

Welcome to Diegel Chiropractic

Robert W. Diegel D.C. 49780 Van Dyke Avenue Shelby Twp, MI 48317
(586) 254-2060

How did you hear about this practice? _____

TELL US ABOUT YOURSELF

Name: _____ Date of Birth: _____ (Age: _____)

Gender: Male Female Marital Status: S M D W Height: _____ Weight: _____

Number of Children and Ages: _____

Street: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

Email: _____ SSN: _____ - _____ - _____

Occupation: _____ Employer: _____

Insurance Carrier: _____

HEALTH HABITS

Yes No Do you exercise? How much/often? _____

Yes No Do you drink water? How much/often? _____

Yes No Do you smoke? How much/often? _____ When did you start? _____

Yes No Do you drink alcohol? How much/often? _____

Yes No Are you currently under medical care? Who is your Doctor? _____

Yes No Taking any prescription drugs? Name/quantity _____

Yes No History of trauma? (e.g. car accidents, fall, etc.) Explain: _____

Yes No Any surgeries? Explain all: _____

Yes No Any allergies? Explain all: _____

Yes No Any recreational drug use? What, how much/often? _____

Yes No Do you drink coffee/tea? How much/often? _____

Yes No Do you eat enough vegetables? How much/often? _____

Yes No Do you get enough good sleep? How much/often? _____

Yes No Are you stressed? Rate your stress level (0-10; 10 being the most): _____

Yes No Do you consider yourself truly "healthy"?

Yes No Are you willing to WORK for BETTER HEALTH?

WHAT IS WRONG?

Primary reason for this visit: _____

When did this begin? _____

The pain is getting: Better Worse Same

The pains are: Constant Intermittent

Describe the pain: Dull Achy Sharp Stabbing

Burning Numbness Tingling

Other: _____

Rate the pain from 0-10 (0-no pain; 10-worst pain): _____

Is it worse at certain times of the day?: Yes No

If so, when? _____

What makes it better? _____

What makes it worse? _____

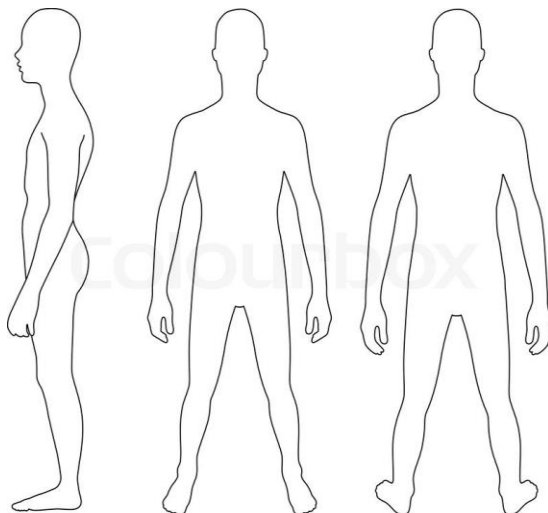
Other health care professionals seen for this condition: _____

Is this a Work Related injury? Yes No Is this an Auto Related injury? Yes No

Other Symptoms:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Flushed Face | <input type="checkbox"/> Depression | <input type="checkbox"/> Cold Hands |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Pins and Needles in Legs | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Upset Stomach |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins and Needles in Arms | <input type="checkbox"/> Fever | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Night Pain |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Fainting | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Loss of Appetite |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Light Headed |

Circle the area(s) of discomfort



FAMILY HISTORY

(Mark all that apply in your immediate family)

Circle: "M" for Maternal (Mother's Side) or "P" for Paternal (Father's Side)

- | | | |
|--|--|--|
| <input type="checkbox"/> Heart Disease (M/P) | <input type="checkbox"/> Arthritis (M/P) | <input type="checkbox"/> High Cholesterol (M/P) |
| <input type="checkbox"/> Stroke (M/P) | <input type="checkbox"/> Diabetes (M/P) | <input type="checkbox"/> Gastrointestinal Disorder (M/P) |
| <input type="checkbox"/> Cancer (M/P) | <input type="checkbox"/> High Blood Pressure (M/P) | <input type="checkbox"/> Other (M/P): _____ |



ASSIGNMENT OF PAYMENT

I hereby authorize and direct my attorney(s) and/or insurance company(ies) to directly pay Diegel Chiropractic Clinic any monies due on my account. The payment shall be made first and foremost before all other payments or obligations. The monies for this payment shall be deducted from any and/or all settlement monies that are made to the other interest parties or myself.

