



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](mailto:info@wholebodybalance.com)



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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 (LLs) 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 \_\_\_\_\_

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

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.

<input type="checkbox"/> Past	<input type="checkbox"/> Present	<input type="checkbox"/> Past	<input type="checkbox"/> Present	<input type="checkbox"/> Past	<input type="checkbox"/> Present
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Use Tobacco Products
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip/Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/> Knee/Lower Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss		
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite		
<input type="checkbox"/>	<input type="checkbox"/> Joint Swelling/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain		
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Ulcer		
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis		
<input type="checkbox"/>	<input type="checkbox"/> General Fatigue	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder		
<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination	<input type="checkbox"/>	<input type="checkbox"/> Cancer		
<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances	<input type="checkbox"/>	<input type="checkbox"/> Tumor		
<input type="checkbox"/>	<input type="checkbox"/> Dizziness	<input type="checkbox"/>	<input type="checkbox"/> Asthma		
		<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis		

**Females Only**  
 Birth Control Pills  
 Hormonal Replacement  
 Pregnancy

**Other Health Problems/Issues**

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 your 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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