West Mesa Wellness

Dr. David B. Greif, D.C.

PATIENT INFORMATION FORM

Name: _____ Today's Date:_____/_____/_____

Social Security Number _____-_____-_____ Date of Birth: _____/_____/_____ Age: _____

Gender: F / M Height: _____ Weight:_____

Marital Status: ☐ Married ☐ Separated ☐ Widowed ☐ Single

CURRENT ADDRESS

Street _____

City_____ State_____ Zip _____

Phone (_____)_____-_____ Cell (_____) _____-_____ Work (_____) _____-_____

Occupation _____ Employer _____

Student at _____ ☐ Full-Time ☐ Part-Time

EMERGENCY CONTACT _____ Phone (_____) _____-_____

Address of contact person _____

Purpose of today's visit?_____

Is your condition or injury due to an accident or work-related cause? ☐ Yes ☐No

Where did the injury occur?

_____

Approximate date of injury _____/_____/_____

Please indicate any other healthcare providers who you've seen for this injury/condition and dates seen

Name: _____ Type of Practice: _____ Last Visit ____/____/____

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Have you been treated for any health condition by a physician in the last year: ☐ Yes ☐ No

Describe: _____

I have read, understood and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient Signature: _____ Date: _____/_____/_____

If Patient is a minor, a parent or legal guardian must sign a consent form.

8625 Golf Course Rd NW, Ste A2, ABQ NM 87114 (505)899-6600 fax (505) 899-3262

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GENERAL HEALTH HISTORY

General History: Check only the conditions that apply to you

- ○ Osteoporosis, osteopenia, ankylosing spondylitis
- ○ Osteoarthritis, rheumatoid arthritis or gout
- ○ Bulging or herniated disks
- ○ Scoliosis, spondylothesis, spina bifida or fused vertebrae
- ○ High blood pressure
- ○ Heart attack or have a pacemaker or neck/chest shunt
- ○ History of strokes, epilepsy, seizures or fainting
- ○ Diabetes, hypoglycemia
- ○ Cancer/cancer treatment Describe:_____
- ○ Cigarette use
- ○ Currently pregnant Trimester? _____

Check all symptom areas that apply

- ○ Headaches/Migraines
- ○ Neck pain, soreness or stiffness
- ○ Low back pain, soreness or stiffness
- ○ Upper back pain, soreness or stiffness
- ○ Hip pain
- ○ Arm/hand pain, numbness or tingling
- ○ Leg/foot pain, numbness or stiffness
- ○ Other _____

Please list any prior injury/surgery

_____

_____

_____

Please list medications you are taking

_____

_____

_____

Consent for Care: It is my choice to receive manual therapy, and I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health.

Patient Signature:_____Date:_____/_____/_____

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Patient Informed Consent to Chiropractic Treatment

As with any healthcare procedure there are certain complications which may arise during chiropractic manipulation and therapy. Doctors of Chiropractic are required to advise patients that there are risks associated with such treatment. In particular you should note:

1.) Some patients may experience some stiffness or soreness following the first few days of treatment.
2.) Some types of manipulation have been associated with injuries to the arteries of the neck leading or contributing to serious complications including stroke. This occurrence is exceptionally rare and remote. However, you are being informed of the possibility regardless of the extreme remote chance.
3.) I will make every effort to screen for any contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.
4.) Other complications may include fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns.

The probabilities of these complications are rare and generally result from some underlying weakness of the bone or tissue which I check for during the history, examination, and x-ray (when warranted).

I acknowledge I have had the opportunity to discuss the associated risks as well as the nature and purpose of treatment with my chiropractor.

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

_____ _____

Patient Signature Patient Name (Please Print)

_____

Witness Signature

_____

Date

PATIENT CONSENT FORM

Regarding the Use & Disclosure of Protected Health Information (HIPAA "Consent Form")

For the purposes of this Consent Form, "Office" shall refer to : Taylor Ranch Family Chiropractic d/b/a WEST MESA WELLNESS.

I understand that some of my health information may be used and/or disclosed by the Office to carry out treatment, payment or health care operations and that for a more complete description of such uses and disclosures I should refer to the Office's privacy notice entitled, "Our Privacy Practices." I understand that I may review this privacy notice at any time prior signing this form.

I understand that over time the Office's privacy practices may need to change in accordance with law and that if I wish to obtain a copy of the notice as revised, I can call the Office to request such copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment or health care operations and that I can also revoke this Consent in, but only to the extent that the Office has not taken action in reliance thereon and also provided that I do so in writing.

I understand that for my protection, any requests to amend my health information or to access my medical records must be made in writing.

Patients Name (please print): _____

Signature: _____Date: _____/_____/_____

FINANCIAL POLICY AND AGREEMENT
West Mesa Wellness

I, the undersigned, in consideration of the Office's services, agree to the following terms:

Definitions, In this Agreement, "Office" and "Clinic" shall refer to Taylor Ranch Chiropractic d/b/a West Mesa Wellness located at 8625 Golf Course Rd, NW, Ste A-2, Albuquerque, NM 87114. "Financial Policy" or "Agreement" shall refer to this document.

