Confidential Patient Information

(for children under 14 years)

Last Name ______________________________ First Name __________________________ MI ___

Appointment Date
/ /20___

What name would you like the staff to call you? ______________________

Address ____

City _______________________ State ______ Zip ________________

Date of Birth	Social Security Number
/ /	- -

Gender	Age	Height	Weight
M F			

Current Grade	Mom's Name

Mom's Social Security #
- -

Phone1: Home Work Cell	Phone2: Home Work Cell	Phone3: Home Work Cell

Email address ___________________________

School Attending _________________________

Appointment Reminder

We like to help make your appointments here by reminding you. We've found for most people the best way to do this is by texting. By default, we will text you a reminder of your appointment via text the day before your appointment to the cell phone you list above.

- ❑ Absolutely. Great idea. I'd love to get text reminders.
- ❑ I do not wish to have text reminders. I want my reminders as voice calls to this phone _____________.

Dad's Name

Dad's Social Security #
- -

Brothers & Sisters (with ages)

Physician Names

How did you hear about this office? Check all that apply.

- ❑ Friend Name ____
- ❑ Coworker Name ____
- ❑ Relative Name ____
- ❑ Health Care Professional Name ____
- ❑ Lecture Where? ____
- ❑ Google search
- ❑ Clinic Website
- ❑ Facebook
- ❑ Radio show
- ❑ Dr. Berglund's book
- ❑ Know through Church
- ❑ Know through homeschool
- ❑ Other source not listed above ____

____

By signing below, I authorize payment of benefits to Berglund Health & Wellness Center for all services provided, and authorize the release of any records or information necessary to process this claim. I understand that health & accident insurance policies are an arrangement between myself and my insurance company and that I am ultimately responsible for payment in full unless other arrangements are made and put in writing. I agree to pay for my portion of payment on the day services are rendered. I understand that most orthopedic devices/orthotics and nutritional supplies and laboratory tests are not covered services/products and you will be asked to pay for them on each visit.

Payment options:
- cash
- personal check
- debit card
- MC
- VISA
- Discover

Signature ____ Date _________________________________

Do you have any current concerns regarding you child's health? ____

____

Have you had these conditions evaluated before? *YES* *NO*

If yes, by whom and what did they find? ____________________________

When did you first notice these symptoms? ____________________________

Are these symptoms getting progressively worse? ____________________________

Which symptoms are constant? ____________________________

Which symptoms come & go? ____________________________

How many hours does your child sleep/night?

1 2 3 4 5 6 7 8 9 10 11

On a scale from 0-10, how healthy is your child's diet?

1 2 3 4 5 6 7 8 9 10

0 = terrible 10 = perfect

Child's favorite foods	Child's Most Common Beverages	**Has your child…?**
1.	1.	❑ … ever been x-rayed?
2.	2.	❑ … ever had any broken bones?
3.	3.	❑ … ever been vaccinated?
4.	4.	❑ … had problems nursing?

Any Medications? YES NO IF YES, please list.	List any surgeries and/or dates of hospitalization?	**What descriptions fit your child?**
1.	1.	1. Obedient, compliant
2.	2.	2. High maintenance
3.	3.	3. Chronically sick
4.	4.	4. Tired and/or lazy
		5. None of these even remotely resembles my child.

