FOSSO GELHAR Chiropractors of the Fox Valley

Date_____

Patient Name_____Sex (circle one) Female Male

Address_____City_____State_____Zip_____

Home/Cell#_____Date of Birth_____Social Security #_____

Employer_____Work #_____

Spouses Name_____Spouses Phone#_____

Emergency Contact (Name/Phone/Relationship):_____

E-mail Address (please print clearly)_____

Would you like appointment reminders? Text or E-mail How were you referred_____

Family Dr. _____

Previous Chiropractic Care Y or N When was your last treatment?_____

Ethnicity (Circle One) Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Race (Circle One) American Indian or Alaska Native / Asian / Black or African American / White

Native Hawaiian or Pacific Islander / Decline to Answer

Electronic Records Waiver-

☐ I choose to decline electronic access to my clinical records. *** You may revoke this waiver at any time***

Assignment and Release

I hereby authorize and assign directly to Fosso Gelhar-Chiropractors of the Fox Valley all insurance benefits, if otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions and for excess to MedHx.

Responsible Party Signature_____

Relationship_____Date_____

Please make available all insurance information.

NAME _____Date_____

Family History

	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Mother	Father	Sibling	Sibling
Living								
Deceased								
Cancer								
Diabetes								
Heart Disease								
Psychological								
Scoliosis								
Stroke								
Thyroid Disease								
Multiple Sclerosis								
Rheumatoid Arthritis								

Please list any past:

Please list any Surgeries: _____
_____

Traumas or Accidents: _____
_____

Current Illnesses or hospitalizations in the last year:
_____
_____
_____

Current Medications/Why are you taking them:
_____
_____
_____
_____.

☐ I am currently not taking any medication.

Fosso Gelhar Chiropractors of the Fox Valley- 155 N Sawyer St Oshkosh WI 54902

Patient's Name _____Date_____

Reason for today's visit_____

When did your symptoms first appear_____

Is this condition a result from an accident or injury?_____

Please circle the one that applies: Single Married Divorced Widowed

Allergies to any medications_____

Employer_____Occupation_____

Working Status (circle) full time part time

Work Activity (circle what applies): Sitting Standing Light Labor Heavy labor

Smoking Status (circle one) Every Day Smoker Occasional Smoker Former Smoker Never Smoker

Other tobacco products (circle one) Yes No Please specify is yes_____

Illegal Drug Use (circle one) Yes No Specify type of drug_____

How many caffeinated beverages do you consume daily? _____

Do you exercise (Circle) Yes No How often_____What type of activity_____

Alcohol Use (circle) Yes No How often do you have an alcoholic beverage_____

Constitutional Symptoms

- Chills
- Night sweats
- Poor appetite
- Fever
- Weight Change
- Fatigue

Eyes

- Blurry vision
- Eye pain
- Change in vision
- Double vision

Respiratory

- Coughing up blood
- Wheezing
- COPD
- Cough
- Coughing up phlegm
- Asthma
- Breathing issues

Genitourinary

- Difficulty urinating
- Vaginal or penile discharge
- Kidney stones
- Menstrual Problems
- Prostate Problems

Neurological

- Weakness
- Dizziness
- TIA's
- Multiple Sclerosis
- Parkinson's
- Headache
- Seizure
- Tremor
- Stroke
- Epilepsy
- Polio

Sleep

- Gasping
- Restless legs
- Snoring
- Insomnia
- Difficulty sleeping
- Sleep Apnea

Nose, Mouth & Throat

- Change in sense of smell
- Runny nose
- Nose bleeding
- Sores in the mouth
- Sore throat
- Difficulty or pain swallowing

Gastrointestinal

- Nausea
- Diarrhea
- Heartburn
- Abdominal pain
- Vomiting
- Constipation

Skin

- Rash
- Ulcers that will not heal
- Moles that are changing
- Psoriasis
- Eczema

Lymph and Heme

- Swollen lymph nodes
- Easy bleeding

Cancer

Please list below.

