Pinnacle Health and Wellness -PATIENT INFORMATION

(Please fill in your information **in detail** so we can make our BEST recommendations for your treatment)

Name:_____ Date:_____

Address:_____ E-mail:_____

City/State/Zip:_____

Home#:_____ Work#:_____ Cell#_____

Sex:___M ___F Height:_____ Weight:_____ Age:_____ Date of birth:_____

Occupation:_____ Employer:_____

Marital Status:_____ Spouse's Name:_____ # of Children:_____

Who is responsible for this account?_____

How did you find out about our office?_____

Muscles & Joints (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

How long have you been dealing with this condition(s)? __1 week, __1 month, __1 year, __over 1 year

What have you tried in the past to improve your condition?(Circle): Medicine, PT, Chiro, Massage, Exercises, Cryotherapy, Surgery, Supplements. Did anything help?_____

What are your goals for seeking out care for your condition?

___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 health condition? (Circle)
Overweight, Poor Diet, Diabetes, Arthritis, Autoimmune Condition, Stress, Anxiety, Poor Sleep, Fatigue

What would you do today if you no longer had to deal with your neck pain, back pain, headaches, chronic pain? What could you do that you are not able to do or have a lot of trouble doing because of the pain?

_____

How long do you think it will take to not only feel better, but to actually get well?_____(months, years)

Are you open minded to the idea of natural, alternative health care? E.g. nutritional and spinal treatments?
Yes____ No____

Please download our Pinnacle Health App from QR CODE before you come in for your initial visit

Apple Google

Assignment of Benefits (AOB)

This AOB form is required to bill on your behalf!

My signature and date in the box below authorizes each of the following:

1. Assignment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits to Dr. Tyler Hamel, DC for medical services, treatments or medical supplies furnished to me by Dr. Tyler Hamel DC.

2. Direct billing to Medicare, Medicaid, Medicare Supplemental or other insurer(s).

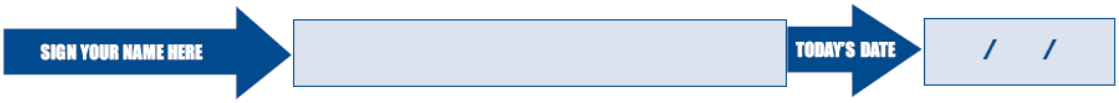
3. Release of my medical information to Medicare, Medicaid, Medicare Supplemental or other insurers and their agents and assigns.

4. Dr. Tyler Hamel, DC to obtain medical or other information necessary in order to process my claim(s), including determining eligibility and seeking reimbursement for medical supplies and treatments provided.

5. Dr. Tyler Hamel, DC to contact me by telephone or mail regarding my medical treatments, or a medical supplies order.

I agree to pay all amounts that are not covered by my insurer(s) including applicable co-payments and/or deductibles for which I am responsible.

Your Phone # ( )



I request that payment of Medicare, Medicaid, Medicare Supplemental or other insurance benefits be made on my behalf to Dr. Tyler Hamel DC and/or any of our corporate affiliates for any medical services or supplies furnished to me by Dr. Tyler Hamel DC. I authorize any holder of medical information about me to release to Dr. Tyler Hamel DC, my physician(s), caregiver, CMS, its agents and to my primary and/or other medical insurer any information needed to determine or secure eligibility information and/or reimbursement for covered services. I agree to pay all amounts that are not covered by my insurer(s) and for which I am responsible.

I _____ appoint _____ to act as
(name of beneficiary) (name of representative)
my personal representative with Medicare, Medicaid or private insurance.

Their relationship to me is spouse, child, parent, sibling, other _____.
(choose one) (or write in)

The reason I cannot sign is: _____.
(list reason)

My representative does or does not live with me.
(choose one)
If not, their address and phone number is:
Address: _____ Phone: _____

City/St/Zip: _____

Signature: _____ Date: _____
My signature and date above authorizes the above named person to sign on my behalf.