JOHN RIEGLEMAN, D.C.
Mayville Chiropractic Center

PATIENT OFFICE POLICY

The purpose of this patient office policy is to allow us to better serve you and to get the best results in the shortest period of time. It is our experience that those who adhere to the following policies get the best results.

Signing In

When you arrive, please sign in at the front desk. You will be called and assigned a treatment room in the order you signed in. Other patients may be called before you because of the particular services being received that day or their doctor may be available before yours. When you go to the assigned treatment room, rest, relax and the doctor will be in as soon as possible.

New Injuries

In the event you sustain a new injury, please let the front desk coordinator know as soon as possible. There may be additional paper work to be filled out.

Appointments

After your visit, please see the front desk coordinator to make or confirm your next appointment.

New Patient Health Orientation

It is strongly suggested that all patients attend our New Patient Health Orientation. This explains how the body functions, how chiropractic works and most importantly, how you can expedite the healing process. Family and friends are encouraged to attend.

Payment of Bills

We will expect that you honor all financial agreements made with our office. If you find that you cannot fulfill your financial obligation, notify our office manager immediately so that new arrangements can be made. Our policy is that patients maintain a zero personal balance. Insurance companies are expected to pay their portion within 45 days of claim submission. If they do not, we expect you to call your insurance company and help get the claim paid. If an insurance company sends a check to your home, it should be brought or sent to our office as soon as possible. Please also bring in the attached explanation of benefits.

Rescheduling Appointments

We set up specific treatment schedules for our patients. A certain number of treatments in a set amount of time are required for us to get the results we both desire. If you need to change this time, please reschedule your appointment for another time. If the same day is not possible, be sure to make up the missed appointment within one week.

Progress Evaluations & Re-examinations

Progress evaluations & re-examinations will be performed periodically to determine your rate of progress and future course of treatment. There is a fee for all progress evaluations. A special time will be set up for your re-evaluation appointments.

Upsets

We are here to serve you. Please speak with the staff or doctor about anything that could be upsetting you (e.g., long waits, treatment confusion). We see your comments as helping us to help you and others.

I, _____ (print patient name) have read, understand and agree to the above patient office policy.

_____ _____

Patient Signature Date

JOHN RIEGLEMAN, D.C.
Mayville Chiropractic Center

Patient File #: _____ **Today's Date:** _____ / _____ / _____

WELCOME: The doctor and staff welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to our care, we will refer you to the appropriate healthcare provider. If you are a candidate for care in this office, then a treatment plan will be recommended to fit your individual needs.

INSTRUCTIONS: Please complete the following information in its entirety. The information submitted on this form is strictly confidential. If you have difficulty understanding any portion of this form, please ask the receptionist for assistance. If the question does not pertain to you, simply write in N/ A for non-applicable.

PERSONAL INFORMATION:

Name: *(First)* _____ *(Middle)* _____ *(Last)* _____ Jr., II, III, IV
Address: _____ City: _____ State: _____ Zip: _____
Birth Date: ___ / ___ / ___ Age: _____ Marital Status *(Circle)*: Divorced Married Single Separated Widowed
Gender *(Circle)*: Male / Female Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____
Social Security #: _____ - _____ - _____ Email Address: _____ @ _____
Spouses Name: _____ Names & Ages of Children: _____
Is your spouse a patient in our office? ❑ **Yes** ❑ **No**

Employer/Employment Status ❑ Employed ❑ Unemployed ❑ Full Time / ❑ Part Time Student ❑ Other
Business Name: _____ Occupation/Job Title: _____
Business Address: _____
Business Phone: (_____) _____ - _____ Type of Work: _____
Is it ok to contact you at work? ❑ Yes ❑ No

Emergency Contact Information

Name: *(First)* _____ *(Middle)* _____ *(Last)* _____ Jr., II, III, IV
Address: _____ City: _____ State: _____ Zip: _____
Relationship _____ Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____
Your Primary Care Physician: _____ Physician Phone: (_____) _____ - _____

Insurance Information

GENERAL INSURANCE INFORMATION: Who besides yourself is responsible for your bill? ❑ Worker's Comp
❑ Auto Insurance ❑ Medicare ❑ Medicaid ❑ Other *(Be Specific)*: _____
Personal Health Insurance Carrier: _____ Health ID Card #: _____
Insured Person's Name: _____ Group #: _____
Insured Person's Date of Birth: _____ / _____ / _____ Insured Person's Social Security #: _____ - _____ - _____

ACCEPTANCE AS A PATIENT:

