CONFIDENTIAL PATIENT INFORMATION

Name: _____
Phone # :_____ Email: _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Date of Birth: _____ Social Security: _____
Age: _____ Gender: M F Marital Status: M S D W Are you Pregnant: Yes No
Emergency Contact: _____ Phone: _____

How did you hear about us**?** _____

Is your visit with us today due to injuries resulting from an auto accident? Yes or No If yes, and you are expecting to utilize an auto claim, please notify our front desk right away.

If not, have you ever been in an automobile accident? Yes or No If yes, please summarize the incident: _____

WORK OR DAILY ROUTINE INFORMATION:
What is your occupation? _____
Are you typically at a desk or on your feet? _____
What repetitive tasks do you do? _____

HEALTH INFORMATION:
What are the main symptoms that brought you in to see us today? _____
(Note: you'll have a chance to describe these symptoms in more detail on the last page of our paperwork)

Have you had any surgeries that may pertain to the symptoms that you're having? Yes No If yes, explain: _____ Do you have an imaging from this injury? _____

Are you taking any medications for your condition? _____

Have you ever suffered from: (check all that apply)
____Arthritis ____ Asthma ____ Back Pain ____Diabetes_____ Digestive Issues
_____Dizziness _____ Heart Trouble _____Headaches _____Hearing Loss _____Migraines _____Neck Pain
_____Numbness _____Nervousness _____Restless Leg Syndrome _____Ringing in Ears _____Sciatica
_____Sinus Issues _____Stroke _____Tuberculosis _____Trouble Sleeping

How old is your mattress: _____ Is it comfortable: Yes No

Do you like your pillow? _____What kind of pillow do you sleep on:_____

What type of shoes do you most often wear: _____

INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including but not limited to various modes of physical therapy, rehabilitation procedures and future diagnosis studies including x-rays by Chiropractic providers and staff employed for The Wellness Center of Boise.

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, disk injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all 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, is in my best interest. **The Wellness Center of Boise will not be responsible for any pre-existing medically diagnosed conditions.**

I have read, or have read to me, the above. 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.

By signing below, I acknowledge that I've read and accept all terms of the above agreement. I also understand that I'm welcome and encouraged to express all concerns arising out of the financial aspects of my medical care.

OFFICE FINANCIAL POLICY AND SERVICE CONTRACT

_____ 1. I am aware that I can request a copy of the notice informing me of my **HIPAA** privacy rights and understand that my health information will be used for treatment, billing, and office operation.

_____2. I understand that even though I may have health insurance, The Wellness Center of Boise does not accept or bill insurance, therefore, I am opting out of my insurance and agree to **SELF PAY in full** for all of the services that I receive at The Wellness Center of Boise. I understand that I can request a Superbill for my visit and can submit it to my insurance company on my own for reimbursement according to my insurance benefits.

*_____ 3. **Chiropractic Appointment Cancellations, Reschedules and No Shows -** 24-hour advance notice is required when canceling a chiropractic appointment. We feel that this is a courtesy for all of our patients so that appointments are available when needed. You may cancel or reschedule your chiropractic appointment without charge by contacting us no less than 24-hours in advance of your appointment. We regret that we will have to charge a per provider fee of **$25 for same-day cancellations / or reschedules and no call-no shows**.

*_____4. **Report of Findings - There is a $75 fee for cancellations, reschedules and no show/no calls for this special appointment.** This is Part II of your initial visit. The Doctor will allocate a full one hour for this second appointment which is called your Report of Findings. These Reports are at no charge to you as the Doctor feels that they are a one time golden opportunity to thoroughly educate you on his findings and to make a plan for working together to get you out of pain. You won't want to miss it. Should you miss this appointment, it can be rescheduled, however, there will be a cost of $70 for this service.

ABN - ADVANCED NOTICE OF COST OF SERVICES

A. Estimated Cost of Chiropractic Services:

1. *Chiropractic adjustments $45-$70*
2. *Chiropractic exams $65*
3. *Chiropractic X-rays $65-$250*

B. Estimated Cost of Therapeutic Services:

1. *Class IV Laser Treatments $39-$59 ($20 per additional area)*
2. *Manual Traction Table $10*
3. *Ultrasound Treatments $35 ($20 per additional area)*
4. *Electric Muscle Stimulation $25*
5. *Therapeutic or Strengthening Exercises $35*
6. *Therapeutic Devices (vary)*
7. *Decompression Treatments (vary)*
8. *Neuropathy Treatments (vary)*
9. *Rossiter Therapy Treatments ($50)*

PAYMENT

I understand the above policies and procedures as identified in this document for my chiropractic services at The Wellness Center of Boise.

OPT OUT OF BILLING INSURANCE:
I understand that The Wellness Center of Boise will no longer be billing health insurance for my chiropractic care. I am electing to **self-pay** for the services that I receive at The Wellness Center of Boise.
I have been notified that I can submit a superbill to my insurance company for these services for reimbursement according to my benefits.

I understand and accept that this clinic is NO LONGER ABLE to bill my health insurance, and is in transition as IN NETWORK or OUT OF NETWORK status with many of the insurance companies. I understand that there are several self pay/time of service payment options for me and am opting to self pay despite my insurance status. I understand that I am financially responsible for all charges, have reviewed the estimated costs of my appointment and understand that payment is due in full at the time of the appointment.

Name: _____Date of signature and consent: _____

Name of minor/other if applicable_____ (I am an authorized representative)

Signature: _____Relationship to patient: _____

Name: _____Date: _____

Your Subjective Assessment:

(tell us about your pain or discomfort)

What are your chief complaints? _____

What is the approximate date or onset of these conditions? _____

Does the discomfort radiate to anywhere else in your body? _____

On a scale from 1-10 (10 being most severe) please rate your pain?

1 2 3 4 5 6 7 8 9 10

Is the pain or discomfort the result of an injury or auto accident? _____

What is the frequency of pain?

Constant (100% of the time) in the _____ areas of the body.

Frequent (75% of the time) in the _____ areas of the body.

Occasional (50% of the time) in the _____areas of the body.

Intermittent (less than 25% of the time) in the _____ areas of the body.

What is the quality of discomfort? (Circle all that apply)

ACHING ANNOYING BURNING DEEP DULL HEAVY INTOLERABLE PULLING SHARP SHOCK-LIKE STABBING STIFF THROBBING TIGHT TINGLING NUMBING PINCHING Other: _____

This symptom is relieved by: _____

This symptom is aggravated by: _____

Past episodes of this complaint: _____

Past care or medication for this complaint: _____

Recent diagnostic images or tests for this complaint: _____

We're looking forward to helping you feel better!