Hamel Chiropractic and Wellness -PATIENT INFORMATION

(Please fill in your information **in detail** so Dr. Hamel 1. Can determine whether he can help you or not and 2. If so give you his best recommendations so you can get the results you are looking for.)

Name:____ Date:________________

Address:____

City/State/Zip:____

Best Email Contact:__________________________________Cell#____________________

Sex:___M ___F Height:_______ Weight:_____ Age:_________ Date of birth:________________

Occupation:________________________ Employer:__________________________________

Marital Status:______ Spouse's Name:_________________________ # of Children:___________

Name of Primary Care Doctor/MD____

Who can we thank for referring you in?____

____

If your MD did not refer you, how did you find out about our office?____________________________

____

Where is your pain and/or other symptoms? (check what applies)

__Neck and back Pain/Stiffness __Sciatica __Knee Pain ___Bulging/Herniated Discs/Degeneration

__Headaches/Migraines __Hip Pain __Arthritis/Joint Inflammation __Shoulder Pain __Carpal Tunnel

What kind of pain are you having (circle): shooting burning stabbing numbness sharp throbbing

What do you really love to do, or enjoy doing that you can't right now because of the PAIN?, Check
__ Gym __ Play with kids __Travel __Golf __ Housework __ Garden __Run

__ Competitions __ Pickleball __ Walk the dog __ Handyman stuff __

How long have you been dealing with this pain/problem? __1 week, __1 month, __1 year, __over 1 year

Since your problem started is it: ___about the same ___getting better ___getting worse

If we can solve this problem/pain for you; how would your life be different? ____________________

____

If you become a patient Dr. Hamel will send you an email with specific information about your diagnosis and corrective exercises to help get you better quicker, is this OK: ___Yes ___ No

Impact Of Your Symptoms

In general, how is the symptom/condition interfering with your life?, (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work					Lifting				
Exercise					Sitting				
Relationships					Standing				
Sleep					Walking				
Self Care					Travel				
Energy					Driving				
Hobbies					Other				

Why is it important to fix this pain/problem now?________________________________

____

What have you tried in the past to solve this problem/pain(Circle): Medicine, PT, Chiro, Massage, Exercises, Cryotherapy, Surgery, Supplements. Did anything help?

____

What are your goals for seeking out care in our office for your condition(s)?

___I just want to take pills to feel better

___I would like to correct the underlying problem so it doesn't return

___I want to correct the underlying cause and have a strategy to be pain free long term.

What other health issues do you have that might be contributing to your aches and pains? (Circle) Overweight, Diabetes, Arthritis, Autoimmune Condition, Stress, Anxiety, Poor Sleep, Fatigue, Cancer, Thyroid, Hormone Imbalances.

Would you like to learn corrective exercises to help you feel better quicker and have the treatments be more effective? Yes___ No___

Are you open minded to taking natural supplements to help with pain, inflammation and to help speed up the healing process? Yes____ No____

Is there any other health concerns that you would like Dr. Hamel to address? Knee pain, shoulder pain, tennis elbow, other?

____

Notice of Privacy Practices

Acknowledgment Form

We will never share your personal or private information with others. We may only disclose information about you in the following ways:

- To another health-care provider, hospital or facility if they request it in order to assist them in caring for you.

- To an insurance carrier or employer if they are possibly responsible for payment or reimbursement of services.

- If you are not available to receive an appointment reminder, a message may be left on your answering machine or with a person in your household or at work. We may also send you correspondence by email/text.

Patient Responsibilities: I accept the recommendations for chiropractic care and any other services or products from this office. I promise to participate in the care of my treatment to the best of my capabilities, I am here to feel better and I am committed to the process.

Doctor Responsibilities: Explain diagnosis, treatment recommendations and answer any questions regarding patient care, appointments, supplements, shockwave therapy or cost of care. Make sure each patient has clear instructions about expectations, their treatment goals and outcomes.

My signature acknowledges I have read this notice, understand it and agree with the policies explained above.

Name (Print) ____

Signed ____________________________________ Date ____/____/____

ASSIGNMENT OF BENEFITS

Financial Responsibility

I have requested and/or received professional healthcare services from a healthcare provider associated with Practice on behalf of myself or my dependents, and understand that by making this request, I am responsible for charges incurred during the course of said services. I understand that fees for services rendered are due and payable on the date of service and agree to pay such charges according to the arrangements that have been made.

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I and/or my dependents are entitled to Pinnacle Health and Wellness Inc, (dba Hamel Chiropractic and Wellness). I certify that the health insurance information that I have provided is accurate as of the date set forth below and that I am responsible for updating all health insurance information. I hereby authorize Pinnacle Health and Wellness Inc, (dba Hamel Chiropractic and Wellness), and any affiliates on behalf of me and my healthcare provider to submit claims on my, and/or my dependent's behalf to the benefit plan to pay directly for services rendered to me or my dependents.

I am aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services are paid in full. I understand that I am responsible to pay my deductible and coinsurance.

Authorization to Release Information

I hereby authorize my health care provider to: (1) release any information necessary to my health plan (or its administrator) regarding my treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a copy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause of action that I may have under such insurance policy and/or benefit; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to the right to including, but not limited to, pursuing available administrative appeals or filing suit and all other causes of action on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. 2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of services I received from my provider and Pinnacle Health and Wellness Inc., (dba Hamel Chiropractic and Wellness), and, to the extent permissible by law, to claim on my behalf such benefits, claims, reimbursement, and any other applicable remedy, including fines.

A copy of this Assignment/Authorization shall be as effective and valid as the original.

Patient Name ______________________________ DOB ____________

Name of Subscriber ____________________________ DOB ____________

Patient or Guardian Signature ____________________________ Date ____________