Please write in legible handwriting in order to have accurate information

Relief Chiropractic and Wellness Center

Patient Information

Name: Last: _____ First: _____ Preferred Name: _____

Street: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Carrier: _____

Birth Date: _____/_____/_____ Age: _____ Email: _____

Referred By: _____ Occupation: _____

Employer: _____ Work Phone: _____ Extension: _____

Past Medical History

1. Have you been to a chiropractor before? Y N If yes, who and when? _____
2. Do you have a family physician? Y N Physician Name: _____
3. When was your last physical exam? _____
4. Do you have any images (X-rays, MRI, CT scan) of your spine or area of complaint? Y N
5. Have you been hospitalized in the last 10 years? Y N If Yes, please explain? _____
6. Have you had surgery? Y N If Yes, what kinds? _____

Recent Health History Problem

- ❑ Low blood pressure
- ❑ High blood pressure
- ❑ Cardiovascular disease
- ❑ Diabetes (Type I or II)
- ❑ Recent neck strain
- ❑ Dizziness or lightheadedness
- ❑ Fainting
- ❑ Temporary memory loss
- ❑ Numbness: face or arms
- ❑ Wear glasses/contacts
- ❑ Recent severe, sudden head pain
- ❑ Chronic headaches
- ❑ Migraine headaches
- ❑ Sinus trouble
- ❑ Loss of smell
- ❑ Ringing in ears
- ❑ Asthma
- ❑ Allergies _____
- ❑ Thyroid trouble
- ❑ Twitching of face
- ❑ Fatigue
- ❑ Muscle spasms in neck
- ❑ Increased pain when you cough or sneeze
- ❑ Grating in neck
- ❑ Neck pain
- ❑ Tightness of shoulder muscles
- ❑ Pins and needles in arms, hands
- ❑ Cold hands
- ❑ Cold sweats
- ❑ Shortness of breath
- ❑ TB
- ❑ Chest pain
- ❑ Heart attack
- ❑ Chest and left arm pain
- ❑ Rheumatic fever
- ❑ Ulcers
- ❑ Mid back pain
- ❑ Liver trouble
- ❑ Gallbladder trouble
- ❑ Indigestion (GERD, IBS)
- ❑ Constipation
- ❑ Kidney trouble
- ❑ Bladder trouble
- ❑ Menstrual cramps, pain, or irregularity
- ❑ Sleeping problems
- ❑ Painful joints
- ❑ Swollen joints
- ❑ Arthritis
- ❑ Slipped disc
- ❑ Ruptured disc
- ❑ Previous disc surgery
- ❑ Low back pain
- ❑ Pinched nerves in back
- ❑ Leg pain
- ❑ Numbness in legs
- ❑ Swollen ankles
- ❑ Cold feet
- ❑ Pain in legs, feet

Women Only

Are you or could you be pregnant? Y N Have past pregnancies been normal? Y N

Are you seeing an OB-GYN regularly? Y N Date of last exam _____

Medications, Vitamins, Supplements

Medications you are currently taking (if none, please indicate "NONE"):

_____ _____

_____ _____

_____ _____

Vitamins and/or Supplements

_____ _____
_____ _____
_____ _____

Social Health History

1. Do you smoke? Y N If yes, _____ packs per day
2. Alcohol Y N If yes, how much? _____
3. Caffeine Products Y N What kind? _____ How Much? _____
4. Sleeping Habits Average Hours Per Night? _____ Are you rested afterwards? _____
5. Hobbies? _____

Family Health and Illness History

Please tell us if members of your immediate family are living and if they have any major health problems.

Mother Alive Health Problems:
Deceased Age: _____ Cause of Death: _____

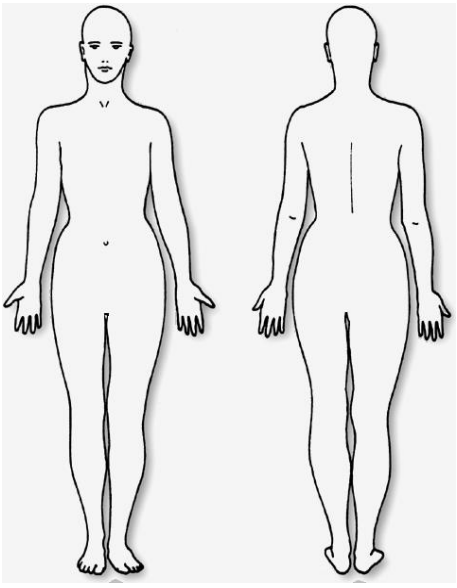
Father Alive Health Problems: _____
Deceased Age: _____ Cause of Death: _____

Sibling Alive Health Problems: _____
Deceased Age: _____ Cause of Death:_____

Sibling Alive Health Problems: _____
Deceased Age: _____ Cause of Death: _____

Please mark area & type of pain using the picture and the codes listed below

N-Numbness **P**-Pain
T-Tingling **A**-Ache
S-Soreness **ST**-Stiffness



Doctor's Notes:

_____
_____
_____
_____
_____
_____
_____
_____

BP ___/___ BPM _____ Weight _____

Height _____ Temp_____

Chief Complaints

What is the reason for your visit today_____

1. Date when Symptoms began _____/_____/_____ How did they start? _____
2. How often do your symptoms occur? Occasional Constant Intermittent Frequent
3. How would you rate your pain today? (0 = No pain 10 = Worst pain) _____
4. Are you getting: Better Worse Same Have you had this in the past? Yes No
5. Have you had treatment for this condition? Yes No (If yes, with who and what did they do_____)
6. Are your symptoms stopping you from doing any activities, either work or recreation?