I understand and agree that office has the right to refuse to accept me as a patient at any time before treatment begins, or terminate my care as a patient if in the course of treatment I am not following the treatment plan for my condition, or be referred out to another health provider as the doctor deems medically necessary. I understand that the taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

PERSONAL INFORMATION:

Have you ever had surgery or been hospitalized? *Yes / No* **List Surgeries:** _____
Please list any past serious accidents, injuries, or motor vehicle accidents with dates: _____
Please list any medications or vitamins you are currently taking: _____
Please list anything that you may be allergic to: _____

Do you have, or have you ever had any of the following health problems? **(Check all that apply)**

____ Headaches ____ Achiness / General Pain ____ High / Low Blood Pressure ____ Auto Accidents
____ Migraine ____ Difficulty Concentrating ____ Excessive Sweating ____Other Accidents/Falls
____ Neck Pain / Stiffness ____ Memory Loss / Forgetful ____ Stomach Problems ____ Sports Injuries
____ Shoulder Pain / Stiffness ____ Frequent Colds / Flu ____ Nausea ____ Work Injuries
____ Numbness / Tingling Arm(s) ____ Nervousness ____ Ulcers ____ Fainting
____ Elbow Pain / Stiffness ____ Irritability ____ Liver / Gall Bladder Problems ____ Depression
____ Wrist / Hand Pain or Stiffness ____ Diabetes ____ Kidney Problems ____ Mood Disorder
____ Upper Back Pain or Stiffness ____ Cancer ____ Digestion Problems ____ Emotional Disorders
____ Mid Back Pain or Stiffness ____Vision / Eye Problems ____ Diarrhea Tension
____ Low Back Pain or Stiffness ____ Hearing / Ear Problems ____ Constipation __ Stress
____ Hip Pain or Stiffness ____ Ear Infections ____ Bladder Problems ____ Anxiety
____ Knee Pain or Stiffness ____ Sinus Problems ____ Incontinence ____ Poor Diet
____ Ankle/Foot Pain or Stiffness ____ Thyroid Problems ____ Impotence ____ Pain w / coughing
____ Pain shooting down leg(s) ____ Allergies ____ Prostate Problems ____ Pain w/ sneezing
____ Trouble Walking ____ Asthma ____ Bed Wetting ____ Pain at stools
____ Sore Muscles ____ Trouble Breathing ____ Menstrual Problems (PMS) ____ Restricts Daily Activity
____ Painful Joints ____ Heart Problems ____ Fractured Bones ____ Restricts Exercise
____ Tiredness / Fatigue ____ Circulation Problems ____ Dizziness ____ Unable to Work
____ Other Problems not listed: _____

1. List all of your symptoms/complaints/conditions here: Low Back Pain, Neck Pain, Right Shoulder Pain, etc.
   Chief Complaint: _____
   _____
   2nd Complaint: _____
   _____
   3rd Complaint: _____
   _____
   4th Complaint: _____
   _____
2. Describe the quality of your symptoms: ❑ Burning Pain ❑ Diffuse ❑ Dull/Aching ❑ Localized ❑ Radiating ❑ Sharp ❑ Shooting ❑ Stabbing ❑ Throbbing ❑ Tightness ❑ Tingling ❑ Other_____
3. How would you describe your current symptoms: ❑ Pain ❑ Numbness ❑ Stiffness ❑ Weakness

4a. On a scale of 0 to 10, zero being the lowest level and ten being the highest, how would you rate the effect your primary condition has **on your daily functioning when you are at rest?** *(Circle)* 0 1 2 3 4 5 6 7 8 9 10

4b. On a scale of 0 to 10, zero being the lowest level and ten being the highest, how would you rate the effect your second condition has **on your daily functioning when you are at rest?** *(Circle)* 0 1 2 3 4 5 6 7 8 9 10

4c. On a scale of 0 to 10, zero being the lowest level and ten being the highest, how would you rate the effect your third condition has **on your daily functioning when you are at rest?** *(Circle)* 0 1 2 3 4 5 6 7 8 9 10

4d. On a scale of 0 to 10, zero being the lowest level and ten being the highest, how would you rate the effect your fourth condition has **on your daily functioning when you are at rest?** *(Circle)* 0 1 2 3 4 5 6 7 8 9 10

4e. On a scale of 0 to 10, zero being the lowest level and ten being the highest, how would you rate the effect your fifth condition has **on your daily functioning when you are at rest?** *(Circle)* 0 1 2 3 4 5 6 7 8 9 10

5a. On a scale of 0 to 10, zero being the lowest level and ten being the highest, how would you rate the effect your primary condition has **on your daily functioning when you are active?** *(Circle)* 01 2345678910

