Please retain the "Welcome to feeling better" cover sheet. Bring pages 2 through 8 into your appointment and give to Dr. Brad. Thank you!

welcome
to feeling better.

Reading this page supports your care and helps Hope Clinic run smoother. Keep this first page!

SUBSCRIBE, FOLLOW & LIKE
Hope Clinic's social media for educational content by Dr. Brad!

As part of your care, Dr. Brad may recommend videos and tips for you!

hopeclinicMN.com
@hopeclinicMN
@hopeclinicMN

YOUR SCHEDULING CHECKLIST
☐ Attend the hope class or send a friend!
☐ Book your first appointment.
☐ Book appointments for your loved ones.

BRING THE COMPLETED PAPERWORK TO YOUR FIRST APPOINTMENT
☐ Please fill out this paperwork before your scheduled appointment.
☐ Bring all of the supplements or medications that you are currently taking in the original bottles.
☐ Bring any labs or medical records from the past 6 months.
—Call us at 763-537-5555 at least 48-hours in advance if you need to make a change to your appointment.
—Arrive at least 5+minutes early to your appointments, this helps keeps things running smoothly.

HELP YOURSELF GET THE BEST RESULTS—YOU DESERVE IT!
1. Have the checklist items ready for the appointment.
2. Share all your symptoms and concerns with Dr. Brad. Bring a list/journal if that's helpful.
3. Let Dr. Brad know what's improving!
4. For your benefit Dr. Brad may refer you to another practitioner as well.
5. The appointment time is about you. Focus on your well-being.
6. Getting well is an investment; we understand that. Try your best to avoid commenting about cost during your appointment time; it can distract from the focus on recommendations and your treatment.

KEEP YOUR APPOINTMENT TIME.
—Arriving in the lobby early is considered on-time.
— Please call 763-537-5555 if you will be late. If you haven't arrived at the start time of your appointment, we will give you a courtesy call to learn your status.
—Patient flow at Hope Clinic is smoothest when patients are on time. Unfortunately, anything beyond a few-minutes late could be considered a missed appointment.

WE WANT YOU TO GET THE CARE YOU NEED!
If we sound like sticklers regarding being on time to your appointment, here's why—it is not realistic for Dr. Brad to treat a patient by rushing an appointment. This can limit the care you need and what you are investing in; Dr. Brad's unique case-by-case treatments and next-step recommendations.

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 with someone who has missed their appointment.

Note: If you miss a same-day appointment or cancel within the 24-48-hours policy, our current policy allows for a one-time grace at no charge. Any future missed appointments will be charged as a normal appointment visit.

IF SOMETHING COMES UP IN BETWEEN APPOINTMENTS:
Dr. Brad offers phone consults for $6/minute. With his callbacks, 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.

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 〈Emergency contact _____ Ph (____)____ - _____〉

Children☐ 1. _____age_____2._____ age___ 3._____age 4._____ age__

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

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

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

*Do we have your 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

Have you had the same or a similar condition in the past? describe_____

PAST MEDICAL HISTORY — DATE OF YOUR LAST PHYSICAL EXAM _____

Have you ever been diagnosed with or have you suffered from: (Place a ✓ by all that apply to you.)

___Broken or Fractured Bones	___A Congenital Disease	__Epilepsy	__Ruptures	__Trauma/PTSD
___Circulatory Problems	___Excessive Bleeding	__Pace Maker	__Coughing Blood	__Drug Addiction
___Rheumatoid Arthritis	__High/Low Blood Pressure	__Strokes	__Eating Disorder	__HIV Positive
__Seizures/Convulsions	__Osteoarthritis	__Cancer	__Alcoholism	__Gall Bladder
__Ulcers				__Depression

__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 recommended treatment was*_____

List all medications/drugs and reason for taking < *please bring all medications (and supplements) with to your first appointment in the original 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 55+ include the date you will be on Medicare

Are you on a Medical/Government Assistance plan? ☐ yes ☐ no

*See page 8, Payment Policy. Hope Clinic does not bill insurance providers.

