



**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
(Last) (First) (MI) (Home Phone)

Home Address: \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
(Street) (Cell Phone)

\_\_\_\_\_  
(City) (State) (Zip) (\_\_\_\_\_) \_\_\_\_\_  
(Work Phone)

Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: S, M, D, W, Other  
(Please Circle One)

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
(Name) (Relationship) (Phone)

Who may we thank for referring you to our office: \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Insured Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
mm/dd/yyyy

ID# \_\_\_\_\_ Group# \_\_\_\_\_

Responsible Party: \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
(Name) (Relationship) (Phone)

**CONSENT TO TREAT FOR MINORS**

I hereby authorize Stadelman Chiropractic Health Center and whomever they designate as an assistant to administer treatment as deemed necessary to \_\_\_\_\_ my ( ) son ( ) daughter.

\_\_\_\_\_  
Name of Parent or Guardian (Print)

\_\_\_\_\_  
Parent or Guardian (Signature)

\_\_\_\_\_  
Date \_\_\_\_\_  
Witness (Signature)

**IS THIS VISIT RELATED TO**

- Work Related Injury or Symptoms
- Sports or Recreational Injury
- Motor Vehicle Crash Injury
- Motorcycle-Bicycle Injury
- Home Injury/Symptoms
- School/Employment Physical
- Non-Injury Pain/Symptoms
- Check-up Only
- Other (Describe) \_\_\_\_\_

**OFFICE POLICIES**

We believe that a clear definition of our office policies allows us both to concentrate on the big issue....regaining and maintaining your health. We will be happy to answer any questions you may have regarding this policy, your account or insurance coverage. Each office visit will be clinical in nature. Should you have any health related questions that require more than a few minutes, a separate appointment for another time will be made in order to give you all the time and attention necessary to answer all of your questions fully.

Please turn off or silence your cell phones and pagers, all phones conversations must be made out in the hallway.

**APPOINTMENT POLICY:**

In order to better serve all of our patients, we ask that you call if you are going to be late or unable to make you scheduled appointment time. Your appointment time is reserved for you. If you fail to notify our office, it leaves a time slot open that could be used to help other patients. Please help us help others. "Walk-In" (those with no scheduled appointment) means you will be seen after the scheduled patients have been treated.

Please do not wear strong perfumes or colognes. We see many patients with allergies or respiratory problems.

**DO NOT LET YOUR INSURANCE DICTATE YOUR HEALTH:**

Insurance may only pay for a portion of the care that you may need to be and remain healthy. After your insurance benefits have been exhausted, we have economically affordable payment plans available for you to continue with the care that you need to completely correct and maintain a healthy spine.

**HARDSHIP CASES:**

We have set aside 10-15% of our services toward hardship cases. If you feel you qualify for this, please speak with the doctor.

**WELLNESS CARE POLICY:**

We have a Wellness Care Program for those who have completed their initial and reconstructive care program.

**CHILDREN'S POLICY:**

Our philosophy is that children need Chiropractic and Naturopathic care; it is not just for adults. Our goal is to treat minor problems before they become major health problems. Spinal checkups for children are complimentary. We also have information in our office, which is available to you at any time.

**DISCHARGE POLICY:**

If you discharge yourself from your care plan, your account will be due and payable in full, unless other financial arrangements have been made. Continued services will be billed at the per-visit fee schedule unless another written agreement is made.

**LAPSE OF TREATMENT POLICY:**

If you have not been in for treatment for 6 (six) months or longer and/or have experienced an accident or injury, a re-examination may be necessary before treatment is performed. If you suffer a new injury, and if the Doctor's clinical opinion is that the new injury requires additional services, a new agreement will be required.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Our office needs to leave messages, return telephone calls, and send office mail to your home address as part of our normal practice. Federal/State Health Insurance Portability and Accountability Act (HIPAA) patient privacy laws allow you to restrict doctor/staff communication with you or to contact you through alternative means. Please list telephone numbers that are acceptable for our office to call. Your agreement will allow our office to use your name and the indicated mailing address for sending reminders about scheduled appointments, re-activation letters, sending birthday/holiday cards, office newsletters, or providing information about other health related matters that may be of interest to you, billing statements/questions, status of your account, and other office related matters. We will use your home address, noted above, unless you indicate a preferred address. You may indicate a preferred mailing address by indicating so on this form. This authorization may be revoked by you at any time, by advising our office (Privacy Officer) of this revocation in writing. If you choose not to sign this authorization, this will not have any adverse effect on your treatment, eligibility for benefits, enrollment, or payment.

Yes No I authorize the use of my phone numbers. Yes No I authorize the use of my address for mailings.

Yes No I authorize the use of my email address for scheduling and health newsletter announcements by this office only.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_