Wellness Intake Application
The office of *Dr. Donald E. Reese, DC PC*
www.reesefamilychiro.com
Well Adjusting Families Since 1985

Reese Family Chiropractic
4512 Oleander Drive, Suite 600
Wilmington, NC 28403
910-763-3611

Personal Information **Today's Date: / /**

First Name:_____ Last Name:_____

Home Address:_____City/State/Zip_____

Mailing Address:_____City/State/Zip_____

Home #_____ Cell # _____ Work # _____

Date of Birth:_____ Age:_____ Email: _____

Marital Status: M W D S Spouse's name:_____ # of children:_____

Who may we thank for referring you? _____ Relationship: _____

Occupation: _____ Your employer: _____

Previous Chiropractic Care: Y N If so, when & where: _____

Health Condition Information

Reason for your visit today:_____

Date symptom(s) started: _____ Have you had this problem before: Y N

If so, when: _____ Family member with same problem:_____

Is this the result of an Auto or Work injury: _____ If so, when:_____/_____/_____

Rate the discomfort affecting you using the 0 - 10 scale (0 = none & 10 = worst): _____

Problem interferes with: work / sleep / exercising / recreation / general mood

Describe problem: sharp / dull / burning / cramping / throbbing other:_____

How often does this affect your daily routine: constant / comes & goes / other:_____

What are your Chiropractic goals?:_____

Financial Information

- ❏ *Self Pay*- We offer affordable care plans & special rates for Military and/or First responders.
- ❏ *Health Insurance*- As a courtesy we will verify your coverage and file for reimbursement.

Primary Health Insurance Co.:_____

(If applicable) Secondary Insurance Co.: _____

Health Insurance Portability and Accountability Act

As per **HIPAA Laws**, we are required to have written authorization to perform some of our everyday practices. At Reese Family Chiropractic, *your health information is private and protected*. Please check the box beside each statement, allowing our office to provide you with each of these services.

- ❏ *Reese Family Chiropractic* and its staff may send you important information regarding office hours, schedule changes, appointment reminders and other office info via email.
- ❏ *Reese Family Chiropractic* and its staff may add you on our social networking pages such as Facebook and /or Instagram.
- ❏ *Reese Family Chiropractic* and its staff may send you mail including birthday cards.
- ❏ *Reese Family Chiropractic* and its staff may leave a voicemail or send you a text message.

List of authorized person(s) Reese Family Chiropractic and its staff may discuss and/or release your private health care information:

Name:_____Relation:_____Contact #: _____

Name:_____Relation:_____Contact #: _____

Your signature: _____ **Date**: _____

Authorization Information

Authorization to Release Health Care Information

I authorize the release of any health care information necessary to process my insurance claim(s) and also certify that all insurance information given to Reese Family Chiropractic be accurate and complete.

Patient/Guardian Signature:_____ **Date**:_____

Request for Payment of Benefits to Provider of Care

I hereby authorize _____ Insurance Co./Insurance admin to pay directly to Donald E. Reese, DC PC with the expense benefits allowable and otherwise payable to me under my current policy as payment toward that total charges for professional health care services rendered. I have agreed to pay, in current manner, any balance of said professional charges. I hereby agree that this office be given the power of attorney to endorse/sign my name on any and all drafts for payment of my medical bills.

Patient/Guardian Signature:_____ **Date**:_____

X-ray/Health Care Records Release

I have requested the release of my x-rays and/or health care records, from the following facility _____. In consideration of the foregoing, I hereby release and forever discharge Donald E. Reese, DC PC from any and all responsibility or liability of any kind, nature or character whatsoever arising from said treatment. I hereby acknowledge receipt of said records or request that these records be sent to the offices of Reese Family Chiropractic.

Patient/Guardian Signature:_____ **Date**:_____

Wellness Intake Application (Part 2)
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Consent for Treatment

I, the undersigned, a patient in this office, hereby authorize Dr. Donald E. Reese, DC PC, and whoever he may designate as his assistant(s) to administer treatment as is necessary. I also certify that no guarantees or assurances have been made to me as to the results that may be obtained. I understand and agree that health and accident insurance policies are an arrangement between me and my insurance carrier. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collections from any insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my credit. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. Lastly, I understand and agree to any interest on any unpaid balance that is due at the conclusion/termination of the treatment administered at a rate of 1.5 percent (18% APR) or as allowed by law, until the balance is fully paid.

Patient/Guardian Signature:_____ **Date**:_____

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 only has one goal: to **eliminate misalignments within the spinal column, which interfere with the expression of the body's innate wisdom**. It is important that each patient understand both the objective and the method that will be used to attain our goal. This will prevent any confusion or disappointment.

Adjustment: the specific application of forces to facilitate the body's correction of vertebral subluxation. Our Chiropractic method of correction is 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 Subluxation: 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 irs maximum health potential.

We do not offer to diagnose or treat any disease or condition, other than vertebral subluxation. However, if during the course of Chiropractic spinal examination we encounter non-chiropractic or unusual 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 major interference to the expression of the body's innate wisdom. Our only method is specific adjustment(s) to correct vertebral subluxations.**

All questions regarding the doctor's objectives pertaining to my care in the office have been answered to my complete satisfaction. I, therefore, accept Chiropractic care on this basis.

Patient/Guardian Signature:_____ **Date**:_____

Witness Signature:_____ **Date:**_____