MEIER
FAMILY CHIROPRACTIC
—ADJUST YOUR LIFE—

CONFIDENTIAL CASE HISTORY

Please complete this questionnaire. Your answers will help us determine if our care can help you. If we do not sincerely believe that your condition will respond satisfactorily, we will not accept your case but will work to refer you to the appropriate healthcare provider. If you need help with this form, please ask our staff.

Name:_____ Marital Status: ☐M ☐S ☐W ☐D

Address:_____ City:_____ State:_____

Zip Code:_____ Birth Date:_____ S.S. #: _____

Cell Phone #:_____ Home Phone #: _____

Work #:_____ Sex: ☐ Male ☐ Female

Occupation:_____ Employer: _____

Whom may we thank for referring you? _____

If the above patient is a minor, please fill out the following information:

Person responsible for account : _____
(Parent and/or Guardian)

Address (if different):_____ Birth Date: _____

S.S. #: _____

I hereby state the above information to my knowledge is accurate.

Signature:_____ **Date:**_____

WEBSITE MEMBERSHIP ENROLLMENT

The information on our website will help you **GET WELL** and **STAY WELL.** Please provide the following details so we can establish you as a member of our website. By joining our website, you authorize us to send monthly healthcare related emails to you. We will never out-source your email address to any company. Naturally, you may opt-out at any time. Please review our complete privacy policy on our website.

Email Address: _____

PATIENT CONDITION

HEALTH INFORMATION:

Have you ever been to a chiropractor before? ☐Yes ☐ No

Reason for today's visit: _____

When did your symptoms appear? _____

Is this condition getting progressively worse? _____

Have you ever been seen previously by someone for the same condition? ☐ Yes ☐ No

If yes, who? _____

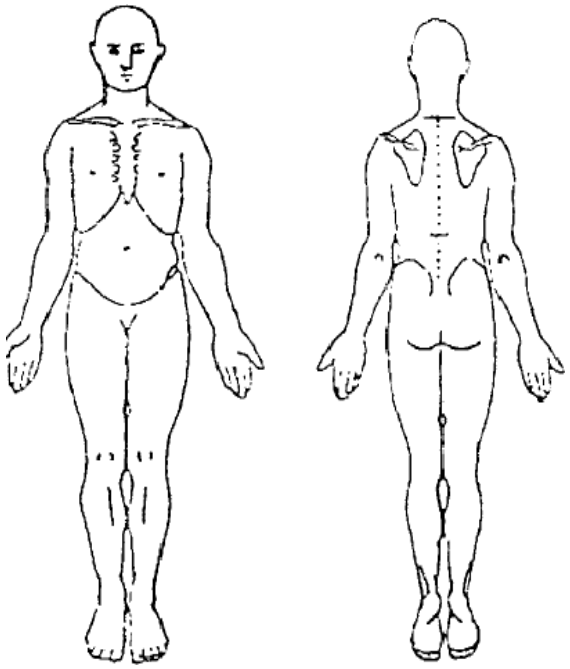
Have you had this or a similar condition in the past? ☐ Yes ☐ No

If yes, when? _____

On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters: **A.** Ache **B.** Burning **C.** Cramping **D.** Dull pain **R.** Throbbing **N.** Numbness **T.** Tingling

Current & Past Health History

❒ Headaches	❒ Cancer
❒ Tension	❒ Heart Attack
❒ Dizziness	❒ Neck Pain
❒ Shortness of Breath	❒ Chest Pain
	❒ Fatigue
❒ Broken or Fractured Bones	❒ Seizures
	❒ Pacemaker
❒ Diabetes	❒ Memory Loss
❒ Depression	❒ Fever
❒ Ringing in Ears	❒ Arthritis
❒ Fainting	❒ Diarrhea
❒ Loss of Taste	❒ Tumors
❒ Numbness	❒ Stroke
❒ Breech baby	❒ Vertigo



Do you have pain and/or difficulty performing any of the following activities?

- ☐ Daily Routine
- ☐ Lifting
- ☐ Working
- ☐ Driving
- ☐ Sleeping
- ☐ Recreation
- ☐ Walking
- ☐ Sitting
- ☐ Standing

Rate the severity of the pain on a scale of 1 to 10 _____

How often do you have this pain? _____

List surgical operations and years: _____

_____

List any medications, Vitamins, and Natural Supplements you currently take: _____

_____

_____

Are you wearing: ☐Heel Lifts ☐Sole Lifts ☐Inner Soles ☐ Arch Supports or Orthotics

Have you been in an auto accident: ☐None ☐Past Year ☐Past 5 years? ☐Over 5 Years

Describe _____

Have you had any other personal injury or accidents: ☐None ☐Past Year ☐Past 5 years? ☐Over 5 Years

Describe _____

REASON FOR CONSULTING THIS OFFICE:

☐I have a specific problem and require help only with this problem.

☐After my specific problem has been relieved, I am interested in strategies to ensure it does not return.

☐After my specific problem has been resolved and I understand methods to ensure it does not return, I am interested in strategies to improve my general health.

Financial Agreement

We appreciate and thank you for choosing our office for your chiropractic needs. We would like to clarify the financial aspect of your care so we may direct all of our attention to helping you get well.

