Dr. Matthew E. Thiel

429 North Warpole Street, Upper Sandusky OH 43351

419-294-3489 (Phone) 419-294-2791 (Fax)

Patient Name: _____ **Date:** _____

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patent in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor of course, will not give any treatment or care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health are regimen. I understand that if I am accepted as a patient by Dr. Matthew Thiel, I am authorizing him to proceed with any treatment that he may deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Women Only:

To the best of my knowledge **I am/am NOT** pregnant and (give my permission/don't give my permission) to x-ray me for diagnostic interpretation.
(Circle one above) *(Circle one above)*

Consent to Evaluate and Treat a Minor

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance And hereby grant permission for my child to receive chiropractic care.

Communications:

In the even that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____ Phone: _____

Children: _____ Phone: _____

Others: _____ Phone: _____

No One: _____

May we leave a message regarding your personal healthcare information on any answering device,

i.e. home answering machine or voicemails? Yes ☐ No ☐

May we contact you via e-mail? Yes ☐ No ☐

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPPA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____

Signature: _____ **Date:** _____

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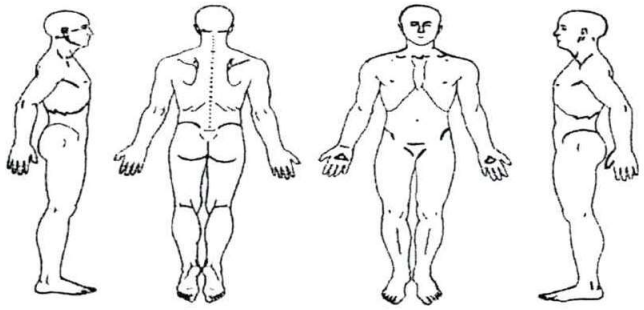
CASE HISTORY

Name: _____ Ht: ____Wt:____BP:____/____ HR:____

1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain).

Condition / Problem	Severity (Minimal → Severe)	Frequency (% of week) (Occasional → Constant)
a._____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
b._____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
c._____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
d._____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
e._____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

(Please mark the figures where you experience pain.)



2. Symptoms are worse in the (circle what applies)

-Morning -Increase during the day
-Afternoon -same all day
-Night -decrease during the day

3. Symptom (a.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
4. Symptom (b.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
5. When did your symptoms begin (onset date)? _____
6. How did your symptoms begin? _____
7. Have you experienced these before? _____
8. Do your symptoms radiate? _____
9. Has your condition? ____ Improved ____ Gotten Worse ____ Stayed the same since it began
10. Circle the things that make your problems worse:

Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping

11. Is there anything you can do to relieve the problems? ____No ____Yes Describe: _____

If No, what have you tried that has not helped? _____

12. Have you been treated for this before? ____No ____Yes how long ago? _____
13. What treatment did you receive? _____
14. Results of previous treatment? ____Good ____Poor Comments _____
15. Were you referred to our office by anyone? _____
16. Is this condition interfering with ____ Work ____Sleep ____Daily Routine ____Recreation
17. List any major injuries, or surgeries you have had : _____
18. List any medications, or supplements you currently are taking:_____
19. Any other musculoskeletal problems? ____No ____Yes …Neurological problems? ____No ____ Yes

___Additional information on backside of sheet.

I certify that the above information is accurate to the best of my knowledge.

Parent/Guardian Signature_____ Date: _____

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Date: _____

Confidential Patient Information

Patients Name: _____ Chief Complaint: _____

Address: _____ Home Phone: _____

City: _____ Zip:_____ Cell Phone: _____

SS#: _____ Email: _____

Date of Birth: _____ Marital Status: M S W D

Occupation: _____ Employer: _____

Address of Insured (if different than above): _____

Are your present systems or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) ___ Yes ___No

Ins. Company: _____ Ins. Phone #: _____

ID#: _____ Group #: _____

Name of Policy Holder: _____ Policy Holder DOB: _____

Policy Holders Employer: _____

Family Physician: _____ (Note: May we send your health information to this provider **Y / N**)

Person to contact in case of emergency (Name and Phone): _____

Have you ever been under Chiropractic Care? Y N If so, Who? _____

Have you had any SPINAL X-Rays / MRI's / CT's taken in the last year? Y N If so, Where? _____

What operations have you had? _____ When? _____

Serious Illness: _____ When? _____

Infectious Diseases: _____ When? _____

Do you have a pace maker? **Y / N** Have you ever had any Hip or Knee Replacements **Y / N**

What medications or drugs are you taking? (check those that apply): Pain Killers ____ Insulin _____ Cholesterol Meds _____
Blood Pressure Meds ___ Muscle Relaxers ___ Birth Control ___ Other: _____

What is your goal in our office? _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at physicians request, and convey directly to Dr Thiel all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor any and all plan documents, insurance policy and/or settlement information upon written request from such doctor in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor in any attempts by such doctor to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor against such insurers and/or employee health care plan in my name but at such doctor expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____
Signature of Insured / Guardian Date