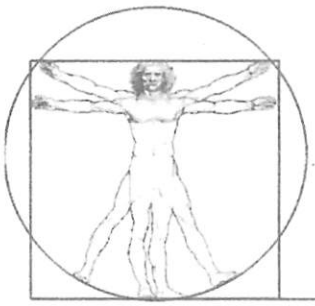

O'Dell Family Chiropractic

28245 Southfield Rd., Lathrup Village, MI, 48076 Phone: 248-552-1110, Fax: 248-552-0771

PATIENT INTRODUCTION CARD

TO SAVE TIME AND ALLOW US TO BETTER SERVE YOU, PLEASE COMPLETE ALL QUESTIONS **DATE:**

1. Name *(Please Print)*			2. Phone (_____) Cell (_____) Email
3. Complete Address Street City State Zip			4. Date of Birth / 5. Age
6. ❑ Married ❑ Widowed ❑ Male ❑ Single ❑ Divorced ❑ Female	7. No. of Children	Smoke? ❑ Yes ❑ No Drink? ❑ Yes ❑ No	8. Occupation
9. Employer Name, Address and Phone No.			
10. Drivers Lic. No. Social Security No.	11. Referred by		12. Have you had chiropractic care before? ❑ Yes Where? ❑ No
13.What is you major complaint? How long have you had it? Cause if known. Have you had this before? When and for how long?			
NOTE: Do you want maximum correction or just temporary relief? *(Circle One)*			
14a. Do you have health insurance? *(If yes, please provide us with a copy of insurance card)* ❑ Yes ❑ No	14b. Policy Holder Name 14c. Policy Holder SS#		14d. Policy Holder Gender *M F* 14e. Policy Holder Date of Birth
15. Are you on Medicare? ❑ Yes Medicare No. ❑ No	16. Are you on Medicaid, (ADC), etc.? ❑ Yes Medicaid No. ❑ No	17. Are you on a reimbursing insurance policy? ❑ Yes Company ❑ No	
18. Please indicate if you are here because of: ❑ an on the job injury *or* ❑ an auto accident *or* ❑ home injury Date injured Insurance Company Attorney's Name *(if any)* Attorney's Address			

19. Have you ever had any falls, auto accidents, or injuries? ❑ Yes Please Describe ❑ No	MONTH, YEAR	TYPE OF ACCIDENT	DESCRIBE INJURY

20. Have you ever had surgery? ❑ Yes Please Describe ❑ No	MONTH, YEAR	TYPE OF SURGERY	COMMENTS

21. Are you presently taking medication? ❑ Yes Please Describe ❑ No	NAME OF DRUG	DOSES PER DAY	REASON FOR	HOW LONG

(PLEASE TURN OVER)

22. Please check any of the following that give you difficulty.

❑ Headaches	❑ Fainting	❑ Heart attacks	❑ Numbness
❑ Shooting head pains	❑ Loss of Balance	❑ High blood pressure	❑ Constipation
❑ Sinus trouble	❑ Ringing in ears	❑ Low blood pressure	❑ Kidney trouble
❑ Loss of smell	❑ Blurred vision	❑ Anemia	❑ Menstrual cramps and pain
❑ Allergies	❑ Lights bother eyes	❑ Stomach trouble	❑ Menstrual irregularity
❑ Hayfever	❑ Neck pain	❑ Nerves and nervousness	❑ Diabetes
❑ Asthma	❑ Muscle spasms in neck	❑ Inner tension	❑ Cancer
❑ Loss of taste	❑ Grating in neck	❑ Irritability	❑ Sleeping problems
❑ Tightness of throat	❑ Tightness of shoulder muscles	❑ Cold sweats	❑ Painful joints
❑ Inflammation of throat	❑ Pain in shoulder and arms	❑ Gall bladder trouble	❑ Swollen joints
❑ Thyroid trouble	❑ Pins and needles in arms and hands	❑ Indigestion	❑ Pinched nerves in back
❑ Twitching of face	❑ Cold hands	❑ Intestinal gas	❑ Pins and needles in legs
❑ Loss of memory	❑ Carpal Tunnel Syndrome	❑ Low Back Pain	❑ Swollen ankles
❑ Fatigue	❑ Shortness of breath	❑ Mid-back pain	❑ Cold feet
❑ Depression	❑ Chest pain	❑ Dizziness	❑ Pains in legs and feet

Medical History

1. What types of medical practitioners have treated you for this condition? NEUROLOGIST M.D. – ORTHOPEDIC SURGEON M.D. – GENERAL PRACTITIONER M.D. – GENERAL PRACTITIONER D.O. – PHYSICAL THERAPIST – OTHER _____

2. What was their diagnosis of your condition? _____

3. What type of treatment have you received for this condition, and for how long? _____

4. Have you, or any member of your family, ever been diagnosed as having SCOLIOSIS?_____ If so, who, how long ago, and what was the nature and duration of treatment, if any? _____

5. Have you ever lost time off work for this or any other spinal condition?_____ If so, give the approximate dates and duration of time off work. _____

6. Do you consider yourself an energetic, physically active person?_____ If so, do you exercise regularly? Explain. _____

Previous Chiropractic Care

Have you ever received chiropractic care?

