Harbor Front Family Chiropractors, LLC

707 N. Washington Ave. Ludington, MI 49431
Phone (231) 845-7800 www.ludingtonchiropractors.com Fax (231)845-7885

Please fill out this form as completely and accurately as possible.

Today's Date _____ Patient File # _____

PERSONAL DATA

Name_____ Age _____ Date of Birth _____
Parents' names (if you are under 18) _____
Home Address_____ City _____ State_____ Zip _____
Home Phone (_____) _____ Business Phone (_____) _____
Cell Phone (_____) _____ E-Mail Address_____
Occupation_____ Employer _____
Marital Status ❑ S ❑ M ❑ D ❑ W Spouse/Partner's Name: _____
Names and ages of children _____
Whom may we thank for referring you to our office? _____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Harbor Front Family Chiropractors can address for you?

_____

Are these concerns affecting your quality of life? (Please circle only those applicable to you)

Work Y N	Driving Y N	Sleep Y N
School Y N	Walking Y N	Sitting Y N
Exercise/sports Y N	Eating Y N	Other Y N

HEALTH CARE PRACTITIONER HISTORY

Have you ever received Chiropractic care? ❑Y ❑N Name of D.C._____
How long under care? ❑_____ days ❑_____ weeks ❑_____ months ❑_____ years
Date of last visit: _____Why did you stop?

_____

How was your experience?_____
Have you consulted, or do you regularly consult, any of the following providers? (Check all that apply.)
❑Medical Physician ❑Naturopath ❑Acupuncturist ❑Homeopath
❑Massage Therapist ❑Psychotherapist ❑Energy Healer ❑Dentist
Reason why: _____

FOR WOMEN ONLY

Are you pregnant? ❑Y ❑N Possible / Unknown
If pregnant Due date? _____ Name of OBGYN or Midwife: _____
If x-rays are recommended, your signature is required to indicate that you are **not pregnant**.
Signature: _____ Date: _____

HEALTH, WELLNESS AND CHIROPRACTIC CARE

The primary system in the body, which coordinates health, is the CENTRAL NERVE SYSTEM. The vertebrae, the bones of the spinal column, surround and protect the delicate NERVE SYSTEM. Chiropractors are specialists trained in "early detection" of injury to the SPINE AND NERVE SYSTEM.

The information below will help us to see the types of PHYSICAL, EMOTIONAL and CHEMICAL stressors you have been subjected to and ***how they may relate to your present spinal, nerve and health status.***

CURRENT PHYSICAL STRESS

Please describe your usual work position and how long you maintain it during the day. For example, do you work at a computer, talk on the phone or stand at a machine for most of the day?

_____

Does your job require regular airline travel and hotel stays? ❑Y ❑N If yes, how often? _____
How long is your daily commute? _____ How many hours do you typically work in a week? _____
How many hours per week do you watch T.V.? ____ Are you sitting or lying on a couch? _____
Please describe your exercise/sports program including type and frequency:

_____

_____

How many hours of sleep do you typically get each night? _____ Do you sleep well? ❑Y ❑N
Do you ever sleep on your stomach? ❑Y ❑N How old is your mattress? _____
Do you wear orthotics (foot supports) or a heel life? ❑Y ❑N If yes, for how many years? _____
Do you use a cervical pillow? ❑Y ❑N

PAST PHYSICAL TRAUMAS

Please Circle: Were you born at home or in a hospital?
Medication used? ❑Y ❑N C-section? ❑Y ❑N Forceps/vaccum? ❑Y ❑N
Did you have any **significant childhood injuries**? (fractures, stitches, falls, sports-related, etc.) Please list dates, injury and treatment: _____

_____

Have you had any **surgeries or significant adult injuries**? Please list dates, injury and treatment:

_____

_____

Have you had any **automobile accidents or work-related injuries**?
Date:_____ driver/front passenger/rear passenger Seatbelt? Y N Airbag discharged? Y N
Injuries: _____ Care received: _____
Date:_____ driver/front passenger/rear passenger Seatbelt? Y N Airbag discharged? Y N
Injuries: _____ Care received: _____

EMOTIONAL STRESS

Please indicate if you have experienced any of the emotional stresses below:

Childhood trauma	❑Y	❑N	Loss of loved one	❑Y	❑N	Abuse	❑Y	❑N
Work or school	❑Y	❑N	Divorce/separation	❑Y	❑N	Financial	❑Y	❑N
Lifestyle change	❑Y	❑N	Parents divorce	❑Y	❑N	Illness	❑Y	❑N

CHEMICAL STRESS

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g., food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will reveal exposures you may have had.

Were you **vaccinated?** ❑Y ❑N If yes, did you have a **reaction**? ❑Y ❑N

Have you been **exposed to** any of the following on a regular basis, past or present?

