CREEKSIDE PERFORMANCE CENTER

Patient UPDATE FORM

We would like to welcome you back to the Creekside Performance Center, Sheboygan's Premier Chiropractic and Sports Rehab facility. Voted Best Of Sheboygan by the Sheboygan Press in '19, '20, '21, '22, 23, and 2024 including: best chiropractic office, best sports rehab facility, best acupuncture (dry needling) and best massage therapy. To help us assist you, please complete the following form to the best of your ability. This will confirm that we have your current personal and health information, which helps ensure you are receiving the best treatment and there are no complications with billing, etc. Thank you and we look forward to serving you!
-The Creekside Team

PERSONAL INFORMATION

If there are no changes since your last visit, check the box to the left and move on to the next line.
If there are changes, please fill in the applicable information.

Full Name :

☐ Date of Birth : ____/____/____ Race: _____ Gender: _____

☐ Address : _____

☐ City : _____ State : _____ Zip : _____

☐ Cell Phone Number: _____ Cell Phone Provider : _____

☐ Home Phone Number: _____ E-Mail : _____

☐ Marital Status : _____ Spouse's Name (if applicable) : _____

☐ Occupation : _____ Employer : _____

☐ Primary Insurance Carrier : _____ Secondary Insurance Carrier: _____

☐ Emergency Contact Name : _____ Relation : _____

☐ Emergency Contact Phone Number : _____

Are you seeking treatment due to an automobile or work accident? ☐ Yes ☐ No

BRIEFLY EXPLAIN WHY YOU ARE SEEKING TREATMENT TODAY

_____

_____

Date Symptoms Appeared ____/____/____ Have you had this issue in the past? ☐ Yes ☐ No

Have you seen anyone else for this condition? If yes, who? Yes ☐ No _____

Other Notes : _____

_____

MEDICAL HISTORY

Height : _____ Weight: _____

Please answer the following questions:

- ☐ Yes ☐ No Do you have a history of cancer?
- ☐ Yes ☐ No Do you have a current or recent UTI, respiratory tract, or other infection?
- ☐ Yes ☐ No Have you recently lost any weight unexpectedly?
- ☐ Yes ☐ No Is your pain worse with resting?
- ☐ Yes ☐ No Are you over 70 years old?
- ☐ Yes ☐ No Have you had spinal pain consistently over the last four weeks?
- ☐ Yes ☐ No Have you had prolonged use of corticosteroids?
- ☐ Yes ☐ No Do you have a history of IV drug use?
- ☐ Yes ☐ No Are you currently taking any immunosuppression medications?
- ☐ Yes ☐ No Do you have a history of significant trauma? (car accidents, etc)
- ☐ Yes ☐ No Do you have osteoporosis or osteopenia?
- ☐ Yes ☐ No Do you have problems holding your urine in (urinary incontinence)?
- ☐ Yes ☐ No Do you have problems with bowel control (fecal incontinence)?
- ☐ Yes ☐ No Do you have numbness in your groin area?
- ☐ Yes ☐ No Do your legs give out or are you unable to support your body weight at times?

Please list any current medications, vitamins, or supplements (name, dosage, frequency, what it is taken for):

_____

_____

_____

Please list any current health conditions (i.e. hypertension, diabetes, hypothyroidism, etc.):

_____

_____

_____

Please list all prior surgeries, procedures, and/or injections (include body area, procedure type, and date):

Please list any recent hospitalizations (within the last 6 months):

Please list any allergies:

Are there any notable diseases in your family history? (i.e. hypertension, diabetes, stroke)
Please also list family member relationship for each disease (i.e. mother):

☐ Yes ☐ No Do you use tobacco products?
If so, what type? (cigarette, vape, etc.) and amount?

☐ Yes ☐ No Do you consume alcohol?
If so, how many drinks per week?

☐ Yes ☐ No Do you use any illegal substances?
If so, what type & frequency of use?

☐ Yes ☐ No Do you exercise regularly?
If so, what type of exercise & frequency?

☐ Yes ☐ No Do you consider your diet healthy?
Please explain:

SIGNATURES

I hereby certify that, to the best of my knowledge, the provided information is true and accurate.

