Dear Patient:

Welcome to our practice! Whether you were referred by a friend or family member or stumbled upon us by chance, we hope to meet all your needs here at Wilkinson Chiropractic Care.

This introductory letter is a rather unconventional way to discuss everyone's favorite topic: fees. We want to make your initial visit as smooth as possible, answering all of your questions and concerns regarding fees before we get started.

Our initial visit fee is $100. This includes your examination, therapies if indicated and your adjustment. Office visits after the initial visit are $55 and include a therapy and an adjustment.

If you are filing Medicare, Medicare requires an exam and/or x-ray of the main area of complaint, which are $50 and Medicare does not cover. Your spine has been working hard for you for 65+ years and chances are there is a lot of wear and tear on it. If conventional methods of chiropractic adjusting are even to be considered, our assessment must be thorough. We would not be practicing good doctoring if we first did not have a visual of what we were working with. X-rays provide that visual. If you have had x-rays or an MRI of the same area within the last 6 months, we will be happy to view those in place of taking our own films.

If you are a new patient that has had an injury-- fall, twist, crash or accident--it is likely that we will take an x-ray of the area of concern. Again, your safety is our #1 concern and working on an area that is fractured, torn, severely sprained or strained is contraindicated. Please allow us to care for you in the most effective and conservative manner we are able.

Any additional charges you might incur on this visit that exceed the expected $100 initial visit fee and $50 x-ray fee will be discussed with you, by the doctor, prior to delivering said service. This applies to any of your office visits. We give you our opinion, you make your decision. Your health care is always in your hands, but we must reserve the right to refuse care if a decision, in our opinion, is not in your best interest. If you have any questions regarding fees or insurance coverage, please direct them to our office manager Sue.

We look forward to caring for you and hope that you find great healing with chiropractic care.

In Health,

Dr. Sherry Shamp Dr. Joseph Shamp

Office manager: Sue

Office Staff: Val, Kim, Waneta and Maddox

Massage Therapists: Ericka, Stephanie, Gina and Brittany

**Please read and initial ______________

PATIENT NAME: ______________________________

WILKINSON CHIROPRACTIC CARE
DR. SHERRY L. SHAMP   DR. JOSEPH J. SHAMP

PATIENT INFORMATION FORM
(PLEASE PRINT)

DATE: ___/___/___

PATIENT NAME: ____________ ____________ ___ DATE OF BIRTH: ___/___/___ AGE: ___ SEX: M F
LAST FIRST MI

HOME ADDRESS: ______________________ CITY/STATE: ______________ ZIP: ________

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (___) ___-_____ YES NO

WORK PHONE #: (___) ___-_____ YES NO

CELL PHONE #: (___) ___-_____ YES NO

E-MAIL: ______________________ YES NO

WHO IS RESPONSIBLE FOR PAYMENT? ________________ RELATIONSHIP TO PATIENT? __________

HAVE YOU HAD CHIROPRACTIC CARE? YES NO LAST CHIROPRACTIC ADJUSTMENT? ______________

REFERRED BY: ____

INSURANCE INFORMATION

ARE YOU ELIGIBLE FOR MEDICARE? __________

PRIMARY INSURANCE COMPANY NAME: ____________________________________

SECONDARY INSURANCE COMPANY NAME: __________________________________

THE FRONT OFFICE WILL NEED TO MAKE A COPY OF YOUR INSURANCE CARD(S).

