WELCOME TO OUR OFFICE!

We are committed to providing you with the best care possible and are pleased to discuss our professional fees with you at any time. Your clear understanding of our policies is important of our professional relationship. Our office adheres to a strict "payment is due when services are rendered" policy. Thank you so much for your patronage.

- **Limited Release of Medical Information:** I authorize this Chiropractic office to make inquiries and to release any pertinent information to any insurance company, adjuster, attorney, or government agency to facilitate collections/reimbursements under these assignments.
- **Insurance Patients:** I understand that my health insurance is a contract between the insurance carrier and myself. I understand that I am ultimately responsible for any fees for services rendered that are not covered by my insurance company. I agree to pay my portion of fees at the time of treatment is rendered. I authorize my insurance benefits be paid directly to the physician. I also authorize this office or my insurance company to release any information required to process my claims. I understand that this office accepts billing for individual or group policies, personal injury cases, authorized worker's compensation and Medicare.
- **Missed Appointments:** In the event I am accepted for care in this office, I understand that it is vital to adhere to the recommended treatment plan. As a courtesy to others and to improve your results, our office has the following missed appointment policy: 1st offense: warning, 2nd offense: $10 fee. **Massage appointments require a 24 hour notice of cancellation**
- **Nonpayment:** Please be aware if your account becomes delinquent we may refer you to a collection agency. In this event, all collection agency fees and/or legal fees and any unpaid balance would be your responsibility.
- **No Guarantee of Results:** I recognize that this office can not guarantee the results of my health and that it is based upon my cooperation and my body's ability to recover.
- **Promotions and Discounts:** I understand that this office may attempt to assist me in my financial obligations for care needed by offering a promotion or discounted program if I prepay for my care. In the event I decide to not follow the recommendation for this care, I agree and understand that I would be liable for whatever services were rendered at the office's normal fee.
- **HIPPA Acknowledgement:** I have had the opportunity to read the HIPPA policies of this office.

I have read and understand the payment policies listed above and agree to abide by its guidelines:

Patient Name (please print): _____ Date: _____

Signature of Patient or Responsible Party_____ Date:_____

Note: This is a confidential record and will be kept in this office. Information contained here will not be released to anyone without authorization to do so.

AUTHORIZATION TO RELEASE X-RAYS AND INFORMATION

To _____

Address _____

I, _____Date of Birth _____ request the following information

☐ X-rays ☐ History ☐ Records ☐ Reports ☐ Diagnosis

concerning my ☐ Illness ☐ Accident ☐ Injury ☐ Other

To be released to:	**Dr. Mike Schloemp, D.C.** **Chandler Chiropractic Clinic** **2100 W Chandler Blvd, #34 Chandler AZ 85224** **480.899.9855 | Fax: 480.899.4655**

I understand that I have the right to receive a copy of this authorization upon my request. Accordingly, the patient or legal representative of a minor child has the right to require a health provider to release original x-rays on a loan basis to other providors within 15 days of a written request because the patient alone owns the information rights contained therein.

Signature _____ Date _____

☐ Patient ☐ Parent ☐ Spouse ☐ Guardian

Power of Attorney to Endorse Checks

KNOWN ALL MEN BY THESE PRESENT: That the undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint Chandler Chiropractic Clinic and any of it's duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders, which are made payable to the undersigned alone or to the undersigned and said Chandler Chiropractic Clinic, which checks, drafts, money orders are to pay for chiropractic services or the like , which have been made by Chandler Chiropractic Clinic at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

The undersigned by these presents does thus give and grant unto said Chandler Chiropractic Clinic as attorney the full power and authority to do and perform all and every act and thing whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said checks are concerned.

The undersigned does hereby and confirm any and all actions taken by the said attorney in accordance with this special power of attorney and which the said attorney shall do or cause to be done by virtue of these presents.

IN WITNESS WHEREOF the undersigned have herunto se their hands, this
_____ day of _____, 20_____.

_____ _____

Witness of Patient's Signature Patient's Full Name

_____

Signature of Patient

Chandler Chiropractic Clinic
2100 W Chandler Blvd, #34 Chandler AZ 85224
480.899.9855 | chandlerchiropractic.com

CONSENT FOR CARE OF A MINOR

I (we) being the parent or guardian of _____
A minor, at the age of _____ do herby consent, authorize and request all Doctors of Chiropractic at Chandler Chiropractic Clinic to administer such care deemed advisable, necessary or requested on the above minor.

