ARCTIC EAST MATSU
CHIROPRACTIC, PHYSICAL THERAPY & MEDICAL

D. ENGELBRECHT, DC, C. MODRELL, DC , Z. RICHARDS, DC, R. JAHN, LAc, T. PHILLIPS, DPT, A. PORTER, DPT & S. PACKARD, FNP-BC

PERSONAL

First Name_____MI____Last Name_____

Address_____

City_____State_____Zip_____

SSN_____Date of Birth_____Age_____Male ☐ Female ☐

Primary Contact #_____HM/Cell/Work

Secondary Contact #_____HM/Cell/Work

Email_____

How did you hear about our clinic? _____

Marital Status Single ☐ Married ☐ Divorced ☐ Widowed ☐

Occupation_____

Emergency Contact Name_____Phone#_____

CASE TYPE Self Pay / Insurance / Work Comp Ins / Auto Accident / Medicare / Medicaid

PRIMARY INSURANCE

Insurance Name_____

Policy or Subscriber #_____Group#_____

GUARANTOR

Policy Holder Name_____MI____Last Name_____

SSN_____Date of Birth_____Age_____Male ☐ Female ☐

Primary Contact #_____HM/Cell/Work

Secondary Contact #_____HM/Cell/Work

Employer_____

SECONDARY INSURANCE

Insurance Name_____

Policy or Subscriber #_____Group#_____

GUARANTOR

Policy Holder Name_____MI____Last Name_____

SSN_____Date of Birth_____Age_____Male ☐ Female ☐

Primary Contact #_____HM/Cell/Work

Secondary Contact #_____HM/Cell/Work

Employer_____

CURRENT COMPLAINT

Nature of Injury Automobile ☐ Work ☐ Other ☐

Please describe

Date of Injury Date symptoms appeared

Have you ever had the same condition? No ☐ Yes ☐ If yes, when?

List other practitioners seen for this inury/condition

Have you ever been under chiropractic care? No ☐ Yes ☐

If yes please describe

ARCTIC MEDICAL CENTER MATSU

MEDICAL HISTORY

Today's Date: Patient Print Name: Date of Birth:

What brings you in today?

When did it start? _____ How did it start? _____ (fall, car accident, etc.) How would you describe it? _____ (burning, aching, stabbing, electric, constant, intermittent, etc.)

What makes it worse? _____

Do you have any associated symptoms? ☐ no ☐ yes _____ (numbness, tingling, weakness, etc.)

What makes it better? _____ (Tylenol, ibuprofen, stretching, rest, etc.)

Severity (please circle) no pain/discomfort **0 1 2 3 4 5 6 7 8 9 10** worst pain ever experienced

Goals for treatment/function: _____ (walk the dog, play football with the grandchildren, climb a flight of stairs)

Do you now, or have you ever had the following:

- ☐ Abnormal PAP
- ☐ Acid reflux
- ☐ Anxiety
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune disorder _____
- ☐ Back pain
- ☐ Bleeding issues _____
- ☐ BPH (prostate enlargement)
- ☐ Bowel issues _____
- ☐ CAD (coronary artery disease)
- ☐ Cardiac arrythmia _____
- ☐ Cancer _____
- ☐ CHF (congestive heart failure)
- ☐ Chicken pox
- ☐ COPD
- ☐ Degenerative disc disease
- ☐ Depression
- ☐ Diabetes type: ☐ 1 ☐ 2
- ☐ Eczema
- ☐ Endometriosis
- ☐ Gout
- ☐ Hearing difficulty
- ☐ Heart attack
- ☐ Hepatitis, type _____
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hypothyroidism
- ☐ Kidney disease _____
- ☐ Liver disease _____
- ☐ Lung disease _____
- ☐ Measles
- ☐ Migraines, frequency _____
- ☐ Mumps
- ☐ Neck pain
- ☐ Rheumatic disease
- ☐ Seasonal allergies
- ☐ Seizure disorder
- ☐ Sexually transmitted infection _____
- ☐ Shingles
- ☐ Sleep apnea
- ☐ Tuberculosis
- ☐ UTI (urinary tract infection)
- ☐ Other _____

Food/Medication Allergies and Their Reactions:

_____
_____
_____
_____

Have you ever had surgery? If yes, what kind?

