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 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
155 N Sawyer St
Oshkosh WI 54902
920-230-7600

NEWBORN HISTORY Birth to 2 months

Patient's Name ____Date:____________________

The following questions are designed to help the doctor provide the best possible spinal care for you child.

How many hours does your baby sleep between feeds? During Day______________ At night______________

Yes	NO	
☐	☐	Does your baby go to sleep easily? ____
☐	☐	Does baby have a preferred sleeping position? _______________________________________
☐	☐	Does baby cry if you change this sleeping position? ____________________________________
☐	☐	Does baby have any feeding difficulties? ____
☐	☐	Is baby being breast fed? If no, for how long was baby breast fed_________ weeks/mths
☐	☐	Does baby have a one sided breast-feeding preference? Preferred breast Left / Right
☐	☐	Is baby formula fed? Which formula or other milk source? __________________________
☐	☐	Does baby frequently spit-up after feeding? ____
☐	☐	Does your baby cry a lot? ____________ For how many hours each day? _________________
☐	☐	Does baby pass a lot of intestinal gas? ____
☐	☐	Does baby have a preferred head position? ____
☐	☐	Does baby frequently arch his/her head and neck backwards? __________________________
☐	☐	Does baby cry or become irritable during a diaper change? ____________________________
☐	☐	Has baby ever had a fever? ____
☐	☐	Has baby had any falls? ____
☐	☐	Has baby been in a car accident or near-miss? ____
☐	☐	Has baby had any other trauma? ____
☐	☐	Has your baby been vaccinated? ____
☐	☐	Do you have any other concerns you wish to discuss? _________________________________.
		____

Fosso Gelhar Chiropractors of the Fox Valley
155 N Sawyer St
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BIRTH HISTORY

Patient Name ____ Date ____________________________

Labor and Delivery

How long was the labor from the first regular contractions to the birth? _______________ hours

How long was the 2^{nd} stage (the pushing phase) of the labor? ________________ hours

	Yes	No	
Vaginal Delivery	☐	☐	____________________________________
Planned C-section	☐	☐	____________________________________
Emergency C-section	☐	☐	____________________________________
Was birth Induced (Pitocin)	☐	☐	____________________________________
Forceps delivery	☐	☐	____________________________________
Vacuum extraction	☐	☐	____________________________________
Anesthesia administered	☐	☐	____________________________________
Fetal distress	☐	☐	____________________________________
Meconium staining	☐	☐	____________________________________
Head presentation	☐	☐	____________________________________
Face presentation	☐	☐	____________________________________
Breech presentation	☐	☐	____________________________________

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.

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_________________________________