CONDITIONS YOU HAVE HAD OR BEEN DIAGNOSED WITH AT ANY TIME IN PAST

1. ADD/ADHD
2. Aggressive personality
3. Allergies
   - ❑ animal
   - ❑ dust
   - ❑ food
   - ❑ grass
   - ❑ mold
   - ❑ pollen
   - ❑ ragweed
   - ❑ other
   - ❑ __________
   - ❑ __________
4. Antibiotics – How many times?
5. Appendicitis
6. Asthma
7. Behavior problems
8. Bladder Infection
9. Bleeding disorders
10. Bronchitis
11. Bumpy skin on back of arms
12. Cancer
13. Cavities (dental) FEW SOME
14. Chicken pox
15. Colic
16. Constipation
17. Cough (chronic)
18. Diabetes
19. Diarrhea (regular or persistent)
20. Ear Infections
21. Eczema
22. Epilepsy
23. Fractures
24. Frequent colds/flus
25. Headaches
26. Heart disease
27. Hernia
28. HIV positive
29. Insomnia or other sleep problems
30. Kidney disease
31. Liver disease
32. Measles
33. Mononucleosis
34. Mumps
35. Pneumonia
36. Polio
37. Rheumatoid arthritis
38. Rheumatic Fever
39. Ringworm
40. Scarlet fever
41. Sinus Infections
42. Stomach aches
43. Temper tantrums
44. Throat infections/sore throat
45. Thyroid problems
46. Thrush
47. Tonsillitis
48. Tumors/growths
49. Whining and/or weepy
50. Whooping cough
51. Yeast infections
52. OTHER CONDITIONS

Family History		Vaccinations	
❑ Diabetes	❑ Heart Disease	❑ Measles	❑ Hepatitis B
❑ Gestational Diabetes	❑ Alcoholism	❑ Mumps	❑ Polio
❑ Hypoglycemia	❑ Substance abuse	❑ Rubella	❑ Diphtheria
❑ Food allergies	❑ Depression	❑ Chicken Pox	❑ Pertussis
❑ Cancer	❑ Migraine headaches	❑ Pneumonia/Flu-# of times ___	❑ Tetanus
❑ Stroke	❑ Varicose veins	❑ I have chosen to not have this child vaccinated	

Circle Blood Type	Ethnicity
❑ A positive	❑ Caucasian
❑ A negative	❑ Asian
❑ B positive	❑ Black
❑ B negative	❑ American Indian
❑ O positive	❑ Jewish
❑ AB positive	❑ Middle Eastern
❑ O negative	❑ Pacific Islander
❑ AB negative	❑ Hispanic
	❑ Other (describe)

By signing below, I acknowledge the above to be true to the best of my knowledge.

Parent/GuardianSignature ____ Date _____________ Doctor's Initials/date __________

This section is entirely voluntary: The following questions are geared to help the doctor in evaluating where your beliefs are at spiritually. There is a connection between mind, body and spirit. Although the doctor is not a pastor, nor is he a psychologist, it is necessary for the doctor to evaluate your condition from every perspective to gain insight into what is going on and how best to help you.

Check those box(es) that describe your beliefs (as many as apply):

- ❑ I believe that there is a God/creator.
- ❑ I am a Christian (believe in Jesus Christ)
- ❑ I am a Muslim
- ❑ I am a Buddhist
- ❑ I am Jewish
- ❑ I am an atheist/agnostic (do not believe in a god)
- ❑ Other (please describe) ____

  ____

Which Church/synagogue/temple/mosque do you attend? ________________________________ City _______________________

