FINANCIAL AGREEMENT HEALTH INSURANCE

We would like to take a moment to welcome you to our office and assure you that you will receive the very best of care available for your condition. In order to familiarize you with the financial policy of this office, we would like to explain how your medical bills will be handled.

Explanation of Insurance Coverage:
Many insurance policies do cover chiropractic care but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for chiropractic care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage and will bill your insurance in a timely manner as a courtesy to you.

Payment Arrangements
If you have **insurance**, we will bill for you as a courtesy. Payment for deductibles, if it has not been met is the responsibility of the patient as well as any copayment or remaining balance after insurance payment. We do participate in many insurance plans that may allow nominal out of pocket expense. **Your co-pay is due as services are rendered**. You are also responsible for portions of your bill that exceed your insurance limits.

Assignment of Benefits
By signing this form you are authorizing payment of medical benefits will be made directly to this office. If your insurance carrier sends payment to you for services incurred in this office, you agree to send or bring those payments to this office upon receipt. However, if you pay for your visits in full the assignment will not be reported by this provider and any payment will be sent directly to you.

Release of Information
If your insurance company requires medical reports or records to document your treatment or progress, your signature below authorizes this office to release the medical information necessary to process your claim.

Voluntary Termination of Care
If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are charged directly to you, and you ultimately will be personally responsible for payment regardless of your insurance coverage.

We hope this answers any questions you might have concerning the financial policy of this office. Once again we welcome you to our office, and will be glad to answer any further questions that you might have.

I have read and agree to the above.

_____ _____

Signature **Date**

FINANCIAL POLICY

We offer several methods of payment for your chiropractic treatment, and you may choose the plan which best suits your needs. Please read carefully and choose the plan which you prefer. This information will enable us to better serve you and help us to avoid misunderstandings in the future. If special financial arrangements are necessary, please consult with the business manager during your initial consultation.

OUR MAIN CONCERN IS YOUR HEALTH AND WELL-BEING AND WE WILL DO OUR BEST TO HELP YOU.

PLAN ONE:
The **self-pay** plan means that all fees will be paid when rendered.

PLAN TWO:
If you have **insurance,** we will bill your plan as a courtesy. Payment for deductibles, if it has not been met is the responsibility of the patient as well as any copayment or remaining balance after insurance payment. We do participate in many insurance plans that may allow nominal out-of-pocket expenses. **Your co-pay is due as services are rendered**. You are also responsible for portions of your bill that exceed your insurance limits.

Credit Cards will be accepted for all or partial payments WITH A NOMINAL FEE.

If care is discontinued, the balance for care received up to that date is due in full in 30 days.

I understand that all responsibility for payment of services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. I permit this office to endorse co-issued remittances for the conveyances of credit to my account. In the event payments are not received by the agreed-upon dates, I understand that a 1.5% finance charge (18% APR) will be added to my account. I agree to pay all attorneys and collection fees if this account is turned over for collection.

PLEASE ADVISE WHICH PLAN YOU WOULD LIKE TO USE:_____

Please sign below to indicate your understanding of our financial policies. If you do not understand, please allow us to review the policies with you until they are clear.

_____
Signature Date:_____

_____
Print Name

_____
Witness Date:_____

ROBERT P. SEILER INVOICE

PLEASE PRINT LEGIBLY!

Patient: Last Name: _____ First Name: _____

Address: _____

City, State, Zip: _____ _____ _____

Date of Birth: ____/____/____ Social Security: _____/_____/_____ Gender: _____

Patient Status: New Patient ____ Established ____ Evaluation Only ____

Pt Phone: _____ Pt Email: _____

Policy Holder: if not Patient: Last Name: _____ First Name: _____

Address: _____

Date of Birth: ____/____/____ Social Security: _____/_____/_____ Gender: __

City, State, Zip: _____ _____ _____

Relation to Policy Holder: Self: ____ Spouse: ____ Child: ____ Other: ____

Auto Insurance Name: _____

Claim #: _____ DOL: _____

Adjustor's Name: _____ Adj's Ph: _____

Adj's Fax: _____ Adj's Email: _____

Adj's Address: _____

Representing Law Firm: _____

Attorney's Last Name: _____ First Name: _____

Address: _____

Fax: _____ Ph: _____

Send Bills & Clinicals to: Legal Assistant or Attorney

Best Email Address: _____

- **Patient Signature:** _____ Date: ____/____/____

Holistic Chiropractic & Wellness
Dr. Bob Seiler, Chiropractic Physician
150 S 600 E, Suite 6C, Salt Lake City 84102
801-230-0166

PATIENT INFORMATION

Name:_____ Date:_____

What You Prefer To Be Called: _____ Sex: [ ] M [ ] F Marital Status: [ ] M [ ] S [ ] D [ ] W

