

# PATIENT CONFIDENTIALITY PERSONAL DATA

No. \_\_\_\_\_ Date \_\_\_\_\_  
Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Social Security No.: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Employer: \_\_\_\_\_ Address: \_\_\_\_\_  
Name of Spouse: \_\_\_\_\_ SS No.: \_\_\_\_\_ No. of Children: \_\_\_\_\_  
Spouse's Employer: \_\_\_\_\_ Address: \_\_\_\_\_  
How did you learn of this clinic? \_\_\_\_\_  
Nearest relative not living with you? \_\_\_\_\_ Phone: \_\_\_\_\_  
Who is responsible for payment?  Self  Spouse  Other \_\_\_\_\_  
PATIENT'S INSURANCE SPOUSE'S INSURANCE  
Name of Company: \_\_\_\_\_ Name of Company: \_\_\_\_\_  
Address: \_\_\_\_\_ Address: \_\_\_\_\_  
ID & Group No.: \_\_\_\_\_ ID & Group No.: \_\_\_\_\_  
Phone No.: \_\_\_\_\_ Phone No.: \_\_\_\_\_  
Purpose of this appointment and list your complaints: \_\_\_\_\_

Date of illness: \_\_\_\_\_ Time: \_\_\_\_\_  AM  PM Location: \_\_\_\_\_  
How did accident occur?  Auto  On the job  Other, \_\_\_\_\_  
Please describe the circumstances and what makes the condition(s) better or worse: \_\_\_\_\_

Other Doctor seen for this condition: \_\_\_\_\_  
Have you been treated by a Doctor for any health condition in the last year?  Yes  No  
If yes, please describe: \_\_\_\_\_

## INSURANCE INFORMATION

*I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.*

Signature Physician: \_\_\_\_\_ Signature Patient: \_\_\_\_\_

## CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

*I hereby authorize the doctor and whomever he may designate as his assistants to administer treatment, physical examination, X-Ray studies, laboratory procedures, chiropractic care or any clinic services that he/she deems necessary in any case; and I further authorize him/her to disclose all or any part of my (patient's) record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patient's employer.*

Patient's Signature: \_\_\_\_\_  
Parent's or Guardian's Signature: \_\_\_\_\_

# HEALTH QUESTIONNAIRE

Please Check Mark Each of the Conditions Below that You are Currently Experiencing

Date: \_\_\_\_\_

Patient: \_\_\_\_\_ No.: \_\_\_\_\_

## MUSCULO SKELETAL SYSTEM

- Low back pain
- Mid back pain
- Pain between shoulders
- Neck pain
- Arm problems
- Leg problems
- Swollen joints
- Painful joints
- Stiff joints
- Sore muscles
- Weak muscles
- Walking problems
- Spasms
- Broken bones
- Shoulder pain

## GENITO-URINARY SYSTEM

- Bladder trouble
- Excessive urination
- Scanty urination
- Painful urination
- Discolored urine

### FEMALE

- Vaginal discharge
- Vaginal bleeding
- Vaginal pain
- Breast pain
- Lumps on the breast

ARE YOU PREGNANT?

YES  NO

## GASTRO-INTESTINAL SYSTEM

- Poor appetite
- Excessive hunger
- Difficult chewing
- Difficult swallowing
- Excessive thirst
- Nausea
- Vomiting Blood
- Abdominal pain
- Diarrhea
- Constipation
- Black stool
- Bloody stool
- Hemorrhoids
- Liver trouble
- Gall bladder problems
- Weight trouble

## CARDIO-VASCULAR RESPIRATORY

- Chest pain
- Pain over heart
- Difficult breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Rapid heartbeat
- Blood pressure problems
- Heart problems
- Lung problems
- Varicose veins

## EYE, EAR, NOSE AND THROAT

- Eye strain
- Eye inflammation
- Vision problems
- Ear pain
- Ear noises
- Ear discharge
- Hearing loss
- Nose pain
- Nose bleeding
- Nose discharge
- Difficult breathing through nose
- Sore gums
- Dental problems
- Sore mouth
- Sore throat
- Hoarseness
- Difficult speech
- Sinus
- Allergy
- Jaw Pain

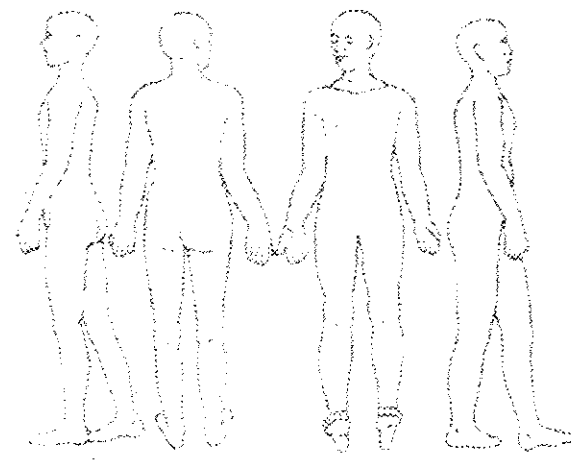
## NERVOUS SYSTEM

- Numbness
- Loss of feeling
- Paralysis
- Dizziness
- Fainting
- Headaches
- Muscles jerking
- Convulsions
- Forgetfulness
- Confusion
- Depression
- Insomnia