5b. On a scale of 0 to 10, zero being the lowest level and ten being the highest, how would you rate the effect your second condition has **on your daily functioning when you are active?** *(Circle)* 0 1 2 3 4 5 6 7 8 9 10

5c. On a scale of 0 to 10, zero being the lowest level and ten being the highest, how would you rate the effect your third condition has **on your daily functioning when you are active?** *(Circle)* 0 1 2 3 4 5 6 7 8 9 10

5d. On a scale of 0 to 10, zero being the lowest level and ten being the highest, how would you rate the effect your fourth condition has **on your daily functioning when you are active?** *(Circle)* 0 1 2 3 4 5 6 7 8 9 10

5e. On a scale of 0 to 10, zero being the lowest level and ten being the highest, how would you rate the effect your fifth condition has **on your daily functioning when you are active?** *(Circle)* 0 1 2 3 4 5 6 7 8 9 10

6. When did this condition originally begin? _____
7. Is your condition currently: ❑ Worsening ❑ Improving ❑ Unchanged?
8. If you condition has worsened or is worsening, when did the increased symptoms start?_____
9. When was the last time you experienced these symptoms?

10. Is your condition worse in the: ❑ Morning ❑ Afternoon ❑ Night ❑ With Activity and is it mostly: ❑ Intermittent ❑ Constant throughout the day.
11. Is your condition better in: ❑ Warm Temp ❑ Cold Temp ❑ Neither
12. Is your condition worse in: ❑ Warm Temp ❑ Cold Temp ❑ Damp ❑ None
13. Check any of the following ???? symptoms that are associated with your current condition:
    ❑ Headaches (Describe your headaches in detail): _____
    ❑ Blurred Vision ❑ Depression ❑ Dizziness ❑ irritability / Mood Swing ❑ Ringing in the ears ❑ Fainting ❑ Confusion ❑ Loss of Concentration ❑ Loss of Smell ❑ Localized Tingling ❑ Nausea ❑ Ringing in Ears ❑ Stiffness ❑ Problems Sleeping ❑ Radiating Pain/Sensation (Describe the location and type of sensation): _____
    ❑ Weakness (Describe the location): _____ ❑ Aches ❑ Cold Limb ❑ Dizziness ❑ Ecchymosis ❑ Fatigue ❑ Fever ❑ Heartburn ❑ Muscle Spasm ❑ Nausea ❑ Numbness ❑ Pale Bluish Skin ❑ Panic ❑ Pins & Needles ❑ Runny Nose ❑ Short Breath ❑ Stiffness ❑ Sweating ❑ Swelling ❑ Tingling ❑ Vomiting ❑ Others Not Listed (Describe): _____
14. Do your symptoms seem to be better with: ❑ Nothing ❑ Activity ❑ Bending ❑ Cold ❑ Heat ❑ Massage ❑ Movement ❑ Over-The-Counter Medications ❑ Prescription Medications ❑ Rest ❑ Stretching ❑ Sitting ❑ Standing ❑ Twisting ❑ Walking

PAST HEALTH HISTORY

This section will identify key factors and indicators about your history that may impact or contribute to your current health condition. Please give us information on any below that apply to you.

15. Please list any medications or nutritional supplements that you are currently taking: _____
16. Please list any other doctors or providers that you have seen for this condition or for any conditions that you may be currently treating and the type of treatments provided: _____
17. Childhood Illnesses (Please list any illnesses that you have had as a child): _____
    _____
18. Adult Illnesses (Please list any illnesses that you have had as a child): _____
19. Surgeries (Please list all surgical procedures that have had in the past): _____
20. Injuries (Please list any significant injuries, falls, trauma, accidents that you have had in the past): _____
    _____
21. Immunizations (Please list any vaccinations that you have had): _____
22. Non Drug Allergies and how you react to those substances: _____

Is there any other information that you feel would be relevant to your current condition that was not covered? Please explain in the following section any information that you feel would be helpful to the doctor in reviewing your case.

_____
_____
_____
_____
_____

FINANCIAL INFORMATION

Authorization for Release of Information

I authorize the release of any medical information necessary to process my insurance claims.

Authorization of Assignment

I authorize payment of medical benefits to _____ for services rendered to me.

Reimbursement Policy

We often do not know exactly what your insurance company will pay us until we receive payment. Either way, we usually accept their payment after any deductible, co-payment and co-insurance is handled. Please understand that your insurance is an agreement between you and your insurance company and all services rendered to you are ultimately your responsibility.

_____ _____

PATIENT SIGNATURE **DATE**