Body Symptom Diagram

Name ____ Date ___________________

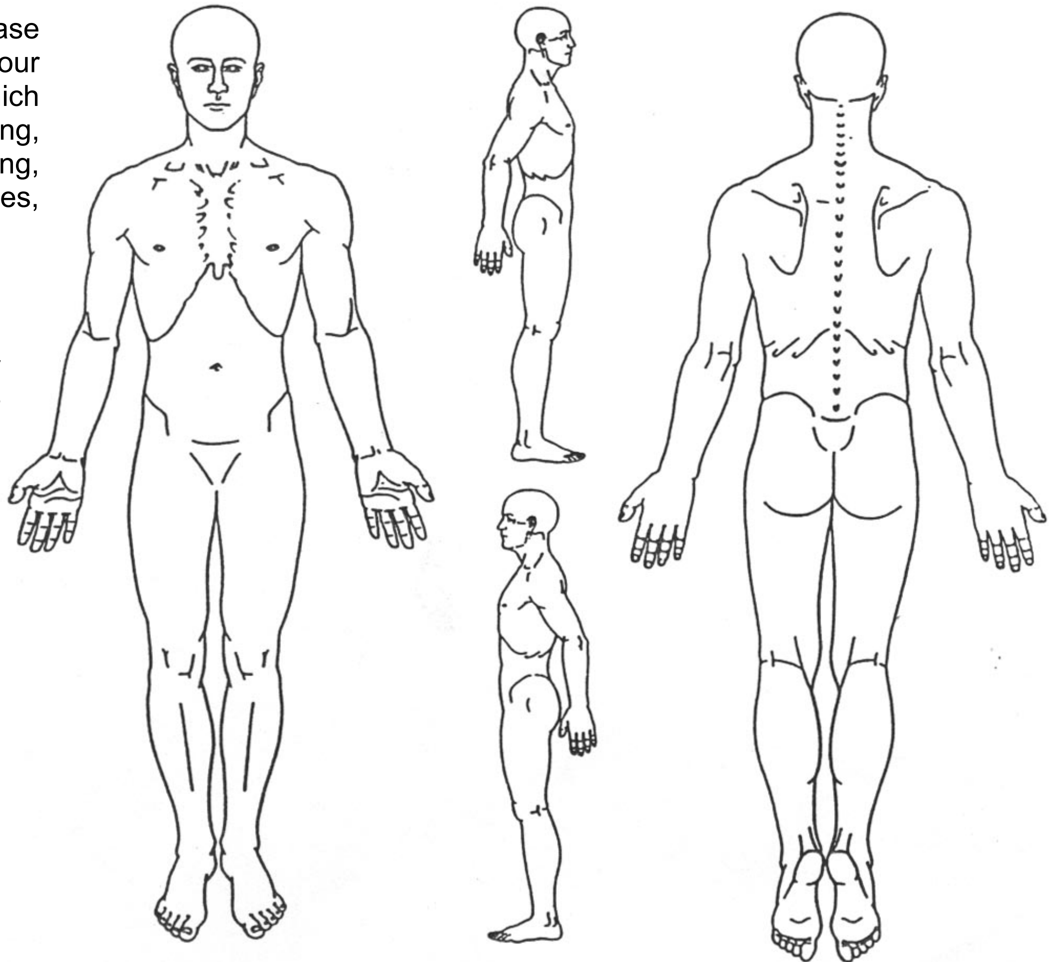
Describe the conditions you would like the doctor to address:

1.	5.
2.	6.
3.	7.
4.	8.

On a 0-100 scale with 0 being no symptoms and 100 being the worst symptoms imaginable, please write the numbers in the box to the right (corresponding to the numbers above) indicating the level of symptoms (pain, fatigue, burning, indigestion, etc) for the conditions listed above.	1. _____ 2. _____ 3. _____ 4. _____	5. _____ 6. _____ 7. _____ 8. _____

On the body diagram, please mark the areas of all your symptoms. Please note which symptoms are achy, burning, numb, stabbing, pounding, tingling, pins and needles, congested, itchy rash, etc.

(Placing the appropriate condition number noted above on the diagram below may help the doctor isolate the problem area better.)



Signature ____ Date: ___________________

Berglund Health & Wellness Center

Patient Goals

In order of importance, what do you hope to achieve by coming to Berglund Health & Wellness Center?
(e.g. "help me get rid of low back pain," or "get me so I'm not so tired.") Use as many spaces as you need.

1. ____________________
2. ____________________
3. ____________________
4. ____________________

Doctor's Goals ------------------------------ **(patients, please don't write below this line)** ------------------------------

1.
2.
3.
4.

- ❑ bfood
- ❑ f-food
- ❑ act cmt C T L S P
- ❑ cmt C T L S P
  - antC
  - seatedC
  - antT
  - dropLS
  - sl-LS
  - standing T
- ❑ xcmt
  - 1st rib R L
  - ribs
  - knees R L
  - ankles R L
  - elbows R L
  - wrists R L
  - shoulders R L
  -
- ❑ cranial O P T F
- ❑ soft tissue massage
- ❑ pulse oximetry

consultation
- ❑ weight loss
- ❑ exercise
- ❑ stretches

Exam
1 2 3 4 5

CMT12 CMT34 XCMT

Food test

urinalysis blood test

B-draw
- ❑ chem
- ❑ lipid _____
- ❑ cbc
- ❑ LDH
- ❑ SGPT (ALT)
- ❑ Ferritin
- ❑ Iron
- ❑ ESR
- ❑ crp
- ❑ GGTP
- ❑ Fibringoen
- ❑ Homocysteine
- ❑

