Dr. Monte Hessler

PATIENT REGISTRATION FORM

☐ NEW PATIENT ☐ UPDATE
☐ Private ☐ Worker's compensation ☐ Motor vehicle

Name: _____ ☐ Male ☐ Female
Last First Initial

Address: _____ Apt. # _____
City: _____ State: _____ Zip: _____ Birth Date: _____ Age: _____
Social Security # _____-_____-_____ Home Phone: _____
Work Phone: _____ Cell Phone: _____
E-mail address: _____
Employed: ☐ Yes ☐ No Employer Name: _____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
May we leave messages at home with other residents? ☐ Yes ☐ No
May we leave messages on your answering machine / voice mail? ☐ Yes ☐ No
May we contact you via E-mail or cellular telephone? ☐ Yes ☐ No
We cannot assure the confidentiality of any information shared by these means.

Who may we contact in case of emergency? Name: _____ Relationship: _____
Phone #1: _____ Phone #2: _____
Would you like to authorize another individual with whom we may talk about your medical concerns?
☐ Yes ☐ No **Note: We cannot give any info including appointment times to anyone not listed by you**
Name: _____ Relationship: _____

INSURANCE INFORMATION

Primary Insurance Company: _____ Social Security #: _____
Cardholder Name: _____ Birth Date: _____ Co-payment: $ _____
Address: _____ ID: _____ Group: _____
Is insurance through employer? ☐ Yes ☐ No If yes, employer: _____
Relationship to cardholder: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Secondary Insurance Company: _____ Social Security #: _____
Cardholder Name: _____ Birth Date: _____ Co-payment: $ _____
Address: _____ ID: _____ Group: _____
Is insurance through employer? ☐ Yes ☐ No If yes, employer: _____
Relationship to cardholder: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

If private and card carrier is not patient
Card carrier name: _____ Social Security #: _____
Sex: ☐ Male ☐ Female Date of Birth: _____ Relationship to patient: _____

Signature: _____ Today's Date: _____

Witness Signature: _____ Today's Date: _____

Dr. Monte Hessler

NAME: _____ **AGE:** _____ **DATE:** _____

REFERRING DOCTOR: _____

ARE YOU: ☐ MALE ☐ FEMALE
☐ RIGHT HANDED ☐ LEFT HANDED ☐ AMBIDEXTROUS

WORK HISTORY:

OCCUPATION: _____ EMPLOYER: _____ HOW LONG IN POSITION? _____

PLEASE DESCRIBE YOUR JOB DUTIES: _____

_____

ARE YOU WORKING? ☐ NO DATE LAST WORKED: _____
☐ YES ☐ FULL TIME ☐ PART TIME

RESTRICTIONS: ☐ NO ☐ YES

IF YES, PLEASE DESCRIBE: _____

_____

_____

CHIEF COMPLAINT:

REASON FOR VISIT: _____

LOCATION OF YOUR PAIN:

☐ HEAD	☐ SHOULDER	☐ MID BACK	☐ LEG
☐ NECK	☐ ARM	☐ LOW BACK	☐ KNEE
☐ HEADACHES	☐ WRIST/HAND	☐ HIPS/BUTTOCKS	☐ ANKLE/FOOT

HISTORY OF PRESENT ILLNESS:

DATE OF INJURY OR SYMPTOM ONSET: _____

TYPE OF INJURY: ☐ SPORTS INJURY ☐ JOB ACCIDENT ☐ CAR ACCIDENT

☐ OTHER (EXPLAIN): _____

PLEASE DESCRIBE IN DETAIL HOW YOU INJURED YOURSELF: _____

_____

_____

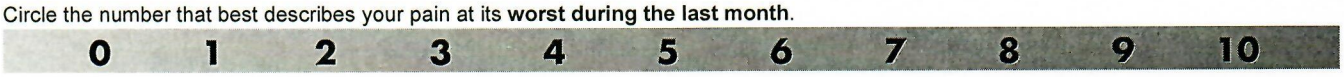
_____

PLEASE DESCRIBE YOUR **CURRENT SYMPTOMS:** _____

Circle the words that describe your pain.