☐ No ☐ Yes

_____
_____
_____

Medications and Supplements (please list name, dose, and frequency and reason):

_____
_____
_____
_____
_____

Family Medical History: (please include age and medical conditions)

Mother: _____
Father: _____
Siblings: _____
_____
Mother's mother: _____ father: _____
Father's mother: _____ father: _____
Children: _____

Marital Status/Living Situation:

- ☐ Married
- ☐ Single
- ☐ Separated/Divorced
- ☐ Widowed
- ☐ Significant other/roommate

Sexual Health:

Sex with: ☐ Men ☐ Women ☐ Both
☐ Not currently sexually active

Birth control type: _____

Any issues with periods? _____

Year went into menopause: _____

Any issues with sex? _____ (dryness, erectile dysfunction, orgasm)

Alcoholic beverages/week: _____ Tobacco use: ☐ Current, PPD _____ ☐ Former, quit year _____ ☐ Never ☐ Second-hand exposure

Marijuana use: ☐ None ☐ Smoke ☐ Edibles Frequency: _____ Drugs: ☐ None ☐ Type: _____ Frequency: _____ ☐ IV

Do you have a safe place to go live, free of abuse of any kind? ☐ Yes ☐ No

Are you having any thoughts of hurting yourself or anyone else? ☐ Yes ☐ No

In the last two weeks, have you:

Had little interest/pleasure in doing things your normally enjoy? ☐ Yes ☐ No

Felt down, depressed, or hopeless? ☐ Yes ☐ No

Do any of the following apply to you?

- ☐ Military service, present or past
- ☐ Blood transfusion
- ☐ Wake up feeling tired
- ☐ Sleep less than 6 hours a night
- ☐ Special dietary needs
- ☐ Perform self-exams
- ☐ Actively employed ☐ FT ☐ PT
- ☐ Occupational/hobby hazards

Occupation: _____

ARCTIC MEDICAL CENTER MATSU

REVIEW OF SYSTEMS

Print Name: _____ Date of Birth: _____

Preferred Pharmacy: _____ Today's Date: _____

Please check boxes pertaining to your visit today.

General:
- ☐ Yes ☐ No Fever
- ☐ Yes ☐ No Chills
- ☐ Yes ☐ No Fatigue
- ☐ Yes ☐ No Hot flashes
- ☐ Yes ☐ No Night sweats
- ☐ Yes ☐ No Difficulty with sleep
- ☐ Yes ☐ No Unexpected weight gain
- ☐ Yes ☐ No Unexpected weight loss

Eyes:
- ☐ Yes ☐ No Eye pain
- ☐ Yes ☐ No Changes in vision
- ☐ Yes ☐ No Discharge
- ☐ Yes ☐ No Foreign body sensation

Ears/Nose/Throat:
- ☐ Yes ☐ No Changes in hearing
- ☐ Yes ☐ No Earaches
- ☐ Yes ☐ No Ringing in ears
- ☐ Yes ☐ No Nasal congestion
- ☐ Yes ☐ No Nasal discharge
- ☐ Yes ☐ No Postnasal drip
- ☐ Yes ☐ No Nose bleeds
- ☐ Yes ☐ No Dental pain
- ☐ Yes ☐ No Difficulty chewing
- ☐ Yes ☐ No Difficulty swallowing
- ☐ Yes ☐ No Bleeding gums
- ☐ Yes ☐ No Cold sores
- ☐ Yes ☐ No Voice changes (hoarseness)
- ☐ Yes ☐ No Foreign body sensation
- ☐ Yes ☐ No Sore throat

Cardiovascular:
- ☐ Yes ☐ No Chest pain/discomfort
- ☐ Yes ☐ No Palpitations
- ☐ Yes ☐ No High blood pressure
- ☐ Yes ☐ No Leg cramps
- ☐ Yes ☐ No Trouble laying flat
- ☐ Yes ☐ No Swelling in the hands/feet