Weakness
- ❑ Thyroid
- ❑ Heart
- ❑ Lungs
- ❑ Stomach
- ❑ Spleen
- ❑ Liver
- ❑ Gall bladder
- ❑ Intestines
- ❑ Kidneys R L
- ❑ Ovary R L
- ❑ Testicle R L

History notes

Screen
- ❑ allergy/sensitivity (sa/s)
- ❑ chiropractic (schiro)
- ❑ biochemistry (sbio)

Reaction
- ❑ See food sheet

More	Less	checklist

Height	Weight	Body Fat	Oxygen Saturation	Heart Rate	blood pressure	Respirations	Temp
in	lbs	%	%	bpm	right / left /	rpm	'F

BERGLUND
HEALTH & WELLNESS CENTER

Notice of Privacy Practices

Berglund Health & Wellness Center

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 IT CAREFULLY. USE AND DISCLOSURE OF HEALTH INFORMATION

Berglund Health & Wellness Center (BH&WC) may use your health information (information that constitutes protected health information as defined by the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996) for the purposes stated below. BH&WC have established a policy to guard against unnecessary disclosure of your health information.

Your health information may be used to: **Provide Treatment:** BH&WC may use your health information to provide care to you and disclose your health information to others who provide care for you. For example, physicians involved in your care will need information about your symptoms in order to prescribe appropriate medications. BH&WC may also disclose your health care information to individuals outside of the provider involved in your care including family members, pharmacists, suppliers of medical equipment or other health professionals.

Obtain Payment: BH&WC may include your health information in invoices to collect payment from third parties for the care you receive. For example, BH&WC may be required by your health insurance to provide information regarding your care in order to reimburse you and/or BH&WC. In addition, BH&WC may need to explain your need for health care and the services that will be provided to you in order to obtain prior approval from your insurance.

Conduct Health Care Operations: BH&WC may use and disclose health information for its own operations in order to facilitate the function of BH&WC and as necessary to provide quality care to all of our patients. Health care operations include activities such as:

Quality assessment and improvement activities: • Activities designed to improve health or reduce health care costs.

- Protocol development, case management, and care coordination.
- Contacting health care providers and patients with information about treatment alternatives and
- other related functions that do not include treatment.
- Professional review and performance evaluation.
- Training programs including those in which students, trainees, or practitioners in health care learn under supervision.
- Training of non-health care professionals.
- Accreditation, certification, licensing or credentialing activities.
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
- Business planning and development including cost management and planning related analyses formulary development.
- Business management and general administrative activities of BH&WC.
- Certain marketing activities for BH&WC.

For example, BH&WC may use your health information to evaluate its staff performance, combine your health information with other BH&WC patients in evaluating how to more effectively serve all of their patients, disclose your health information to BH&WC staff and contracted personnel for training purposes, use your health information to contact you as a reminder regarding a visit to you, or contact you or your family as part of general fundraising and community information mailings (unless you do not want to be contacted).

For facility directory:

BH&WC may disclose certain information about you including your name, general health status, and where you are located in a facility directory while you are in the facility. Provider may disclose this information to people who ask for you by name. If you do not want BH&WC to include your information in the directory, you must notify the clinic at 262-925-8600.

For appointment reminders:
BH&WC may use and disclose your health information to contact you as a reminder that you have an appointment for treatment or care with BH&WC.

For treatment alternatives:
BH&WC may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

When legally required:
BH&WC will disclose your health information when it is required to do so by any Federal, State, or Local law.