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: _____

_____

_____

_____

Any vaccinations in the last year? ☐ Yes ☐ No if any, please list: _____

Any Covid shots EVER? ☐ Yes ☐ No If yes, when? _____

Do you wear a dental appliance? (Invisalign, retainer, etc…) ☐ Yes ☐ No

Do you have plans for orthodontic care in the future? ☐ Yes ☐ No

SOCIAL HISTORY

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

Do you use any tobacco products? _____ Do you smoke? ___ If yes, packs per day: _____

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

_____

Do you consume caffeine? ____ If yes, 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 all insurance coverage that may be applicable. We do not bill insurance, see the 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 ☐

SYMPTOM SURVEY FORM

Patient _____ Doctor _____ Date _____

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

Pulse: Recumbent _____ Standing _____ Vegetarian: Yes ☐ No ☐

Blood pressure: Recumbent _____/_____ Standing _____/_____ Ragland's Test is Positive ☐

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*

GROUP 1

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

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

Patient Name:

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document.

The Nature of the Chiropractor Adjustment: The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I may use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as t move your joints. That 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 with 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 an old illness returning for a while as the body now has the tools 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.

Analysis/Examination/Treatment: By signing this page you are consenting to including but not limited to chiropractic, orthopedic, kinesiologic and general physical examination, a thorough health history, chiropractic treatment 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 therapy. These complications include but are not limited to fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring: Factures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination. If there is concern, I will order medical imaging which may include X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and according to research are estimated to occur between one in one million and one in 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 painkillers

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated: Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it 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. I have discussed it with Dr. Molskness and have had 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: _____

_____
Patient's Name

_____
Signature of Patient, Parent or Guardian

Dated: _____

Brad Molskness, DC

_____
Signature

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. We do not bill insurance companies in this office. You may do so yourself using your receipts, superbill, or letter of medical necessity as appropriate.

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 reimbursement.* Be assured that this office will limit the release of all PHI to the minimum needed.
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
3. We do not directly bill insurance companies in this office. We can provide superbills or letters of medical necessity as requested by the patient.
4. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
5. The patient may provide a written request to revoke consent at any time during care. This would not affect 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.
6. 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.
7. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
8. 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 agree to these policies and procedures.

Patient Name_____

Signature _____

Date _____

hope clinic

multiple specialists. one patient.

Payment Policy

The Payment Policy of Hope Clinic may be changed at any time without notice to you the patient. Payment for all services and products are due in full at the time of the checkout process. Hope Clinic fully expects its services and products to be paid out of pocket by the patient, as we don't bill patient insurance providers. With that, we can provide you with a super-bill receipt that provide the appropriate billing codes for your insurance provider. Hope Clinic currently accepts different forms of payment, such as cash, personal or business check, debit card and or credit card.

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 health care decisions. Our charges are based on your requested service and scheduled appointment time. Refunds are not offered or provided against services already rendered. Your appointment time has been reserved specifically for you. We reserve the right to charge you for the full amount of your scheduled appointment if you don't provide a 24-hour cancelation prior to your appointment. Refunds are allowed for products, but only if they were: 1) purchased from Hope Clinic, 2) never been opened, 3) untampered with, 4) in the original packaging and 5) within the expiration date stated on the packaging.

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 the practitioner. You will be aware of your appointment fee 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 will be happy to let you know the fee for any service we provide.

I understand and agree to the Hope Clinic Payment Policy

Patient Name _____

Signature _____

Date_____

Release to Share Information

The intention of this form is for the patient to list anyone they are authorizing permission for Dr. Brad to discuss their health information with. The patient will initial next to each person as well as sign and date at the top of the form. We keep this form on file.

I, (patient)_____ give Dr. Brad permission to discuss my health information with the people listed below.

Patient Signature: _____ Date: _____

---

1. Name: _____ Patient Initials: _____

Phone Number: _____
Best phone number for Hope Clinic to call back; cell number or a number with voicemail is best

2. Name: _____ Patient Initials: _____

Phone Number: _____
Best phone number for Hope Clinic to call back; cell number or a number with voicemail is best

3. Name: _____ Patient Initials: _____

Phone Number: _____
Best phone number for Hope Clinic to call back; cell number or a number with voicemail is best

4. Name: _____ Patient Initials: _____

Phone Number: _____
Best phone number for Hope Clinic to call back; cell number or a number with voicemail is best