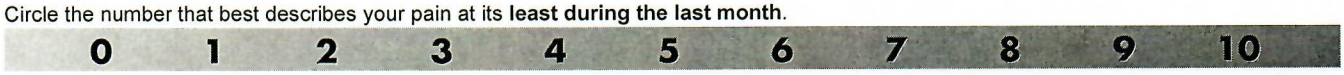
Aching	Sharp	Penetrating
Throbbing	Tender	Nagging
Shooting	Burning	Numb
Stabbing	Exhausting	Miserable
Gnawing	Tiring	Unbearable
Intermittent	Continuous	

Circle the number that best describes your pain at its **worst during the last month**.



No Pain — Worst pain imaginable

Circle the number that best describes your pain at its **least during the last month**.

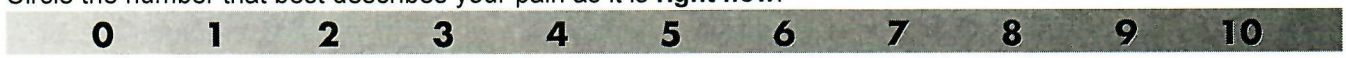


No Pain — Worst pain imaginable

Circle the number that best describes your pain **on average during the last month**.

No Pain — Worst pain imaginable

Circle the number that best describes your pain as it is **right now**.



No Pain — Worst pain imaginable

WHAT MAKES YOUR PAIN WORSE? _____

WHAT MAKES YOUR PAIN BETTER? _____

SINCE ONSET, IS YOUR PAIN: ☐ BETTER ☐ SAME ☐ WORSE

IF YOUR PAIN HAS CHANGED, BY WHAT PERCENTAGE: 10 20 30 40 50 60 70 80 90 100%

PREVIOUS TREATMENT:

HAVE YOU HAD TREATMENT SINCE YOUR INJURY? ☐ NO ☐ YES

E.R.?	☐ NO	☐ YES	WHERE? _____	DATE _____	
X-RAYS?	☐ NO	☐ YES	WHERE? _____	BODY PART _____	DATE _____
CT SCAN?	☐ NO	☐ YES	WHERE? _____	BODY PART _____	DATE _____
MRI?	☐ NO	☐ YES	WHERE? _____	BODY PART _____	DATE _____
EMG?	☐ NO	☐ YES			
EPIDURAL?	☐ NO	☐ YES			

OTHER (PLEASE EXPLAIN) _____

MEDICAL:

DR. _____ DATE OF 1ST VISIT _____ LAST VISIT _____

DIAGNOSIS GIVEN: _____

MEDICATIONS GIVEN: _____

OTHER TREATMENT PROVIDED: _____

DR. _____ DATE OF 1ST VISIT _____ LAST VISIT _____

DIAGNOSIS GIVEN: _____

MEDICATIONS GIVEN: _____

OTHER TREATMENT PROVIDED: _____

DR. _____ DATE OF 1ST VISIT _____ LAST VISIT _____

DIAGNOSIS GIVEN: _____

MEDICATIONS GIVEN: _____

OTHER TREATMENT PROVIDED: _____

CHIROPRACTIC: ☐ NO ☐ YES

DR. _____ DATE OF 1ST VISIT _____ LAST VISIT _____

DIAGNOSIS GIVEN: _____

FREQUENCY: ☐ EVERY DAY ☐ THREE TIMES/WEEK ☐ TWO TIMES/WEEK ☐ WEEKLY

HAS IT HELPED? ☐ NO ☐ YES

PHYISCAL THERAPY: ☐ NO ☐ YES

DATE OF 1ST VISIT _____ LAST VISIT _____ ONGOING? ☐ NO ☐ YES

HAS IT HELPED? ☐ NO ☐ YES HOME EXERCISE PROGRAM? ☐ NO ☐ YES

TREATMENT RECEIVED IN THERAPY:

☐ HOT/COLD PACKS ☐ TRACTION ☐ RANGE OF MOTION ☐ EXERCISE/STRENGTHENING

☐ ULTRASOUND ☐ MASSAGE ☐ AEROBICS ☐ AQUA THERAPY (POOL)

FUNCTIONAL HISTORY:

HAS THIS CONDITION INTERFERED WITH YOUR:

