Chiropractic New Patient Information
Dr. Kevin Meyer, D.C.

Personal and Family Health History

Name _____ Date of Service _____

Address _____ Phone: (H) _____

City _____State _____ Zip _____ (W) _____

E-mail _____ Marital Status S M D W

Date of Birth _____ (Age _____)

Occupation _____Employer_____

Spouse's Name _____Spouse's Occupation _____

In case of emergency contact_____

How did you hear about Whole Body Balance? Google ___ Yahoo ___ City Search___ Dex Online ___ Other Online Search or Online Yellow Pages _____

Dex Yellow Pages___ Yellow Book Yellow Pages___ Verizon Yellow Pages _____
Other_____

As a result of my chiropractic care, I would like to ***(Please check all that apply)***

- ☐ Feel better quickly
- ☐ Have a healthier spine
- ☐ Have a healthier body by keeping my nerve system healthy
- ☐ Live a healthier lifestyle

_____ _____
Signature Date

2995 Baseline Road, Suite 110
Boulder, CO 80303
PH: 303.444.0192 FAX: 720.206.0982
info@wholebodybalance.com

WHOLE BODY BALANCE
Boulder's Complete Wellness Center

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Please read thoroughly, initial at each section and sign at the bottom. Thank You.

Guarantee of Payment

_____ I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of this health care facility.

Cancellation Policy

_____ 24 hour notice is required if you have to cancel your appointment, otherwise the full treatment price will be charged. Thank You.

Information about Possible Risk of Chiropractic Treatment

_____You have the right, as a patient, to be informed about your condition and the recommended integrative and complementary procedure to be used so that you make an informed decision whether or not to undergo the procedure after knowing the risks and hazard involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

Doctors of chiropractic, Medical Doctors and Physical Therapists using manual therapy treatment for patients with headaches and cervical spine (neck) complaints are required to explain that there have been rare cases of injury to a vertebral artery as a result of treatment. Such an injury has been known to cause a stroke, sometimes with serious neurological damage. The rare chance of this happening is estimated to be approximately from 1 to 400,000 treatments to 1 per 10 million treatments. Appropriate tests will be performed to help identify if you may be susceptible to this type of injury; you will be notified if that is the case. If you have any questions about this, please do not hesitate to speak with your practitioner.

As with any health care procedure, complications may arise during treatment. These complications include soreness, muscle or ligament sprain/strain, dislocation, fractures, disc injuries or physiotherapy burns. These are extremely rare occurrences.

Consent for Treatment

_____I authorize the performance of diagnostic tests, procedures and treatment deemed necessary by personnel involved in my care.

_____I authorize the performance of **Cold Laser Therapy** procedures if deemed necessary by personnel involved in my care. Unlike high-power medical lasers, Low Level Lasers (LLLs) or cold lasers penetrate the surface of the skin with little or no heating effect and no potential tissue damage. The energy is directed deep into treatment area stimulating the body's cells which convert the light energy into chemical energy to promote natural healing. These lasers are single wavelength in the red portion of the electromagnetic spectrum, and they travel in a straight line. They are polarized, meaning they concentrate energy to a defined spot and their power level is low ranging from 10-50,000 pulsed milliwatts.

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Financial Policy

Thank you for choosing Whole Body balance, Inc. as your health care provider. We are committed to the success of your care. Please understand that payment is considered part of your care. The following is a statement of our **Financial Policy**, which we require you to read and sign prior to any care.

WHOLE BODY BALANCE ACCEPTS CASH, CHECK, VISA, MASTER CARD, and DISCOVER.

Dr. Kevin Meyer is in-network with several private insurance plans, including Aetna, United Healthcare, and Cigna. Please note that it is ultimately your responsibility to understand what services are covered under your insurance policy. Please check your insurance policy to determine your coverage.

If you have insurance benefits, we are happy to process your insurance claims. To prevent any misunderstandings about your insurance coverage and our billing / collections procedure, we would like to inform our patients that we can not render services under the ASSUMPTION that we will be reimbursed by your insurance company. **Please understand that you will be fully responsible for all professional services that your insurance company does not pay.**

It is our policy to:

1. **Collect all co-pays at the time services are rendered.**
2. **Collect full payment for cash patients the day services are rendered. If payment is not collected on the day of service, the time of service discount will no longer apply and you will be billed the full standard fee.**
3. **Charge a late fee if payment is not received by the due date on the statement.**
4. **Charge a $25 late fee on all returned checks.**
5. **Charge for missed appointments at the rate of a normal office visit if the visit is not cancelled 24 hours prior to the appointment time. (Please help us serve you better by keeping scheduled appointments.)**

_____ Patient Initials

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Usual and Customary Rates

Whole Body Balance is committed to providing the best care for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

_____Patient Initials

Assignment of Insurance Proceeds

If you have insurance, please sign this assignment of benefits agreement. By agreeing to this assignment, we will direct your insurance company to make any payments for your chiropractic, physiotherapy, physical rehabilitation, diagnostic testing, or any other reimbursable treatment or evaluations you receive to our clinic directly.

In exchange for services and supplies rendered, I do assign to Whole Body Balance, Inc., any insurance proceeds, including accident and health insurance benefits and bodily injury claim awards up to the amount of any unpaid balance with interest as allowed by law.

Signature _____ Date _____

Records Release Authorization

You, Whole Body Balance, Inc. are authorized to release any information contained in my file to any insurance company, attorney, adjuster or member of my office staff, including any contracted billing services representing the clinic, in order to process any claim for reimbursement of charges incurred for supplies furnished to me or services rendered to me by you or another member of the clinic. I further authorize phone contact with the above listed third parties, should phone contact be required for the purpose of obtaining payment for charges outstanding.