## HABITS

- Cigarettes
- Alcohol Abuse
- Coffee or Tea
- Drug Abuse

SYMPTOM LOCALIZATION



P \_\_\_ Pain                      T \_\_\_ Tender  
 N \_\_\_ Numb                     H \_\_\_ Hypoesthesia  
 S \_\_\_ Spasm

Pain Index

Least 1 2 3 4 5 6 7 8 9 10 Worst

Patient's Signature \_\_\_\_\_

.....DO NOT WRITE BELOW THIS LINE.....

Patient Accepted?  Yes  No      Doctor's Signature \_\_\_\_\_

## LETTER OF INFORMED CONSENT FOR LANGEL CHIROPRACTIC CLINIC P.C.

**Patient Name:** \_\_\_\_\_ **Patient No:** \_\_\_\_\_

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

### **The nature of the chiropractic adjustment.**

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to 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.

### **Analysis / Examination / Treatment**

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> spinal manipulative therapy | <input type="checkbox"/> palpation          | <input type="checkbox"/> vital signs                   |
| <input type="checkbox"/> range of motion testing     | <input type="checkbox"/> orthopedic testing | <input type="checkbox"/> basic neurological testing    |
| <input type="checkbox"/> muscle strength testing     | <input type="checkbox"/> postural analysis  | <input type="checkbox"/> Electronic Muscle Stimulation |
| <input type="checkbox"/> Ultrasound                  | <input type="checkbox"/> hot/cold therapy   | <input type="checkbox"/> X-rays                        |
| <input type="checkbox"/> Other (please explain)      |   |  |

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*Patient should initial the above procedures they are consenting to.*

### **The material risks inherent in 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 contribution 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.**

Fractures 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 and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and 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
- \*Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- \*Hospitalization
- \*Surgery

If you chose to use one of the above noted “other treatments” 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 APPROPRAITE 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. Rodney Langel, D.C. and have had my questions answered to my satisfaction. By signing below, I state that I have weighted 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:** \_\_\_\_\_

**Dated:** \_\_\_\_\_

\_\_\_\_\_  
**Patient's Name**

\_\_\_\_\_  
**Doctor's Name**

\_\_\_\_\_  
**Signature of Parent or Guardian (if a minor)**

# Notice of Privacy Practice Acknowledgement Effective April 14, 2004

Langel Chiropractic Clinic P.C. keeps a record of the health services we provide to you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get information about it by contacting Dr. Rodney D. Langel.

*By my signature below I acknowledge receipts of the Notice of Privacy Practices.*

\_\_\_\_\_  
**Patient or Authorized Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed name if signed on behalf of patient**

## *Notice of Privacy Practice Summary*

Langel Chiropractic Clinic P.C. uses health information about you for treatment, to obtain payment for treatment with your authorization as required for administrative purposes, and to evaluate the quality of care that you receive.

Langel Chiropractic Clinic, P.C. will not disclose your information to others unless you tell us to do so, or unless the law authorizes us to do so.

Langel Chiropractic Clinic, P.C. may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

Langel Chiropractic Clinic, P.C. may disclose your information for public health activities to funeral directors to enable them to carry out their duties, for organ and tissue donations, research, health and safety, governmental function in order to comply with workers compensations laws and regulations, a right to request restriction, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting for your health records.

You may complain to the Privacy Officer, Dr. Rodney D. Langel, and to the Dept. of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Langel Chiropractic Clinic, P.C. must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction and how your information is used or disclosed, accommodate reasonable request you may make to communicate with health information for reasons other than those listed above and permitted by law.

If you have any questions or complaints, please contact Dr. Rodney D. Langel at (515)267-1600.

**Langel Chiropractic Clinic, P.C.**  
**5907 Ashworth Rd**  
**West Des Moines, IA 50266**  
**(515)267-1600**

Patient ID# \_\_\_\_\_

# Patient Summary Form

PSF-750 (Rev. 2/18/2006)

**Instructions**  
Please complete this form within the specified timeline and fax to the specified fax number as indicated on Plan Summary or plan information previously provided.  
\*Fax number may vary by plan.

