Diegel Chiropractic: Robert W. Diegel D.C. 49780 Van Dyke Ave. Shelby Twp Mi 48317 586-254-2060

How did you hear about us? ZocDoc ☐ Friend/Family: ☐_____ Other:_____

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

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

Number of Children:_____ Ages:_____

Mailing/Billing Address: _____ City:_____ Zip:_____

Home Phone:_____ Cellphone:_____ SSN #:_____

Email:_____ Occupation:_____

Employer:_____ Insurance Carrier: _____ Is this Auto Related: YES / NO

Have you been to a Chiropractic office before? YES / NO **Today's Date:**_____ **Initials:**_____

Health Habits: PLEASE BE AS DETAILED AND ACCURATE AS POSSIBLE Please circle yes or no

YES / NO Do you exercise? How much/often? _____

YES / NO Do you drink water regularly? How much?_____

YES / NO Do you smoke? (cigs/vapes/ect Do you still smoke? YES / NO How much/often?_____ Start?_____

YES / NO Do you drink alcohol? How much/often:_____

YES / NO Are you currently under any other medical care? For what?_____ Dr.'s Name:_____

YES / NO Are you currently using any prescription drugs? Name:_____ Dose:_____

YES / NO History of physical trauma? (Car accidents, falls, general accidents?)

Explain if yes:_____

YES / NO Any surgeries? If yes explain:_____

YES / NO Any Allergies? If yes explain:_____

YES / NO Do you drink coffee/tea? How much/often:_____

YES / NO Do you eat enough vegetables? (average needed is 2-3 cups) If no how much?:_____

YES / NO Do you get enough sleep daily? Average needed is 7-9hrs) If no how much?:_____

YES / NO Would you consider yourself to be stressed? Rate 1-10, 10 being the most if yes:_____

YES / NO Recreational drug use? If yes what/ how often:_____

Please include any past or present drug use including medical marijuana, or harder substances. This is for diagnosis purposes only.

YES / NO Do you consider yourself healthy? **YES / NO** Are you willing to work towards better health?

Notice of Privacy Practices-Acknowledgment

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 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 (the patient) acknowledge receipt of the Notice of Privacy Practices, and that the information provided is accurate to the best of my knowledge.

Signature:_____ Date:_____

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WHAT IS WRONG WHAT BRINGS YOU IN?

Primary reason for this visit: _____

When did this begin?_____

How did this begin? _____

Any other concerns?_____

The pain has been getting? Better / Worse / Same

The pain/s are: Constant / Intermittent

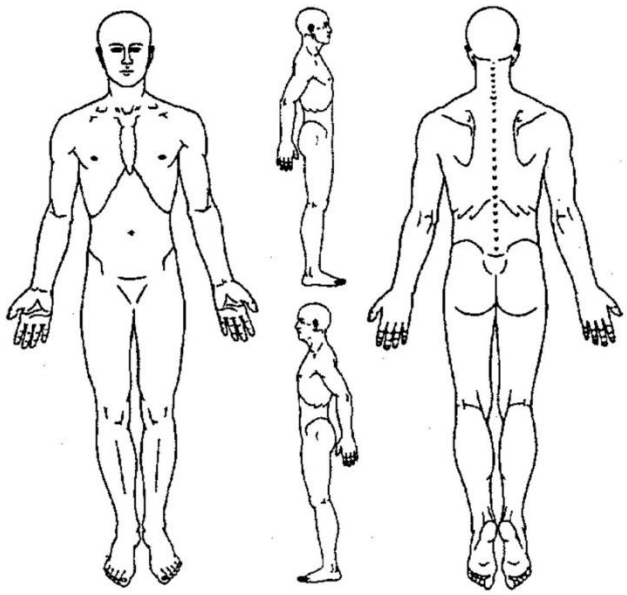
Describe the pain: Dull Achy Sharp Stabbing Burning Numbness Tingling

Other:_____

Rate the pain from 0-10: 10 being worst:_____

Please circle the best descriptors of your conditions.

Please Mark Any Areas You Are Experiencing Pain



Is it worse at certain times of the day? **YES / NO**

If so, when?_____

What makes it better? _____

What makes it worse?_____

Have you seen any other professionals for this issue? _____

YES / NO Is this work related/ on the job injury **YES / NO** Is this auto case related

Other Symptoms: please check off any symptoms you experience

O Headaches	O Flushed Face	O Ringing in Ears	O Constipation
O Migraines	O Stiffness	O Fevers	O Diarrhea
O Neck pain	O Pins & needle/legs	O Light sensitivity	O Cold sweats
O Mid back pain	O Pins & needles/arms	O Loss of smell	O Night pains
O Low back pain	O Numbness in fingers	O Loss of taste	O Loss of appetite
O Nervousness	O Numbness in toes	O Buzzing in ears	O Light headedness
O Tension	O Dizziness	O Loss of balance	O Arthritis
O Irritability	O Fainting	O Cold hands	O Neuropathy
O Chest pain	O Depression	O Cold feet	O Sprains/strains
O Shortness of breath	O Loss of memory	O Upset stomach/bowels	O Swelling of the legs/feet

Family History: mark all that apply, circle M for maternal (mom) P for paternal (dad)

O Heart Disease (M / P) **O** Arthritis (M / P) **O** High Cholesterol (M / P) **O** Strokes (M / P) **O** Diabetes (M / P)

O Gastrointestinal Disorder (M / P) **O** Cancer (M / P) **O** High Blood Pressure (M / P) **O** Other:_____ (M / P)

Signature:_____ **Printed Name:**_____ **Date:**_____

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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). See the fee disclosure page for more information.

Signature:_____Date_____

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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. It is also your responsibility to make sure we have the correct insurance on file to bill. If we do not have the correct insurance you will be charged for any uncovered services.
- 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 company should send payment within 30 days of billing. If your insurance company has not paid within 90 days, you must pay the balance and be reimbursed by your insurance company. If your insurance company does not respond to a claim, it will fall on you to pay for your care. If you paid for your care and the insurance company covers your care in full you will be refunded via check.
- A payment MUST be made each month if there is an outstanding balance. Or before you are seen for the day
- 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/all protected health information. By signing you are agreeing to this.

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.

Signature: _____ **Printed:**_____ **Date:**_____

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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
MLS Laser Therapy	$60.00 per session
Copays	$1.00 - $60.00 (as determined by your insurance plan)
Deductible/ O.O.P Max	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.

Signature:_____ **Printed:**_____ **Date:**_____

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General Information Release Form

The person/s mentioned below will have full access to my health information and records in case of emergency or allowing them to pick up records, pay bills, share protected health information regarding your care.

To whom it may concern,

I, _____ give consent to Diegel Chiropractic to discuss and share medical, billing, and insurance information regarding my care to the below mentioned individuals/companies.

- _____ Phone:_____
- _____ Phone:_____
- _____ Phone:_____
- _____ Phone:_____
- _____ Phone:_____
- _____ Phone:_____

Signature:_____ Printed:_____ Date:_____