STOIBER HEALTHCARE, S.C.
CONFIDENTIAL PATIENT INFORMATION FORM

Full Name:____ Date:____/____/____

Address:____
(City) (State) (Zip Code)

Employer: ____________________________ Cell phone: (______)____________________

- "By submitting your phone number, you are authorizing us (opting in) to send you text messages and notifications. Message/data rates apply. Reply STOP to unsubscribe to a message sent from us. No mobile information will be shared with third parties/affiliates for marketing/promotional purposes. All other categories exclude text messaging originator opt-in data and consent; this information will not be shared with any third parties."

E-Mail Address: ____

Age:________ Date Of Birth:____/_____/_____ SS:____________________ # of Children:________

Marital Status: Married Single Widow/Widower Divorced (Please circle one)

Race: Asian Black Caucasian Hispanic Native American Prefer not to answer (Please circle one)

Ethnicity: Non-Hispanic Hispanic Prefer not to answer (Please circle one)

Name of spouse or legal guardian:____

Billing address: ____

Spouse or legal guardian employer: ______________________________ **Work phone: (_____)**______________

Who may we thank for referring you to us? ____________________ *May we use your name to send this person a thank you from the doctors?* _____ *yes* _____ *no*

How did you hear about us? _____ *Word of mouth* _____ *Phone book* _____ *Newspaper Ad*
_____ *Radio* _____ *Website* _____ *Other*

INSURANCE INFORMATION

Our office will copy your insurance card(s). We will gladly bill your insurance(s) for you IF we have all the proper information. Please inform us of your insurance(s) now and if there are any future changes.

Primary Insurance Co: __________________ Name of Insured:________________ DOB____________

Secondary Insurance Co: __________________ Name of Insured:________________ DOB____________

Supplemental Insurance Co:________________ Name of Insured:________________ DOB____________
*Supplemental Ins. applies only to Medicare patients

Your payment today will be made by CASH _______by CHECK _______ by CREDIT CARD:___________

****SIGNATURE of patient or legal guardian:** ________________________________Date:____________

PLEASE READ: By signing above, I clearly understand the conditions of my personal insurance policy as it affects chiropractic coverage and agree that ALL services rendered me are charged directly to me and that I AM PERSONALLY RESPONSIBLE FOR PAYMENT of all charges incurred. I further authorize payment of medical benefits to Stoiber Healthcare, S.C.

If this is an **AUTOMOBILE accident or WORK related: Complete the following:**

Date of accident: ______________ **Time:** __________ **am/pm** **Location:** __________________

How did the accident occur? On the job Auto collision Other Contact Number: ____________

If not Auto, then please describe: ____

Patient Health Questionnaire

ChiroCare of Wisconsin, Inc.

ChiroCare Use Only rev. 4/19/99

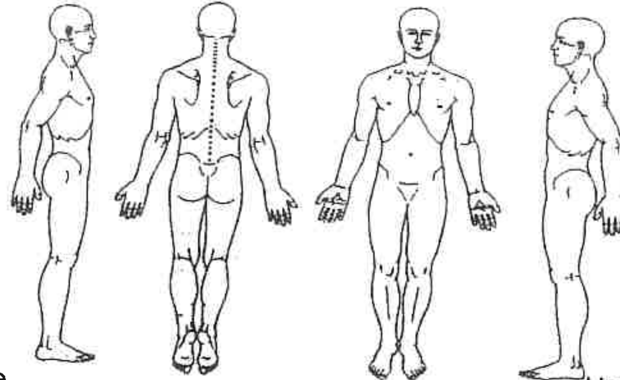
Patient Name________________________________ Date________________

1. When did your symptoms start:____________________ Describe your symptoms and how they began:

____

____

2. How often do you experience your symptoms? Indicate where you have pain or other symptoms
(1) Constantly (76 -100% of the day)
(2) Frequently (51-75% of the day)
(3)Occasionally (26-50% of the day)
(4)Intermittently (0-25% of the day



3. What describes the nature of your symptoms?
(1) Sharp (4) Shooting
(2) Dull ache (5) Burning
(3) Numb (6) Tingling

4. How are your symptoms changing?
(1) Getting better
(2) Not changing
(3) Getting worse

5. How bad are your symptoms at their:

	None										Unbearable
a. worst:	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
b. best:	(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)

6. How do your symptoms affect your ability to perform daily activities?

(0)	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
No complaints		Mild, forgotten with activity		Moderate, interferes with activity		Limiting, prevents full activity		Intense, preoccupied with seeking relief		Severe, no activity possible

7. What activities make your symptoms worse:

☐Nothing ☐Lying down ☐Walking ☐Standing ☐Sitting ☐Movement or exercise ☐Inactivity☐ Other______________

