



# WELCOME

## PATIENT INFORMATION

Date \_\_\_\_\_

SS/HIC/Patient ID # \_\_\_\_\_

Patient Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_

Sex M F Age \_\_\_\_\_ Birthday \_\_\_\_\_

Married Widowed Single Minor

Separated Divorced Partnered for \_\_\_ years

Occupation \_\_\_\_\_

Patient

Employer/School \_\_\_\_\_

Employer/School Phone (\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthday \_\_\_\_\_ SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## INSURANCE

Who is responsible for this account? \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

Is the patient covered by additional Insurance? YES NO

Subscriber's Name \_\_\_\_\_

Birthday \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to the Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

## ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to Dr. \_\_\_\_\_

all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, I authorized the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

## PHONE NUMBERS

Home Phone (\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_

## IN CASE OF EMERGENCY, CONTACT

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

## ACCIDENT INFORMATION

Is condition due to an accident? Yes No

Date \_\_\_\_\_

Type of accident Auto Work Home Other

To whom have you made a report of your accident?

Auto Insurance Employer Work Comp. Other

Attorney Name (if applicable) \_\_\_\_\_

## PATIENT CONDITION

Reason for your visit? \_\_\_\_\_

When did your symptoms first appear? \_\_\_\_\_

Is this condition getting progressively worse YES NO UNKNOWN

Mark accordingly on the picture where you continue to have (P) pain, (N) numbness, or (T) tingling.

Rate the severity of your pain on a scale from 0 (no pain) to 10 (severe pain) \_\_\_\_\_

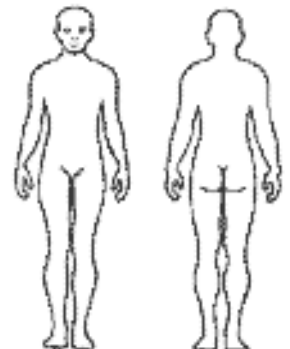
Type of pain: Sharp Dull Throbbing Numbness Aching Shooting

Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? \_\_\_\_\_ Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform Sitting Standing Walking Bending Lying





# CHALMERS WELLNESS GROUP

Matt Chalmers, DC

## OFFICE POLICY

Our office is pleased to accept your insurance assignment, as soon as your exact coverage is verified by the responsible party. We will file your claim forms and assist you in every way we can.

***It must be fully understood that the contract is between you and your insurance company and you are fully responsible for any amount not paid by your insurance.***

1. **Payment for services is due at the time of the office visit.** Payment options include: cash, check, MasterCard, Visa or Discover. A credit card number is required to be kept on file to satisfy financial obligations and/or missed appointments.  
MC/VISA/DISC      CC# \_\_\_\_\_  
  
Exp. Date \_\_\_\_\_ Name on card \_\_\_\_\_
2. Filing your insurance is a courtesy and may be withdrawn if circumstances warrant it.
3. If you discontinue care without the Doctor's authorization, the balance of your account is due and payable in full immediately, even if your insurance has been filed. If the insurance does pay, it will be refunded if you have a zero balance.
4. Your insurance should pay within 30 days. If your insurance has not paid within 60 days, you must pay the balance due and be reimbursed by your insurance company when and if it pays.
5. Our office does NOT guarantee that your insurance will pay. We will make every attempt, at the beginning of your healthcare, to receive verification of your policy and what it covers. However, if for some reason your insurance claim is denied, you are responsible for the full amount of your bill.
6. Our office will NOT enter into a dispute with your insurance company over your claim. This is your responsibility and obligation.
7. All special arrangements regarding finances must be signed by the Doctor and patient and/or other representative.
8. Missed Appointment Policy: If an appointment cannot be kept, please give 24 hours notice
9. Returned Check Policy: Our returned check fee is \$25.00

If you understand and agree to the above policies, please sign your name below.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

**Chalmers Wellness Group**

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF  
PRIVACY PRACTICES**

**\*\*You May Refuse to Sign This Acknowledgement\*\***

I, \_\_\_\_\_, have read and understand a copy of Chalmers Wellness Group notice of Privacy Practices.

\_\_\_\_\_  
(Please Print Name)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

**FOR OFFICE USE ONLY**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# CHALMERS WELLNESS GROUP

## TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working toward the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxations: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition unrelated to vertebral Subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate any interference to the expression of the body's nervous system. Our chief method is with specific adjusting to correct vertebral Subluxations.

I, \_\_\_\_\_ have read and fully understand the above statements.  
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(date)

### **Consent to evaluate and adjust a minor child**

I, \_\_\_\_\_ being the parent or legal guardian of \_\_\_\_\_ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

### **Medicare Patients ONLY**

Medicare pays for services rendered on what they determine to be medically necessary. They may or may not pay up to 12 visits per calendar year for chiropractic care, and this is decided after they have reviewed your case. Therefore, we would like you to be aware that they base your care on what Medicare determines to be medically necessary.

I, \_\_\_\_\_ have read the above paragraph and understand that whatever services Medicare does not find medically necessary I will be responsible for:

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(date)

# CHALMERS WELLNESS GROUP

## CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-rays and physical therapy techniques on me (or the patient named below for which I am legally responsible) which are recommended by Dr. Matt Chalmers.

I understand that, as with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications may include but are not limited to: Fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of the 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 and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts known, and are in my best interest.

I have had the opportunity to discuss with the doctor and/or with the 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 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 treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Signature of Patient or Legal Guardian (if minor)

\_\_\_\_\_  
Date

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Signature

Date