

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.

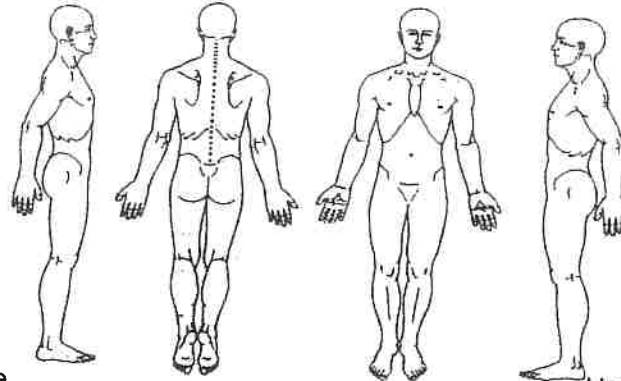
ChiroCare Use Only rev. 4/19/99

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

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 (3) Medical doctor (5) Other
- (2) Other chiropractor (4) Physical therapist

When and what treatment? _____

What tests have you had for your symptoms and when were they performed?

- (1) X-rays date: _____ (3) CT scan date: _____
- (2) MRI 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 (3) Medical doctor (5) Other
- (2) Other chiropractor (4) Physical Therapist

11. What is your occupation?

- (1) Professional/executive (4) Laborer (7) Retired
- (2) White collar/secretarial (5) Homemaker (8) Other
- (3) Tradesperson (6) FT Student

a. If you are not retired, a homemaker, or a student, what is your current work status?

- (1) Full-time (3) Self-employed (5) Off work
- (2) Part-time (4) Unemployed (6) Other

12. What do you hope to get from your visit/treatment (select all that apply):

- (1) Reduce symptoms (3) Explanation of condition/treatment (5) How to prevent this from occurring again
- (2) Resume/increase activity (4) Learn how to take care of this on my own (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.**

<p>SECTION 1 - Pain Intensity</p> <p>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.</p>	<p>SECTION 6 - Standing</p> <p>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.</p>
<p>SECTION 2 - Personal Care</p> <p>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.</p>	<p>SECTION 7 - Sleeping</p> <p>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.</p>
<p>SECTION 3 - Lifting</p> <p>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.</p>	<p>SECTION 8 - Social Life</p> <p>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.</p>
<p>SECTION 4 - Walking</p> <p>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.</p>	<p>SECTION 9 - Traveling</p> <p>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.</p>
<p>SECTION 5 - Sitting</p> <p>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.</p>	<p>SECTION 10 - Changing Degree of Pain</p> <p>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.</p>

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.**

<p>SECTION 1 - Pain Intensity</p> <p>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.</p>	<p>SECTION 6 - Concentration</p> <p>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.</p>
<p>SECTION 2 - Personal Care (Washing, Dressing, etc.)</p> <p>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.</p>	<p>SECTION 7 - Work</p> <p>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.</p>
<p>SECTION 3 - Lifting</p> <p>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.</p>	<p>SECTION 8 - Driving</p> <p>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.</p>
<p>SECTION 4 - Reading</p> <p>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.</p>	<p>SECTION 9 - Sleeping</p> <p>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)</p>
<p>SECTION 5 - Headaches</p> <p>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.</p>	<p>SECTION 10 - Recreation</p> <p>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.</p>

COMMENTS: _____

NAME: _____ **DATE:** _____ **SCORE:** _____



NOTICE OF PATIENT PRIVACY PRACTICES

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.

This Notice of Privacy Practices describes how Stoiber HealthCare, SC may use and disclose your health information and how you can access this information. This Notice explains how we use and share your health information and describes your rights and our legal duties under federal and state privacy laws.

Who This Notice Applies To

This Notice of Privacy Practices applies to our chiropractic practice and all related services we provide, including those performed by our support staff and business associates who help deliver or manage your care. We follow the requirements of the Health Insurance Portability and Accountability Act (HIPAA). This Notice applies to you as a patient of our practice and to any services we provide in connection with your care.

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

Privacy Officer: *Arien Stoiber-Alde, DC*

Practice Name: *Stoiber HealthCare, SC*

Address: *1210 Parkwood Drive, Wisconsin Rapids, WI 54494*

Phone: *715-424-4646*

OUR OBLIGATIONS

We are required by law to:

- Maintain the privacy of your protected health information (PHI)
- Provide you with this Notice of our legal duties and privacy practices
- Follow the terms of the Notice currently in effect

We may change the terms of this Notice from time to time. When we make a significant change, we will post the revised version in our office and, if applicable, on our website. You may obtain the current version at any time by contacting our Privacy Officer or asking at the front desk. You may contact our Privacy Officer in person at our office, by mail at the address above, or by phone.



WHAT IS PROTECTED HEALTH INFORMATION (PHI)?

Protected Health Information (PHI) is information about you that may identify you and relates to your past, present, or future physical or mental health condition, the provision of health care to you, or payment for that care.

USES AND DISCLOSURES PERMITTED WITHOUT AUTHORIZATION

Federal law (HIPAA) permits us to use and disclose your protected health information for treatment, payment, and health care operations without a separate written authorization, as described in this Notice.

