Dear new Patient,

I would like to take this opportunity to welcome you and thank you for choosing my clinic. My primary concern is to provide you with quality chiropractic care. My goal is to build a relationship with you of confidence and trust. I hope your experience with us will be pleasurable and will make you want to refer your family and friends for the benefits of Chiropractic care with us.

I would like to take a minute to explain some of our office policies at this time.

APPOINTMENTS

When appointments are made, that time has been reserved for you. As a courtesy we ask that if you will be unable to keep your scheduled appointment that you call 24 hours prior to your appointment to reschedule. If not, I reserve the right to charge you $25.00 for missed appointments
Initials _____

SERVICES AND SUPPLIES

All orthopedic supplies and nutritional supplements must be paid for when received.
Initials _____

PAYMENTS

Payment is expected for all services when rendered unless prior arrangements have been made. Payment plans are available and my staff will be happy to discuss them with you. For those who have insurance, as a courtesy, we will verify your insurance coverage at the beginning of your care. However, ***We Can Not Guarantee Benefits***. If you have a hand book you should refer to it or call to verify your benefits yourself. Your carrier does not guarantee the benefits they describe to us over the phone. Claims must be submitted and reviewed. ***Please note.*** Authorization by a utilization review board does not guarantee payment of those visits authorized. You are responsible for knowing your insurance limits, maximums and restrictions. *Your care is not based on the number of visits your insurance carrier may authorize, but on the care most appropriated for your condition.*. We will also bill directly to your insurance carrier for you as a courtesy and make every attempt to see your claims are paid. If problems occur, we will not enter into any dispute over unpaid claims with your insurance carrier. The contract is between you and your carrier and is your responsibility. All unpaid claims are your financial responsibility. All deductibles and co-payments are due at the time of your visit.
Initials _____

I welcome your referrals and offer free consultation to your family and friends as a courtesy. This consultation is designed to let them meet the doctor, discuss their concerns and see if chiropractic care is appropriate for them.

Please, if you have any questions or concerns feel free to ask us. My staff is always available to answer your questions and help in any way they can.

Welcome To My Clinic !

Patient signature _____ Date _____

Stephen Wellens, DC

Patient Information Form

1) Patient Number _____ Fin Class: ( ) 2) Date ____/____/____ 3) Claim Number _____
Date of Accident/Occurrence _____ Drivers Lic. # _____

4) First Name _____ 5) M.I. ____ 6) Last Name _____ Phone ( ) _____
Address _____ City _____ State _____ Zip _____
7) Age ____ 8) Sex ____ Birthdate ____/____/____ Marital Status (S M W D) Spouse's Name _____
Social Security # _____ - _____ - _____ Occupation _____ Employer _____
Work Phone ( ) _____ Work Address _____
Referred by _____ Person responsible for this account _____
Nearest relative _____ Address _____ Phone ( ) _____

Primary Health Insurance Policy # _____
Name of Insured _____ Relationship to Patient _____ SS # _____
Insurance Co _____ Group # _____
Address/City/State/Zip _____ Phone _____

Secondary Health Insurance: Policy # _____
Name of Insured _____ Relationship to Patient _____ SS # _____
Insurance Co. _____ Group # _____
Address/City/State/Zip _____ Phone _____

AUTO #1 Patient Auto Insurance Carrier: Date of Accident: _____ Policy# _____ Claim # _____
Name of Insured _____ Relationship to Patient _____ SS # _____
Insurance Co. _____ Phone _____
Address _____ City _____ State _____ Zip _____
Agent _____ Phone _____

AUTO #2 Insurance of person's car you were in: _____ Policy # _____ Claim # _____
Name of Insured _____ Relationship to Patient _____ SS # _____
Insurance Co. _____ Phone _____
Address _____ City _____ State _____ Zip _____
Agent _____ Phone _____

AUTO #3 Insurance of car that hit you: _____ Policy # _____ Claim # _____
Name of Insured _____ Relationship to Patient _____ SS # _____
Insurance Co. _____ Phone _____
Address _____ City _____ State _____ Zip _____
Agent _____ Phone _____

Attorney Information:
Attorney Name _____ Phone _____
Address/City/State/Zip _____

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment of all charges incurred at this office.
I **AUTHORIZE** the release of any medical information necessary to process my insurance claims.