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Mobile:_____ Social Security #:_____

Age:_____ Birthdate:_____ Emergency Contact:_____

Address:_____ City:_____ State:_____ Phone:_____

Email:_____ May we email you our wellness newsletter? [ ] Y [ ] N

Who may we thank for your first visit? Referred By:_____ OR [ ] Website [ ] Google [ ] Other

Occupation:_____ Employer:_____

Work Address:_____ Work Number:_____

Significant Other's Name:_____ Do you have children? [ ] Y [ ] N Ages:_____

MEDICAL HISTORY AND SYMPTOM / PAIN INFORMATION

(Additional room provided to answer questions on the back of this form)

A. Reason for today's visit: [ ] work [ ] auto [ ] sports/competition [ ] trauma [ ] stress [ ] anxiety [ ] chronic [ ] other

B. Explain what happened:_____->

C. Please describe the pain intensity and its location on the included "Pain Diagram" page.

D. When did this condition begin? ___/___/___ Is it getting worse? [ ] Y [ ] N [ ] Constant [ ] Comes & Goes

E. Is this condition interfering with your: [ ] work [ ] sleep [ ] daily routine [ ] relationships Please explain _____->

F. Have you had this or similar conditions in the past? [ ] Y [ ] N Please explain_____->

G. Have you ever been treated by a Medical Physician for this condition? [ ] Y [ ] N If so, where_____->

H. Have you ever been treated by a Chiropractic Physician? [ ] Y [ ] N If so, for what_____->

I. Please list any falls, slips, concussions, or accidents you may have had with dates:_____->

J. Family Health History (genetics, your environment, epigenetics):_____->

K. The feet are the foundation of your body. Are you now wearing? [ ] heel lifts [ ] sole lifts [ ] inner soles

[ ] arch supports [ ] custom-made orthotics

SYMPTOMS YOU HAVE EXPERIENCED IN THE PAST 6 MONTHS

[ ] High Blood Pressure
[ ] Cholesterol
[ ] Thyroid Imbalance
[ ] Insulin Resistance/Diabetes
[ ] Headaches: Migraine, Tension
[ ] Fibromyalgia
[ ] [ ] Weight gain/loss
[ ] Stress, Anxiety, Depression
[ ] Nightmares
[ ] Trauma: Physical/Emotional
[ ] Loss of Family Member/Friend
[ ] Insomnia
[ ] Mood Swings
[ ] Joint Pain
[ ] Posture
[ ] Fallen-arches
[ ] Extensive Alcohol/Drug Use

A.

B.

C.

D.

E.

F.

G.

H.

I.

J.

K.

Name:_____ Health History Intake Form Date:_____

Email: _____ Phone: _____

What are your health goals?

☐ Remove Pain
☐ Gain More Energy/Stamina
☐ Restore Health/Reduce Illness
☐ Achieve Optimal Wellness

What are your top 3 health complaints?

1)_____
2)_____
3)_____

Question	Y N	Patient Comment	Practitioner Comment
Are you on a particular diet or currently restricting certain foods?	Y N		
Do certain foods upset your stomach or cause constipation, IBS, or headaches?	Y N		
Do you have certain food cravings?	Y N		
Do you get shaky or anxious between meals?	Y N		
Do you drink **less** than half your body weight in water oz daily? (ex: if you weigh 150 lbs, 75 oz would be your daily water intake)	Y N		
Do you drink soda, sports, or energy drinks?	Y N		
Do you chew gum, drink diet drinks or consume sugar-free foods?	Y N		
Have you ever been unconscious, had a concussion, whiplash, closed head injury?	Y N		
Do you get muscle cramps, "charley horses", or eye twitches?	Y N		
Do you frequently use Tylenol, Ibuprofen, or other pain relief medications? (How many milligrams? How often?)	Y N		
Have you taken fish oil & had difficulty keeping it down?	Y N		
Do you have indigestion, belching, gas or bloating?	Y N		
Do you typically go **more** than 24 hours **without** a bowel movement?	Y N		
Have you had any organs surgically removed or medically altered? (appendix, gallbladder, etc.)	Y N		
Have you gained more than 15 lbs in the past year?	Y N		
Do you grind your teeth while you sleep?	Y N		
Do you have trouble falling or staying asleep?	Y N		
Have you had an illness that you have not fully recovered from?	Y N		

Do you have a health diagnosis or are you concerned with any of the following:

☐ High Blood Pressure
☐ Cholesterol
☐ Insulin Resistance (Diabetes)
☐ Thyroid Imbalance
☐ Arthritis
☐ Fibromialgia
☐ Cardiovascular
☐ Migraines/Headaches
☐ Stress
☐ Other_____