When there are risks to public health:
BH&WC my disclose your health information for the following public activities and purposes:

- To prevent or control disease, injury or disability, report disease, injury, vital events such as birth or death and the conduct of public health surveillance, investigations and interventions.
- To report adverse events, product defects, to track products or enable product recalls, repairs, and replacements of the Food and Drug Administration.
- To notify a person who has been exposed to communicable disease or who may be at risk of contracting or spreading a disease.
- To an employer about an individual who is a member of the workforce as legally required.

To report abuse, neglect, or domestic violence:
BH&WC are allowed to notify government authorities if BH&WC believes the patient is a victim of abuse, neglect, or domestic violence. BH&WC will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.

To conduct health oversight activities:
BH&WC may disclose your health information to a health oversight agency for activities including: audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary action. BH&WC, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of and is not directly related to your receipt of health care or public benefits.

In connection with judicial and administrative proceedings:
As permitted or required by State law, BH&WC may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when BH&WC makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

For law enforcement purposes:
As permitted or required by State law, BH&WC may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

In the event of a serious threat to health or safety:
BH&WC may, consistent with applicable law and ethical standards of conduct, disclose your health information if BH&WC in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health or safety of the public.

For specified government functions:
In certain circumstances, the Federal regulations authorize BH&WC to use or disclose your health information to facilitate specified government functions relating to the military and veterans, national security and intelligence activities, protective services for the President and others, medical suitability determinations and inmates and law enforcement custody.

For worker’s compensation:
BH&WC may release your health information for worker’s compensation or similar programs.

AUTHORIZATION TO US OR DISCLOSE HEALTH INFORMATION
Other than the circumstances described in the preceding examples, any other use or disclosure of your health information will only be made with your written authorization. If you or your representative authorizes BH&WC to use or disclose your health information, you may revoke that authorization in writing at any time. You may be unable to revoke your authorization for health information that has already been released before your request to revoke authorization is received, or if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights with respect to your health information that BH&WC maintains:

- **Right to request restrictions:** You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on BH&WC disclosure of your health information to someone who is involved in your care or payment of your care. However, BH&WC are not required to agree to your request. If you wish to make a request for restrictions, please contact the office at 262-925-8600.
- **Right to receive confidential communications:** You have the right to request that BH&WC communicates with you in a certain way. For example, you might ask that BH&WC only conduct communications pertaining to your health information with you privately with no other family members present. If you wish to receive confidential communications, please contact the office at 262-925-8600.
- **Right to inspect and copy your health information:** You have the right to inspect and copy your health information, including billing records. A request to inspect and copy records containing your health information may be made to the office at 262- 925-8600. If you request a copy of your health information, BH&WC may charge you a reasonable fee for copying and assembling costs associated with your request.
- **Right to amend your health information:** You or your representative have the right to request that BH&WC amend your records, if you believe your health information records are incorrect or incomplete. That request may be made as long as the information is maintained by BH&WC. A request for an amendment of records must be made in writing to the office. BH&WC may deny the request if it is not in writing or does not include a reason for the amendment. The request also may be denied if your health information records were not created by BH&WC, if the records your are requesting are not part of BH&WC records, if the health information you wish to amend is not part of the health information you or your representative are permitted to inspect and copy, or if, in the opinion of BH&WC, the records containing your health information are accurate and complete.
- **Right to an accounting:** You or your representative have the right to request an accounting of disclosures of your health information made by BH&WC for certain purposes authorized by law and certain research. The request for an accounting must be made in writing to Drs. Michael or Eileen Berglund, 5027 Green Bay Road, #118, Kenosha, WI 53144. Accounting requests may not be made for periods of time in excess of six (6) years. Accounting requests will be subject to a reasonable cost-based fee.
- **Right to a paper copy of this Notice:** You or your representative have a right to a separate paper copy of this Notice at any time even if you or your representative have received this Notice previously. To obtain a separate paper copy, please contact either of the doctors at 262-925-8600.