Ears

- Ear pain
- Hearing loss
- Ringing

Cardiovascular

- Palpitations
- Fainting
- High blood pressure
- Heart Attack
- Heart Condition
- Chest Pain
- Swollen Legs
- Shortness of breath
- High cholesterol
- Pacemaker

Musculoskeletal

- Bone pain
- Swollen or red joints
- Osteoporosis
- Spinal Cord Injury
- Scoliosis
- Muscle Pain
- Joint Pain
- Broken bones
- Arthritis
- Rheumatoid Arthritis
- Fibromyalgia

Endocrine

- Heat or cold intolerance
- Frequent urination
- Unusually thirsty
- High or low blood sugar
- Thyroid issues
- Liver issues
- Diabetes

Psychiatric

- Anxiety
- Bipolar
- ADD
- Depression
- Hallucinations
- ADHD

Name:_____ Date:_____

FOSSO GELHAR CHIROPRACTORS OF THE FOX VALLEY

155 N Sawyer St Oshkosh WI 54902

Patient Name_____ Date of Birth_____

I consent to the use or disclosure of my protected health information by Fosso Gelhar Chiropractors of the Fox Valley, S.C. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct the health care operations of Fosso Gelhar Chiropractors of the Fox Valley, S.C. This consent includes my permission for Fosso Gelhar Chiropractors of the Fox Valley to leave messages on my answering machine or voicemail. I have the right to revoke this consent in writing at any time, except to the extent that Fosso Gelhar Chiropractors of the Fox Valley has taken action in reliance on this consent.

My protected health information (PHI) means health information, including my demographic information collected from me and created or received by my chiropractor, another health care provider, a health plan, my employer or health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review the notice of privacy practices prior to signing this document. The notice of privacy practices has been provided to me. The notice describes the types of uses and disclosure of my protected health information that will occur in my treatment, payment of my bill or in the performance of healthcare operations. This notice is also provided in the lobby of Fosso Gelhar Chiropractors of the Fox Valley.

Electronic Format: I acknowledge that my records are stored in an electronic format. I understand that Fosso Gelhar Chiropractors of the Fox Valley maintains their patient records electronic format only. Original documents are destroyed after being converted to an electronic format.

Release of Information: I hereby give Fosso Gelhar Chiropractors of the Fox Valley permission to release information regarding my medical condition when a signed authorization is received or it is necessary to secure the payment of benefits from my insurance carrier. I understand the areas discussed with these people could include treatment options, financial information, test results, etc.

_____Date_____

Signature of Patient or Personal Representative

Fosso Gelhar Chiropractors of the Fox Valley

Informed Consent to Chiropractic Treatment

Dear Patient,

The State of Wisconsin requires every patient be informed of the risks of treatment and the alternative to treatment prior to beginning treatment. The following is Fosso Gelhar Chiropractors of the Fox Valley's informed consent. We intend this consent form to cover the entire course of treatment for your present condition and for any future conditions for which you seek treatment at this or any other Fosso Gelhar office.

The Nature of Chiropractic Treatment: In this office we use trained staff to assist the doctor with portions of your consultation, examination, and treatment. Occasionally when your doctor is unavailable, another clinic doctor will treat you. The doctor will use her hands or a mechanical device in order to move your joints. You may hear a 'click' or a 'pop', similar to when a knuckle is 'cracked', and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or traction, red light therapy, as well as exercise instruction may also be used.

Benefits of Chiropractic Treatment: Many or most patients will feel improvement in motion, decreased muscle and joint pain and improved well-being after a series of chiropractic adjustments.

Possible risks: As with any health care procedure, complications are possible following a chiropractic treatment. Complications could conceivably include muscular strain, ligamentous sprain, dislocations of joints, fracture of bone, or injury to intervertebral discs, nerves or spinal cord. 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. There are reported cases of stroke associated with visits to medical doctors and chiropractors. The best quality scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather it indicates that patients may be consulting medical doctors and/or chiropractors for symptoms of headache and neck pain when they are in the early stages of stroke. The possibility of such injuries occurring in association with chiropractic treatment is extremely remote.

Probability of Risks Occurring: The risks of complications due to chiropractic treatment have been described as "rare" to "extremely 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, increased cardiovascular risk, and other side effects in a significant number of cases.
- Medical care, typically anti-inflammatory drugs, tranquilizers and analgesics. Risks of these prescription drugs include all side effects as above, plus patient dependence in a significant number of cases.
- Hospitalization in conjunction with medical care adds additional risk exposure to medical error, infection and other complications in a significant number of cases.
- Surgery in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risk 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 the condition, and make further rehabilitation difficult.

Concerns of Questions: Please ask your Doctor of Chiropractic. We at Fosso Gelhar Chiropractors of the Fox Valley have gone to great lengths to make your health and safety our top priority. We will be glad to explain any concern about treatment you might have.