Signature _____ Date _____

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Patient Name _____ ***Date*** _____

1. When did your symptoms start: _____ ***Describe your symptoms and how they began:***

_____

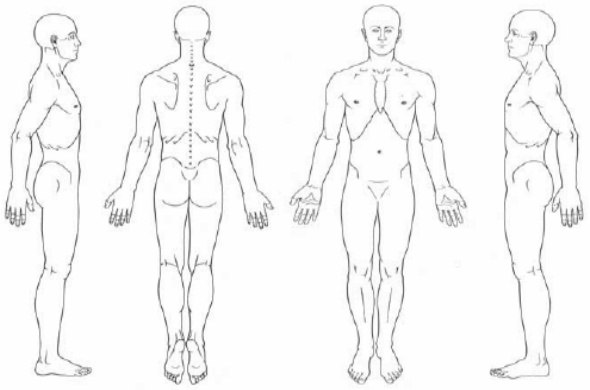
_____

2. How often do you experience your symptoms?
① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

3. What describes the nature of your symptoms?
① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?
① Getting Better
② Not Changing
③ Getting Worse

Indicate where you have pain or other symptoms



5. How bad are your symptoms at their:

	None										Unbearable
a. worst:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
b. best:	⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩

6. How do your symptoms affect your ability to perform daily activities?

⓪	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
No complaints		*Mild, forgotten with activity*		*Moderate, interferes with activity*		*Limiting, prevents full activity*		*Intense, preoccupied with seeking relief*		*Severe, no activity possible*

7. What activities make your symptoms worse: _____

8. What activities make your symptoms better: _____

9. Who have you seen for your symptoms?
① No One
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. When and what treatment? _____

b. What tests have you had for your symptoms and when were they performed?
① Xrays *date:* _____
② MRI *date:* _____
③ CT Scan *date:* _____
④ Other *date:* _____

10. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?
① This Office
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

11. What is your occupation?
① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

_____

a. If you are not retired, a homemaker, or a student, what is your current work status?
① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

12. What do you hope to get from your visit/treatment *(select all that apply):*
① Reduce symptoms
② Resume/increase activity
③ Explanation of condition/treatment
④ Learn how to take care of this on my own
⑤ How to prevent this from occurring again
⑥

Patient Signature _____ ***Date*** _____

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What type of regular exercise do you perform? ①None ②Light ③Moderate ④Strenuous

What is your height and weight? Height [ ][ ][ ] Weight [ ][ ][ ] lbs.
Feet *Inches*

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			
○	○	Low Back Pain	○	○	Angina	○	○	Smoking/Use Tobacco Products
						○	○	Drug/Alcohol Dependence
○	○	Shoulder Pain	○	○	Kidney Stones			
○	○	Elbow/Upper Arm Pain	○	○	Kidney Disorders	○	○	Allergies
○	○	Wrist Pain	○	○	Bladder Infection	○	○	Depression
○	○	Hand Pain	○	○	Painful Urination	○	○	Systemic Lupus
			○	○	Loss of Bladder Control	○	○	Epilepsy
○	○	Hip/Upper Leg Pain	○	○	Prostate Problems	○	○	Dermatitis/Eczema/Rash
○	○	Knee/Lower Leg Pain				○	○	HIV/AIDS
○	○	Ankle/Foot Pain	○	○	Abnormal Weight Gain/Loss			
			○	○	Loss of Appetite	***Females Only***		
○	○	Jaw Pain	○	○	Abdominal Pain	○	○	Birth Control Pills
			○	○	Ulcer	○	○	Hormonal Replacement
○	○	Joint Swelling/Stiffness	○	○	Hepatitis	○	○	Pregnancy
○	○	Arthritis	○	○	Liver/Gall Bladder Disorder	○	○	
○	○	Rheumatoid Arthritis						
			○	○	Cancer	***Other Health Problems/Issues***		
○	○	General Fatigue	○	○	Tumor	○	○	
○	○	Muscular Incoordination				○	○	
○	○	Visual Disturbances	○	○	Asthma	○	○	
○	○	Dizziness	○	○	Chronic Sinusitis			

Indicate if an immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○_____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

Patient Signature _____ ***Date*** _____

Doctor's Additional Comments

_____

_____

_____

Doctors Signature _____ ***Date*** _____

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Dr. Kevin's Chiropractic, INC and Whole Body Balance, we may use or disclose personal and health related information about you in the following ways:

*Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.

*Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are responsible for the payment of your services.

*Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with you r care.

Under Federal Law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

*If we are providing health care services to you based on the orders of another health care provider.

*If we provide health care services to you in an emergency.

*If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.

*If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

*If we are ordered by the courts or other professional agency.

Any use or disclosure of your protected health information, other as outlined above, will only be made upon your written authorization.

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We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like this information in a different form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: **Dr. Kevin Meyer, D.C.**
If you would like further information about our privacy policies and practices please contact our privacy officer **Dr. Kevin Meyer, D.C.** at **(303) 444-0192**.

This notice is effective as of _____. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have read and understand this notice.

_____ _____ _____
Name (Printed please) Signature Date

Authorization to Treat a Minor (under the age of 18)

I hereby request and authorize my doctor at this clinic to perform diagnostic tests and render chiropractic adjustment and other treatment to my minor son/daughter. This authorization also extends to include radiographic examination at the doctor's discretion. As of this date, I have legal right to select and authorize health care services for the minor child named above. Under the terms and conditions of my divorce (if applicable), separation or other authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify Whole Body Balance.

_____ _____ _____
Personal Representative Printed Personal Representative Signature Date

_____
Description of the authority to act on behalf of the patient.

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