Office Policy

Welcome to Lake Pointe Chiropractic and Wellness.
Please review the Practice Information and Policies below.

Payment
Payment is due at the time of service. LPCW accepts cash, checks (made payable to LPCW), Visa, and MasterCard. Payment plans are available.

Insurance
Insurance benefits are not a guarantee of payment by your insurance company. We will submit chiropractic claims for you when warranted. Insurance plans do not cover nutritional consultations, wellness services, supplements, herbs, and other products. Payment for these items is your responsibility and due at the time of service/purchase.

It is your responsibility to notify LPCW immediately if your insurance coverage changes or if you are involved in an automobile or worker's compensation accident.

Cancellation Policy
LPCW understands that from time to time there may be conflicts with your schedule. We request that you notify us 24 hours prior to your appointment if you need to cancel or change an appointment. You will be responsible in full for the charges of the appointment with less than 24 hours notice.

Perfumes and Fragrances
Please help those clients with compromised immune systems and sensitivities by not wearing perfumes or fragrances to the office.

HIPAA
The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared an explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your information.

If you would like a complete copy of this explanation, please initial here: _____

Please sign and print your name and provide the date below to acknowledge that you understand our Notice of Privacy Practices and Office Policies.

Patient Name: _____

Signature: _____ Date: _____

LAKE POINTE
CHIROPRACTIC & WELLNESS

5000 W 36th St. Suite 120 Minneapolis, MN 55416
Phone: 612.922.8100 Fax: 612.922.8130 lpwellness.com

Patient Information:

Patient Name: _____ Sex: □ Male □ Female

Date of Birth: _____ Age: _____ Today's Date: _____

Parent/Guardian(s): _____

Address: _____

City: _____ State: _____ ZIP _____

Phone: (Home)_____ (Cell)_____ (Work)_____

Email: _____

Would you like to be added to our email list? □ Yes □ No Best time/place to reach you? _____

Emergency contact: _____ Relationship to patient: _____

Contact Phone: _____ Alternate Phone: _____

Patient Condition & History:

Chief Complaint: _____

Accidents: _____ Illness/Hospitalizations/Surgeries: _____

Birth History: (vaginal, c-section, forceps, medications, length, normal, etc.) _____

_____

Vaccinated: □ According to recommended schedule □ Modified schedule □ Homeopathic □ None

If yes, most recent: _____

Sleep Patterns: _____

General Disposition/Temperament/Social Interactions: _____

Previous Chiropractor: _____

Pediatrician: _____

Other Healthcare Providers: _____

Digestion:

Breast fed: □ Yes □ No If yes, for how long? _____

If no, what type of milk? _____

Nursing: □ Prefers one side □ Difficulty with latch □ Reflux □ Gulping

How frequently does your child eat? _____

What foods does your child currently eat? _____

_____

Sugar intake? □ Yes □ No If yes, how much per day? _____

Supplements/Medications: _____

Food allergies/sensitivities: _____

Does anyone in the household smoke? □ Yes □ No

Is there anyone you would like us to keep informed regarding your child's treatment at Lake Pointe?

□ Yes □ No If yes, please specify below:

Name of person/institution: _____ Phone: _____

Address : _____

I authorize Lake Pointe Chiropractic and Wellness to release protected health information to the person(s) or institute named above.

Signature: _____ Date: _____

This authorization is effective one year from signature and may be revoked in writing.

I hereby authorize Lake Pointe Chiropractic & Wellness to administer care as they feel necessary to my child/ward (listed above). I accept responsibility for payment of services rendered.

Signature of parent/guardian: _____ **Date:** _____