I (we) agree to hold Chandler Chiropractic Clinic (Dr. Mike Schloemp, D.C.) free and harmless from any claims, suits for damages or complications, which may result from such care.

Signed _____

Date _____

Witness _____

Professional Fee Schedule

Consultation …… No Charge
Chiropractic Examinations ……$35-$145
Chiropractic Office Visit……..$50-$275
Chiropractic X-ray Studies ……$35-$275
Doctor/Patient Conference ……..$50
(All fees are standard and primarily based on our professional association guidelines.)

Our experience has shown that it is wise to have an understanding with our patients as to our office policies and fees. Therefore, this form has been prepared for your convenience and information. We offer several methods of payment for your chiropractic care in our office and you may choose the plan that best fits your needs. Please read carefully and choose the plan, which you prefer. This information will enable us to better serve you and help to avoid misunderstandings in the future. If special arrangements are necessary, please consult with the doctor. Our main concern is your health and well being, and we will do our best to help you.

PLAN #1 – INSURANCE: If you have insurance that covers chiropractic care, we will bill your insurance directly. Please bring us your insurance identification card on or before your first visit. Until we have completed necessary insurance information to verify chiropractic coverage, you are required to pay for your care. In the event the insurance check should come to you, you are expected to bring the check to us. Remember, insurance companies balk at "maintenance" and long-term rehabilitation. Usually you will not get much help after your initial corrective care. Most ordinary "health" policies are designed and intended to only take care of acute problems, so you should plan to "get off" insurance and be on your own when you get down to once a week or less (except, certain types of injuries.)

PLAN #2 – CASH: Fees are to be paid at the time services are rendered, unless special arrangements have been made in advance.

PLAN #3 –WEEKLY/MONTHLY CASH AGREEMENT: For those non-transient, but active patients who qualify, we will extend knowledgeable credit through this plan, however, should you become inactive by discontinuing your care, your entire unpaid balance will be due immediately. This plan applies to all cases, except Work Injury or Auto Injury claims.

PLAN #4 – CASH PRE-PAY: Ask Doctor for details.

PLAN #5 – INDUSTRIAL: You need to report your accident to your employer, bring in necessary insurance information, and sign industrial forms for billing by second visit. We will bill your insurance directly.

PLAN #6 –AUTO INJURY: You need to supply us with the accident report, your car insurance, health insurance and liable parties insurance and attorney if applicable. Until necessary insurance information is gathered and verified for chiropractic care, you will be required to pay for your care. We will bill your insurance directly after verification of coverage. In the event the check should come to you, you are required to bring the check to us.

I QUALIFY AND UNDERSTAND PLAN # _____ REQUIREMENTS

SIGNATURE _____ DATE _____

FAMILY HEALTH HISTORY

PATIENT _____ DATE _____

PLEASE INDICATE ALL THAT APPLY DR _____

	DAD	MOM	SIBLINGS				CHILDREN			
CONDITION	AGE ___	AGE ___	AGE ___	AGE ___	AGE ___	AGE ___	AGE ___	AGE ___	AGE ___	AGE ___
example	X			X			X			
Allergies										
Asthma										
Arthritis										
Back Pain										
Bursitis										
Cancer										
Constipation										
Diabetes										
Disc Problems										
Headaches										
High Blood Pressure										
Insomnia										
Migraines										
Nervousness										
Neuritis										
Pinched Nerves										
Scoliosis										
Sinus Infections										
Sinus Problems										
Stomach Problems										
Other										
Other										
Other										
Additional Notes										
Additional Notes										
Additional Notes										

Chandler Chiropractic | 2100 W Chandler Blvd, Chandler 85224 | 480.899.9855

Name _____Address: _____

City _____ State _____ Zip _____ Home # _____

Cell # _____Email _____

SSN _____Date of Birth _____ Age _____ Weight _____ Height _____

Male ❑ Female ❑ Single ❑ Married ❑ Divorced ❑ # of children _____Name of spouse (or parent) _____

Employer _____ Address _____

City _____State _____Zip _____Work # _____ Occupation _____

What is the name of your family physician? _____City Located? _____

Have you ever had Chiropractic care? ❑ Yes ❑ No If yes, doctor name: _____ Date of last visit _____

