Meyer Chiropractic Clinic

104 E McElroy
Stillwater, OK 74075
Ph: 405-372-6919 Fax: 405-372-3359
www.drmeyerechiropractic.com

BY PRINTING AND SIGNING YOUR NAME BELOW YOU ARE STATING THAT THIS OFFICE VISIT IS NOT CONNECTED TO ANY OR ALL OF THE FOLLOWING:

1. MOTOR VEHICLE ACCIDENT/ OR CLAIM RELATING TO A MOTOR VEHICLE ACCIDENT
2. WORKER'S COMPENSATION CLAIM
3. PERSONAL INJURY CLAIM

DATE ______________ PATIENT'S NAME ________________________________

PATIENT'S SIGNATURE________________________________

Welcome to our office, we are thankful you came here for your chiropractic needs!

If your case type changes (for example you were a self pay patient but now have health insurance for us to file), or any other changes apply in the future such as; insurance information,address, email or phone number,any new injuries - please notify the front desk before your treatment or scheduling an appointment.

ANY QUESTIONS REGARDING INSURANCE FILING AND/OR YOUR PATIENT ACCOUNT SHOULD BE DIRECTED TO OUR BILLING AND OPERATIONS OFFICE BY CALLING:

AXIS Billing Company 940-584-0197
Email AxisJen1@gmail.com

Welcome To Our Office

Patient Forms

First Name: | Last Name: | Date Of Birth:

Home Phone: | Mobile Phone: | Work Phone:

@E-Mail: | Preferred Communication: (Circle) H M W E@

Street Address: | Apt/Suite #:

City: | ZipCode: | State:

SSN: | Gender: ♀ Female ♂ Male | Preferred Language: ❑ English ❑ Other ____________

Race & Ethnicity:

- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ Hispanic or Latino
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ White
- ❑ Other

Marital Status:

❑ Single ❑ Married ❑ Other
❑ Divorced ❑ Widowed ❑ Separated

Emergency Contact Name: | Phone: | Relationship:

Primary Care Provider Name: | Phone:

Street Address: | Apt/Suite #:

City: | ZipCode: | State:

Employer/Company Name: | Phone:

Street Address: | Apt/Suite #:

City: | ZipCode: | State:

Job Title/Position: | Currently Working: ❑ Yes ❑ No ➩ Date Stopped Working:

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Medical Detail

Reason For Your Visit

☐ Wellness & Health Maintenance		
☐ Injury, Pain Complaint, or Ailment	Date Of Injury (When Did Your Pain Start?)	
☐ Accident — ☐ Automobile Related Accident ☐ Other Type Of Accident	Date Of Accident:	State: Where Accident Occurred
Please Provide Brief Details Of Your Injuries & Pain:		

Referring Provider

☐ I Was Referred By My Primary Care Physician (Same Doctor Listed On First Page)

☐ I Was Referred By Another Doctor (Please Fill Out Doctor Info Below)

Referring Provider Name:		Phone:
Street Address:	Apt/Suite #:	@ E-Mail:
City:	ZipCode:	State:

Representative Details (If You Are Being Represented By An Attorney For An Accident Please Provide Info)

Referring Provider Name:		Phone:
Street Address:	Apt/Suite #:	@ E-Mail:
City:	ZipCode:	State:

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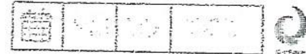
Medical History

Lifestyle



Are You A Smoker?	❑ Yes	❑ No	If Yes ➩ How Often? ______________ /Day /Week
Do You Drink Alcohol?	❑ Yes	❑ No	If Yes ➩ How Often? ______________ /Day /Week
Do You Exercise?	❑ Yes	❑ No	If Yes ➩ How Often? ______________ /Day /Week

Have You Ever Been Hospitalized? ❑ Yes ❑ No

Have You Had Any Surgeries? ❑ Yes ❑ No

If Yes, Please List Dates/Details:

Do You Have Any Allergies? ❑ Yes ❑ No ➩ Do You Require Medical Treatment For Your Allergies? ❑ Yes ❑ No

If Yes, Please Provide Details:

Do You Take Any Medications? ❑ Yes ❑ No

Please List All Medications & Dosage (How Much & How Often?)

Please Provide Any Other Medical Information You Feel The Doctor Needs To Know About

____
Patient Signature

____
Date

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INFORMED CONSENT FOR TREATMENTS and PRIVACY POLICY

- **The nature of Chiropractic Treatment:** The doctor will use his hands or a mechanical device in order to move joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation and therapeutic ultrasound may also be used.
- **Possible Risks:** Complications are possible following a chiropractic manipulation and could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.
- **Injectable Nutrients** are administered at this office. If this therapy applies to your care – all benefits, risks and alternatives will be explained by your doctor before you elect to receive this service. If you would like a copy of these benefits, risks and alternatives please ask the front desk.
- **Graston Technique®** is an instrument assisted variation of cross fiber or transverse friction massage. GT is a form of treatment used to "break up" or soften scar tissue, thus allowing for the return of normal function in the area being treated. Graston Technique® may produce the following: 1. Local discomfort during the treatment. 2. Reddening of the skin. 3. Superficial tissue bruising.4. Post treatment soreness.
- I authorize staff of Meyer Chiropractic Clinic to perform any necessary services needed during diagnosis or treatment. I authorize the provider to release any information required to process insurance claims.
- **All HIPPA guidelines and requirements are followed in this office If you would like a copy of the HIPPA requirements please ask for them at the front desk.**
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any change to the information I have provided. This includes all personal & insurance information.

DATE_______ SIGNATURE____________________

FINANCIAL ARRANGEMENTS

The filing of insurance is a courtesy that we extend to all patients; however, all charges are your responsibility and payment is due at the time services are rendered.

- There is a $25.00 service fee on all returned checks

DATE________ SIGNATURE ___________________________

CONSENT FOR X-RAY

I give my permission to Meyer Chiropractic Clinic and its staff to take X-RAYS as deemed appropriate by the doctor. **I also hereby declare that to my knowledge, I am not pregnant.**

DATE_______ SIGNATURE__________________

CONSENT TO TREAT A MINOR

I hereby authorize Dr. Jennifer Hanson to administer Chiropractic care as deemed necessary to my

__________________(indicate relationship to child), ___________________________(child's name).

DATE_______ SIGNATURE__________________ (Parent or Guardian)

CONSENT TO TREAT A MINOR

I hereby authorize Dr. Jennifer Hanson to administer Chiropractic care as deemed necessary to my ________________(indicate relationship to child), ____________________________(child's name).

DATE_______ SIGNATURE__________________ (Parent or Guardian)

PATIENT RESPONSIBILITY

1. I understand that I am financially responsible for my health insurance deductible, coinsurance, or any non-covered services.
2. Co-Payments, Co-Insurance payments and patient payments are due at time of service.
3. In the event that my health plan determines a service to be "non covered" or "non payable", I will be responsible for the complete charge and agree to pay the costs of all services provided
4. If I am uninsured, I agree to pay for the services rendered to me at the time of service.
5. If my plan requires a referral, I must obtain it prior to my visit, in accordance with my insurance company's requirements and details of a valid referral to authorize chiropractic services.

The undersigned does agree to observe and abide by all of the statements made above.
A photostatic copy of these authorizations and agreement shall be as valid as the original.

DATE________ SIGNATURE___________________________