I AUTHORIZE payment from my insurance carrier to be paid directly to this office with the understanding that all monies will be credited to my account upon receipt. Furthermore, I the undersigned hereby specifically authorized this clinic and or doctors to receive any insurance company checks in payment of the aforesaid service and to **ENDORSE, DEPOSIT AND NEGOTIATE** said checks in payment of undersigned's obligations to this clinic and/or Doctor.

I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. In the event of default I promise to pay legal interests on the indebtedness together with such collection costs and reasonable attorney fees as by required to effect collection. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor any medical diagnosis.
X-RAYS will be taken to assist in the proper management of your case. Proper diagnostic procedure requires that some x-rays may need additional diagnostic evaluation and are sent for a second opinion by a chiropractic radiologist. If this is done, a fee for this procedure will be billed to your account for **$ 25.00**.

IS THERE ANY POSSIBILITY THAT YOU ARE PREGNANT AT THIS TIME PLS INITIAL YES _____ NO _____

Missed appointments are charged **$25.00**. Patient balance over **90 days** may be subject to **interest charges**.

BY MY SIGNATURE I UNDERSTAND AND AGREE TO ALL OF THE ABOVE

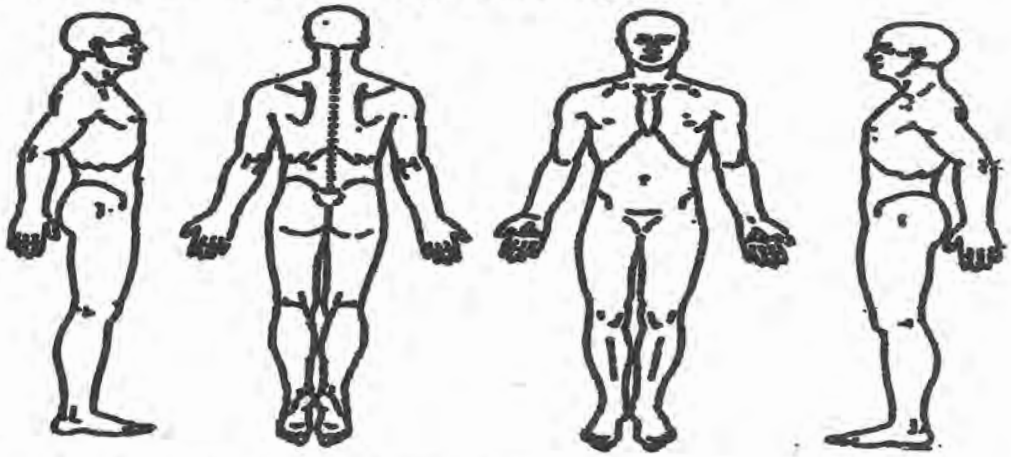
PATIENT SIGNATURE _____ DATE _____

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: ◻ Auto Accident ◻ Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

◻ Constantly (76-100% of the time) ◻ Occasionally (26-50% of the time)
◻ Frequently (51-75% of the time) ◻ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

◻ Sharp ◻ Numb
◻ Dull ◻ Tingly
◻ Diffuse ◻ Sharp with motion
◻ Achy ◻ Shooting with motion
◻ Burning ◻ Stabbing with motion
◻ Shooting ◻ Electric like with motion
◻ Stiff ◻ Other:_____

5. How are your symptoms changing with time?

◻ Getting Worse ◻ Staying the Same ◻ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?

◻ Not at all ◻ A little bit ◻ Moderately ◻ Quite a bit ◻ Extremely

8. How much has the problem interfered with your social activities?

◻ Not at all ◻ A little bit ◻ Moderately Quite a bit ◻ Extremely

9. Who else have you seen for your problem?

◻ Chiropractor ◻ Neurologist ◻ Primary Care Physician
◻ ER physician ◻ Orthopedist ◻ Other:_____
◻ Massage Therapist ◻ Physical Therapist ◻ No one

10. How long have you had this problem? _____

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe?

