Malchar Chiropractic Wellness Center Patient Registration and History

Patient Information

Date____/____/_____

Patient_____ DOB____/____/____ Age_____ ☐Male ☐Female ☐Mr. ☐Mrs. ☐Ms. ☐Dr.

Address_____ City_____ State_____ Zip_____

Home Phone #_____ ☐ Social Security #_____-_____-_____

Cell Phone #_____ ☐ Occupation_____

Email _____ ☐ Employer_____

Marital Status ☐Single ☐Married ☐Divorced ☐Widowed City_____ State_____ Zip_____

Emergency Contact

Name_____ Phone_____ Cell_____ Relationship_____

Insurance Information

Insured's Name_____ Company Name_____ Phone_____

Insured's ID #_____ Group #_____ Relation to Insured_____

Please be sure to provide the front desk with ALL health Insurance and Photo IDs

Assignment and Release

I assign directly to Malchar Chiropractic all medical 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 the insurance. I hereby authorize the use of this signature on all of my insurance submissions whether manual or electronic. Furthermore, I authorize the release of my medical records to secure payment and/or to receive medical information pertaining to my case in the facility.

_____ _____ _____ ____/____/____

Responsible Party Name Responsible Party Signature Relationship Date

Accident Information

Is this condition due to an accident? ☐Yes ☐No What type of accident? ☐Auto ☐Work ☐Home ☐Other

Date of injury ____/____/____ Auto Insurance Company_____ Policy_____

To whom have you submitted a claim? ☐Auto Insurance ☐Employer ☐Worker Comp. ☐Other_____

Attorney Name_____ Attorney Contact Information_____

Additional Information

Were you referred to our office? ☐Yes ☐No If yes, who should we thank?_____

How did you find our office if not by referral?_____

Are you pregnant? ☐Yes ☐No Are you nursing? ☐Yes ☐No Due Date____/____/____ Comments_____

Have you been to a chiropractor before? ☐Yes ☐No Was it for a similar complaint?_____

Chiropractic care focuses on influencing the nervous system by detecting and correcting vertebral subluxation. Subluxations are caused by physical, chemical and emotional stressors to the body. Please complete the following sections below so that we may have a better understanding of your current health status and the nature of the situation that brought you into our office.

Primary Condition

Primary reason for visit_____

How did this occur?_____ ☐Gradual ☐Sudden

Please mark the regions of pain on the diagram →

Have you experienced this before? ☐Yes ☐No If yes, when?_____

What made it better?_____

How long have you had this issue? ☐Years ☐Months ☐Weeks ☐Days

What type of pain? ☐Aching ☐Burning ☐Dull ☐Numbness ☐Sharp
☐Shooting ☐Throbbing ☐Tightness ☐Tingling

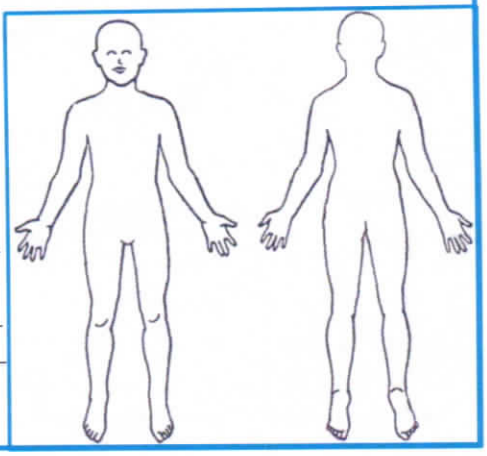
What makes the symptoms worse?_____

What makes the symptoms better?_____

Have you seen anyone else for this complaint?_____

What time of the day is the most noticeable?_____

Please rate your pain (circle one) 1 2 3 4 5 6 7 8 9 10
(0=no pain, 10= worst pain imaginable)



Secondary Condition

Secondary reason for visit_____

How did this occur?_____ ☐Gradual ☐Sudden

Please mark the regions of pain on the diagram →

Have you experienced this before? ☐Yes ☐No If yes, when?_____

What made it better?_____

How long have you had this issue? ☐Years ☐Months ☐Weeks ☐Days

What type of pain? ☐Aching ☐Burning ☐Dull ☐Numbness ☐Sharp
☐Shooting ☐Throbbing ☐Tightness ☐Tingling