Respiratory:
- ☐ Yes ☐ No Cough
- ☐ Yes ☐ No Wheezing
- ☐ Yes ☐ No Shortness of breath at rest
- ☐ Yes ☐ No Shortness of breath with activity
- ☐ Yes ☐ No Sputum/phlegm

Digestive:
- ☐ Yes ☐ No Change in appetite
- ☐ Yes ☐ No Heartburn
- ☐ Yes ☐ No Abdominal pain
- ☐ Yes ☐ No Bloating
- ☐ Yes ☐ No Nausea
- ☐ Yes ☐ No Vomiting
- ☐ Yes ☐ No Constipation
- ☐ Yes ☐ No Diarrhea
- ☐ Yes ☐ No Rectal bleeding
- ☐ Yes ☐ No Hemorrhoids
- ☐ Yes ☐ No Changes in bowel habits

Genitourinary:
- ☐ Yes ☐ No Frequent urination
- ☐ Yes ☐ No Burning with urination
- ☐ Yes ☐ No Urgent need to urinate
- ☐ Yes ☐ No Blood in urine
- ☐ Yes ☐ No Change in urine color/odor
- ☐ Yes ☐ No Discharge from penis/vagina
- ☐ Yes ☐ No Trouble starting urine stream
- ☐ Yes ☐ No Decreased urine stream
- ☐ Yes ☐ No Increased urination at night
- ☐ Yes ☐ No Dribbling
- ☐ Yes ☐ No Incontinence

Reproductive:
- ☐ Yes ☐ No Nipple discharge
- ☐ Yes ☐ No Change in breast appearance
- ☐ Yes ☐ No Concern for STI exposure
- ☐ Yes ☐ No Genital sores
- ☐ Yes ☐ No Genital itching
- ☐ Yes ☐ No Difficulty with erections
- ☐ Yes ☐ No Decreased sex drive
- ☐ Yes ☐ No Vaginal dryness
- ☐ Yes ☐ No Heavy periods
- ☐ Yes ☐ No Irregular periods
- ☐ Yes ☐ No Menstrual cramping
- ☐ Yes ☐ No PMS
- ☐ Yes ☐ No Menstrual changes

First day of last period: _____

Musculoskeletal:
- ☐ Yes ☐ No Back pain
- ☐ Yes ☐ No Neck pain
- ☐ Yes ☐ No Joint pain
- ☐ Yes ☐ No Limited movement
- ☐ Yes ☐ No Muscle cramps
- ☐ Yes ☐ No Joint swelling

Neurological:
- ☐ Yes ☐ No Headaches
- ☐ Yes ☐ No Dizziness
- ☐ Yes ☐ No Numbness
- ☐ Yes ☐ No Tingling
- ☐ Yes ☐ No Fainting
- ☐ Yes ☐ No Seizures
- ☐ Yes ☐ No Poor coordination
- ☐ Yes ☐ No Poor balance
- ☐ Yes ☐ No Change in memory
- ☐ Yes ☐ No Weakness

Psychological:
- ☐ Yes ☐ No Depression
- ☐ Yes ☐ No Anxiety
- ☐ Yes ☐ No Mood swings
- ☐ Yes ☐ No Suicidal thoughts

Skin:
- ☐ Yes ☐ No Skin changes
- ☐ Yes ☐ No Rash
- ☐ Yes ☐ No Sores

Endocrine:
- ☐ Yes ☐ No Cold intolerance
- ☐ Yes ☐ No Heat intolerance
- ☐ Yes ☐ No Excessive sweating
- ☐ Yes ☐ No Excessive thirst
- ☐ Yes ☐ No Excessive urination
- ☐ Yes ☐ No Excessive hunger
- ☐ Yes ☐ No Elevated blood sugar
- ☐ Yes ☐ No Changes in hair/nails

Hematologic/Immunologic:
- ☐ Yes ☐ No Easy bruising
- ☐ Yes ☐ No Unexplained bruising
- ☐ Yes ☐ No Easy bleeding
- ☐ Yes ☐ No Enlarged lymph nodes
- ☐ Yes ☐ No Painful lymph nodes
- ☐ Yes ☐ No Hives
- ☐ Yes ☐ No Persistent infections
- ☐ Yes ☐ No Allergies

Are there any other symptoms you wish to discuss at this visit?

