MEDERI HEALTH CENTER REGISTRATION AND HISTORY

1 Patient Information

Date: _____

Social Security #: _____

Birthdate: _____/_____/_____

Patient Name: _____
Last Name

_____
First Name Middle Initial

Address: _____
City: _____ State: _____ Zip: _____
Home Phone:(____) _____ Cell Phone: (____)_____
Sex □ M □ F Age: _____
Height: _____ Weight: _____
□ Married □ Widowed □ Single □ Minor
□ Separated □ Divorced □ Partnered for _____ year

E-Mail: _____
Patient: Employer/School: _____
Occupation: _____
Employer/School Address: _____
Employer phone: _____
Spouse's Name: _____
Birthdate: _____
SS#: _____
Spouse's Employer: _____
How did you hear about us? _____
_____
May we contact you via email with information about our practice and/or general health information? Y / N

IN CASE OF EMERGENCY, CONTACT:
Name: _____ Relationship _____
Home Phone: (____)_____ Work Phone(____)_____

2 Financial Policy

1. Payment for the Initial New Patient Visit with our doctors is required at the time of your first visit to our office. All other payments, including adjustments, nutritional evaluation, and vitamin/supplements are due at the time that the services are performed. For your convenience we accept cash, checks, MasterCard, Visa, Discover and American Express Credit cards.

2. Because we run a cash practice, we DO NOT file any insurance claims including Medicare. We are currently not providers for Medicare, which means you WILL NOT and CANNOT be reimbursed by Medicare for your visits to our office. Upon request we will print a statement that will provide you and your private insurance carrier with the information necessary to make a claim. If you wish to file a claim you are responsible for contacting your insurance carrier and submitting your claim. Please note that this does not guarantee payment for any part of services rendered. It has been our experience that insurance companies will often deny reimbursement for procedures. It is not uncommon for some insurance companies to deny a claim either at the onset of the patient's acute care or when a patient seeks reimbursement for continued care.

I have read and understand the payment policy of Mederi Health. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Mederi Health and my insurance company. I understand that Mederi Health does not file insurance claims and I am solely responsible for the balance of my account.

Patient's signature (or guardian if patient is a minor) Date

_____

Office Manager/Billing Specialist Date

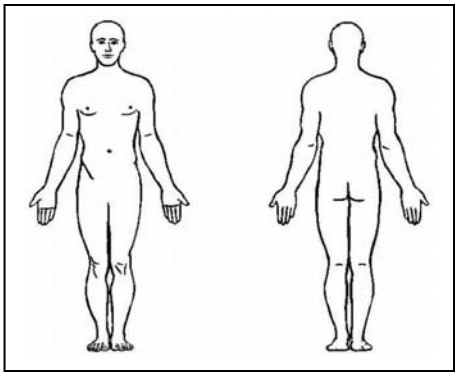
_____

3 ACCIDENT INFORMATION

Is this condition due to an accident? □ Yes □ No
Date: _____
Type of accident □ Auto □ Work □ Home □ Other
To whom have you made a report of your accident?
□ Auto Insurance □ Employer □ Worker Comp. □ Other
Claim Number:
_____

4

Reason for Visit: _____
When did your symptoms appear? _____
What caused your symptoms to appear? _____
Is this condition getting progressive worse? □Yes □No □Unknown
Mark an X on the picture where you continue to have pain, numbness or tingling.→
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____
Type of pain: □ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting
□ Burning □ Tingling □ Cramps □ Stiffness □ Swelling □ Other
How often do you have this pain? _____
Is it constant or does it come and go? _____
Does it interfere with your □ Work □ Sleep □ Daily Routine □ Recreation
Activities or movements that are painful to perform □ Sitting □ Standing □ Walking □ Bending □ Lying Down



5 Health History

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other_____

Names of other doctor(s) who have treated you for your condition: _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on **"YES"** or **"NO"** to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Migraine Head.	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Chemical			Herpes	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Dependency	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Chicken Pox	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No	Other _____		

Any other conditions or illnesses that we should be aware of? _____

_____

_____

EXERCISE

- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

WORK ACTIVITY

- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

HABITS

- ☐ Smoking Packs/Day _____
- ☐ Alcohol Drinks/Week _____
- ☐ Coffee/Caffeine Drinks Cups/Day _____
- ☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

6 MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

On Behalf of Mederi Health and Staff

Patient Consent Form

The Department of Health and Human Services has established a Privacy Rule to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purpose of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name:_____ Signature:_____ Date:_____

(Need Parent or Guardian Name & Signature if patient is a minor)

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse or Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all our employees, mangers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the Privacy Rule. We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses if PHI in accordance with the government rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

The World Health Organization states that when "employed skillfully and appropriately, chiropractic care is safe and effective for the prevention and management of a number of health problems." As with all interventions, there are risks associated with spinal manipulative therapy (SMT). Common, but non-serious side effects include: discomfort, headache, and fatigue which will go away after 24 to 48 hours. Extremely infrequent, but potentially serious side effects include: strokes, spinal disc herniation, vertebral and rib fractures and cauda equina syndrome.

CONSENT TO BE TREATED

I _____ give Dr. Paul Endriss consent to treat ME or

my minor child _____ with Chiropractic Adjustments and/or the patented Active Release Technique®.

Signature:_____ Date:_____

(Need Parent or Guardian Name & Signature if patient is a minor)