If you are experiencing any pain (neck, low back, etc.), health problems, symptoms, and/or complaints, please list in order of severity

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____
4. _____ For how long? _____

Has this problem been getting ❑ worse or ❑ Staying the same?
Currently or in the past have you ever experienced any of these complaints while working? ❑ Yes ❑ No If yes, please describe the activities at work may be causing these complaints: _____

Are there any other activities, incidents, or events outside of work that may have caused these complaints? ❑ Yes ❑ No
If yes, please explain _____

Have you at any time in the past ever suffered a work injury? ❑ Yes ❑ No If yes, what is the date of injury? _____

Do you have an attorney representing you for this work injury ? ❑ Yes ❑ No If yes, who is your attorney? _____

Have you been involved in an auto accident in the last 12 months? ❑ Yes ❑ No If yes, date of auto accident? _____

Do you have an attorney representing you for this auto accident? ❑ Yes ❑ No If yes, who is your attorney? _____

How many other passengers were in the car with you? _____

List other doctors consulted for these conditions: 1. _____ 2. _____

If due to an auto accident, what is the name of your auto insurance company? _____

Have you ever had any surgeries or hospitalizations? ❑ Yes ❑ No If yes, please list _____

Please list any current or past injuries and illnesses not listed above _____

Please check all medications (over the counter and/or prescribed) you are currently taking ❑ Asprin/tylenol ❑ Pain killers ❑ Insulin ❑ Muscle Relaxers ❑ Birth Control ❑ Sleeping pills ❑ Anti-depressants ❑ Other _____

The rating scale below is designed to measure the degree to which several aspects of your life are presently disrupted by your health condition (pain and/or symptoms you may be experiencing). In other words, we would like to know how much your health condition (pain and/or symptoms you may be experiencing) is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each of the six categories of daily living listed, PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES. 0 means no disability at all, and a score of 10 means that all of the activities in which you would normally be involved have been totally disrupted or prevented by your health condition (pain and/or symptoms you may be experiencing).

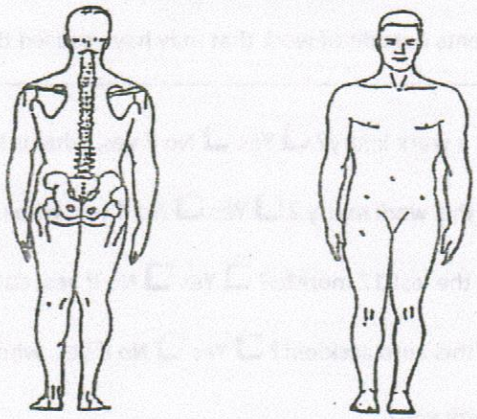
0 1 2 3 4 5 6 7 8 9 10

Completely able to function — Totally unable to function

1. FAMILY/HOME RESPONSIBILITIES: activities related to the home or family including chores and duties performed around the house (yard work, doing dishes, errands, favors for other family members, driving children to school, etc.) _____
2. RECREATION: hobbies, sports, and other similar leisure time activities. _____
3. SOCIAL ACTIVITY: activities which involve participation with friends and acquaintances other than family members including parties, theater, concerts, dining out, and other social functions. _____
4. OCCUPATION: activities that are a part of or directly related to one's job including nonpaying jobs as well, such as that of a homemaker or volunteer worker. _____
5. SELF CARE: activities which involve personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc.) _____
6. LIFE SUPPORT ACTIVITY: basic life supporting behaviors such as eating, sleeping, and breathing. _____

If you are experiencing any health problems, please mark the exact location of your pain on the diagram below. Also describe the type and frequency of your pain. For example, dull, sharp, constant, off and on, when standing, sitting, walking etc.

COMPLETE THESE DIAGRAMS



Method of payment for today's charges: ☐ CASH ☐ CHECK ☐ CREDIT CARD ☐ _____

NOTICE: NOT ALL PATIENTS REQUIRE X-RAYS TO DETERMINE TYPE OF CARE AND LENGTH OF CARE. IF YOUR EXAMINATION WARRANTS X-RAY ANALYSIS, THE FOLLOWING OFFICE POLICY PREVAILS:

1. All first visit charges are payable when services are rendered.
2. The fee paid for x-rays is for analysis only. We are required to maintain your original x-rays. Films may be loaned to another health provider with your prior authorization only.

Patient's Signature _____ Date _____