Personal Responsibility for My Charges, I understand that I remain personally responsible for my Charges and that at any time, I can request a copy of my total Charges from the Office. Except where provided otherwise by law or by contract, I agree to pay the full amount of my Charges to the Office promptly upon its demand. I understand that the Office's Assignment does not constitute an agreement by the Office to await payment of my Charges. Unless otherwise mutually agreed to in writing on a form provided by the Office, I agree that (1) any delay by the Office in making demand for payment, any delay in paying the full amount of my Charges, and any partial payments resolved by the Office towards my Charges, shall not constitute acceptance of any installment payment plan, shall not constitute a waiver of the Office's right to receive payment-in-full promptly upon demand, and shall not constitute an 'accord and satisfaction' of my Charges, regardless of any such terms or restrictions indicated on, or included on , or included with any payments, and (2) any delay in paying the full amount of my Charges beyond fourteen (14) calendar days of demand shall be construed as a 'default' of my obligation.

Personal Responsibility for Verifying the Limitations in My Coverage; Financial Responsibility for Non-Covered Charges, I understand that in any given situation, a Payer may initially refuse to make payment to the Office, may delay payment for an indefinite or unreasonable amount of time, or may actually request a refund from the Office after making payment, and do so either in whole or in part with respect to any given Charge incurred at the Office (collectively, "Deny Payment"). I understand that there may be many situations where a Payer may Deny Payment based on a particular contractual term applicable to me or to the Office (collectively, "Terms of Non-Coverage"). To the extent permitted by law or by contract, I agree that I am solely and exclusively responsible for verifying all Terms of Non-Coverage prior to incurring any Charges at the Office. I agree that if I have any questions about the Terms of Non-Coverage, I can ask to see copies of the Office's verification (e.g., eligibility, pre-authorization) forms to gain further understanding. I further agree that should the Office assist me in any way in the verification, pre-authorization, or billing process, I assume the risk that the Payer and/or the Office may, in my opinion, not accurately understand and/or communicate the Terms of Non-Coverage and/or bill my Charges to my Payers. Should any payer Deny Payment, or should any Payer be likely to Deny Payment as determined by the Office in its sole discretion, I agree that I am personally, fully, and immediately responsible for the portion of my Charges denied or likely to be denied. In no event shall i hold the Office responsible or liable in any of the foregoing instances.

Direction to the Office to Apply the Lowest Mandatory Fee Reduction When Two or More Payers Are Involved, Unless otherwise agreed to in writing, I authorize the Office to submit my Charges, as well as a copy of the Assignment & Lien, to any and all Payers. Notwithstanding the foregoing, in the event that the Office determines in its sole discretion that it has any reasonable basis for either submitting or not submitting my Charges and/or other documentation to a Payer, I hereby authorize the Office to take such action without condition or restriction. I understand that some or all of these Payers may utilize fee schedules which (a) the Office has agreed to accept, directly with said Payers in writing, or (b) law expressly imposes on the Office to accept (collectively, 'Mandatory Fee Reductions"). I further understand that the Mandatory Fee Reductions imposed on the Office with respect to one Payer may exceed the Mandatory Fee Reductions imposed on the Office with respect to another Payer. In such an event, I hereby authorize and direct the Office insofar as permitted by law to apply the lower of the two Mandatory Fee Reductions to its Charges. I further agree that in the special event that Mandatory Fee Reductions are imposed on the Office by virtue of laws which regulate or restrict "balance billing'. I hereby waive the application of such laws. In the event that no mandatory Fee Reductions are actually imposed on the Office with respect to a Payer, I authorize and direct the Office to collect up to its full Charges from such Payer.

Authorization to Sign My Name on Payments; Transfer of Credit Balances, I authorize the Office to endorse or sign my name on any and all payments listing me as a payee which are received by the Office for payment of Charges incurred by me, my spouse or my dependents. In such cases, my printed name, followed by the phrase "by West Mesa Wellness", shall serve as a properly authorized endorsement. I further authorize the Office to apply any credit balances on my charges to any other outstanding Charges still owed by me, my spouse, or my dependents, regardless of whether these other Charges are related to my condition.

Miscellaneous Provisions, I have reviewed the Office's "Assignment & Lien" and Health Insurance Election forms and further agree to the terms and definitions set forth in these documents. Said documents are incorporated herein by reference. In the event that my condition is related to an accident , including without limit automobile accident, I understand that there will be an administrative fee necessary to cover the costs of verifying multiple Payers, filing and terminating liens, and submitting notices of same to Payers.

I have read, understand and agree to the terms of this Agreement.

Patient Name (print): _____

Patient Signature: _____ Date: ____/____/____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (please print): _____

Parent/Guardian Signature: _____ Date: ____/____/____