   Please explain: _____
7. If your complaint includes pain, is it aggravated by? *Coughing* *Sneezing* *Straining at the stool* *Neck movement* *Reaching* *Lifting* *Bending* *Sitting* *Standing* *Walking*
8. Is there anything that relieves the symptoms? _____
9. Since your symptoms began, have you noticed a change in: **Bowel Function** **Bladder Function** **None**

Consent for Release of Medical Information

Complete and sign, if you wish to give us permission to release information to designated people (i.e. spouse, relative). Please be aware that we cannot give out information to anyone but you, unless they are noted on this form.

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Name: _____ Phone: _____ Relationship: _____
Info to be released (Check all that apply): ☐ Financial ☐ Appointment schedule ☐ Insurance ☐ Medical

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Name: _____ Phone: _____ Relationship: _____
Info to be released (Check all that apply): ☐ Financial ☐ Appointment schedule ☐ Insurance ☐ Medical

By signing, I give my permission to have the selected information released to the above-indicated persons:
***Patient Signature**: _____ Date: _____

Informed Consent for Chiropractic Care

I hereby request and consent to the performance of chiropractic manipulation or adjustments and other chiropractic procedures, including various modes of physical therapy or physical medicine procedures. I have had an opportunity to discuss with the Doctor of Chiropractic, Dr. Russell Mead, and/or with other office or clinic personnel, the nature and purpose of chiropractic manipulations or adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all possible risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure, which the doctor feels at the time, based upon the facts then known, and is in my best interest. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition.

***Patient's/Guardian's Signature: _____ Date: _____/_____/_____

Insurance "Signature-on-file" Authorization

I request payment of authorized medical benefits be paid directly to RELIEF CHIROPRACTIC on my behalf. Claims submitted by my chiropractor shall state "Signature on File" in the space provided for my signature on the insurance form. I authorize the release of my information deemed necessary by my chiropractor to process this claim. Should my insurance company not pay for any reason, I understand that I am responsible for all bills incurred at this office. I also understand that if I suspend or terminate my care and treatment, fees for professional services provided will be immediately due and payable.

***Patient's/Guardian's Signature: _____ Date: _____/_____/_____

Consent to use Protected Health Information (PHI) "HIPAA"

Consent to the use or disclosure of my protected health information by Relief Chiropractic for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Relief Chiropractic.

I understand that diagnosis or treatment of me by Russell Mead D.C. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Relief Chiropractic is not required to agree to the restrictions that I may request. However, if Relief Chiropractic agrees to a restriction that I request, the restriction is binding on Relief Chiropractic and Russell Mead D.C.

I have the right to revoke this consent, in writing, at any time, except to the extent that Russell Mead D.C., or Relief Chiropractic has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Relief Chiropractic's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance or health care operations of Relief Chiropractic. This Notice of Privacy Practices also describes my rights and Relief Chiropractic's duties with respect to my PHI.

Relief Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

***Patient's/Guardian's Signature: _____ Date: _____/_____/_____

Appointment Cancellation/Rescheduling Policy

Thank you in advance for your commitment to Relief Chiropractic, Dr. Mead, and our Clinical Team. We are honored that you have chosen to be served at Relief. We have been experiencing an increase in clients seeking treatment/services at our office, yet have been struggling to schedule them, primarily due to the number of last-minute cancellations and no call/no show. In an attempt to maximize accessibility to Dr. Mead and our Clinical Team, we are implementing the new cancellation policy.

As a courtesy to our patients, we offer a text appointment reminder the evening prior to your appointment, as well as the morning of your appointment. If you wish to receive this text appointment reminder, please see the receptionist to provide the information needed.

Failure to cancel and/or reschedule an existing appointment 24 hours prior to that scheduled appointment, will result in a fee outlined below:

Chiropractic Services:

- IF… You call at ***least 24 hours in advance*** to rescheduled or cancel a session: **No Penalty Fee Applied.**
- IF… You call ***same day, and ARE able to be rescheduled on the same day*** of your original scheduled appointment: **No Penalty Fee Applied.**
- IF... You call ***same day, and are NOT able to be rescheduled on the same day*** (regardless of if it is because you cannot come during our open schedule slots or because we are booked and have no additional openings) of their original scheduled appointment: **Penalty Fee Applied of $25.**
- IF… You are a NO CALL NO SHOW: **Penalty Fee Applied of $45.**
- IF…A NEW client calls to schedule a first time visit, the amount charged will be $105, their appointment must be paid for and confirmed 48 prior to scheduled appointment. If they do not confirm 48 hours in advance, then their appointment will be removed from Relief Chiropractic schedule. If the appointment is confirmed and new client does not show, the entire **fee of $105 is the Penalty Fee Applied.** If they can be rescheduled the same day (they are originally scheduled), then **no fee applied**.