SOCIAL LIFE? ☐ NO ☐ YES

SEXUAL FUNCTION? ☐ NO ☐ YES

HOBBIES/SPORTS? ☐ NO ☐ YES

WORK? ☐ NO ☐ YES

AT ANY ONE TIME HOW MANY HOURS CAN YOU: SIT: _____ STAND: _____ WALK: _____

IN AN 8 HOUR DAY, HOW MANY HOURS CAN YOU: SIT: _____ STAND: _____ WALK: _____

HOW MANY POUNDS CAN YOU LIFT AT ONE TIME? _____

HOW OFTEN? ☐ NEVER ☐ OCCASIONALLY ☐ FREQUENTLY ☐ CONTINUOUSLY

HOW FAR CAN YOU WALK? ☐ 0-2 BLOCKS ☐ 4-6 BLOCKS ☐ A MILE OR MORE

CAN YOU USE YOUR HANDS FOR:	RIGHT		LEFT	
SIMPLE GRASPING	☐ NO	☐ YES	☐ NO	☐ YES
PUSHING /PULLING CONTROLS	☐ NO	☐ YES	☐ NO	☐ YES
FINE MANIPULATION	☐ NO	☐ YES	☐ NO	☐ YES

CAN YOU USE YOUR FEET FOR REPETITIVE MOVEMENTS IN PUSHING AND PULLING CONTROLS?

RIGHT: ☐ NO ☐ YES LEFT: ☐ NO ☐ YES BOTH: ☐ NO ☐ YES

ARE YOU ABLE TO:

	NEVER	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
BEND	☐	☐	☐	☐
SQUAT	☐	☐	☐	☐
CROUCH	☐	☐	☐	☐
CLIMB	☐	☐	☐	☐
REACH OVERHEAD	☐	☐	☐	☐
GET ON KNESS	☐	☐	☐	☐

Circle the numbers below that best describe how your condition has interfered with your daily functioning.

General Activity

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

Mood

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

Walking Ability

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

Normal Work Routine

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

Relations With Other People

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

Sleep

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

Enjoyment of Life

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

Ability to Concentrate

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

Appetite

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

What level of pain do you think you could function with on a daily basis?

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst pain imaginable

CURRENT MEDICATIONS FROM DOCTORS AND DENTISTS:

1_____ MG ___ DOSAGE_____ 2_____ MG ___ DOSAGE_____

3_____ MG ___ DOSAGE_____ 4_____ MG ___ DOSAGE_____

5_____ MG ___ DOSAGE_____ 6_____ MG ___ DOSAGE_____

7_____ MG ___ DOSAGE_____ 8_____ MG ___ DOSAGE_____

MEDICATION ALLERGIES: ☐ NO ☐ YES

IF YES, PLEASE LIST:

1. _____ / REACTION: _____

2. _____ / REACTION: _____

3. _____ / REACTION: _____

PAST MEDICAL HISTORY:

☐ ANXIETY	☐ HEART ATTACK/CAD	☐ POLIO	☐ THYROID TROUBLE
☐ DEPRESSION	☐ HIGH BLOOD PRESSURE	☐ CLAUSTROPHOBIA	☐ MIGRAINES
☐ ASTHMA	☐ LIVER DISEASE/HEPATITIS	☐ ULCERS/PUD	☐ HIGH CHOLESTEROL
☐ CANCER	☐ LUNG DISEASE	☐ RHEUMATIC FEVER	☐ ALCOHOLISM
☐ ARTHRITIS	☐ STROKE	☐ DIABETES	☐ SEXUALLY TRANSMITTED DISEASE
☐ HEART MURMUR			

HAVE YOU HAD SIMILAR SYMPTOMS/INJURY BEFORE? ☐ NO ☐ YES

IF YES, WHEN: _____ PLEASE DESCRIBE BRIEFLY: _____

_____

PAST SURGICAL HISTORY:

HAVE YOU HAD ANY SURGERIES? ☐ NO ☐ YES

IF YES, PLEASE LIST TYPE OF SURGERY/DIAGNOSIS AND DATE:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

FAMILY HISTORY:

PLEASE CHECK BOX FOR ANY MEDICAL CONDITION THAT A BLOOD RELATIVE HAS A HISTORY OF:

☐ ANXIETY	☐ ARTHRITIS	☐ PSYCHIATRIC ILLNESS	☐ ULCERS
☐ DIABETES	☐ DEPRESSION	☐ HIGH CHOLESTROL	☐ ALCHOLISM
☐ HEART ATTACK	☐ STROKE	☐ ASTHMA	☐ HIGH BLOOD PRESSURE
☐ CHRONIC PAIN	☐ THYROID DISEASE	☐ CANCER	☐ MIGRAINES
☐ DISABILITY	☐ LUNG DISEASE		