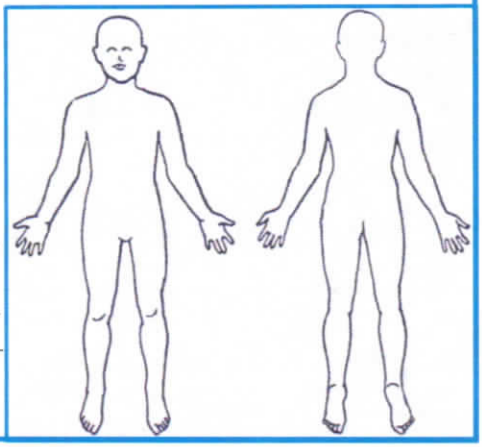
What makes the symptoms worse?_____

What makes the symptoms better?_____

Have you seen anyone else for this complaint?_____

What time of the day is the most noticeable?_____

Please rate your pain (circle one) 1 2 3 4 5 6 7 8 9 10
(0=no pain, 10= worst pain imaginable)



Daily Activities

Please select an option for each item →

Has this condition effected your ability to perform your daily activities? ☐Yes ☐No

What activities are the most effected?

_____

_____

What is your motivation for seeking care in our office?

_____

_____

_____

How committed are you to resolving this condition?
0 1 2 3 4 5 6 7 8 9 10
(0=no commitment, 10=full commitment)

Bathing	☐No Effect	☐Painful	☐Pain Limited	☐Unable to Perform
Carrying	☐No Effect	☐Painful	☐Pain Limited	☐Unable to Perform
Climbing Stairs	☐No Effect	☐Painful	☐Pain Limited	☐Unable to Perform
Computer Use	☐No Effect	☐Painful	☐Pain Limited	☐Unable to Perform
Chores	☐No Effect	☐Painful	☐Pain Limited	☐Unable to Perform
Concentration	☐No Effect	☐Painful	☐Pain Limited	☐Unable to Perform
Dressing	☐No Effect	☐Painful	☐Pain Limited	☐Unable to Perform
Excercising	☐No Effect	☐Painful	☐Pain Limited	☐Unable to Perform
Lifting Children	☐No Effect	☐Painful	☐Pain Limited	☐Unable to Perform
Pet Care	☐No Effect	☐Painful	☐Pain Limited	☐Unable to Perform
Playing	☐No Effect	☐Painful	☐Pain Limited	☐Unable to Perform
Sexual Activity	☐No Effect	☐Painful	☐Pain Limited	☐Unable to Perform
Sitting	☐No Effect	☐Painful	☐Pain Limited	☐Unable to Perform
Standing	☐No Effect	☐Painful	☐Pain Limited	☐Unable to Perform
Walking	☐No Effect	☐Painful	☐Pain Limited	☐Unable to Perform

Health History - select all that apply

- ☐ Recent Accident
- ☐ Muscle Spasm
- ☐ Numbness
- ☐ Tingling
- ☐ Radiating Pain
- ☐ Headaches
- ☐ Depression
- ☐ Anxiety
- ☐ Dizziness
- ☐ Vision Problems
- ☐ Nausea
- ☐ Restricted Movement
- ☐ Sleeping Problems
- ☐ Fatigue
- ☐ Recent Weakness
- ☐ Asthma
- ☐ Breathing Problems
- ☐ High Blood Pressure
- ☐ Hearing Problems
- ☐ Convulsions
- ☐ Heartburn/AcidReflux
- ☐ Allergies
- ☐ Digestive Problems
- ☐ Menstrual Problems
- ☐ Sinus Problems
- ☐ Shoulder Problems
- ☐ Hip/Leg Discomfort
- ☐ Jaw/Mouth Problems
- ☐ HIV/AIDS
- ☐ Tuberculosis
- ☐ Bone/Joint Disorder
- ☐ Degenerative Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Compression Fracture
- ☐ Heart Attack
- ☐ History of Stroke
- ☐ Cancer
- ☐ Diabetes
- ☐ Gout
- ☐ Lupus
- ☐ Lyme Disease
- ☐ Immune Suppression
- ☐ Shingles
- ☐ Anemia
- ☐ Colds/Flu
- ☐ Loss of bladder control
- ☐ Fever > 103℉
- ☐ Neck Stiffness with pain
- ☐ Numbness of thighs
- ☐ Poor balance
- ☐ Leg pain that worsens with exercise
- ☐ Back pain with urinary problems
- ☐ Severe pain that interrupts sleep
- ☐ Constant pain that won't improve
- ☐ Blood in urine or stool
- ☐ Psychiatric Problems