◻ Yes ◻ Yes, at times ◻ No

13. What aggravates your problem?

_____

14. What concerns you the most about your problem; what does it prevent you from doing?

_____

15. What is your: Height_____ Weight _____ Date of Birth _____
Occupation _____

16. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?
□ Stenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
□	□	Headaches	□	□	High Blood Pressure	□	□	Diabetes
□	□	Neck Pain	□	□	Heart Attack	□	□	Excessive Thirst
□	□	Upper Back Pain	□	□	Chest Pains	□	□	Frequent Urination
□	□	Mid Back Pain	□	□	Stroke	□	□	Smoking/Tobacco Use
□	□	Low Back Pain	□	□	Angina	□	□	Drug/Alcohol Dependance
□	□	Shoulder Pain	□	□	Kidney Stones	□	□	Allergies
□	□	Elbow/Upper Arm Pain	□	□	Kidney Disorders	□	□	Depression
□	□	Wrist Pain	□	□	Bladder Infection	□	□	Systemic Lupus
□	□	Hand Pain	□	□	Painful Urination	□	□	Epilepsy
□	□	Hip Pain	□	□	Loss of Bladder Control	□	□	Dermatitis/Eczema/Rash
□	□	Upper Leg Pain	□	□	Prostate Problems	□	□	HIV/AIDS
□	□	Knee Pain	□	□	Abnormal Weight Gain/Loss			
□	□	Ankle/Foot Pain	□	□	Loss of Appetite		**For Females Only**	
□	□	Jaw Pain	□	□	Abdominal Pain	□	□	Birth Control Pills
□	□	Joint Pain/Stiffness	□	□	Ulcer	□	□	Hormonal Replacement
□	□	Arthritis	□	□	Hepatitis	□	□	Pregnancy
□	□	Rheumatoid Arthritis	□	□	Liver/Gall Bladder Disorder			
□	□	Cancer	□	□	General Fatigue			
□	□	Tumor	□	□	Muscular Incoordination			
□	□	Asthma	□	□	Visual Disturbances			
□	□	Chronic Sinusitis	□	□	Dizziness			
□	□	Other:_____						

20. List all prescription medications you are currently taking:
_____

21. List all of the over-the-counter medications you are currently taking:
_____

22. List all surgical procedures you have had:
_____

23. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

24. What activities do you do outside of work?
_____

25. Have you ever been hospitalized? □ No □ Yes
if yes, why _____

26. Have you had significant past trauma? □ No □ Yes

27. Anything else pertinent to your visit today?_____

Patient Signature_____ **Date:**_____

Automobile Accident History Form

Name: _____ Today's Date: _____

Date of Accident: _____ Time of Accident: _____ am / pm

City/State of Accident: _____

Did the police come to the accident scene? YES NO If yes, is there a report? YES NO

Did you go to a hospital? YES NO If yes, how did you get to the hospital? _____

What parts of your body were x-rayed at the hospital? _____

What did the hospital do for your injuries? _____

How long did you stay at the hospital? _____

Did the accident cause bleeding or cuts? YES NO If yes, where? _____

Did the accident cause any bruising? YES NO If yes, where? _____

Where were you seated in the vehicle? _____

Were you aware of the approaching collision prior to impact, or did the impact catch you by surprise?