NUMBER OF BROTHERS: _____ NUMBER OF SISTERS: _____

FATHER: ☐ ALIVE / ☐ DECEASED: AGE _____ CAUSE: _____

MOTHER: ☐ ALIVE / ☐ DECEASED: AGE _____ CAUSE: _____

SOCIAL HISTORY:

MARITAL STATUS: (CHECK ONE OR MORE)

☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ "LIVING TOGETHER" ☐ SEPERATED

NUMBER OF CHILDREN: _____ AGE(S): _____

DO YOU SMOKE? ☐ NO ☐ YES HOW MUCH? _____

PREVIOUS SMOKER? ☐ NO ☐ YES WHEN STOPPED? _____

DO YOU DRINK ALCOHOL? ☐ NO ☐ YES HOW MUCH? _____

COFFEE, TEA, COLA BEVERAGES (CUPS/GLASSES/CANS PER DAY) _____

DO YOU USE RECREATIONAL DRUGS? ☐ NO ☐ YES

IF YES, WHAT TYPE/HOW OFTEN? _____

REVIEW OF SYSTEMS: PLEASE CHECK IF YOU **CURRENTLY** EXPERIENCE ANY OF THE FOLLOWING.

GENERAL ☐ FEVER ☐ WEIGHT GAIN/LOSS ☐ FATIGUE ☐ NIGHT SWEATS ☐ CHILLS ☐ WEAKNESS

DERMATOLOGIC ☐ JAUNDICE ☐ ITCHING/RASH ☐ LESIONS ☐ EASY BRUISING

HEAD ☐ TRAUMA ☐ HEADACHES ☐ TENDERNESS ☐ DIZZINESS

HEARING ☐ CHANGES (LOSS) ☐ RINGING IN EARS ☐ DISCHARGE

VISION ☐ CHANGES (LOSS) ☐ BLURRED VISION ☐ DISCHARGE ☐ GLASSES ☐ BLINDNESS ☐ RINGS AROUND LIGHTS ☐ DOUBLE VISION ☐ LIGHT SENSITIVITY

PULMONARY ☐ WHEEZING ☐ SHORTNESS OF BREATH ☐ CHRONIC COUGH ☐ COUGHING UP BLOOD

CARDIOVASCULAR ☐ CHEST PAIN ☐ SHORTNESS OF BREATH WITH EXCERTION ☐ LEG SWELLING ☐ RACING HEART ☐ USE >2-3 PILLOWS AT NIGHT