Family Medical History

Mother_____ Maternal Grandmother_____ Maternal Grandfather_____

Father_____ Paternal Grandmother_____ Paternal Grandfather_____

Siblings_____ Offspring_____

Social History

Smoking Status ☐ Never Smoked ☐ Former Smoker ☐ Occasional Smoker ☐ Everyday Smoker | Packs/day____ Year____

Race ☐ American Indian ☐ Asian ☐ Black or African American ☐ White or Caucasian ☐ Pacific Islander ☐ Decline to Specify

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I decline to specify

Medication History

Are you currently taking any medications? ☐ Yes ☐ No

Are you allergic to any medications? ☐ Yes ☐ No

_____

_____

Medication	Dosage	Frequency

Primary Care Information

Primary Care Physician_____ Office Phone_____ Date of last exam____/____/____

Date of Last ☐ X-Ray ___/___/___ ☐ Bloodwork___/___/___ ☐ Urine test ___/___/___ ☐ MRI/CT ___/___/____

Please list any major and minor surgery you have had, with dates _____

☐ **I choose to decline receipt of my clinical summary after every visit** (summaries are often blank)

By signing below, I certify that ALL information provided on these forms is true to the best of my knowledge.

Printed Name _____ Signature _____ Date _____

Office Use Only

Height_____ Weight_____ Blood Pressure L ____/____ R____/____

Patient Name: _____ D.O.B.: _____ Date: _____

Financial Policies

❑Self-Pay: Patients without health coverage are expected to make payment in full at the time services are rendered. Any Time of Service and Plan Discounts can only be applied to services paid at the time the services/plans are rendered/initiated. Any billed charges are due and payable within ten days. A service charge of 18.00% per annum may be applied to all unpaid balances over thirty days. Financial Hardship is only available upon proof of said hardship and exclusively at the discretion of the doctor.

❑Health Insurance: Co-payments, Co-insurance and Deductible amounts are due at the time services are rendered. Services that are not covered by your health plan are due at the time services are rendered. Services rendered beyond your policy limits that are your responsibility are due within ten days. Any amounts not covered by your health plan that are your responsibility are due within ten days. A service charge of 18.00% per annum may be applied to all unpaid balances over thirty days.

❑Medicare: Co-Insurance is due at time of service when no secondary insurance coverage is available or benefits cannot be verified. Services not statutorily covered by the Medicare Program are due at the time services are rendered. An Advance Beneficiary Notice will be required for all services not covered or not believed to be covered. Deductibles will be billed and shall be due within ten days. A service charge of 18.00% per annum may be applied to all unpaid balances over thirty days.

❑Medicaid: Coverage must be in effect and able to be verified by our office. Only services covered under the specific Medicaid Policy will be available for coverage. Any services not covered under your Medicaid Policy will be due at the time services are rendered and will not be billable to the Medicaid Program. A service charge of 18.00% per annum may be applied to all unpaid balances over thirty days.

❑Auto / PIP: Assignment will be accepted on Personal Injury Protection benefits only when the following has been satisfied:

- A PIP application has been returned to the PIP Carrier.
- A copy of automobile insurance declaration page or Coverage Selection page has been provided for the vehicle you were in at the time of the accident.
- A copy of your health insurance card (both sides) has been provided if applicable.
- Signed an irrevocable lien.

In the event Benefits have been terminated for any reason, **Malchar Chiropractic Wellness Center** has the right to discontinue assignment of benefits. A service charge of 18.00% per annum may be applied to all unpaid balances over thirty days of being due and payable.

Patient Name: _____ D.O.B.: _____ Date: _____

Financial Policies Continued

❑Personal Injury: Assignment will only be accepted on Personal Injury / Slip and Fall cases when you the patient have signed an irrevocable lien **and** your attorney has countersigned the lien agreeing to protect any unpaid balance due and make payment directly to our office. All services rendered are due at the time of disposition of the case whether in your favor or not. All unpaid balances that are not paid within 30 days of the conclusion of a case will incur a service charge of 18.00% per annum.