If yes:

a. When you were previously under Chiropractic care did you follow a regular schedule of adjustments over an extended period of time to achieve complete restoration of normal function or did you merely continue until the symptoms disappeared? _____

b. Were the results of your previous Chiropractic care successful? _____

c. Have you followed a program of periodic maintenance adjustments to maintain normal function? (If so, what intervals?) _____

d. Are you seeking SYMPTOMATIC RELIEF OR MAXIMUM CORRECTION? _____

Chiropractic care has one focus. This focus is you, and the health of your spinal nerve system. Our job is to *locate* and *correct* any spinal interference called a *vertebral subluxation.*

Patients enter our office for one or more of 4 reasons. **Please circle which reason you are here for:**

1.) **Relief Care** - This care is provided to patients in obvious physical, mental or emotional pain and discomfort.
2.) **Corrective Care** - This care requires regular specific chiropractic adjustments to allow structural improvements for longer lasting results.
3.) **Maintenance Care** - Consistent weekly to monthly adjustments for continued proper spinal health (follows period of corrective care).
4.) **Lifetime Family Wellness Care** - Regular weekly to monthly care for family members; understanding the necessity of a healthy spine for a healthy life and longevity.

_____ Patient Signature

_____ Date

I acknowledge that O'Dell Family Chiropractic's "Notice of Privacy Practices" has been provided to me.

I understand that I have a right to review O'Dell Family Chiropractic's "Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of O'Dell Family Chiropractic.

The Notice of Privacy Practices for O'Dell Family Chiropractic is also provided on request at the front desk of this practice. This Notice of Privacy Practices also describes my rights and O'Dell Family Chiropractic's duties with respect to my protected health information.

O'Dell Family Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practice. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, ask for one at the time of my next appointment or accessing O'Dell Family Chiropractic's website.

I have the right to revoke this consent, in writing, except to the extent that O'Dell Family Chiropractic has taken action in reliance on this consent.

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of a copy of this notice and my understanding and my agreement to its terms.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

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 used to attain it. This will prevent any confusion or disappointment.

Adjustments: An adjustment is the specific application of force to facilitate the body's correction of vertebral subluxations. 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 Subluxations: A misalignment of one or more of the 24 vertebrae 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 subluxations. However, if during the course of chiropractic spinal examination, 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.

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

_____

Parent Signature, if under 18 years

If child is under 18, please sign:

I, _____give consent for my son/daughter _____to receive chiropractic care at O'Dell Family Chiropractic.

Signature of Parent/Guardian_____Relationship_____Date_____

O'DELL FAMILY CHIROPRACTIC
wellness and prevention

Insurance Assignment

1. Waiting for insurance payment is a courtesy provided by this clinic. We reserve the right to withdraw this courtesy at any time. We will bill your insurance company and accept assignment of benefits during you corrective care period. Direct assignment will be discontinued when you have finished corrective care and a maintenance program is recommended. We will notify you of the change.

2. **You must pay all deductible and co-pay amounts as they are applied to you by your insurance company.**

3. The insurance carriers are billed on specific 30 day cycles.

4. If you receive payment from your insurance carrier during the period which the clinic has accepted assignment of benefits, you are to bring the check into this office within one week of receipt and endorse it over to the clinic. Failure to do this will result in collection action.

5. If you discontinue your care for any reason other than discharge by the doctor, you will be responsible for any unpaid balance regardless of any claims submitted to your insurance company.

6. **This office will verify insurance benefits; this is not considered to be a guarantee of benefits or of insurance payment. This clinic does not promise that an insurance company will pay. In the event that the insurance company disputes or rejects the claim, it will be the patient's responsibility to pay the charges and pursue reimbursement from the insurance company.**

I have read the above provisions and wish to participate in the insurance assignment program;
I hereby agree to abide by the provisions of this program as specified above.

_____ _____

Patient Signature Date

_____

Parent Signature, if under 18 years old