Patient's Signature: Date:

Guardian's Signature: Date:

NOTES

Each page is double sided

OFFICE POLICIES & CONSENT TO CHIROPRACTIC SERVICES

Consent to Chiropractic Services:

I hereby request and consent to chiropractic manipulation and other procedures including various modes of physiotherapies, diagnostic x-rays and/or testing by Creekside Performance Center who now or in the future treat me while a patient at this office. I will discuss with my provider the nature and purpose of treatment indicated. I understand that results are not guaranteed and I am informed that, as in the practice of chiropractic there are some risks to treatment, including but not limited to: soreness, fractures, disc injuries, V.A.D., dislocations, and sprain/strains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and will rely on the doctor to exercise judgment during the course of any procedure which the doctor feels at the time is in my best interest. I have read, or have had read to me, the full above consent and have also had the opportunity to ask questions about its content and by signing below I agree to the above terms and procedures. I intend this consent to cover any treatment for my present condition and for any further conditions for which I seek treatment by this clinic and/or employed staff.

Initial: _____

Payment and Insurance:

I understand and agree that the health and accident insurance policies are an arrangement between the insurance carrier and myself. This office will prepare the necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to pay directly to this office will be credited to my account. I clearly understand and agree that all services rendered to me will be immediately due and payable.

Initial: _____

Cancellation Policy:

We kindly ask that if you need to change your scheduled appointment time that you call the office at least 24 hours in advance to make schedule changes.

Initial: _____

HIPPA:

I acknowledge that I have, if requested, received a copy of The Notice of Privacy Practices for Protected Health Information, and I understand the authorizations listed.

Initial: _____

By signing below, I acknowledge that I have read and understand the above stated information. Any questions have been answered satisfactorily, and I agree to the above stated policies.

Patient/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

FINANCIAL OPTIONS

Thank you for choosing Creekside Chiropractic and Performance Center to provide your conservative musculoskeletal health care. We consider it an honor to have been chosen by you to do so. Our goal is to provide the highest quality, yet cost effective care possible in a comfortable environment. This form will highlight the financial options our office provides. Please carefully read the following options and select the box or boxes that best fit you. Sometimes both will apply.

If you have any questions regarding these options, please ask our office staff.

☐ Bill My Insurance

Our office participates with most insurance programs including Medicare and Medicaid. As a courtesy, we will gladly file your claims and accept assignment of chiropractic insurance benefits. We will also verify insurance benefits on your behalf. Although we make every attempt to be as accurate as possible, this is not a guarantee of coverage. Some of the services provided may not be covered under your insurance plan. Benefits differ from one company to another and may be changed without our notification.

All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment.

Fees for non-covered services, along with deductibles and copayments are due at the time of treatment.

☐ Time of Service Discount

Our goal is to make any payment plan easy and affordable. Our fees are based on the quality of the service and experience in performing your needed treatment.

Our office offers a cash booking discount with the understanding that claims will not be submitted to your insurance company. Payment is due before or at every chiropractic treatment.

We hope that financial expense does not prevent you from benefiting from the quality chiropractic care you requested and need. To facilitate this, we have developed the following payment options:

We accept cash, check, debit, and credit cards.

Patient/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

NOTICE OF PRIVACY POLICIES

This notice describes how chiropractic and medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

USES AND DISCLOSURES

Here are some examples of how we might have to use or disclose your health care information:

1. Your chiropractor or a staff member may have to disclose your health information including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health care condition.

2. Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are potentially responsible for the payment of your services.

3. Your chiropractor and members of the staff may need to use your health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run his/her practice.

4. Your chiropractor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left for you on your answering machine.

You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

For more detail on HIPAA Privacy Policies and Procedures, copies are available upon request from the front desk.

APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Your chiropractor and members of the practice staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not available, a message will be left on your answering machine or with the person who answers the phone. By signing this form, you are giving us authorization to contact you with these reminders and information and to leave messages on your answering machine or with the individuals at your home and/or place of employment.

MARKETING AUTHORIZATION

From time to time our practice would like to make you aware of products or services that you may have an interest in purchasing. This marketing would most likely occur in a newsletter that our office sends with the monthly statements. Your chiropractor and members of the practice staff may need to use your health information, including your name, address, phone number, and your clinical records for the purpose of marketing products and services from Creekside Performance Center to you.

SIGNATURES

By signing below, I acknowledge that I may request a copy of The Notice of Privacy Practices for Protected Health Information from the front desk and I understand the authorizations listed above.

Patient Name (Printed): _____

Patient/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____