_____

_____

Provider Notes:

_____

_____

_____

_____

Arctic Chiropractic East Mat-Su, LLC
Or
Arctic Medical Center Matsu

Informed Consent for Medical, Chiropractic , and Physical Therapy Treatment

I hereby request and consent to the performance of any medical procedures, chiropractic adjustments and any other chiropractic and physical therapy procedures, including but not limited to, various modes of therapeutic exercises and activities, modalities, injections, dry needling and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic, doctor of physical therapy, or the Advanced Nurse Practitioner named below and/or other licensed doctors of chiropractic, doctors of physical therapy or Advanced Nurse Practitioner who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the provider named below and/or with other office or clinic personnel the nature and purpose of the medical procedures, chiropractic adjustments and/or physical therapy procedures. I understand that the results are not guaranteed.

I understand and am informed that like in all medicine, in the practice of physical medicine/family medicine, chiropractic and/or physical therapy, there are risks to treatment. I do not expect the doctor to be able to anticipate and explain all the risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____	_____
Responsible Party Signature	Date
_____	_____
Patient's Name	D.O.B.
_____	_____
Name of person completing form if other than patient:	Relationship to Patient

Dr. Dwayne Engelbrecht, DC - Dr. Corey Modrell, DC- Dr. Zach Richards, DC - Todd Phillips, DPT - Amy Porter, DPT - Stephanie Packard, ARNP

Arctic Chiropractic East Mat-Su, LLC or Arctic Medical Center Matsu
1734 Prospect Dr., Palmer, AK 99645
P(907) 746-7842, (907) 745-2222; F(907) 745-7883 or (907)-746-7471

"Life is Good When You're Pain Free"

ARCTIC CHIROPRACTIC EAST MAT-SU, LLC
OR
ARCTIC MEDICAL CENTER MATSU

1734 Prospect Dr, Palmer, AK 96645
(907)746-7842 or (907) 745-2222

ACKNOWLEDGMENT RECEIPT: HIPAA NOTICE OF PRIVACY PRACTICES

In signing this form, you agree that you have received our **Notice of Privacy Practices**. This Notice, among other points, explains how we plan to use and disclose your protected health information for the purposes of treatment, payment and health care operations. This applies to the privacy practices of Arctic Chiropractic East Mat-Su, LLC or Arctic Medical Center Matsu and all affiliated covered entities of Arctic Chiropractic East Mat-Su, LLC or Arctic Medical Matsu is issuing this Notice.

You have the right to review our **Notice of Privacy Practices** prior to signing this form. It provides more detail on how we may use and disclose your information. The Notice of Privacy Practices may change. A current copy may be requested by contacting our HIPAA Manager at (907) 746-7842 or (907) 745-2222 or can be requested when in our office from the front desk.

By signing this form, you acknowledge you have received our Notice of Privacy Practices and that Arctic Chiropractic East Mat-Su, LLC or Arctic Medical Center Matsu and all affiliated covered entities can use and disclose your protected health information in accordance with HIPAA.

Signature of individual or surrogate decision maker

_____	_____	_____
FULL NAME	SIGNATURE	DATE

Relationship to resident/patient/legal authority (if applicable)

_____	_____	_____
FULL NAME	RELATIONSHIP	DATE

Arctic Chiropractic East Mat-Su, LLC or Arctic Medical Center Matsu
FINANCIAL POLICY STATEMENT

We are committed to providing the highest level of medical care to our patients. To ensure that our patients fully understand our billing process, we ask that you read and sign this financial policy statement.