FIRST VISIT

On your first visit you will watch a First Patient Video. You will then meet with the doctor to discuss your current health situation and to see if you are a good candidate for chiropractic care. After the determination has been made, the doctor will conduct a thorough examination. This helps us identify the likely cause(s) of your problem.

Associated fees include:

Physical, Ortho and Neuro Exam	**$68**
Spinal Adjustments	**$46 - $56**
X-Rays	**$65.91 - $70.82** (X-Rays will be taken only if the doctor deems necessary.)
Muscle Stimulation	**$25** (Optional)
Physiotherapy	**$40** (Optional)
Extremity Adjustment	**$10** (Optional)

SECOND VISIT (ROF)

At your **R**eport of **F**indings visit, we will have you watch a video regarding the 2nd visit.

Associated fees with 2nd visit include:

Spinal Adjustments	**$46 - $56**
Muscle Stimulation	**$25** (Optional)
Physiotherapy	**$40** (Optional)
Extremity Adjustment	**$10** (Optional)

REGULAR VISIT

Your care consists of specific adjustments to add motion to spinal segments that are not moving correctly and restore nervous system integrity. Retraining the spine takes time. Each visit builds on the ones before. Some patients see rapid progress and others find their recovery slower.

Associated fees with a Regular visit include:

Spinal Adjustments	**$46 - $56**
Muscle Stimulation	**$25** (Optional)
Physiotherapy	**$40** (Optional)
Extremity Adjustment	**$10** (Optional)

PROGRESS EXAMINATION

We will monitor your progress with periodic exams every 12 visits or 30 days, whichever comes first. These findings help document your recovery. We may modify your visits based on these results.

Associated fees with Progress Examination include:

Brief Examination	**$35**
Spinal Adjustments	**$46 - $56**
Muscle Stimulation	**$25** (Optional)
Physiotherapy	**$40** (Optional)
Extremity Adjustment	**$10** (Optional)

Billing

Outstanding patient balances will be billed monthly. Should my account become delinquent, I agree to pay collection costs, attorney fees and court costs as permitted by law if such are incurred by my physician at Meier Chiropractic. We will pass along the charge of $20 for any returned checks. If your case is a Personal Injury Case or Workers Comp case and you decide to terminate care against the doctor's advice, the entire balance will immediately become due and payable.

Agreement

This is the entire financial agreement between Meier Chiropractic and the patient below. I have read this agreement, understand it and agree with its provisions.

_____ _____

Patient or Responsible Party Date

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of Chiropractic adjustments and any other procedures, including examination tests, diagnostic x-rays and adjustment necessary to treat or diagnose my condition. Furthermore, I consent to treatment by any chiropractor that may be working for, associated with or serving as backup for my regular chiropractor named below.

I understand that, as with any health care procedure, there are certain risks involved. Some of the risks or complications which may occur during a chiropractic adjustment include, but not limited to; fractures, disc injuries, muscle strains, and costovertebral strains and /or separations. In a small percentage of the population there have been injuries to the arteries in the neck resulting in or contributing to stroke. In some of these incidents the manipulative procedures were performed by untrained people such as massage therapists, beauticians, and even medical doctors not adequately trained in the science of chiropractic.

By signing below I state I have weighed the risk involved in undergoing treatment and have myself decided that it is in my interest to undergo the chiropractic treatment recommended. I hereby give consent to the treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any other future conditions for which I seek treatment.

Treating Doctor: *Jeff Meier, D.C, Kim Meier, D.C, Donnie Smith, D.C*

DO NOT SIGN UNTIL YOU HAVE READ THE ABOVE

_____ _____

Printed Name **Date**

_____ _____

Signature Date

_____ _____

Witness Signature Date

HIPAA

INDIVIDUAL AKNOWLEDGEMENT OF PRIVACY PRACTICES

We here at Meier Family Chiropractic take your care very serious and want what is best for you at all times. Under the Health Insurance Portability and Accountability Act (HIPAA), your health care provider may share your information face-to-face, over the phone, or in writing. A health-care provider may share relevant information if:

- You give you provider permission to share this information **OR**
- You are present and do not object to sharing the information

If you would like us to share information (i.e. appointment dates/times, current balances, etc.) please list the person's name and we will be happy to abide by this. I authorize Meier Family Chiropractic to release my healthcare information to the following:

1.) _____

2.) _____

3.) _____

Appointment reminders and private health information will be communicated to you only in the manners in which you have given specific written authorization and you have the option to opt out of any of those methods at any time by notifying our office. Email and standard SMS/text messaging are not confidential methods of communication and may be insecure.

I give permission to contact me, relative to appointment reminders only, by the following methods:

Cell Phone #: _____ ☐ Verizon ☐AT&T ☐ Straight Talk ☐ Cricket

By signing this form, I am indicating that I have been provided a copy of Meier Chiropractic's Notice of Privacy Practices related to health information. I understand that the Notice is subject to change, and I may obtain a current notice by contacting Meier Chiropractic. The doctors and staff of Meier Family Chiropractic will follow the above directions until notified in writing of a change.

_____ _____

Patient/ Authorized Signature Date

I am the: ☐Patient ☐Guardian ☐Other _____