I have read the above explanation 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 herby give my full consent to treatment. I have the right to withdraw my consent at any time, upon written notice. I have the right to refuse treatment at any time.

_____ _____ _____

Printed Name Signature Date

Consent to evaluate and adjust a minor child

I, _____being the parent or legal guardian of _____have read and fully understand the above Informed Consent and herby grant permission for my child to receive chiropractic care.

Lower Mid Back -Low Back Index

Patient Name_____Date_____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes you problem.

Pain Intensity
__I have no pain at the moment
__The pain is very mild at the moment
__The pain is moderate at the moment
__The pain is fairly severe at the moment
__The pain is very severe at the moment
__The pain is the worst imaginable at the moment

Personal Care
__I can look after myself normally without causing extra pain
__I can look after myself normally but it causes extra pain
__It is painful to look after myself and I am slow & careful
__I need some help but manage most of my personal care
__I need help every day in most aspects of self-care
__I do not get dressed, I wash with difficulty and stay in bed

Lifting
__I can lift heavy weight without extra pain
__I can lift heavy weights but gives extra pain
__Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned
__Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
__I can lift only very light weights
__I cannot lift or carry anything at all

Walking
__Pain does not prevent me walking any distance
__Pain prevents me walking more than 1 mile
__Pain prevents me walking more and .5 miles
__Pain prevents me walking more than .25 miles
__I can only walk using a stick or crutches
__I am in bed most of the time and have to crawl to the toilet

Sitting
__I can sit in any chair as long as I like
__I can only sit in my favorite chair as long as I like
__Pain prevents me sitting more than 1 hour
__Pain prevents me from sitting more than .05 hours
__Pain prevents me from sitting more than 10 minutes
__Pain prevents me from sitting at all

Standing
__I can stand as long as I want without extra pain
__I can stand as long as I want but gives me extra pain
__Pain prevents me from standing for more than 1 hour
__Pain prevents me from standing for more than 30 minutes
__Pain prevents me from standing for more than 10 minutes
__Pain prevents me from standing at all

Sleeping
__Pain does not prevent me from sleeping well
__I can sleep well only by using tablets
__Even when I take tablets I have less than 6 hours sleep
__Even when I take tablets I have less than 4 hours sleep
__Even when I take tablets I have less than 2 hours sleep
__Pain prevents me from sleeping at all

Social Life
__My social life is normal and give me no extra pain
__My social life is normal but increases the degree of pain
__Pain has no significant effect on my social life apart from limiting energetic interest such as dancing
__Pain has restricted my social life and I do not go out as often
__Pain has restricted my social life to my home
__I have no social life because of the pain

Traveling
__I can travel anywhere without extra pain
__I can travel anywhere but it gives me extra pain
__Pain is bad but I manage journeys over 2 hours
__Pain restricts me to journeys of less than 1 hour
__Pain restricts me to short necessary journeys under 30 minutes
__Pain prevents me from traveling except to the doctor or ospital

Changing Degree of Pain
__My pain is rapidly getting better
__My pain fluctuates, but is definitely getting better
__My pain seems to be getting better, but improvement is slow at present
__My pain is neither getting better nor worse
__My pain is gradually worsening
__My pain is rapidly worsening

Neck –Upper Mid Back Index

Patient Name_____Date_____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes you problem.

Pain Intensity

___I have no pain at the moment
___The pain is mild at the moment
___The pain comes and goes and is moderate
___The pain moderate and does not vary much
___The pain is severe but comes and goes
___The pain is severe and does not vary much

Concentration

___I can concentrate fully when I want to with no difficulty
___I can concentrate fully when I want to with slight difficulty
___I have a fair degree of difficulty in concentrating with I want to
___I have a lot of difficulty in concentrating when I want
___I have a great deal of difficult in concentrating when I want to
___I cannot concentrate at all

Personal Care (Washing, Dressing, etc.)

