Prater View Chiropractic and Health Clinic

PERSONAL HISTORY

First Name ________________________Middle Initial____ Last Name ________________________ Date _______________

Mailing Address ____

City______________________________ State_________ Zip_________________ E-mail Address _____________________

Date of Birth________________________ Sex: ☐ Male ☐ Female Social Security #_________________________________

Age____________________ Marital Status: ☐ M ☐ S ☐ D ☐ W ☐ SEP

Home Phone #____Cell Phone# ______________________________________

Employer ____ Occupation: ______________________________

Address____ City__________________ State________ Zip____________

Work Phone #_____________________________________

Emergency Contact___________________________________ Emergency Contact Phone # __________________________

How did you hear about us? ____

Have you seen a chiropractor before? ☐ Yes ☐ No

Approximately how long were your visits?___________________________________

Was that too long or not long enough? _____________________________________

RESPONSIBLE PARTY

First Name _____________________________ Middle Initial____ Last Name_______________________________________

Address____ City__________________ State________ Zip____________

Home Phone #____ Cell Phone # _____________________________________

Date of Birth________________________ Sex: ☐ Male ☐ Female Social Security #_________________________________

Age____________________ Marital Status: ☐ M ☐ S ☐ D ☐ W ☐ SEP

Employer ____ Occupation ______________________________________

Address____ City__________________ State________ Zip____________

Work Phone #_______________________________

INJURY STATUS

Reason for today's visit: ☐ Emergency ☐ New Injury ☐ Old Injury ☐ Chronic

Did your injury occur during: ☐ Sports/ Play ☐ Accident ☐ Routine/ Household activity ☐ Other________________________

When did your condition/ accident occur? ________________ **Where did your injury occur?** _______________________

Please explain what happened: ____

____

How often do you experience symptoms? (Circle one) Constantly Frequently Occasionally Intermittently

Describe your symptoms? (circle all that apply) Sharp Dull ache Numbing Burning Tingling Shooting

Is your condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

On a scale of one to ten how intense are your symptoms? Not intense ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

My condition is aggravated by:

□ Standing too long □ Sitting too long □ Driving □ Sneezing □ Coughing
□ Pulling □ Laying on my back □ Laying on my stomach □ Bending □ Bowel movement
□ Pushing □ Twisting □ Stooping □ Vacuuming □ Lifting over __________lbs.

Is your condition interfering with your: □ Work □ Sleep □ Daily Routine? If so, how: ___________________________________

____

CURRENT HEALTH CONDITION(S)

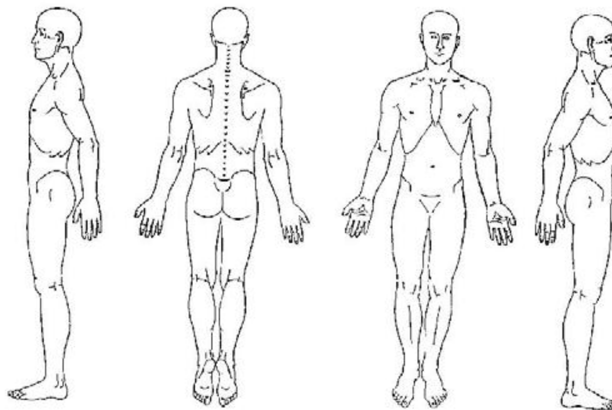
Using the adjacent body charts, please *circle* all affected areas.
What are your current health condition(s)?

1. ____
2. ____
3. ____

Have you been treated by another physician for this/these condition(s)?

□ Yes □ No If so, please list other Doctors:

1. ____
2. ____
3. ____



LEFT BACK FRONT RIGHT

List all prescription, non prescription medications and other supplements you take as well as the associated condition: _______

____

List any surgeries or hospitalizations you have had complete with the month and year for each: __________________________

____

Do you have or have you had any diseases, medical conditions or procedures? ____

____

List any past serious accidents with dates: ____

____

Please list anything that you may be allergic to (medicine/chemicals/etc): ____

____

Family Health History (list all major diseases such as cancer, diabetes, heart problems, bone/joint diseases and the relation to you of the individual):____