Treatment

We may use or disclose your PHI to provide, coordinate, or manage your health care and related services. This includes sharing information with other health care providers involved in your care.

Payment

We may use or disclose your PHI to obtain payment for services provided to you. This may include billing insurance companies, determining eligibility or coverage, utilization review, and related activities.

Health Care Operations

We may use or disclose your PHI to support the business operations of this practice, including quality assessment, employee training, internal audits, and administrative activities.

We may use sign-in sheets or call you by name in the waiting area as part of our normal operations, in a manner consistent with applicable privacy requirements.

BUSINESS ASSOCIATES

We may share your PHI with third-party “business associates” who perform services for us (such as billing, IT support, or transcription). These entities are required by contract to protect the privacy and security of your PHI.

To the extent applicable, we will require, through our agreements with that business associate, that they protect those records in accordance with applicable Part 2 confidentiality requirements.



USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law. These include:

- Disclosures of psychotherapy notes
- Uses and disclosures for marketing purposes
- Disclosures that constitute a sale of PHI
- Other uses and disclosures not described in this Notice

Substance Use Disorder (SUD) Records – 42 C.F.R. Part 2

Certain records related to Substance Use Disorder (SUD), if present in your record, receive additional confidentiality protections under federal law (42 C.F.R. Part 2).

Our primary services are chiropractic care. We are not a substance use disorder (SUD) treatment program as defined by federal law. However, we may receive or maintain information related to SUD treatment if you or another provider shares that information with us.

If our office maintains such information—such as information received from other providers, hospitals, or patient disclosures—those records generally will not be used or disclosed without your specific written authorization, except as otherwise permitted or required by federal law.

A standard authorization to release medical information may not be sufficient to permit disclosure of SUD-protected records. When required by law, we will obtain an authorization that specifically covers SUD information and complies with 42 C.F.R. Part 2. You may revoke your authorization for us to disclose SUD-protected records at any time by submitting a written request to our Privacy Officer. Revocation will not affect disclosures already made in reliance on your prior authorization.

Most patients seen in our chiropractic practice will not have records covered by these special rules. This section applies only if we receive or maintain information from an SUD treatment program.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES

We may use or disclose your PHI without your authorization in the following situations:

Public Health & Safety - For public health activities, reporting communicable diseases, preventing serious threats to health or safety, and as required by law.

Health Oversight - To health oversight agencies for audits, investigations, inspections, and compliance activities.



Abuse, Neglect, or Domestic Violence - As required or permitted by law to appropriate authorities.

Workers' Compensation - As authorized to comply with workers' compensation laws.

Required by Law - When disclosure is required by federal, state, or local law.

Important Note About SUD Records: Some disclosures described in this section do not apply to records protected by 42 C.F.R. Part 2. Please see the "Substance Use Disorder (SUD) Records – 42 C.F.R. Part 2" section of this Notice for information about how we handle SUD-protected records.

LEGAL PROCEEDINGS & LAW ENFORCEMENT

We may disclose PHI in response to a valid court order, subpoena, discovery request, or other lawful process as permitted by law.

Important: Records protected under federal Substance Use Disorder confidentiality regulations (42 C.F.R. Part 2), if applicable, may only be disclosed pursuant to a court order that specifically authorizes such disclosure or as otherwise permitted by federal law. A subpoena or legal request alone may not be sufficient for disclosure of SUD-protected information.

If we maintain records protected by 42 C.F.R. Part 2, those records are subject to stricter rules than other PHI. Please refer to the "Substance Use Disorder (SUD) Records – 42 C.F.R. Part 2" section of this Notice for details.

YOUR RIGHTS

You have the right to:

- **Inspect and Copy** – You may inspect and obtain a copy of your PHI, subject to certain legal exceptions and reasonable, cost-based fees.
- **Request Restrictions** – You may request limits on certain uses or disclosures of your PHI; however, we are not required to agree to all requests.
- **Confidential Communications** – You may request that we communicate with you by alternative means or at alternative locations.
- **Amend** – You may request that we amend your PHI if you believe it is incorrect or incomplete.
- **Accounting of Disclosures** – You may request an accounting of certain disclosures of your PHI as defined by law.
- **Breach Notification** – If there is a breach of your unsecured PHI, we will notify you as required by applicable law.
- **Paper Copy** – You may request a paper copy of this Notice at any time.

To exercise any of these rights, please submit a written request to our Privacy Officer.



*Stoiber
HealthCare SC*

SPECIAL RIGHTS REGARDING SUD RECORDS

If our office maintains records protected under 42 C.F.R. Part 2, you have additional rights related to those records. Disclosure of such information generally requires your written authorization, and you may revoke that authorization at any time. Revocation will not apply to disclosures already made in reliance on your authorization.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer or with the U.S. Department of Health and Human Services by visiting www.hhs.gov/hipaa or calling 1-800-368-1019.

To file a complaint with our office, please contact the Privacy Officer at the address or phone number listed above. You will not be penalized or retaliated against for filing a complaint.

EFFECTIVE DATE

This Notice of Privacy Practices is effective as of: **02/12/2026**
