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: _____

Insurance Information

Primary Insurance: _____ Card Holders Name: _____

Card Holder Date of Birth _____/_____/_____ Social Security _____-_____-_____ (I***f it is Insurance Card I.D. #***)

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 Problems

- ❑ 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 you are currently taking: _____

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: _____

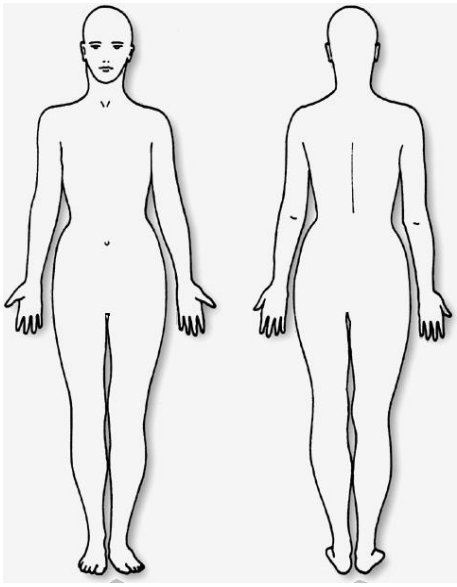
Father Alive Health Problems: _____
Deceased Age: _____ Cause of Death: _____

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:

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: _____
Witnessed by: _____ Title: _____

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 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.

_____ _____

Signature of Patient or Personal Representative *Name of Patient or Personal Representative if needed.*

Date: _____

APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Relief Chiropractic. When you schedule an appointment with Relief Chiropractic we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule with other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Effective April 2018, any established chiropractic patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **24 hour notice** will be considered a No Show and charged a **$20 fee.**
- Any established chiropractic patient who fails to show or does not cancel/ reschedule within 24 hours for a **second** time will be charged a **$30 fee.**
- If a **third** No show or cancel/reschedule not within **24 hours** should occur the patient will pay the full charge of the chiropractic appointment, before they will be seen again.
- If a **massage appointment** is missed, and this is your first occurrence, you will be required to pay ½ of the missed massage up front, before being able to schedule another appointment.
- The fee is charged directly to the patient, not the insurance company, and is **due at the time of the patient's next office visit.**
- If you are late for a massage by over **10 minutes,** you will need to reschedule for a later time.
- If a massage appointment is missed and it is the second or more occurrence, the full cost of the massage will be charged, and due at the time of the next appointment.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may able to waive the No Show fee. You may contact Relief Chiropractic 24 hours a day, 7 days a week at 269-408-0303. If it is not during regular hours, you may leave a massage.

I have read and understand the Appointment Cancellation/No show policy and agree to its terms.

_____ _____

Signature (Self/Parent/Legal Guardian) **Date**

***THIS POLICY WILL BE STRICTLY ENFORCED**

Relief Chiropractic & Wellness Center

4100 M 139 Ste 112 Saint Joseph, MI 49085

Financial Policy

We are committed to providing each and every patient with the best possible chiropractic care. If you have special financial needs, we are willing to work with you. 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 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 **in full at the time of service** for all co pays/deductible/co insurance payments. 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.

2. There are many insurance plans that do not require a co pay or deductible, if this may occur, your co pay will be refunded after the explanation of benefits is received and verified by the office billing manager. In the event that the amount due at the time of visit is unsure, these cases will be handled by case to case. Each patient will still be expected to pay at the visit and will be reimbursed for any amount overpaid.

3. If you have an insurance plan that Relief Chiropractic does not participate with, you will have the option for a “Self Pay” plan. This plan will require a **full payment be made at the time of service** for each visit. If a payment is missed, your account will be handled the same as a delinquent insurance account.

4. In the event that you have missed a payment for a time period of 30 days, you will be notified by letter and will have 7 days to pay off any unpaid balances. If you are unable to pay off the full balance within these 7 days, please contact the office to set up a payment arrangement.

5. If you have not made contact with our office within these 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.

6. After 60 days of no contact from the date of the original letter, your account will be turned over to a collect 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 are able to be made 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.

_____	_____	_____
Signature of Patient	Date	Office Manager IT