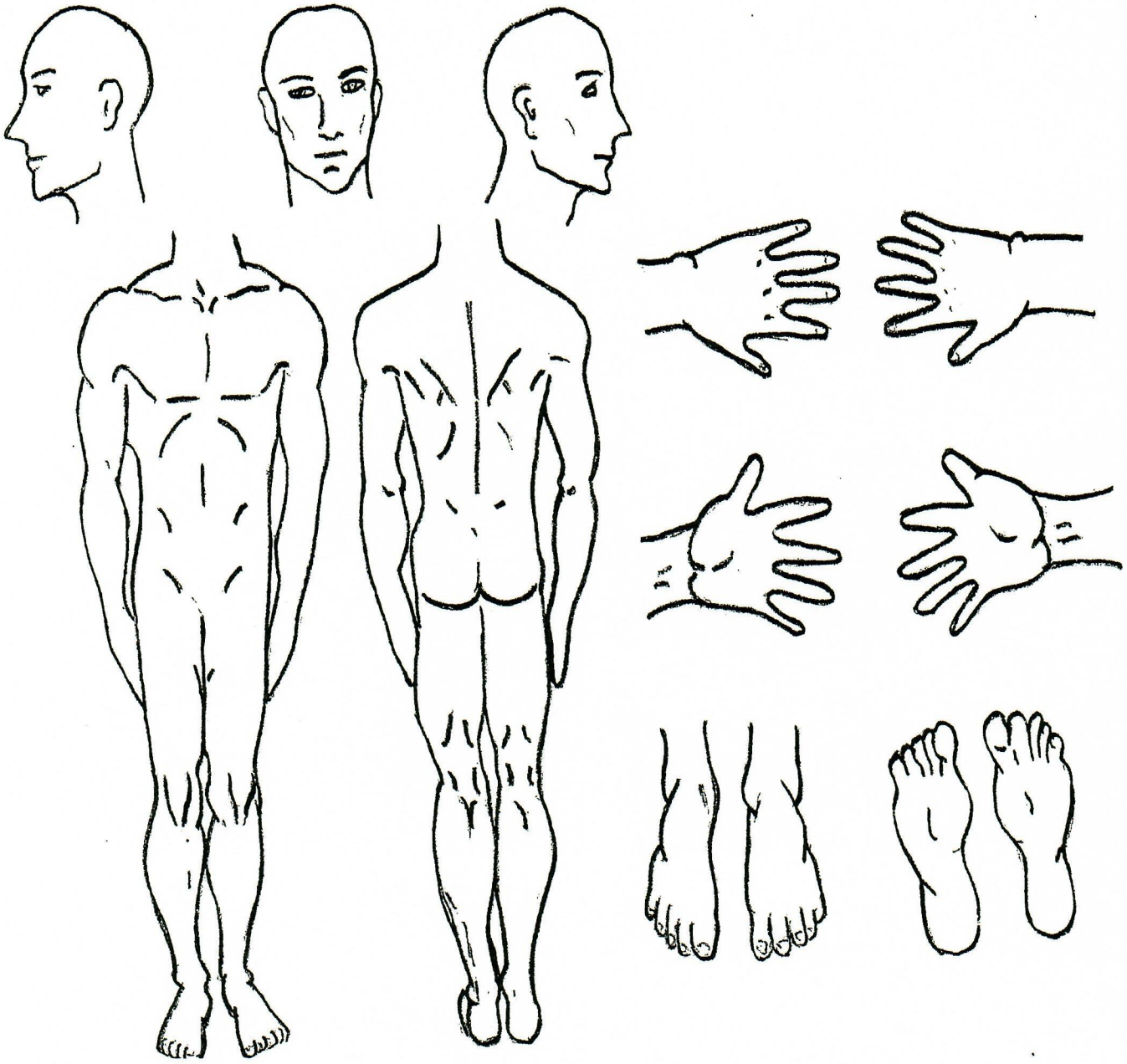
GASTROINTESTINAL ☐ NAUSEA ☐ ABDOMINAL PAIN ☐ DIFFICULTY CONTROLLING BOWELS ☐ BLOODY STOOLS ☐ VOIMITING ☐ HEARTBURN ☐ CHANGE IN COLOR OF STOOL ☐ CONSTIPATION ☐ DIARRHEA

GENITOURINARY ☐ PAIN/BURN ON URINATION ☐ URGENCY WITH URINATION ☐ FREQUENCY OF URINATION ☐ INCONTINENCE ☐ BLOOD IN URINE ☐ URINATION AT NIGHT ☐ STERILITY/IMPOTENCE ☐ DISCHARGE ☐ VENEREAL DISEASE ☐ PREGNANT ☐ SEXUAL PROBLEMS ☐ MENOPAUSE ☐ PAINFUL MENSTRUATION ☐ IRREGULAR MENSTRUATION ☐ VAGINAL BLEEDING

MUSCULOSKETAL ☐ ARTHRITIS ☐ JOINT SWELLING ☐ TRAUMA

MARK THE AREAS ON YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS. USE THE APPROPRIATE SYMBOL. MARK AREAS OF RADIATION. INCLUDE ALL AFFECTED AREAS.

"N"UMBNESS "A"CHE "S"TABING "T"INGLING "C"RAMPING "B"URNING



FOR STAFF USE ONLY – PLEASE DO NOT COMPLETE

HEIGHT _____ **WEIGHT** _____ **BLOOD PRESSURE** _____/_____ **GRIP STRENGTH: L.** ___ ___ ___

R. ___ ___ ___

CIRCUMFERENCE: UPPER ARM: L. _____ **FOREARM: L.** _____ **THIGH: L.** _____ **CALF: L.** _____

R. _____ **R.** _____ **R.** _____ **R.** _____

Pain Treatment History- Mark all of the following pain treatments you have undergone PRIOR to today's visit:

Treatment	No Relief	Moderate Relief	Excellent Relief
☐ Biofeedback	☐	☐	☐
☐ Bracing	☐	☐	☐
☐ Chiropractic	☐	☐	☐
☐ Decompression Therapy	☐	☐	☐
☐ Epidural Steroid Injection	☐	☐	☐
☐ Home Exercise Program	☐	☐	☐
☐ Medical Branch Blocks or Facet Inj	☐	☐	☐
☐ Medications			
☐ Topical Cream	☐	☐	☐
☐ Anti-inflammatories	☐	☐	☐
☐ Muscle Relaxants	☐	☐	☐
☐ Nerve Pain Medications	☐	☐	☐
☐ Physical Therapy	☐	☐	☐
☐ Radiofrequency Ablation	☐	☐	☐
☐ Rest	☐	☐	☐
☐ Spine Surgery	☐	☐	☐
☐ Spinal Column Stimulator Trial	☐	☐	☐
☐ Spinal Column Stimulator Permanent	☐	☐	☐
☐ TENS Unit	☐	☐	☐
☐ Trigger Point Injections	☐	☐	☐

☐ Other treatments:_____

☐ I have not had any prior treatments for my current pain complaints

Factors that Affect your Pain

	Increases Pain	Decreases Pain	No Change
☐ Bending Backward	☐	☐	☐
☐ Bending Forward	☐	☐	☐
☐ Changes in Weather	☐	☐	☐
☐ Climbing Stairs	☐	☐	☐
☐ Coughing/Sneezing	☐	☐	☐
☐ Driving	☐	☐	☐
☐ Lifting Objects	☐	☐	☐
☐ Looking Forward	☐	☐	☐
☐ Looking Downward	☐	☐	☐
☐ Looking Side to Side	☐	☐	☐
☐ Rising from a seated position	☐	☐	☐
☐ Sitting	☐	☐	☐
☐ Standing	☐	☐	☐
☐ Walking	☐	☐	☐

What other factors worsen or affect your pain that is not listed above? _____

Other Physicians you have seen to treat your pain: ☐ Acupuncturist ☐ Neurosurgeon ☐ Orthopedic Surgeon
☐ Pain Physician ☐ Physical Therapist ☐ Primary Care Provider ☐ Psychiatrist/Psychologist
☐ Rheumatologist ☐ Neurologist ☐ Other _____

Activity

How many days a week do you exercise? _____ Type of Exercise: ☐ Bicycle ☐ Cardio ☐ Strength
☐ Swimming ☐ Walking ☐ Other_____

Have you had two or more falls in the past year? ☐ Yes ☐ No

Dr Monte Hessler

CHIROPRACTIC PATIENT INFORMED CONSENT

Doctors of chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

- While rare, some patients may experience short term aggravation of symptoms, rib fractures, burns, or muscle and ligament strains or sprains as a result of manual therapy techniques and modalities; therefore based upon my previous medical history and today's examination, Dr. Hessler will determine if it is clinically appropriate to perform a manual adjustment.
- In an exceptionally small percentage of the population, there have been reported cases of stroke associated with many common neck movements including adjustment of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches, and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge that I understand the above statements and will have the opportunity to discuss, with my chiropractor that nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this consent.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustment. I intend this consent to apply to all my present and future chiropractic care.

_____ _____

Signature Dated

_____ _____

Printed Name Witness

_____

Signature of Parent or Guardian (if a minor)

Dr. Monte Hessler

Patients Bill of Rights

You Have the Right...

- Not to be denied participation in all treatment services based on the grounds of race, color, creed, sex, sexual orientation, national origin, disability, diagnosis, religion, age or socioeconomic status.
- To considerate and respectful care.
- To reasonably expect, from staff members responsible for your care and welfare, complete and current information concerning you condition.
- To know by name and position the staff members responsible for your care.
- To reasonable consideration of your privacy and to be treated with respect and full recognition of your dignity, individuality, and reasonable cultural needs.
- To expect a reasonable response to your request.
- To be from harassment, neglect, or exploitation.
- To be reasonably informed at the time of your check out of medical and/or ancillary services charges.
- To be afforded the opportunity to participate in planning and implementing your treatment program, to refuse care, treatment or services in accordance with law and regulation.
- To the maintenance of confidentially of your clinical record.
- To access information contained within your medical record.
- To be informed, when appropriate, about the outcomes of care, including unanticipated outcomes.

You have the Responsibility...

- To be honest about matters that relate to you as a patient.
- To provide staff with accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters pertaining to your health.
- To report any perceived risks in your care.
- To report any unexpected changes in your condition to those responsible for your care and welfare.
- To follow the care, service or treatment plan developed.
- To ask questions when you do not understand or have concerns about your plan of care.
- To know the staff who are caring for you.
- To be considerate and respectful of the rights of both fellow patients and staff.
- To honor the confidentiality and privacy of other patients.
- To be considerate of the property of Comprehensive Pain Specialists.
- To assure the financial obligations of your healthcare are fulfilled as promptly as possible.