❑ Toxic chemicals ❑Radiation ❑Second hand smoke ❑Chemotherapy ❑Drug therapy ❑Other

If yes, please explain:_____

Do you have any **food allergies**? ❑Y ❑N **If yes, please list:** _____

_____

How many **fast food meals** do you eat per week? _____

How many **alcoholic beverages** do you drink per week? _____

Do you smoke **tobacco products**? ❑Y ❑N If yes, how many packets per day? _____

How many glasses of **water** do you drink per day? _____

How many **caffeinated beverages** (coffee, tea, soda) do you drink per day? _____

Are you currently on **prescription** or **over-the counter medication?** ❑Y ❑N Please list, indicating dose & frequency_____

_____

Please list any **nutritional supplements** you are taking: _____

_____

How do you rate your **physical health**? ❑Excellent ❑Good ❑Fair ❑Poor

QUALITY OF LIFE

How do you rate your **emotional/mental health**? ❑Excellent ❑Good ❑Fair ❑Poor

How do you rate your overall **"quality of life"**? ❑Excellent ❑Good ❑Fair ❑Poor

EXPECTATIONS

I would like to have the following benefits from ***Chiropractic Care***: (Check all that apply)

____ Relief of a symptom or problem

____ Relief and prevention of a symptom or problem

____ Healthier spine and nerve system

____ Optimal health on all levels

What are your top three health goals?

1. _____
2. _____
3. _____

I hereby certify that the information provided is true and accurate.

Patient Signature: _____ Date: _____

CHIROPRACTIC CLINICAL OBJECTIVE

Physical, emotional and chemical STRESSES, common to our contemporary lifestyles, can result in misalignment of the spinal column causing damage to the nerve system. The result is a condition called Vertebral Subluxation. The Chiropractic exam/evaluation is specifically designed to detect Vertebral Subluxations in all phases of their progression.

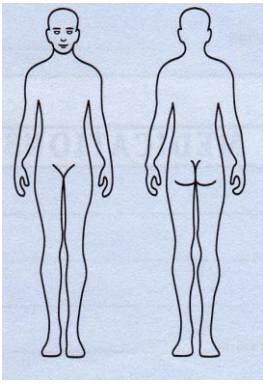
Many common symptoms and conditions are caused by the interference and stress on the nerve system. Please place a (X) on conditions that you are currently suffering from and a (O) on any conditions you have had in the past.

__Arthritis
__Back Curvature
__Mental / Emotional Disorders
__Diabetes
__Swollen or Painful Joints
__Convulsions / Epilepsy
__Skin Problems
__Bruise Easily
__Cancer
__Allergies
__Frequent Colds
__Upper Back Pain / Stiffness
__Excessive Gas
__Constipation / Diarrhea
__Prostate Problems
__Impotence
__Kidney Problems
__Frequent Urination
__Menstrual Problems / PMS
__Menopausal problems

__Headache
__Migraine Headache
__Neck Pain R/L
__Shoulder Pain R/L
__Numbness or Tingling in arms, or hands R/L
__Carpal Tunnel Syndrome R/L
__Dizziness
__Ringing in Ears
__Hearing Loss
__Loss of Balance
__Digestive Problems
__Depression
__Attention Disorder
__Anxiety Disorder
__Eating Disorder
__Trouble Concentrating
__Loss of memory
__Ear Infection
__Learning Disability

__Asthma
__Chest Pain
__Difficult Breathing
__Heart Problems
__Heart Attack
__Stroke
__Bruit
__High / Low Blood Pressure
__Varicose Veins
__Liver Trouble
__Gall Bladder Trouble
__Mid Back Pain / Stiffness
__Pain with cough, or strain
__Hip Pain
__Low Back Pain / Stiffness
__Sciatica
__Numbness or Tingling in legs or feet R/L
__Muscle Tightness
__Trouble sleeping

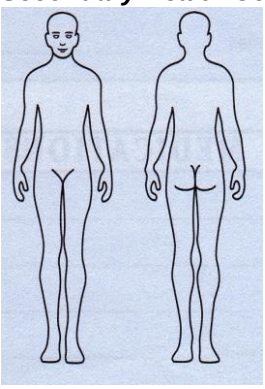
Primary Health Concern:_____



○ Please indicate the location of your pain or discomfort on the diagram
○When did this problem start? _____
○Have you ever had this problem before? □No □Yes If yes, when_____
○Please indicate quality of the pain:
□ Dull □ Burning □ Numb □ Stabbing □ Tingling □ Cramping
○Does this pain radiate or travel? □No □Yes If yes, please indicate on diagram
○Please indicate the severity of the pain on a scale from 1-10 (1 minor pain 10 major pain) 1-----2-----3-----4-----5-----6-----7-----8-----9-----10
○What makes this pain or condition better? _____Worse?_____
○What have you done to treat this problem? _____

Office Use Only:

Secondary Health Concern:_____



○ Please indicate the location of your pain or discomfort on the diagram
○When did this problem start? _____
○Have you ever had this problem before? □No □Yes If yes, when_____
○Please indicate quality of the pain:
□ Dull □ Burning □ Numb □ Stabbing □ Tingling □ Cramping
○Does this pain radiate or travel? □No □Yes If yes, please indicate on diagram
○Please indicate the severity of the pain on a scale from 1-10 (1 minor pain 10 major pain) 1-----2-----3-----4-----5-----6-----7-----8-----9-----10
○What makes this pain or condition better? _____Worse?_____
○What have you done to treat this problem? _____