____

Previous X-rays taken? □ Yes □ No Areas: ____

Do you exercise? □ Yes □ No Hours per week_______________ What activity(s)? ____________________________________

Are you dieting? □ Yes □ No Since: ______________

Do you drink alcoholic beverages? □ Yes □ No _______________drinks per day

Do you smoke? Yes □ No ___________packs per day. How many years have you been smoking? _______________________

Do you wear? □ Heal lifts □ Arch supports □ Prescription Orthotics □ No If so who recommended them? _________________

For women:
Are you pregnant or nursing? □ Yes □ No If pregnant, how many weeks? ______________________________________

Date of last menstrual period: ____

INFORMED CONSENT FOR CHIROPRACTIC CARE

Prater View Chiropractic and Health Clinic
Darnell Simpson D.C.
Devin Simpson D.C.
118 S. Main St. Suite 400
Thayne, WY 83127

Phone: 307-883-7246
Fax: 307-883-7247

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays by the doctor of chiropractic named above.

Chiropractic examination and therapeutic procedures are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to: soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on side-effects and complications is available upon request. It is also our policy to inform you of the procedure being performed and the risks and alternative treatments available. If your physician does not explain to you satisfaction, please ask for more information.

I have read and understand the above statements regarding treatment side-effects. I also understand that there is no guarantee for specific cure or result.

Patient Signature   Date

Parent or Guardian   Date

Record Release and Assignment of Insurance Benefits

The undersigned hereby authorizes the Release of any information relating to claims for benefits submitted. I further agree and acknowledge that I authorize my physician to submit claims for benefits, for services rendered, without obtaining my signature on each claim.
I (patient) ________________________________ hereby authorize (Insurance Co.)________________ _____________ to pay and hereby assign directly to Dr. Darnell Simpson and/or Dr. Devin Simpson all owed benefits. I understand I am financially responsible for all charges incurred.

Patient Signature   Date

Prater View Chiropractic and Health Clinic
118 S. Main St. Suite 400
Thayne, WY 83127
Phone: 307-883-7246

Office and Financial Policy

Cost of Services	Charges	Time of Service Charge
Initial history and exam consult:	$50.00	$30.00
Chiropractic Manipulative Therapy (CMT)	$55.00	$35.00
Kinesio Taping	$55-75.00	$10.00
Ultra Sound	$30.00	$20.00
Electrical Therapy	$30.00	$20.00
Myofascial Release	$30.00	$20.00
Ice/Heat	$18.00	$6.00
Rehabilitation	$30.00	$20.00
Laser Therapy	$25.00	$15.00
Segmental Distraction	$25.00	$0.00
Sports Physical	$65.00	$35.00
DOT Physical	$90.00	$55.00
Massage (30 min.)	$60.00	$30.00
Massage (60 min.)	$120.00	$50.00
Children age 17 and under at a reduced cost		

Insurance
Prater View Chiropractic will file your insurance claim for you. We ask that you pay your co-pay, co-insurance and/or deductible at time of service. If payment is denied by your insurance company, you will be responsible for the amount not covered and a statement will be mailed to you. Your account may be assessed interest and/or late fees after 30 days.

Private Pay Customers: Payment in full is due at time of service for the discounted price. Payment arrangements must be made prior to appointment if you are unable to pay.

Collections: All accounts over 90 days past due or not in good standing will be turned over to our collection agency. Monthly payments must be made to keep your account current. Should collection become necessary, I/We agree to pay all attorney's fees, court costs, filing fees, and all collection costs up to 40% of the amount owing which may be assessed by any collection agency retained to pursue the matter. I/We further agree to pay a finance charge of 18% annual interest rate of the unpaid balances, or a minimum of $1.50.

Confidentiality
Your records or information about your case cannot be shared without your prior written permission. Your records will not be released to anyone without written approval of the patient or the responsible party of a minor.

Missed Appointments
We require at least 24 hours notice if you need to change or cancel your appointment. If you fail to keep your appointment, **or do not provide us with 24 hours notice**, you will be charged a $20.00 "broken appointment fee". Broken appointment fees must be paid prior to rescheduling your next appointment.

I have read the above statement and understand this office policy.

____

Patient Signature Date

____

Parent or Guardian if patient is a minor Date