__I can look after myself without causing extra pain
__I can look after myself normally but it causes extra pain
__It is painful to look after myself and I am slow & careful
__I need some help but manage most of my personal care
__I need help every day in most aspects of self-care
__I do not get dressed: I wash with difficulty and stay in bed

Work

__I can do as much work as I want to
__I can only do my usual work but no more
__I can do most of my usual work but no more
__I cannot do my usual work
__I can hardly do any work at all
__I cannot do any work at all

Lifting

__I can lift heavy weights without extra pain
__I can lift heavy weights, but it causes extra pain
__Pain prevents me from lifting heavy weights off the floor, but I can if they are conveniently positioned.
__Pain prevents me from lifting heavy weights but light to medium weights if they are conveniently positioned
__I can only lift very light weights
__I cannot lift or carry anything at all

Driving

__I can drive my car without neck pain
__I can drive my car as long as I want with slight pain in my neck
__I can drive my car as long as I want with moderate pain in neck
__I cannot drive my car as long as I want because of moderate pain in my neck
__I can hardly drive my car at all because of severe pain in my neck
__I cannot drive my car at all

Reading

__I can read as much as I want to with no pain in the neck
__I can read as much as I want with slight pain in my neck
__I can read as much as I want with moderate pain in my neck
__I cannot read as much as I want because of moderate pain in my neck
__I cannot read as much as I want because of severe pain In my neck
__I cannot read at all because of neck pain

Sleeping

__I have no trouble sleeping
__My sleep is slightly disturbed (less than 1 hour sleepless)
__My sleep is mildly disturbed (1-2 hours sleepless)
__My sleep is moderately disturbed (2-3 hours sleepless)
__My sleep is greatly disturbed (3-5 hours sleepless)
__My sleep is completely disturbed (5-7 hours sleepless)

Headache

__I have no headaches at all
__I have slight headaches that come infrequently
__I have moderate headaches that come in-frequently
__I have moderate headaches that come frequently
__ I have severe headaches that come frequently
__I have headaches almost all the time

Recreation

__I am able to engage in all recreational activities with no pain in my neck at all
__I am able to engage in all recreational activities with some pain in my neck
__I am able to engage in most, but not all, recreational activities because of pain in my neck
__I am able to engage in only a few of my usual recreation activities because of pain in my neck
__I can hardly do any recreational activities because of pain in my neck
__I cannot do any recreational activities at all

Fosso Gelhar Chiropractors of the Fox Valley
FINANCIAL POLICY

Thank you for choosing Fosso Gelhar Chiropractors of the Fox Valley for your chiropractic needs. We appreciate the opportunity to serve you and are committed to providing you with the best possible care.

As part of our services to you, we try to contain the ever-rising cost of health care. In an effort to do this, we have implemented the following Financial Policy. **Please read and sign below**. Your cooperation in following our credit policy will allow for a prompt settlement of your claim.

Insurance: Fosso Gelhar Chiropractic accepts assignment from many insurance companies. However, Insurance is a contract between you and your insurance company. We are NOT party to this contract. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges for services rendered but not covered by your plan or not paid (denied) by your insurance. Any services rendered after insurance eligibility terminates will be charged at our standard fees.

Medicare/Medicaid: Fosso Gelhar Chiropractic will accept assignment for Medicare or Medicaid. Patients are responsible for their co-payment and payment for any service not covered by Medicare/Medicaid. You agree to pay any portion of the charges for services rendered but not covered by your plan or not paid (denied).

Workers' Compensation: Work-related injury cases are accepted on assignment with permission of the employer and prior authorization from the employer's compensation insurance carrier. You agree to pay any portion of the charges for services rendered but not covered by your plan or not paid (denied).

Patients WITHOUT Insurance Coverage: Patients without insurance coverage are required to pay for services as rendered.

Payments: Unless other arrangements are approved by us, the balance on your statement is due and payable when the statement is issued, and is past due if payment is not received within 30 days.
Payment options: You may pay by cash, check, MasterCard, Visa, Discover cards.

Missed appointments: Habitual missed appointments will be documented and future care will be terminated with our office.

Returned checks: There is a fee (currently $35.00) for any checks returned by the bank. Returned checks not redeemed within 21 days will be turned over to collection agency and associated costs will be added to the balance due.

Divorce: In case of divorce or separation, the parent accompanying the child and authorization treatment will be the parent responsible for the charges on the day of service. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, or to a lawyer, you agree to pay all of the collection costs, lawyers' fees plus all court costs which are incurred. In case of suit, you agree that the venue be in Winnebago County, Wisconsin.

Effective Date: Once you signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

This is an agreement between Fosso Gelhar Chiropractors of the Fox Valley, S.C., a Wisconsin Professional Corporation, and the Patient named on this form.

By executing this agreement, you are agreeing to pay for all services that are received, and agree to all the policies hereby within.

Print Patient's Name_____

Responsible party Signature_____Date_____