Office Use Only:

HARBOR FRONT FAMILY CHIROPRACTORS, LLC

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: *An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.*

Health: *A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.*

Vertebral Subluxation*: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.*

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(signature) (date)

Consent to evaluate and adjust a minor child

I**,** _____ being the parent or legal guardian of _____have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

HARBOR FRONT FAMILY CHIROPRACTORS, LLC

INSURANCE ASSIGNMENT AGREEMENT

This office is pleased to accept your case on an insurance assignment basis as soon as your insurance company or responsible party verifies your coverage. We will file your claim forms to assist you in every way we can for reimbursement.

However, it must be understood that insurance contracts are between you, the patient, and your insurance company; you are responsible for any amount not paid by your insurance company.

In accepting your insurance on assignment we are extending you credit. We will extend a credit limit of $50.00. This courtesy may be withdrawn if circumstances below warrant it.

1. Our office does **not** guarantee that your insurance will pay. You will need to make every attempt to obtain verification of your policy coverage. However, if for any reason, your insurance claim is denied, you are responsible for the full amount of your bill.

2. Deductibles must be confirmed and satisfied prior to assignment being enacted.

3. Your insurance contract may state that you have a maximum monetary yearly benefit or visit benefit. Once you have reached your limit, we have cash plans that we can transfer you to.

4. Your insurance should pay within 30 days. If your insurance has not paid within 60 days, then you are required to pay the balance due. You will be reimbursed by your insurance company if and when it pays.

5. We will continue to bill your insurance on 30 day cycles as long as you are receiving active chiropractic care in this office.

6. Our office will not enter into a dispute with your insurance company over your claim. This is your responsibility and obligation.

7. If you choose to cease or dismiss yourself from care without the doctor's authorization, the balance of your account is due and payable in full at time of your discontinuance even if your insurance has been filed. If and when your insurance pays, the remainder will be credited/refunded once you have a zero balance.

8. Any special arrangement regarding finances must be signed by the doctor and patient and/or their representatives.

9. Any balances beyond 30 days will be assessed a $10 late fee. Any balances beyond 90 days will be assessed to collections which could potentially double your balance for any legal or collections fees incurred.

If you understand and agree with all the above policies, sign your name below and we will accept your insurance assignment as stated above.

_____ _____ _____

Patient Signature Date Staff Signature

HARBOR FRONT FAMILY CHIROPRACTORS, LLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This notice is effective as of November 28, 2005. By signing and dating below, I acknowledge that I was given the opportunity to read Harbor Front Family Chiropractors' Notice of Privacy Practices.

Print Name: _____

Signature: _____ Date: _____

Consent for Care:
By signing below, I voluntarily consent to chiropractic care. I understand that I am under the care and supervision of Merisa Stokely-Toellner and Christopher Toellner, D.C. and it is the responsibility of the staff to carry out the instruction of the said chiropractors.

Consent for Release of Information:
By signing below, I authorize Harbor Front Family Chiropractors to release any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

Assignment of Benefits:
By signing below, I hereby authorize payment of medical benefits to Harbor Front Family Chiropractors.

Signature: _____ Date: _____

_____ _____
Personal Representative Printed Personal Representative Signature

_____ _____
Description of personal representative's authority to act for the patient Date

If acknowledgement could not be obtained from the patient, the reasons must be documented below.

_____
_____
_____
_____
_____

_____
Authorized Staff Signature and Date

Chiropractic Insurance Verification

Harbor Front Family Chiropractors, LLC

Dr. Merisa Stokely-Toellner, Dr. Christopher Toellner

Patient Name: _____ DOB: _____

Insurance Information

Type of Insurance: _____ Phone #:_____

Contract #:_____ Group #:_____

Insured's Name: _____ Insured's DOB: _____

Relation to Insured: _____ Insured's Employer: _____

Additional Insurance? YES / NO If YES, Type of INS: _____

Contract #_____Group#:_____

Additional info: _____

Effective Date of Policy: _____

Is the policy? Calendar / Yearly

Individual Deductible: _____ **Family Deductible:** _____ **Does it apply to Chiropractic?** YES / NO

Has deductible been met? YES / NO **If NO, how much has been met?** _____

Is there a yearly maximum $ amount for chiropractic? _____

X-Ray coverage? YES / NO

X-Ray Co-Pay? _____ **Does Deductible apply to X-Rays?** YES / NO

Initial visit (exam) coverage/copay? _____ **Visit Co-Pay?** _____

Limit to # of Visits? _____ **Is this # combined with any other services?** _____

How many visits are left? _____

Additional Coverage Info: _____

Is there an HSA (health savings account) associated with this policy? YES / NO

Date looked up: _____ Internet / Phone

Representative Name:_____ Signature :_____