8. What activities make your symptoms better:

☐Nothing ☐Lying down ☐Walking ☐Standing ☐Sitting ☐Movement or exercise ☐Inactivity☐ Other______________

9. Who have you seen for your symptoms? (1) No one (2) Other chiropractor (3) Medical doctor (4) Physical therapist (5) Other

When and what treatment? ____________________
What tests have you had for your symptoms and when were they performed? (1) X-rays date:__________ (2) MRI date:__________ (3) CT scan date: __________ (4) Other date:__________

10. Have you had similar symptoms in the past? (1) Yes (2) No

a. If you have received treatment in the past for the same of similar symptoms, who did you see? (1) This office (2) Other chiropractor (3) Medical doctor (4) Physical Therapist (5) Other

11. What is your occupation? (1) Professional/executive (2) White collar/secretarial (3) Tradesperson (4) Laborer (5) Homemaker (6) FT Student (7) Retired (8) Other

____

a. If you are not retired, a homemaker, or a student, what is your current work status? (1) Full-time (2) Part-time (3) Self-employed (4) Unemployed (5) Off work (6) Other

12. What do you hope to get from your visit/treatment (select all that apply):
(1) Reduce symptoms
(2) Resume/increase activity
(3) Explanation of condition/treatment
(4) Learn how to take care of this on my own
(5) How to prevent this from occurring again
(6)

Patient Signature________________________________ Date________________

Name____________________________ **Date___/___/2023**

Please update the following information

Medications/Supplements (As Written on Bottle)

Name of Medication	Dose	Frequency	Form (Liquid/Tablet/Capsule/Spray)

Please put additional medications or supplements on the back of this form

Allergies

____

Tobacco use: ___ Yes (number of years____) ___Never

_____Former User (quit date_____) (number of years used______)

Women over 50 years of age, have you had a mammogram? ____________

Patients over 65 years of age, have you had a pneumonia vaccine? ________

Please check mark if your immediate family has had any of the following

Family History	Cancer	Diabetes	Heart Disease/ High Blood Pressure	Arthritis	Other
Father:					
Mother:					
Siblings:					
Children:					

Stoiber HealthCare, S.C.
1210 Parkwood Drive
Wisconsin Rapids, Wisconsin 54494
PH: 715-424-4646

Notice of ChiroUp and Foot Levelers Policy

Consent to Use ChiroUP and Foot Levelers Services

ChiroUP is a third party service that provides educational materials and best practice guidelines for treatment of musculoskeletal conditions. This service also provides access to patient exercises online and surveys for treatment satisfaction.

Foot Levelers is a third party service used in this facility to obtain laser image scans for the purpose of creating custom orthotics.

All information provided to these service providers are protected under privacy contracts and encryption of all electronic PHI-protected health information.

"I acknowledge and understand that this office may contact and survey me via e-mail regarding my satisfaction and outcomes. I understand that an independent vendor(s) may assist with this data collection. I understand that in addition to the aforementioned confidential survey, this office or their designated vendor may also send an automated email to allow me to voluntarily and publicly rate and review my provider online through sites like; Google Review, HealthGrades, Yelp, etc. I acknowledge that my responses, like other online responses, may be published on the respective review site(s) and will be publicly disclosed and accessible to anyone who accesses that site. I understand that reviews are optional, and I am under no obligation to provide a review. I also understand that if I do choose to provide a review, I will not include any sensitive, personal, identifying, or medical information that I do not wish to be publicly disclosed in an online review, including but not limited to: name, contact information, social security number, health history, diagnosis, medications, etc. I understand, acknowledge, and agree that if I include Protected Health Information, I am doing so voluntarily and with full knowledge and intent. When submitting a survey or review, I agree to fully release, waive and indemnify this office and/or the associated vendors from any and all claims arising from my voluntary disclosure of Protected Health Information to the sites."

By my signature below I give my permission to use and disclose my health information.

_______________________________________ _______________
Patient or Legally Authorized Individual Signature Date

_______________________________________ _______________
Print Patient's Full Name Time

_______________________________________ _______________
Witness Signature Date

Stoiber HealthCare, S.C.

1210 Parkwood Drive • Wisconsin Rapids, WI 54494-5488

(715)424-4646 • Fax (715)424-3354

Notice

In an effort to maintain compliance with various state and federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following financial policies.

1. Our clinic has established a single fee schedule that applies to all patients for each service provided.

2. You may be entitled to a network or contractual discount under the following circumstances:

    a. We are a participating provider in your health plan.

    b. You are covered by a State or Federal program with a mandated fee schedule.

    c. You are a member of ChiroHealthUSA, or any other Discount Medical Plan Organization we may join. Patients who are uninsured, or underinsured (limited benefits for chiropractic care), may join ChiroHealthUSA in our office and will be entitled to network discounts similar to our insured patients. Membership is $49.00 a year and covers you and your dependants. Ask our staff for more information.