Further, I agree to personally pay Diegel Chiropractic Clinic the difference, if any, between the total amount of the charges and the total amount paid by the attorney(s) and/or insurance company(ies).

Further, I agree to personally pay Diegel Chiropractic Clinic the full amount of the charges should my condition(s) be such that treatment for the before mentioned conditions(s) is not covered by an insurance policy, or if for any reason the insurance company(ies) refuse to pay the claim.

Name _____ Address _____
Insurance Company(ies) _____
Signature _____ Date _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Diegel Chiropractic Clinic to release any information acquired in the course of my examination or treatment(s) to any insurance company(ies), attorney(s) and/or other doctor(s).

Signature _____ Date _____

AUTHORIZATION FOR TREATMENT

I hereby authorize Diegel Chiropractic Clinic to perform any and all acts within the lawful scope of chiropractic, which in the sole discretion of the chiropractor, would be beneficial to my case.

Signature _____ Date _____

PREGNANCY FORM

I verify that my last menstrual period was _____ and that I am NOT pregnant. The Diegel Chiropractic Clinic has been informed of my condition and is not responsible for any future condition as a result of diagnostic x-rays taken on _____. I also agree to inform the above mentioned parties of any change in this condition prior to any and all treatment(s) and/or diagnostic evaluations.

Signature _____ Date _____

X-Ray Technician _____ Date _____

CONSENT TO TREAT MINOR CHILD

I hereby authorize Diegel Chiropractic Clinic to render any treatment of chiropractic as permitted by law and which, in their sole discretion, would benefit _____, minor child.

Signature _____ Date _____

FEES FOR X-RAYS

I hereby acknowledge that I have been informed that if x-rays are necessary, that there will be a fee charged for those x-rays over and above the cost of the treatment(s) and I agree to pay Diegel Chiropractic Clinic any monies owed, not covered by the insurance company(ies).

Signature: _____ Date _____



NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy, that record. You may also ask to correct that record. We will not disclose your records to others unless you direct us to do so, or unless the law authorizes us to do so. You may see your records, or get more information about it by contacting Nicole Henson at (586) 254-2060.

Our Notice of Privacy Policy describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

Patient/Parent/Guardian Signature

Date

Printed name if signed on behalf of patient / Relationship to patient (parent, legal guardian, personal representative, etc)
(Notation if any by staff)



OFFICE POLICY AND EXPLANATION OF COVERAGE

Diegel Chiropractic Clinic desires to assist our patients whenever possible. The following insurance and payment program will allow you, our patient, to receive the care you need without the undue financial strain.

- It must be fully understood, that the contract is between you and your insurance company and, that you are fully responsible for any amount not paid by your insurance.
- Our office will NOT enter into a dispute with your insurance company over your claim.
- Our office does NOT guarantee that your insurance will pay.
- Your insurance should pay within 30 days after billing. If your insurance company has not paid within 90 days, you must pay the balance and be reimbursed by your insurance company, when and if it pays.
- A payment MUST be made each and every month there is an outstanding balance.

I hereby instruct and direct my insurance company(ies) to pay by check or EFT deposit, made out and mailed directly to Dr. Robert W. Diegel, D.C. the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy(ies), as payment toward the total charges for professional services rendered to me. In the event my insurance is a reimbursing contract and I receive payment from my insurance carrier(s), I agree to bring in the checks and endorse them over to the clinic within one week of receipt. A photocopy of this assignment shall be considered as effective and valid as the original.

I agree to be financially responsible for all charges incurred at this office including, but not limited to, insurance deductible, co-payments and any services rejected by my insurance company(ies).

If have read the above provisions and hereby agree to abide by them as specified.

Patient/Parent/Guardian Signature

Date



TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of a vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well-being, not merely the absence of infirmity.

Vertebral subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment of these findings, we will recommend that you seek services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTIC OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

Patient/Patient/Guardian Signature

Date



GENERAL INFORMATION RELEASE FORM

To whom it may concern,

I, _____ give consent to Diegel Chiropractic to discuss medical and
or insurance information regarding my care

to _____,

to _____,

to _____,

to _____.

Signature

Date