_____ _____

Patient Signature Date

Dr. Monte Hessler

THIS NOTICE DESCRIBES HOW PRIVATE HEALTH INFORMATION ABOUT YOU MAYBE USED AND DISCLOSED, AND HOW YOU MAY ACCESS THIS INFORMATION

Our Healthcare Practice takes patient privacy matters seriously. We work hard to meet and exceed all existing rules and regulations and will work to keep you informed regarding our policies and your personal rights regarding privacy.

We are required by federal and state law to maintain the privacy of your health information. We are also required to give you this NOTICE about our privacy practices, our duties, and your rights concerning your personal health information. We must follow the privacy practices described in this Notice while it is in effect. This Notice takes effect on April 14, 2003, and will remain in effect until we replace it, at which time we will issue a new Notice to Patients indicating a new activation date. You may request a copy of our Notice at any time, and may request additional copies, as needed by contacting our office.

How We Disclose Health Information:

Specialist Referrals:
We use and disclose health information about you for treatment within our practice, for general healthcare operations and payment collection. That means your information is available to our immediate staff, and to other practitioners who we may refer you to for additional treatment. This includes, but is not limited to, other healthcare specialists such as surgeons, laboratories and the like. We will exercise our judgment in only distributing the minimum necessary information needed when sending health information to any outside Associates.

General Business Operations:
Your information may be reviewed in the course of general healthcare operations for activities such as conducting quality reviews, assessing practitioner performance, evaluation of business costs, conducting training programs, licensing, accreditation, and certain certification activities, and other business related evaluations to help us in improving our delivery of healthcare to our patients.

Payment and Collection:
Your health information will be sent to third party payers for insurance collection and, when applicable, to collection agencies for assistance to us receiving payment for services rendered. Additionally information maybe used from time to time as necessary to secure payment for services. We will use our professional judgment and experience with common practice to make decisions on what information to disclose to secure payment.

Family, Friends, Personal Representatives and Others:
We may disclose your information to a family member, friend, or other persons to the extent necessary to help with your healthcare or with payment for your healthcare. You may however request that we not disclose to anyone with your healthcare or with payment for your healthcare. You may however request that we not disclose to anyone other than yourself, of which we will abide. We will use our professional judgment and experience with common practice when disclosing your health information that is directly relevant to the person's involvement in your healthcare. We may disclose health information to others who may be involved in your healthcare and are trying to ascertain your general condition, your current location, or learn of your death.

Marketing Health-Related Services:
We will not use your health information for marketing communications without written authorization. Under federal privacy rules we may send you update information about our practice or healthcare system, send you information regarding programs and products we offer to further enhance your care and treatment, send reminder notices for appointments, and offer small nominal gifts from time to time, such as tooth brushes, which is not considered marketing. We will never provide your name to an outside organization for marketing.

Our Business Associates:
We require all our Business Associates to sign a contract specifying they too are strictly following privacy rules and regulations. We will act swiftly and decisively if we find any violated provisions of their contract.

When the Law Requires Us to Disclose:

We may disclose your health information to government agencies or others, as required by law. Additionally we disclose to military authorities for purposes such as national security.

Abuse and Neglect:
We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or are the victim of possible other crimes. We disclose to the extent necessary to avert further harm to you or others.

PATIENT RIGHTS

Access to Records:
You have a right to look at copies of your health information, with limited exceptions. You may request photocopies and copies of x-rays. We will use the format you request, unless we are unable to do so. You must make your request to access for health information in writing to our practice. We can provide with a form to do this, or you may do it by writing a letter specifying exactly what you want to review. If we can provide photocopies we will charge you a set amount for each page copied. If you wish to receive x-ray duplicates we will charge you a set fee per film copied. Check with the office for the current fee schedule. If you request an alternate format we will charge you per the expenses we incur to satisfy your request.

We have up to 30 days (and sometimes longer) to respond, depending on what is required to meet your request. Specifics will be provided upon request.

List of Disclosures:
You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment healthcare operations and a few other activities as specified by law, for the last six years, but not before April 14, 2003. If you request this list more than once in a 12 month period we will charge you a reasonable cost based fee for responding to the additional requests. Fees will be disclosed prior to action being taken.