PATIENT RESPONSIBILITY: It is the responsibility of the patient to pay his/her co-payment, co-insurance, any unpaid portion of the deductible, or non-covered service, at the time of service. Any additional co-payments, deductibles, co-insurance, and/or non-covered service will be billed to the patient as indicated by your insurance carrier on their Explanation of Benefits (EOB). Your insurance company will mail you an EOB outlining the services rendered and the portion of the bill which is your responsibility. All patients without insurance must pay in full at the time services are rendered unless other arrangements are made.

PAYMENT OPTIONS: For your convenience we offer a variety of payment options. We accept Visa and MasterCard, Personal Checks, Cashier/ Bank Checks, Money Orders, and of course CASH. All returned checks will be assessed a $30.00 returned check fee in addition to the original charge. A written payment plan may be established in cases of financial hardship.

INSURANCE COVERAGE: While we make a good faith attempt to verify your coverage, we are not able to guarantee that the benefits quoted to us by your insurance are correct nor, do they guarantee payment for the services rendered. It is your responsibility alone to know what insurance plan you are on, supply us with the correct information at the time of your visit, and know what services may or may not be covered by your insurance. We encourage you to refer to your benefits manual or call your insurance if you have any questions about covered services. Be aware that some and perhaps all of the services provided may not be covered by your insurance. You will be responsible for payment of all non-covered services at the time they are rendered.

INSURANCE PAYMENTS: Your insurance policy is a contract between you and your insurance company, **NOT** between Arctic Chiropractic East Mat-Su, LLC, or Arctic Medical Center Matsu, and your insurance company. **Be assured our billing agent works diligently to obtain payment from your insurance company.** However**,** if we file your insurance, and the claim has not been paid for any reason within 90 days or if you suspend or terminate your schedule of care as prescribed by Arctic Chiropractic East Mat-Su, LLC or Arctic Medical Center Matsu, we require that you pay the balance using one of the approved payment methods without exception. In the event that your insurance pays us after that time, you will be reimbursed.

DENIED CLAIMS: Our billing agent will not become involved in disputes between you and your insurance company regarding uncovered charges, coordination of benefit issues, eligibility issues, pre-existing conditions, or any other matter that is your responsibility, which causes the claim to be denied. Should your claim be denied for any of these reasons or any other reasons not listed here, the claim will become the responsibility of the patient and payment will be expected immediately.

"ON THE JOB" INJURY (WORKERS' COMPENSATION): If you are injured on the job, you will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If you do not provide us with this information, or if benefits are denied, any fees and services are due by you.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS: Please notify your auto or personal injury insurance carrier of your visit to our office immediately. If you do not carry a medical payment policy on your auto or personal injury insurance please provide us with your private health insurance information and we will bill your insurance for you.

THIRD PARTY PAYORS (NOT AT FAULT AUTO OR PERSONAL INJURY): Please notify our office immediately that this is a third party payor claim. If an attorney is representing you inform our billing agent as soon as possible. If you have any medical pay on your auto or personal injury insurance, or have private health insurance please provide us with that information and we will bill your insurance for you. Please notify your auto or personal injury insurance carrier, or private health insurance of your visit to our office immediately. If you do not have any insurance we will wait for a settlement for up to six months after your care is initiated. Once the claim is settled or if you suspend or terminate care, any fees for services are due by you immediately.

PATIENT AUTHORIZATION: I have read, understand, and agree to abide by the terms stipulated above. "I herby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Workers' Compensation, Auto, Personal Injury, Commercial Insurance, or any other insurance benefits I am entitled to, to Arctic Chiropractic East Mat-Su, LLC, or Arctic Medical Center Matsu. I understand that I am financially responsible for all the charges whether or not covered by said insurance. I hereby authorize said assigned to release any information necessary to secure payment on my behalf. I further authorize the use of my signature below on all insurance submissions for services rendered or to be rendered. I agree that a photocopy of this agreement shall be as valid as the original.

_____	_____
Responsible Party Signature	Date
_____	_____
Patient's Name	D.O.B.
_____	_____
Name of person completing form if other than patient:	Relationship to Patient

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