SOCIAL HISTORY

EMPLOYER: ______________________ OCCUPATION: ______________________

HOW MUCH ARE YOU ON YOUR FEET AT WORK? ☐10% ☐25% ☐50% ☐75% ☐100%

EXERCISE: ☐ NEVER ☐RARE ☐ OCCASIONAL ☐WEEKLY ☐ SEVERAL TIMES A WEEK ☐DAILY

TYPES OF EXERCISE: ____

MARITAL STATUS: ☐ SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED

NAME OF SPOUSE: ______________________ NUMBER OF CHILDREN: ______________

PATIENT NAME: ______________________________

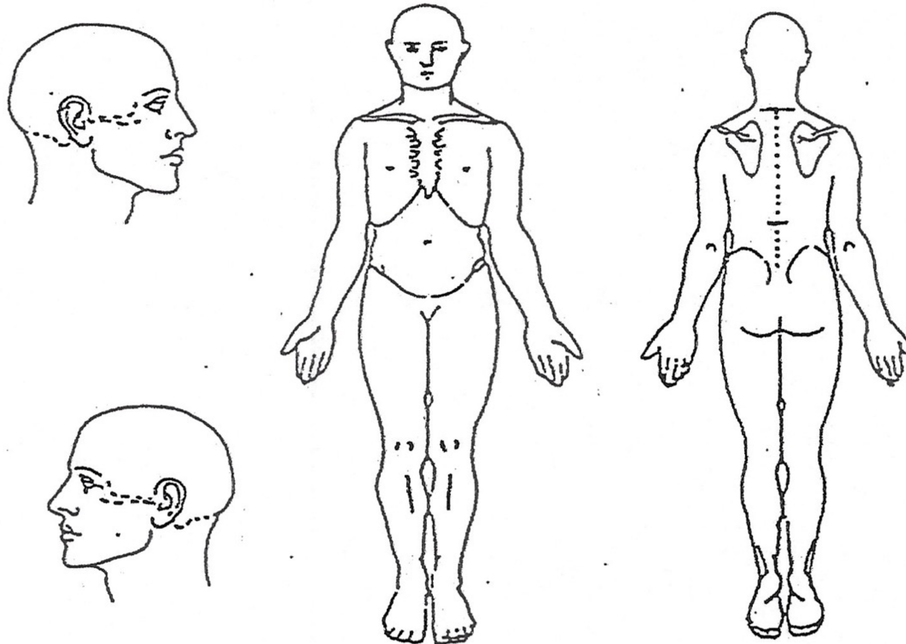
CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY? ______________________________________

HAVE YOU HAD THIS CONDITION IN THE PAST? ______ IF YES, WHEN? __________

DID YOU SEEK TREATMENT BY A DOCTOR FOR THIS CONDITION? _______ IF YES, BY WHOM? __________________

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.



HOW LONG AGO DID THIS PROBLEM FIRST START? ________ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: ☐ BEGIN ALL OF A SUDDEN ☐ GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? ☐ NO PAIN ☐ SHARP ☐ DULL ☐ ACHING ☐ BURNING
☐ RADIATING ☐ ITCHING ☐ STABBING ☐ OTHER ______________________________

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10?
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 *(WORST PAIN POSSIBLE)*

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: ☐ STAYED THE SAME ☐ BECOME WORSE ☐ IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? ☐ WALKING ☐ STANDING ☐ DAILY ACTIVITIES
☐ RESTING ☐ RUNNING ☐ OTHER ______________________________

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER? ______________________________

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? ______________________________

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK? ______________________________

WAS THIS PROBLEM CAUSED BY AN INJURY? ☐ YES (DESCRIBE) ______________________________ ☐ NO

IF YES, WAS IT A WORK-RELATED INJURY? ☐ YES ☐ NO

PATIENT NAME: ______________________________

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: ☐ DIABETES ☐ CANCER ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE ☐ STROKE ☐ CORONARY ARTERY DISEASE ☐ SPINAL STENOSIS ☐ RHEUMATOID ARTHRITIS ☐ OTHER ______________________________

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME ADDRESSING WHAT CONDITION?