3. As part of our compliance plan, as of July 16th, 2014 our office will be unable to extend any type of discounts other than those listed above.

4. Any returned checks will add $35.00 to your account.

Acknowledged By:____

Date:______________________

OSWESTRY

REVISED OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE

PLEASE READ: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but ***PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.***

SECTION 1 - Pain Intensity

A The pain comes and goes and is very mild.
B The pain is mild and does not vary much.
C The pain comes and goes and is moderate.
D The pain is moderate and does not vary much.
E The pain comes and goes and is severe.
F The pain is severe and does not vary much.

SECTION 2 - Personal Care

A I would not have to change my way of washing or dressing in order to avoid pain.
B I do not normally change my way of washing or dressing even though it causes some pain.
C Washing and dressing increases the pain, but I manage not to change my way of doing it.
D Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E Because of the pain, I am unable to do some washing and dressing without help.
F Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 - Lifting

A I can lift heavy weights without extra pain.
B I can lift heavy weights, but it causes extra pain.
C Pain prevents me from lifting heavy weights off the floor.
D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, eg. on a table.
E Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F I can only lift very light weights, at the most.

SECTION 4 - Walking

A Pain does not prevent me from walking any distance.
B Pain prevents me from walking more than one mile.
C Pain prevents me from walking more than 1/2 mile.
D Pain prevents me from walking more than 1/4 mile.
E I can only walk while using a cane or on crutches.
F I am in bed most of the time and have to crawl to the toilet.

SECTION 5 - Sitting

A I can sit in any chair as long as I like without pain.
B I can only sit in my favorite chair as long as I like.
C Pain prevents me from sitting more than one hour.
D Pain prevents me from sitting more than 1/2 hour.
E Pain prevents me from sitting more than ten minutes.
F Pain prevents me from sitting at all.

SECTION 6 - Standing

A I can stand as long as I want without pain.
B I have some pain while standing, but it does not increase with time.
C I cannot stand for longer than one hour without increasing pain.
D I cannot stand for longer than 1/2 hour without increasing pain.
E I cannot stand for longer than ten minute without increasing pain.
F I avoid standing, because it increases the pain straight away.

SECTION 7 - Sleeping

A I get no pain in bed.
B I get pain in bed, but it does not prevent me from sleeping well.
C Because of pain, my normal night's sleep is reduced by less than one quarter.
D Because of pain, my normal night's sleep is reduced by less than one-half.
E Because of pain, my normal night's sleep is reduced by less than three-quarters.
F Pain prevents me from sleeping at all.

SECTION 8 - Social Life

A My social life is normal and gives me no pain.
B My social life is normal, but increases the degree of my pain.
C Pain has no significant effect on my social life apart from limiting my more energetic interests, My e.g., dancing, etc.
D Pain has restricted my social life and I do not go out very often.
E Pain has restricted my social life to my home.
F I have hardly any social life because of the pain.

SECTION 9 - Traveling

A I get no pain while traveling.
B I get some pain while traveling, but none of my usual forms of travel make it any worse.
C I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D I get extra pain while traveling which compels me to seek alternative forms of travel.
E Pain restricts all forms of travel.
F Pain prevents all forms of travel except that done lying down.

SECTION 10 - Changing Degree of Pain

A My pain is rapidly getting better.
B My pain fluctuates, but overall is definitely getting better.
C My pain seems to be getting better, but improvement is slow at present.
D My pain is neither getting better nor worse.
E My pain is gradually worsening.
F My pain is rapidly worsening.

COMMENTS: ______________________________

____

____

NAME: ____________________ DATE: __________ SCORE: __________

Vernon Mior

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

PLEASE READ: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but *PLEASE JUST CIRCLE THE ONE. CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.*

SECTION 1 - Pain Intensity

A I have no pain at the moment.
B The pain is very mild at the moment.
C The pain is moderate at the moment.
D The pain is fairly severe at the moment.
E The pain is very severe at the moment.
F The pain is the worst imaginable at the moment.

SECTION 2 -Personal Care (Washing, Dressing, etc.)

A I can look after myself normally without causing extra pain.
B I can look after myself normally, but it causes extra pain.
C It is painful to look after myself and I am slow and careful.
D I need some help, but manage most of my personal care.
E I need help every day in most aspects of self care.
F I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 - Lifting

A I can lift heavy weights without extra pain.
B I can lift heavy weights, but it gives extra pain.
C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E I can lift very light weights.
F I cannot lift or carry anything at all.