AWARE SURPRISE

Did you lose consciousness or black out upon impact? YES NO If yes, for how long? _____

Do you remember the actual collision? YES NO

Did you experience a flash of light or explosion in your head? YES NO

Did you experience any of the following due to the accident? (circle all that apply)

CONFUSION DISORIENTATION LIGHT HEADEDNESS DIZZY NAUSEA

BLURRY VISION RINGING/BUZZING IN EARS

Do you still have any of the above symptoms? YES NO If yes, which ones do you still have? _____

_____

Are you currently suffering from any of the following? (circle all that apply)

RESTLESSNESS IRRITABILITY DIFFICULTY CONCENTRATING SLEEPLESSNESS

REDUCED TOLERANCE TO HEAT DIFFICULTY WITH MEMORY

Did you head go back over the top of your vehicle's headrest? YES NO

Were you wearing a seatbelt? YES NO If yes was it a lap seatbelt or a shoulder-lap seatbelt? _____

Does your vehicle have an airbag? YES NO If yes, did the airbag deploy? YES NO

Did you receive an injury from the airbag? YES NO If yes, please describe _____

_____

Write down the make, model, and year of the vehicle you were in: Make _____ Model _____ Year _____

Write down the make, model, and year of the other vehicle: Make _____ Model _____ Year _____

Was your car stopped at the time of impact? YES NO

If yes, was the driver's foot also on the brake? YES NO

If no, estimate the speed of the vehicle you were in: _____ mph

On what part of the automobile did your body parts hit?

Head hit the _____ Chest hit the _____

Right / Left shoulder hit the _____ Right / Left arm hit the _____

Right / Left hip hit the _____ Right / Left leg hit the _____

Right / Left knee hit the _____ Other _____

Did you receive any injury or bruise from the seatbelt? YES NO If yes, where? _____

Did the steering wheel break or bend during the accident? YES NO

Was your chest pointed straight forward at the time of collision? YES NO If no, what direction was your body in?

_____

Was your head pointed straight forward at the time of collision? YES NO If no, what direction was your head facing?

_____

ACCIDENT DIAGRAM

- Please draw out how the accident occurred.
- Make sure to note, as completely as possible, all of the involved vehicles and/or structures.
- Include city location, street names, and lane descriptions.
- Use arrows for direction markers to describe the direction of vehicle movement.
- Please note the exact location of the collision and the final resting position of your vehicle.

AUTO ACCIDENT INSURANCE POLICY

**You may pay for your care by using one of these three methods*

1) MED-PAY

Your auto insurance Med-Pay coverage will pay for your care in full, regardless of fault. Med-Pay is a set amount of funds, usually $1,000, $5,000, or $10,000, which is put aside to pay your medical bills in case of an accident. You pay extra for this benefit, so use it. Your insurance rates are not affected by the cost of the health expense, unless you were at fault. It is your responsibility to notify your claims office that you are being treated in this office and have them send any necessary paperwork directly to us.

In the event your auto insurance DENIES that you hold insurance, REFUSES payment, DOES NOT HAVE Med-Pay Coverage, or you have EXHAUSTED your Med-Pay Coverage, charges for services are due and payable.

2) GROUP HEALTH INSURANCE

Your group health insurance can be billed for your care. If you have an accident rider on your policy, it may be covered at 100%. You pay your deductible and co-payments as required and we will wait for the balance from the insurance company.

3) PATIENT PAYMENT

You can pay for your care as you go or we can arrange a convenient monthly payment plan for you. We will prepare billings for you to submit to your attorney, third party, etc.

****

You are considered a cash patient until all the required information is submitted to our billing office.

The only circumstance in which we will accept a lien is when all the above options are exhausted and you are making personal payments on your account. In this case, a lien may be accepted as a promise to pay the remaining portion of your bill.

We will bill your auto or health insurance and have you assign payment to us. In the event that your insurance company sends a check directly to you, be sure to send or bring it in, along with the attached stub, within three days. Otherwise, we may rebill in error, which will delay future payments.

If the insurance company fails to pay a portion of your bill after 90 days, that balance will be due and payable by you.

PLEASE NOTE THE INFORMATION BELOW IS YOUR AUTO INS.

Policyholder's Name: _____

Insurance Company's Name: _____

Policy #: _____ Claim #_____

Med-Pay Coverage?: (yes)_____ (no)_____ Amount: $_____

Adjuster's Name:_____ Phone #: (____)_____

Claims Office Address:_____