Restrictions:
You have the right to place additional restrictions on our use or disclosure of your health information. We are not required to agree with these restrictions, however, if we do agree, we will abide by our agreement, except in certain emergency situations.

Communications to You:
You may request we communicate with you about your health information by alternative means or to alternative locations, when you make the request in writing. You must specify the alternative means or locations and provide satisfactory explanation how payments will be made under alternative means or location.

Amendment to Records:
You have the right to request that we amend your health information when requested in writing. We may deny your request however, we will note in your records your request to amend and reason. We cannot delete anything from the formal record but we can add addendums to the record that may be able to meet your amendment request.

Electronic Notice of This Information:
If you received this information electronically (via email), you are entitled to receive this in written hard copy form.

Dr. Monte Hessler

Financial Policy and Patient Responsibilities

Thank you for choosing us as your Chiropractic health care provider. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

Dr. Hessler is committed to providing the best treatment possible for his patients. Patients are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

If your insurance plan does not cover our services, payment in full is expected at the time of your visit. We accept cash, checks, MasterCard, Visa, AMEX, and debit cards.

Updated insurance information must be given to us at the time of service. We will require a copy of your insurance cards before services are performed and these will be scanned into our system. We file all insurance claims in a timely manner. After filing, we allow 60 business days for your insurance company to pay. If your insurance company fails to make payment, you will be responsible for payment in full.

If the patient is a minor, the adult accompanying the child for treatment will ultimately be responsible for payment. We cannot become involved in third party liabilities, personal injury, or custody issues to determine the responsible party for payment. We cannot accept an attorney's letter of payment guarantee.

If you have a past due personal balance on your account, you will need to contact the billing office to make payment arrangements prior to receiving most services. Any account that is past due will be sent to an independent collection service and may be subject to reporting to the credit bureau and possible termination of the doctor/patient relationship.

Copays, Co-insurance and /or Deductibles – There are copay, co-insurance or deductible charges associated with certain medical services and tests. Patient payment of the copay, co-insurance, or deductible is required at the time of service.

Pre-certification – Pre-certification or prior approval may be required by your health plan before certain procedures, tests, or surgeries are performed. We will assist you in the precertification process by contacting your insurance company on your behalf. It is your responsibility to confirm that you have been granted approval of certification before your appointment so you do not incur any unnecessary personal charges.

Other physician charges – Our practice is committed to providing the best treatment for our patients that may necessitate the outsourcing of some services to other professionals. When this occurs, you may receive a statement from the provider of ancillary services such as Pathology, Laboratory, and/or Radiology interpretation services.

Motor Vehicle Accident – Medical insurance will be filed and any copay, co-insurance or deductible is required to be paid at the time of service. If no payment is received from the insurance company after 60 business days, it will become the patient's responsibility.
Filing claims to the auto insurance carrier is the responsibility of the patient.

Unless contractually prohibited by your insurance carrier, you will be personally charged the following additional fees. These fees will not be filed to your insurance carrier and are the

direct responsibility of the patient. Please initial to the left of each category to indicate your acknowledgement.

_____***Missed Appointments*** – Unless canceled at least 24 hours in advance, depending on the type of (INITIAL) appointment, you will be charged a fee of $25.00 to $50.00 for each occurrence.

_____***Forms / Letters / Copy of Medical Records*** – There is a charge for completion of all forms, (INITIAL) letters, or copying of medical records. Payment must be made before the forms, letters, or medical records are given to the patient. Forms and letters are typically $10.00 - $40.00. Copying of medical records is charged according to state guidelines.

I certify that the information given by me in applying for payment under my insurance contract is correct. I authorize any holder of medical or other information about me to release to any third party payers (including Medicare and Medicaid) information needed for claims for health care benefits. I request that payment of authorized health care benefits be paid and I assign the benefits payable for the physician services to the physician or organization furnishing the services. I authorize such physician or organization to submit a claim to my health insurance carrier or any other third party payer, including Medicare and Medicaid, on my behalf. I request payment of benefits under Title XVIII (Medicare and XIX Medicaid) of the Social Security Act to Dr. Monte Hessler. I understand that I am financially responsible for charges not covered by the assignment, and I hereby guarantee timely payment in full of any such charges.

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Print Patient Name: _____Date _____

Signature of Patient or Responsible Party _____