

Optimal Wellness Family Chiropractic

Name _____ Date of Birth _____ Gender _____

Address _____ City _____ State _____ Zip _____

Primary Phone _____ Secondary Phone _____ Email _____

Occupation(s) _____ Current Employer _____

Primary Physician _____ Physician address/phone _____

Emergency Contact _____ Relationship To You _____ Phone _____

How did you hear about us? _____ Who referred you? _____

Have you ever been to a chiropractor before? _____

What are your primary concerns for treatment? Date of occurrence?

1. _____

2. _____

3. _____

What do you expect to get from chiropractic care?

Please list any major illnesses, accidents, or surgeries

Please list any medications or supplements you are currently taking

Please circle any illnesses that have occurred in blood relatives

Diabetes High Blood Pressure Heart Disease Kidney Disease Cancer Stroke

How would you characterize your health, in general? Good Fair Poor

How was your health as a kid? Good Fair Poor

When was your last complete medical exam? _____

Do you have a good support network (friends, family, church)? _____

Optimal Wellness Family Chiropractic

General/Energy

Fatigue/exhaustion	Low appetite	Sweating at night	Depression
Restless sleep	Excessive hunger	Fever/chills	High stress/overwhelm
Trouble falling asleep	Strong thirst	Bleed/bruise easily	Anger/irritability
Trouble staying asleep	Weight loss/gain	Cold hands/feet	Sadness/grief
Anxiety/worry	Cravings _____	Dizziness/vertigo	Mental fog

Digestive System

Nausea	Ulcers	Diarrhea/loose stool	Blood/pus in stool
Vomiting	Acid reflux	Constipation/hard stool	Hemorrhoids
Belching	Gas/farting	Intestinal cramps/pain	Other _____

Musculoskeletal/

Neurological

Muscle strain/pull	Swollen joints	Weakness/limited use	Epilepsy
Joint pain	Nerve pain	Limit range of motion	Tics
Body aches/heaviness	Numbness/tingling	Seizures	Other _____

Cardiovascular

Chest pain	High blood pressure	Irregular heartbeat	Swollen ankles
Hardening of arteries	Low blood pressure	Previous heart attack	Blood Clots
Poor circulation	Fainting		Other _____

Head/Eyes/Ears/Nose/

Throat/Respiratory

Headaches	Swollen glands	Difficulty breathing	Gum problems
Migraines	Frequent colds	Persistent cough	Tooth problems
Earaches/infections	Allergies/hay fever	Coughing blood	Tongue problems
Ear ringing	Sinus problems	Coughing Phlegm	Eye pain/strain
Loss of hearing	Chronic sore throat	Wheezing/asthma	Other _____

Skin and Hair

Rashes	Psoriasis	Dry skin	Fungal infections
Hives	Acne	Itchiness	Non-healing sores
Eczema	Warts	Hair loss	Other _____

Genito/Urinary

Difficult urination	Painful urination	Kidney infection	Lowered libido
Frequent urination	Blood/pus in urine	Kidney stones	Edema/water retention
		Urine incontinence	

Male

Prostate trouble		Miscarriage
Erection difficulties		Menopause
Other _____		Pregnant

Female

Painful periods	Breast problems
Irregular periods	Abortion
Heavy flow/spotting	Given birth
PMS	

Have you given birth?

How many?

How was pregnancy?

How was labor?

How was delivery?

Optimal Wellness Family Chiropractic

FINANCIAL POLICY

We are committed to providing you the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your financial responsibilities.

Our office participates in several insurance plans. Each plan has its own set of rules and regulations. Our office participates in these programs to allow you (the patients) to reduce your health care cost in this office.

REFERRALS

If your insurance plan requires a referral from your primary care physician it is *your* responsibility to obtain it prior to your appointment and have it with you at the time of your visit. *If you do not have your referral, you will be responsible for all charges up to the date of the referral.* It is then your responsibility to provide us with the referral as soon as possible.

DEDUCTIBLES & COPAYMENTS

By law we must collect your carrier designated co-payments at the time of service. Please be prepared to pay deductible or co-payment at each visit.

NON-COVERED THERAPIES

In the event that your policy does not cover the cost for therapeutic modalities (ie: muscle stimulation, ultrasound) you will be responsible for the cost of those services if they are chosen to be used.

NON-COVERED XRAY'S

With some insurance policies x-rays or re-examination x-rays will not be covered. You will be responsible for any charges that are not covered by your insurance company.

We cannot guarantee payment as we are not the insurance carrier. However, as a courtesy we will confirm coverage. Since we often are given misinformation it is our suggestion that you also confirm your chiropractic coverage. If claims are delayed by more than three months, we require you to reimburse our office in full for services rendered.

The patient is liable for any and all expenses incurred in our office.

SIGNED _____

PATIENTS WITHOUT INSURANCE COVERAGE

Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

MEDICARE

We will submit to Medicare for the Medicare allowed amount. The patient will be responsible for the exam, x-rays, therapies, deductible and 20% co-insurance which can be billed to secondary insurance if you have one.

SIGNED _____

THIS APPLIES TO TODAY'S VISIT AND ALL FUTURE VISITS. OUR OFFICE ACCEPTS CASH, CHECKS, MASTERCARD, DISCOVER AND VISA.

Optimal Wellness Family Chiropractic

To: Optimal Wellness Family Chiropractic

In consideration of your undertaking to treat me, I agree to the following:

AUTHORIZATION TO RELEASE INFORMATION

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjustor in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you, and I hereby release you of any consequence thereof.

SIGNED _____

BENEFITS ASSIGNED

I hereby authorize payment to Optimal Wellness Family Chiropractic for professional services rendered and I shall be personally responsible for any unpaid balance to the Doctor. I hereby authorize the attending Doctor to release any information concerning my examination or treatment.

Who is ultimately responsible for this account?

Full name _____ Relationship to you _____

Billing address _____ Phone _____

City _____ State _____ Zip _____

To expedite payments, unless other arrangements are made, I authorize Optimal Wellness Family Chiropractic to use the following credit card (we will notify you before taking this action)

Credit card type: Visa MC Discover Full name on card _____

Card # _____ Security code _____ Expiration _____

SIGNED _____ DATE _____

NOTICE OF PRIVACY POLICY

I acknowledge receipt of a copy of the *Notice of Privacy Policy* of Optimal Wellness Family Chiropractic.

SIGNED _____ DATE _____

Optimal Wellness Family Chiropractic

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including, but not limited to, examination tests, diagnostic x-ray(s) and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by Dr. Michaella Walter and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for Dr. Michaella Walter.

I understand that, as with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications including and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with the doctor and/or with office personnel the nature, purpose and risks of Chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

Printed name of patient

Printed name of representative

Signature of patient/representative

Date