Please note that any client that is assessed a cancelation or reschedule or No Show fee, must have this fee paid prior to their next schedule session or bring the moneys in full to their next scheduled session.

None of the fees under this cancellation policy are covered by your Insurance.

Massage Services:

- IF… You call at ***least 24 hours in advance*** to rescheduled or cancel a session: **No Penalty Fee Applied.**
- IF… You call ***same day, and ARE able to be rescheduled on the same day, for the same duration*** of their original scheduled appointment: **No Penalty Fee Applied.**

- IF... You call ***same day, and <u>NOT</u> able to be rescheduled on the same day*** (regardless of if it is because they cannot come during our open schedule slots or because we are booked and have no additional openings) of their original scheduled appointment: **Penalty Fee Applied of $55 (90 minute)/ $40 (60 minute)/ $22.50 (30 minute)**
- IF… You are a NO CALL NO SHOW: **Penalty Fee Applied of $110 (90 minutes)/ $80 (60 minutes)/ $45 (30 minutes)**

Please note that if you are late for a scheduled massage, you will still be seen for service, yet the scheduled ending time will be observed and followed. The massage will be shortened dictated by the lateness of the patient. However, the full fee of the massage will be charged for this service, as Relief Chiropractic has reserved this time for you.

If you cancel a massage appointment within 24 hours or do not show up for your appointment, after the second time, payment will be required at the time of scheduling future appointments.

Please note that any client that is assessed a cancellation or reschedule or No Show fee, must have this fee paid prior to their next schedule session or bring the moneys in full to their next scheduled session.

None of the fees under this cancellation policy are covered by your Insurance.

I have read and understand the practice's cancellation policy and I agree to be bound by its terms.

I also understand and agree that such terms may be amended by the practice from time to time and each patient will be viewed case by case.

***Patient's/Guardian'sSignature:_____Date:_____/_____/_____

Relief Chiropractic & Wellness Center

Financial Policy

We are committed to providing each and every patient with the best possible chiropractic care. The following information is provider to all patients to avoid any misunderstanding or disagreement concerning payment for professional services. We will file all insurance claims for you with any carrier currently accepted at this office; however, you are ultimately responsible for all your charges.

1. Our office participates with a variety of insurance places.

a. It is your responsibility to:

   i. Verify all insurance benefits prior to the start of your treatment.
      1. Verification of benefits by self or the office DOES NOT guarantee payment of claim, and you will be responsible for these unpaid claims. Any claims unpaid by insurance after 45 days will be billed to you.
   ii. Pay at the time of service for all co pays/deductible/co insurance and Preliminary out of pocket client responsibility. These payments can be made by cash, check or credit.
   iii. Pay in full at the time of service for any medical services rendered that are not covered under your insurance plan.

IV. We require preliminary payment at each visit. This preliminary amount may be more or less than you're actual co-pay or deductible. Any overage paid will be refunded after the explanation of benefits is received and verified by the Billing Officer. In the same manner, any amount remaining on your balance after explanation of benefits have been received, will be billed to you and will need to be paid in full before your next visit.

V. If you wish to bypass your insurance for any reason, you will be considered a cash client. Please note that if you choose to be a cash client, we WILL NOT bill your insurance.

2. If you are a Cash Client.

a. It is your responsibility to:

   i. You will be required to pay in full for the charge of treatment on the day of treatment.

3. If you leave the office after treatment without paying your balance in full, a $10 account managing fee will be applied to your account.

4. If you have not made contact with our office within 7 days, your account will then be assessed a $10 late fee per bill per every 14 days the bill is continued to be late. If you have multiple days of service that are owed, each day will be assessed the late fee. This could result in a significant price increase.

5. After 60 days of no contact from the date of the original letter, your account will be turned over to a collection agency. If this happens, you will no longer be able to be seen at our office and will be assessed multiple fees regarding collection agency and lawyer fees.

   a. After your collection account is cleared, you will be able to be seen as a patient but will be required to pay for each appointment at the time the appointment is made, and will not be allowed to use any insurance benefits. Credit card payments can be processed over the phone and will be required in these cases.

Here at Relief Chiropractic we strive to make sure all patients can receive the care they need, while maintaining the integrity of the office and respecting the financial aspect.

By signing this form, you, the payer, have agreed to the terms stated above in the financial policy of Relief Chiropractic. By signing this form you also authorize DR. RUSSELL MEAD/RELIEF CHIROPRACTIC to release to government agencies, insurance carriers or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

I have read and understand the practice's financial policy and I agree to be bound by its terms.
I also understand and agree that such terms may be amended by the practice from time to time and each patient will be viewed case by case.

***Patient's/Guardian's Signature: _____ Date: _____/_____/_____