SECTION 4 - Reading

A I can read as much as I want to with no pain in my neck.
B I can read as much as I want to with slight pain in my neck.
C I can read as much as I want to with moderate pain in my neck.
D I cannot read as much as I want because of moderate pain in my neck.
E I cannot read as much as I want because of severe pain in my neck.
F I cannot read at all.

SECTION 5 - Headaches

A I have no headaches at all.
B I have slight headaches which come infrequently.
C I have moderate headaches which come infrequently.
D I have moderate headaches which come frequently.
E I have severe headaches which come frequently.
F I have headaches almost all the time.

SECTION 6 - Concentration

A I can concentrate fully when I want to with no difficulty.
B I can concentrate fully when I want to with slight difficulty.
C I have a fair degree of difficulty in concentrating when I want to.
D I have a lot of difficulty in concentrating when I want to.
E I have a great deal of difficulty in concentrating when I want to.
F I cannot concentrate at all.

SECTION 7 - Work

A I can do as much work as I want to.
B I can only do my usual work, but no more.
C I can do most of my usual work, but no more.
D I cannot do my usual work.
E I can hardly do any work at all.
F I cannot do any work at all.

SECTION 8 - Driving

A I can drive my car without any neck pain.
B I can drive my car as long as I want with slight pain in my neck.
C I can drive my car as long as I want with moderate pain in my neck.
D I cannot drive my car as long as I want because of moderate pain in my neck.
E I can hardly drive at all because of severe pain in my neck.
F I cannot drive my car at all.

SECTION 9 - Sleeping

A I have no trouble sleeping.
B My sleep is slightly disturbed (less than 1 hour sleepless).
C My sleep is mildly disturbed (1-2 hours sleepless).
D My sleep is moderately disturbed (2-3 hours sleepless).
E My sleep is greatly disturbed (3-5 hours sleepless).
F My sleep is completely disturbed (5-7 hours)

SECTION 10 - Recreation

A I am able to engage in all of my recreational activities with no neck pain at all.
B I am able to engage in all of my recreational activities with some pain in my neck.
C I am able to engage in most, but not all of my recreational activities because of pain in my neck.
D I am able to engage in a few of my recreational activities because of pain in my neck.
E I can hardly do any recreational activities because of pain in my neck.
F I cannot do any recreational activities at all.

COMMENTS: ______________________________

NAME: ______________________ DATE: __________ SCORE: __________

Stoiber HealthCare, S.C.
1210 Parkwood Drive
Wisconsin Rapids, Wisconsin 54494
PH: 715-424-4646

Notice of Patient Privacy Policy

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

If you have any questions about this Notice please contact our Privacy Officer or any staff member in our office.

Our Privacy Officer is: Arien Stoiber-Alde.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out your treatment, collect payment for your care and manage the operations of this clinic. It also describes our policies concerning the use and disclosure of this information for other purposes that are permitted or required by law. It describes your rights to access and control your protected health information. "**P**rotected **H**ealth **I**nformation" (PHI) is information about you, including demographic information that may identify you, that relates to your past, present, or future physical or mental health or condition and related health care services.

We are required by federal law to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. You may obtain revisions to our Notice of Privacy Practices by accessing our website www.stoiberhealthcare.com, calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

A. Uses and Disclosures of Protected Health Information

By applying to be treated in our office, you are implying consent to the use and disclosure of your protected health information by your doctor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to bill for your health care and to support the operation of the practice.

Uses and Disclosures of Protected Health Information Based Upon Your Implied Consent

Following are examples of the types of uses and disclosures of your protected health care information we will make, based on this implied consent. These examples are not meant to be exhaustive but to describe the types of uses and disclosures that may be made by our office.

- **Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to another physician who may be treating you. Your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object

In the following instance where we may use and disclose your protected health information, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your doctor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

- **Others Involved in Your Healthcare:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location or general condition. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted and Required Uses and, Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

- **Required By Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

- **Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

- **Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

- **Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

- **Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

- **Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

- **You may have the right to have your doctor amend your protected health information.** This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

- **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, pursuant to a duly executed authorization or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limits.

- ***You have the right to be notified by our office of any breech of privacy of your Protected Health Information.***

- **Certain treatments may be performed in a common therapy area and/ or you may find yourself within public areas within the clinic times, but please note private rooms are always available, upon request, for discussing your private health information.**

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

C. Complaints

You may complain to us, or the Secretary of Health and Human Services, if you believe your privacy rights have been violated by us. *To file a complaint you may go to:* https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html

Or our office can provide you with a written form in which to file your complaint. You may also file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

Our Privacy Officer is Arien Stoiber-Alde. You may contact our Privacy Officer or any staff member, including Mozelle Stoiber, at the following phone number: 715-424-4646 or on our website: www.stoiberhealthcare.com for further information about the complaint process.

This notice was published and becomes effective on 01/01/2023.