❑Workers Comp. - Assignment of benefits may be accepted only when the Utilization Review Information is provided to allow our office to request approval of a treatment plan. A valid claim and claim information must also be provided by you (the patient). A service charge of 18.00% per annum may be applied to all unpaid balances over thirty days

I have read and understand the above Financial Policy. I fully understand that I am ultimately responsible for payment of all services and any costs associated with the collections including but not limited to attorney's fees for any balance due at to the above office and doctor.

_____ _____

Signature of patient or authorized representative Date

_____ _____

Authorized Representative Name Printed Relationship to patient

Patient Name:
Patient D.O.B.:
Patient Number:

Informed Consent for Chiropractic Services

I have been informed of the following:

1. That the process of delivering a "Chiropractic Adjustment (manipulation)" may be performed manually or with an instrument to the vertebra(e) of the spine and/or associated structures (legs, arms etc.), often resulting in an audible pop or click sound;
2. As an addition to the Chiropractic Adjustment "Supportive Therapies" may be applied by the chiropractor or by staff under their direction or supervision incorporating the use of light, sound, vibration, electricity, traction, motion, bracing, nutritional advice, heat, or cold;
3. I have been informed on occasion some temporary soreness and/or stiffness may occur; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely bruising, swelling, even more rare separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a Chiropractic Adjustment. The listed possible consequences and possible complications have been explained to me by the chiropractor;
4. I acknowledge that the chiropractor has made no guarantee of a positive outcome from treatment;
5. I have been afforded ample opportunity for questions and answers; and
6. The condition, possible benefits, risks of the treatment procedures, options, and financial obligations have been explained to me by the chiropractor.

Therefore by signing below:

I consent to the performance of the diagnostic and therapeutic procedures performed by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

I consent to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

Patient Signature:_____ Date:_____

Witness Signature:_____Date:_____

2023/2024 Non-Covered Fee Disclosure

Please note the following services are expenses not covered by insurance.

Orthotics*

$255.00 - $450.00

Cold Laser*

1 Session: $30.00

Celluma*

1 Session: $25.00

Zyto*

1 Session $65.00

BioCharger*

1 Session $ 35.00

NeuroCare Pro*

1 Session $65.00

iTovi*

1 Scan $15.00

Erchonia Laser*

1 Session $35.00

StemWave*

1 Mapping visit $49.00

***Can be paid for via HSA/FSA/CareCredit**

Cash Patient Office Visits*

Initial Appointment ½ Hour - $155.00

Follow Up Appts - $55.00

Re-Exam Appt - $80.00

Nutritional / TBM Visits*

Initial Appointment 1 Hour $180.00

Follow Up ½ Hour Appointment $105.00

Supplements are not included in the price. If any supplements to be shipped, there is additional fee of $10.00.

Forms

TDI / Disability Paperwork - $10.00

Medical Records - $1.00 per page up to 25 pages then $.50 per additional page

Copy of Previously Sent/Requested Records - $15.00

Fax Fee - $1.00 first page then $.50 per additional page

Medicare Active Patient Non-Covered Fees

New Patient Exam - $80.00

Re Exam (Every 30 Days) - $35.00

Electro Stimulation Unit - $45.99 + tax (Once a Year)

Electro Stimulation (staff performed) - $20.00 per visit

Please Review back page and make personal selections.

The nature of our practice is one of total wellness solutions for our Patients. This often means our Doctors and/or Staff will make nutritional or alternative healthcare recommendations. These recommendations may come at an additional cost not covered by health insurance. Please check the appropriate box below.

- ☐ I choose to accept Doctor and/or Staff recommendations and nutritional/ alternative healthcare advice, even when it may or may not be at additional cost. (Total Wellness Patient)
- ☐ I choose to decline Doctor and/or Staff recommendations and nutritional/ alternative healthcare advice, even when it may or may not be at additional cost. (Traditional Chiropractic Patient)

_____ _____

Patient Signature Date

Please note that bloodwork review will automatically be added to any ROF or Follow Up the Doctor deems medically necessary. To decline review of bloodwork during report of findings or follow-ups please check the appropriate box below.

- ☐ I choose to accept review of any/all Bloodwork
- ☐ I choose to decline review of any/all Bloodwork

_____ _____

Patient Signature Date

Please Indicate that you have read and understand the information presented to you on this document.

- ☐ I understand the information on this document

_____ _____

Patient Signature Date