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:__________Carrier__________

Email:____________________ SSN:______-_____-__________

Occupation:____________________ Employer:____________________

Insurance Carrier:____________________

Have you ever been to a chiropractor before? Yes / No Todays Date:____________________

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? Signature:____________________

Notice of Privacy Practices-Acknowledgment

We keep a record of the health care services we provide you. You make 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 our office 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)

WHAT IS WRONG?

Primary reason for this visit:____

When did this begin?____

How did the pain begin?____

The pain is getting: ☐Better ☐Worse ☐Same

The pains are: ☐Constant ☐Intermittent

Describe the pain: ☐Dull ☐Achy ☐Sharp ☐Stabbing

☐Burning ☐Numbness ☐Tingling

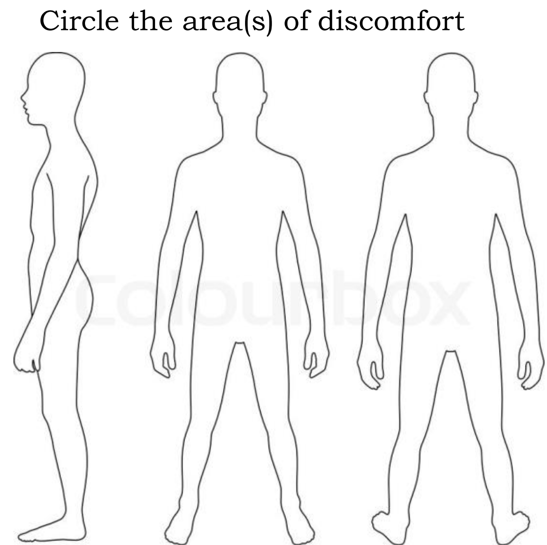
☐Other:________________________

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?____________________________________

Circle the area(s) of discomfort



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:

☐Headaches ☐Flushed Face ☐Depression ☐Cold Hands

☐Migraines ☐Stiffness ☐Loss of Memory ☐Cold Feet

☐Neck Pain ☐Pins and Needles in Legs ☐Ears Ring ☐Upset Stomach

☐Back Pain ☐Pins and Needles in Arms ☐Fever ☐Constipation

☐Nervousness ☐Numbness in Fingers ☐Lights Bother Eyes ☐Diarrhea

☐Tension ☐Numbness in Toes ☐Loss of Smell ☐Cold Sweats

☐Irritability ☐Dizziness ☐Loss of Taste ☐Night Pain

☐Chest Pain ☐Fainting ☐Buzzing in Ears ☐Loss of Appetite

☐Shortness of Breath ☐Fatigue ☐Loss of Balance ☐Light Headed

FAMILY HISTORY

(Mark all that apply in your immediate family) Circle: "M" for Maternal (Mother's Side) or "P" for Paternal (Father's Side)

☐Heart Disease (M/P) ☐Arthritis (M/P) ☐High Cholesterol (M/P)

☐Stroke (M/P) ☐Diabetes (M/P) ☐Gastrointestinal Disorder (M/P)

☐Cancer (M/P) ☐High Blood Pressure (M/P) ☐Other (M/P):______________

Signature:____________________________________ Todays Date:________________________________

ASSIGNMENT OF PAYMENT

I hereby authorize and direct my attorney(s) and/or insurance company(ies) to directly pay Diegel Chiropractic Clinic any mon ies 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 t hat treatment for the before mentioned conditions(s)is not covered by an insurance policy, or if for any reason the insurance com pany(ies) refuse to pay the claim.

Name____Address______________________________________

Insurance Company(ies)____

Signature____Date___________________________________

AUTHORIZATION TO REALEASE INFORMATION

I hereby authorize Diegel Chiropractic Clinic to release any information acquired in the course of my examination ro treatmen t(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 t he 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 ins urance company(ies).

Signature:____Date___________________________________

Diegel Chiropractic Clinic

49780 Van Dyke Avenue Shelby Twp, MI 480317

(586) 254-2060

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.
- We are not responsible for monitoring your insurance company, it is your responsibility to know your insurance benefits. (visit allowance, copays, deductibles, oop maxes, etc.) As well as if we are in network or out of network. Please contact your insurance companies with any questions.
- You will be held responsible for all copays, deductibles, coinsurances, or fees not paid or designated to be paid by you from your insurance company.
- In the event we are not participating with your insurance company you will be responsible for all charges.
- Our office will NOT enter a dispute with your insurance company over your claim.
- Our office does NOT guarantee that your insurance will pay.
- Your insurance should be paid 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. If your insurance company does not respond to a claim, it will fall on you to pay for your care.
- A payment MUST be made each month if there is an outstanding balance.
- A mailed billing charge of $5.00 per month may be added for balances that remain outstanding that receive a bill in the mail. Any unpaid balance that hasn't been settled for more than 2 months will be charged a 1% service charge per month on any unpaid balance.
- If we do not receive payment (within 6 months of an owed balance) on your account or have a plan in place to start payments on your account, we are authorized to release your information to a collections company of our choice to collect on our behalf. This may include, amount owed, address, phone numbers, emails, social security number, and other protected health information that may be necessary for them.

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

Fee Disclosure

Your health benefit plan may or may not provide coverage for all the health care services you are scheduled to receive. Your health care benefit plan may or may not reimburse a provider for all services provided if the provider is not in your health benefit plan network. You may be responsible for the costs of services that are not covered by your health benefit plan. If a service is not covered by, denied by, or written of by your insurance company, you will be responsible for the unpaid services.

A nonparticipating provider must provide good faith estimates of the cost of the health care services to be provided. A good-faith estimate does not take into account unforeseen circumstances, which may affect the cost of the health care services provided.

If your insurance doesn't pay for any or all of the services listed below, you will have to pay. The services that may not be covered include, but are not limited to:

Service	**Estimated Cost**
Chiropractic Xrays (per set)	$30.00
Chiropractic Exams	$30.00
Chiropractic Adjustment	$50.00
Traction	$10.00
Cold Laser Therapy	$25.00
Copays	$1.00 - $60.00 (as determined by your insurance plan)
Deductible	as determined by your insurance plan.
Coinsurance	$1.00 - $60.00
Emergency apts	$100.00 or more (at home visits, and other services)
Missed Appointments	$25 no show fee, please cancel appointments before the 24 hr mark

Zocdoc New Patients only $50: a $50 downpayment is needed to officially hold any new patient appointments. This fee is only refundable if the appointment was kept, and the insurance company paid in full for all services rendered and there were no copay, deductible, or coinsurance fees applied to the account.

- Please read this notice so you can make an informed decision about your care.
- Ask us any questions you may have after you finish reading.

You also have a right to request that the health care services be performed by a provider who participates with your health benefit plan network. You may also contact your carrier to arrange for those services to be provided at what may be a lower cost and to receive information on in-network providers who can perform the health care services that you need.

I have received, read, and understand this disclosure.

______________________________________ ____________________

Patient or Patient Representative's Signature Date

______________________________________ ____________________

Please Print Name of Patient or Patient Representative 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

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