Patient/Guardian Signature