**Patient Information**

Female  
 Male

Patient name: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Patient date of birth: \_\_\_\_\_

Patient address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Patient insurance ID# \_\_\_\_\_ Health plan \_\_\_\_\_ Group number \_\_\_\_\_

Referring physician (if applicable) \_\_\_\_\_ Date referral issued (if applicable) \_\_\_\_\_ Referral number (if applicable) \_\_\_\_\_

**Provider Information**

1. Name of the billing provider or facility (as it will appear on the claim form) \_\_\_\_\_ 2. Federal tax ID(TIN) of entity in box #1 \_\_\_\_\_

1 MD/DO  2 DC  3 PT  4 OT  5 Both PT and OT  6 Home Care  7 ATC  8 MT  9 Other \_\_\_\_\_

3. Name and credentials of the individual performing the service(s) \_\_\_\_\_

4. Alternate name (if any) of entity in box #1 \_\_\_\_\_ 5. NPI of entity in box #1 \_\_\_\_\_ 6. Phone number \_\_\_\_\_

7. Address of the billing provider or facility indicated in box #1 \_\_\_\_\_ 8. City \_\_\_\_\_ 9. State \_\_\_\_\_ 10. Zip code \_\_\_\_\_

**Provider Completes This Section**

Date you want **THIS** submission to begin: \_\_\_\_\_

**Cause of Current Episode**  
 1 Traumatic  4 Post-surgical  
 2 Unspecified  5 Work related  
 3 Repetitive  6 Motor vehicle

**Date of Surgery**  
 \_\_\_\_\_

**Type of Surgery**  
 1 ACL Reconstruction  
 2 Rotator Cuff/Labral Repair  
 3 Tendon Repair  
 4 Spinal Fusion  
 5 Joint Replacement  
 6 Other \_\_\_\_\_

**Diagnosis (ICD code)**  
 Please ensure all digits are entered accurately.  
 1° \_\_\_\_\_  
 2° \_\_\_\_\_  
 3° \_\_\_\_\_  
 4° \_\_\_\_\_

**Nature of Condition**  
 1 Initial onset (within last 3 months)  
 2 Recurrent (multiple episodes of < 3 months)  
 3 Chronic (continuous duration > 3 months)

**DC ONLY**  
**Anticipated GMT Level**  
 98940  98942  
 98941  98943

**Current Functional Measure Score**  
 Neck Index \_\_\_\_\_ DASH \_\_\_\_\_ (other) \_\_\_\_\_  
 Back Index \_\_\_\_\_ LEFS \_\_\_\_\_

**Patient Completes This Section**

Symptoms began on: \_\_\_\_\_

(Please fill in selections completely)

1. Briefly describe your symptoms: \_\_\_\_\_

2. How did your symptoms start? \_\_\_\_\_

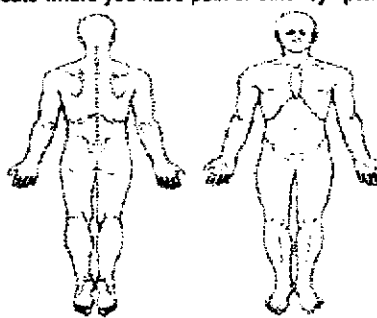
3. Average pain intensity:  
 Last 24 hours: no pain  0  1  2  3  4  5  6  7  8  9  10 worst pain  
 Past week: no pain  0  1  2  3  4  5  6  7  8  9  10 worst pain

4. How often do you experience your symptoms?  
 1 Constantly (76%-100% of the time)  2 Frequently (51%-75% of the time)  3 Occasionally (26% - 50% of the time)  4 Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)  
 1 Not at all  2 A little bit  3 Moderately  4 Quite a bit  5 Extremely

6. How is your condition changing, since care began at this facility?  
 0 N/A — This is the initial visit  1 Much worse  2 Worse  3 A little worse  4 No change  5 A little better  6 Better  7 Much better

7. In general, would you say your overall health right now is...  
 1 Excellent  2 Very good  3 Good  4 Fair  5 Poor

Indicate where you have pain or other symptoms:  


Patient Signature: X Date: \_\_\_\_\_

UnitedHealth Care Insurance

**Patient Billing Acknowledgement Form  
Non-Covered Services\*\***

Under your health plan, you are financially responsible for co-payments, co-insurance and deductibles for covered services, as well as those services that exceed benefit limits. You are also financially responsible for all non-covered services as defined by your health plan contract. For example, this may include items such as supplies, vitamins, or durable medical equipment.

The services or products listed below are not covered according to your health plan. Your acknowledgement below indicates that you have been advised of this information and that you agree to pay for the listed services or products.

**\*\* Not for use in New Jersey**

**P  
R  
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V  
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D  
E  
R**

Services to be provided:

Supply \_\_\_\_\_  DME \_\_\_\_\_

Modalities/Procedures \_\_\_\_\_  Other \_\_\_\_\_

Time frame from \_\_\_\_\_ through \_\_\_\_\_

Schedule/details \_\_\_\_\_

Provider Signature: \_\_\_\_\_

**P  
A  
T  
I  
E  
N  
T**

I \_\_\_\_\_ acknowledge that I have been told  
Patient Name – Printed or Typed  
in advance by my provider that the services/products listed above are not  
covered by my Health Plan. I agree to pay for these non-covered services.

Patient/Guardian Signature

Date

\_\_\_\_\_

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