DUTIES OF BH&WC

BH&WC are required by law to maintain the privacy of your health information and to provide you and your representative this Notice of its duties and privacy practices. BH&WC are required to abide by the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If BH&WC makes a material change to this notice, they will provide a copy of the revised **Notice to you or your appointed representative.** You or your representative have the right to express complaints to BH&WC and the Secretary of Health and Human Services if you or your representative

believe that your privacy rights have been violated. Any complaints to BH&WC should be made in writing to 5027 Green Bay Road, Suite #118; Kenosha, WI 53144-1771. BH&WC encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

CONTACT PERSON

BH&WC has both Drs. Eileen and Michael Berglund as their contact individuals for all issues regarding patient privacy and your rights under the Federal privacy standards. If you have any questions regarding this Notice or your rights, please contact him at: 5027 Green Bay Road, Suite #118; Kenosha, WI 53144-1771. Phone number: 262-925-8600

EFFECTIVE DATE

This Notice has been effect since October 18, 2004.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name ____ **Date** _______/_______/_______

My signature on this form acknowledges that I have read and understood the Berglund Health & Wellness Center's Notice of Privacy Practices. I understand that this document provides and explanation of the ways in which my health information may be used or disclosed by Berglund Health & Wellness Center and of my rights with respect to my health information.

I have been provided with the opportunity to discuss any concerns I may have regarding the privacy of my health information.

____ ______________________

Patient Signature **Date**

If patient is unable to sign or is not of age to give proper authorization::

____ ______________________

Representative Signature **Date**

Name of Personal Representative ________________________________

Relationship to Patient _________________________

Address ____

Home Phone # ( ) ______-_________

Work Phone # ( ) ______-__________

Patient is unable to sign because ____

I give permission for my personal health information TO BE RELEASED to my immediate family (spouse and/or parents) upon their request.

____ ______________________

Patient Signature **Date**

TO BE COMPLETED BY ADMITTING CLINICIAN IF FORM IS NOT SIGNED

1. Was patient provided with a copy of the Notice of Privacy Practices? YES NO

2. Briefly describe efforts made to obtain patient's acknowledgement of receipt of the Notice and explain why the patient did not sign this form: ____

____

BERGLUND
HEALTH & WELLNESS CENTER

Dr. Michael Berglund, DC, DABCI
pediatric & family practice • natural approach

Office Policies

Patients: Please read carefully, sign and date. Mark each item that has been read.

Payment Options

- ☐ The only insurances that Dr. Berglund accepts is Medicare and Medicaid (T19/Forward/Badger Care). These government sponsored insurances will only cover spinal manipulation. If you are coming in for something other than classic chiropractic care, those services can be provided but it will need to be paid in full by the patient. If you'd like to see if your insurance will pay for Dr Berglund's services, we can print you out a receipt that will show the proper codes needed so that you can submit the claim to your own insurance.

Missed Appointments

- ☐ Reminder calls & texts are just a courtesy provided by this office. Although we try to remind our patients every time they are scheduled, it is not guaranteed that you will receive a reminder call or text from us. Ultimately, it is your responsibility to remember your appointment on the day/time it is scheduled. If you do not show up for your appointment without notifying us ahead of time, you will be charged a $20 no show fee.
- ☐ Medicare and Medicaid patients cannot be charged the $20 no show fee. However, they will be limited to three "no show" visits per 12 months starting with the date of their first "no show". After the third no show visit has been reached, that patient will no longer be able to see Dr. Berglund for 12 months following the date of the first "no show".

Supplements

- ☐ We require payment for supplements on the same day they are purchased. If you'd like us to put supplements on hold for you, we will hold them for up to one week. After that, the supplements will no longer be held for you.
- ☐ If you need a particular supplement, please call ahead to make sure we have it in stock and that our office is open.

Courtesy toward other patients

- ☐ Please refrain from wearing perfumes, colognes, scented lotions and essential oils. Also, please refrain from smoking before coming in. The reason we have this rule is to be sensitive to our patients with asthma/allergies/migraine headaches that might experience serious reactions as a result of these types of scents/chemicals.

I have read, understand, and agree to the office policies at Berglund Health & Wellness Center.

______________________________________ __________________

5027 Green Bay Road, Ste. 118 • Kenosha, WI 53144
www.berglundcenter.com • drb@berglundcenter.com

262 925 8600