Please list all medications, supplements, and herbs that you a currently taking:_____

_____
_____
_____
_____
_____

Is there anything else you think I should be aware of: _____

_____
_____
_____
_____

General Pain Disability Index Questionnaire

Name (please print): _____ Date: _____

Age: _____ Date of Birth: _____ Occupation: _____

Use the letters below to indicate the type and location of your sensations right now

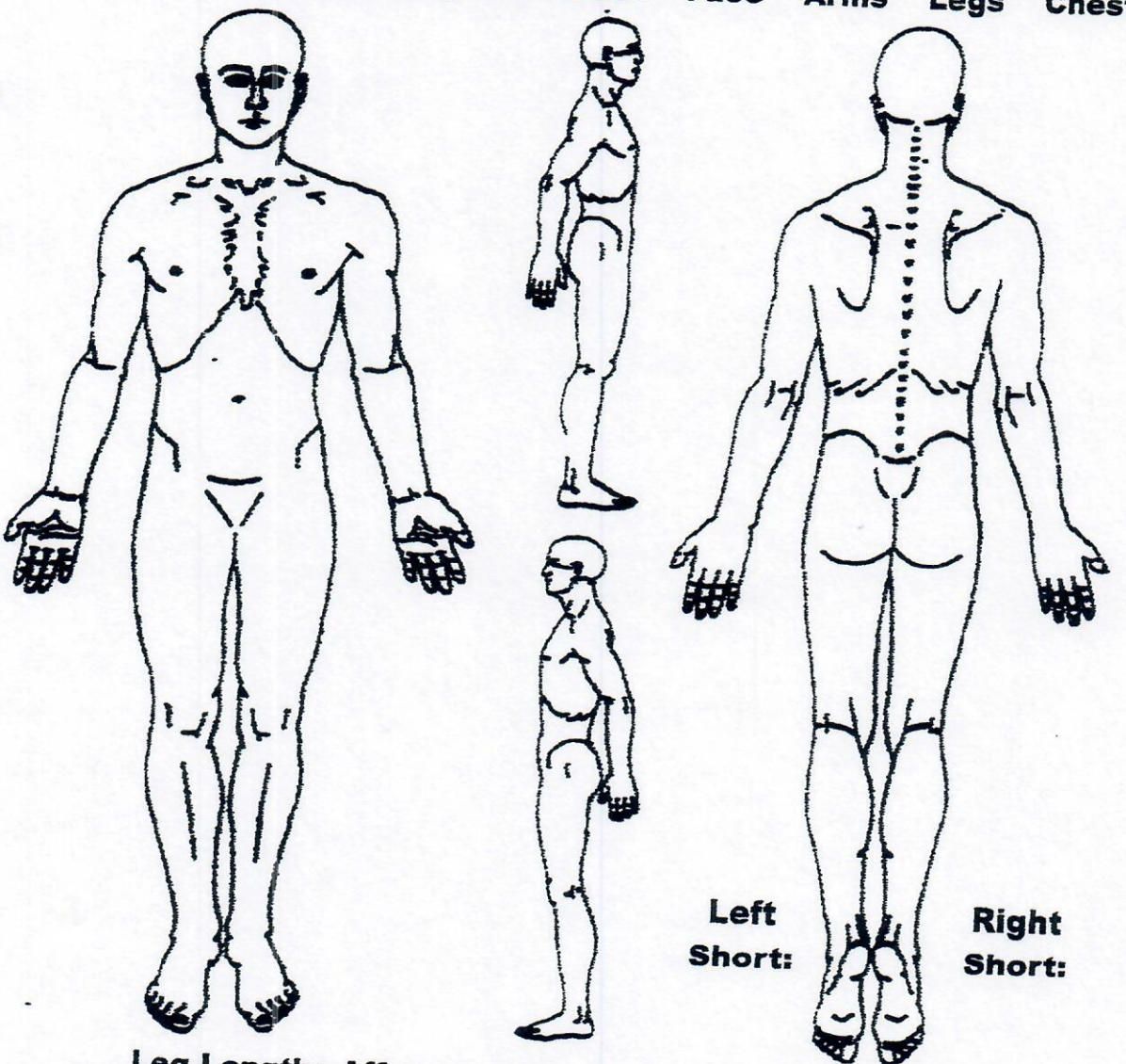
Key:

A = Ache
P = Pins & Needles.
B = Burning
S = Stabbing
N = Numbness
O = Others

Circle → R → Radiating into: Head Face Arms Legs Chest

Height:

Weight:



Left Short:

Right Short:

Leg Lengths Affect Physical - Emotional Stability

What activities do you do for exercise? _____

What activities are you unable to do? _____

DATE NAME: #

IMPORTANT: Please check (X) all present REVIEW OF SYMPTOMS

HEAD:
- ☐ Headache
  - ☐ sinus (allergy)
  - ☐ entire head
  - ☐ back of head
  - ☐ forehead
  - ☐ temples
  - ☐ migraine
- ☐ Head feels heavy
- ☐ Loss of memory
- ☐ Light-headedness
- ☐ Fainting
- ☐ Light bothers eyes
- ☐ Blurred vision
- ☐ Double vision
- ☐ Loss of vision
- ☐ Loss of taste
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Loss of hearing
- ☐ Pain in ears
- ☐ Ringing in ears
- ☐ Buzzing in ears

NECK:
- ☐ Pain in neck
- ☐ Neck pain with movement
  - ☐ Forward
  - ☐ Backward
  - ☐ Turn to left
  - ☐ Turn to right
  - ☐ Bend to left
  - ☐ Bend to right
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Muscle spasms in neck
- ☐ Grinding sounds in neck
- ☐ Popping sounds in neck
- ☐ Arthritis in neck

SHOULDERS:
- ☐ Pain in shoulder joint (R - L)
- ☐ Pain across shoulders
- ☐ Bursitis (R - L)
- ☐ Arthritis (R - L)
- ☐ Can't raise arm
  - ☐ above shoulder level
  - ☐ over head
- ☐ Tension in shoulders
- ☐ Pinched nerve in shoulder (R - L)
- ☐ Muscle spasms in shoulders

ARMS & HANDS:
- ☐ Pain in upper arm
- ☐ Pain in elbow
- ☐ Movement aggravated
- ☐ Tennis elbow
- ☐ Pain in forearm
- ☐ Pain in hands
- ☐ Pain in fingers
- ☐ Sensation of pins & needles in arms
- ☐ Sensation of pins & needles in fingers
- ☐ Numbness in arms (R - L)
- ☐ Numbness in fingers (R - L)
- ☐ Fingers go to sleep
- ☐ Hands cold
- ☐ Swollen joints in fingers
- ☐ Sore joints in fingers
- ☐ Arthritis in fingers
- ☐ Loss of grip strength

MID-BACK:
- ☐ Mid-back pain
- ☐ Location _____
- ☐ Pain between shoulder blades
- ☐ Sharp stabbing
- ☐ Dull Ache
- ☐ Pain from front to back
- ☐ Muscle spasms
- ☐ Pain in kidney area

CHEST:
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Pain around ribs
- ☐ Breast pain
- ☐ *Dimpled or orange peel breast*
- ☐ Irregular heartbeat

ABDOMEN:
- Nervous stomach
- Foods can't eat _____
- Nausea
- Gas
- Constipation
- Diarrhea
- Hemorrhoids

LOW BACK:
- Low back pain
  - Upper lumbar
  - Lower lumbar
  - Sacroiliac
- Low back pain is worse when:
  - working
  - lifting
  - stooping
  - standing
  - sitting
  - bending
  - coughing
  - lying down (sleeping)
  - walking
- Pain relieves when
- Slipped disk
- Low back feels out of place
- Muscle spasms
- Arthritis

HIPS, LEGS & FEET:
- Pain in buttocks (R - L)
- Pain in hip joint (R - L)
- Pain down leg (R - L)
- Pain down both legs
- Knee pain
  - Inside
  - Outside
- Leg cramps
- Cramps in feet (R - L)
- Pins & needles in legs (R - L)
- Numbness of leg (R - L)
- Numbness of feet (R - L)
- Numbness of toes
- Feet feel cold
- Swollen ankles (R - L)
- Swollen feet (R - L)

WOMEN ONLY:
- ☐ Menstrual pain _____ (where)
- ☐ Cramping
- ☐ Irregularity
- ☐ Cycle _____ days
- ☐ Birth control _____ (type)
- ☐ Hysterectomy
- ☐ Genital cancer _____
- ☐ Discharge
- ☐ Menopause _____
- ☐ Tumors
- ☐ Abortions
- ☐ Are you or do you think you are pregnant?

MEN ONLY:
- ☐ Urinary frequency
- ☐ Difficulty in starting
- ☐ Night urination
- ☐ Prostate pain/swelling

GENERAL:
- ☐ Nervousness
- ☐ Irritable
- ☐ Depressed
- ☐ Fatigue
- ☐ Generally feel run-down
- ☐ Normal sleep
- ☐ Loss of sleep _____ hrs /night
- Loss of weight _____ lbs.
- Gain weight _____ lbs
- ☐ Coffee _____ cups/day
- Tea _____ cups/day
- Cigarettes _____ pack/day
- Other _____
- Diabetes
- Hypoglycemia

REMARKS:

REV 11/94