____
____
____
____
____
____
____

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

PLEASE LIST ALL FRACTURES, ILLNESSES OR CONDITIONS: REASON FOR HOSPITALIZATION	DATE	PLEASE LIST ANY ACCIDENTS OR INJURIES:	DATE

YOUR MEDICAL HISTORY

ALLERGIES: ☐ NONE KNOWN ☐ MEDICATIONS ______________________________
☐ OTHER ______________________________

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ACUTE PAIN	Y	N	GOUT	Y	N	OSTEOPENIA	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	OSTEOPOROSIS	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	PREGNANCY	Y	N
BACK TROUBLE	Y	N	HEADACHES	Y	N	RHEUMATOID	Y	N
BLOOD CLOTS	Y	N	HIGH BLOOD PRESSURE	Y	N	STROKE	Y	N
BRONCHITIS	Y	N	JOINT PAIN	Y	N	TMJ ISSUES	Y	N
CANCER	Y	N	LOW BLOOD PRESSURE	Y	N	SLEEP APNEA	Y	N
CHRONIC PAIN	Y	N	MIGRAINE HEADACHES	Y	N	VARICOSE VEINS	Y	N
DIABETES	Y	N	MUSCLE STRAIN	Y	N	OTHER	Y	N

PATIENT NAME: ______________________________

Informed Consent for Chiropractic Treatment

TO THE PATIENT: *You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.*

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that, there are some risks to chiropractic treatment including, but not limited to:

- ☐ Broken bones
- ☐ Dislocations
- ☐ Sprains/strains
- ☐ Burns or frostbite (physical therapy)
- ☐ Worsening/aggravation of spinal conditions
- ☐ increased symptoms and pain
- ☐ No improvement of symptoms or pain
- ☐ Infection (acupuncture)
- ☐ Punctured lung (acupuncture)
- ☐ Other ______________________

In rare cases there have been reported complications of arterial dissections n (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

TREATMENT PLAN: ____

____

____

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition.

To be completed by the patient:

____
print name

____
signature of patient

____
date signed

To be completed by the patient's representative:

____
print name of patient

____
print name of patient's representative

____
signature of patient's representative

as: ______________________
relationship/authority of patient's representative

____
date signed

To be completed by doctor or staff:

____
witness to patient's signature

____
date

____
translated by

____
date

Revised May 2017

January 2022

Re: All Health Insurance Plans

Dear Patient;

Dr. Sherry Shamp and Dr. Joseph Shamp are **out of network providers** with all insurance companies. All of our patients pay at the time of service, we will file the claims and they will go towards your **out of network benefits**. If there is a payment made from the insurance company it would go to you.

In network benefits vary from out of network benefits, for details please call your insurance company.

If you would like to receive care from Wilkinson Chiropractic Care we need to have your written consent.

Patient name printed Date

Patient signature Date

Sincerely,

Susan Wilkinson, Office Manager

PLEASE READ CAREFULLY

** ATTENTION MEDICARE PATIENTS **

- Initial office visit:
  - Brief exam $50 (not covered by Medicare)
  - X-ray $50 (not covered by Medicare)
  - Office visit $54 (Medicare pays 80% of approved amount)
- X-rays, exams, massage therapy, supports, and supplements are **not** covered by Medicare
- **Medicare requires** either an x-ray or exam to document a subluxation of the spine
- The doctors use an x-ray to document the subluxation
- The doctors will also do a neurological/orthopedic exam on your first visit
- Medicare will reimburse you 80% of the Medicare approved amount for spinal manipulation only
- Your supplement will reimburse you 20% of the Medicare approved amount for spinal manipulation only
- Our office is non-participating with Medicare. This means we do not accept assignment, you pay at the time of service and Medicare will reimburse you.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was offered a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

____________________________________ ____________________

Patient name (please print) Date

____

Patient, Guardian or Patient's legal representative

____

Signature

This form will be placed in the patient's chart and maintained for six years.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

____

____

____

____

____

PATIENT NAME: ______________________________

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

____
PRINT NAME OF PATIENT, PARENT OR GUARDIAN

____
IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

____
SIGNATURE

____
DATE

____
SIGNATURE OF DOCTOR

____
DATE