MID VALLEY CLINIC
CHIROPRACTIC

Dr. Woodmansee, DC **Dr. Bryan Gordon DC**

Clinic and Financial Policy (Please Read Very Carefully)

The following is an explanation of our clinic's policies. We believe that a clear definition will allow us both to concentrate on the most important issue: Regaining and maintaining your health. We will be happy to answer any questions you may have regarding our policies, your account, or insurance coverage.

No Charge Consultation

Midvalley Clinic will do a special "No Charge" consultation or brief conference with anyone interested in finding out if chiropractic care can help with their individual health problem. There is no charge or obligation in connection with this service. (Consultation is a discussion which can consist of: Current and Past Medical History, and Current Complains only, this does not include advice, examination, or other "treatment" recommendations.)

Patient Payment Policy

We feel that the patient's health needs are paramount; therefore, the following payment policy is an attempt to allow you, the patient, to receive the care you need along with clear account balances.

New Patient Services

All payments towards deductible and cash are required at the time of service. Properly documented Worker's Compensations and Auto Accident claims are not required to pay at this time if appropriate forms and liens are signed.

Established Patient Care Services

Patients under care are required to make regular payments on all unpaid balances, except for properly documented Worker's Compensation and Auto Accident claims. Payments need to be paid on time according to your arrangements. In the event your account becomes over 60 days late, you agree to the following terms: ***The undersigned specifically agrees to pay all reasonable attorney's fees and court costs in the event legal action is taken to collect on the account. The undersigned further agrees to pay an additional amount representing fifty (50%) of the principle balance if the account is referred to a collection agency or attorney for collection. There will be an additional interest accrued on your account in the amount of 1.5% of the original balance per month. This additional amount is in recognition of the costs associated with said collection action processing.***

Our Policy on Health Insurance

Today, not all insurance companies will cover chiropractic care. We will be happy to file your insurance claim for you and do everything we can to make sure you receive proper reimbursement; however, we cannot take responsibility for what your health insurance will or will not cover. In the event your insurance deems your visit or procedure "not medically necessary" you agree to waive the portion of your agreement with your HMO/PPO and pay for the office visit(s) that day in full or make payment arrangements. In the event you begin a treatment plan in which all visits are not covered, you agree to accept financial arrangements.

Appointments

It is essential that you keep your appointments, failure to do so results in poor results, and a lost opportunity we have to treat someone else. We understand that emergencies and accidents happen; however, we charge for missed appointments in the amount of $15.00 per missed appointment. You are responsible for this fee if you do not give 24 hour notice of missed appointment.

Release of Information

I authorize the release of any information concerning my health and health care services to my insurance companies, pre-paid health plan or Medicare.

Assignment of Insurance Benefits and Payment Agreement

I authorize and direct that payment be made directly to: Dr. Dirk Woodmansee, DC @ Comprehensive Chiropractic Clinic, and/or Dr. Bryan Gordon, DC or other designated corporation located at 2618 West 7800 South Suite #200, West Jordan, UT 84088 (801) 562-1531; for any and all insurance benefits or reimbursement for services rendered by him/them which amounts would otherwise be payable to me under any insurance or pre-paid health care plan. I understand that there is no guarantee that my insurance company or pre-paid health plan will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges.

Privacy Policy

At MidValley Clinic we care about your privacy, and we have taken steps to ensure that your personal information is protected. We will only provide information to those whom you have given authorization in writing to do so. If you would like to review in detail our policies on HIPPA we will provide you one at your request.

Questions and Answers

Your questions about any aspect of your care or account are invited. Please feel free to ask your doctor or any available staff member. We will make every effort to answer your inquiries.

We look forward to serving you.

Name (Printed) Signature Date

MidValley Chiropractic Clinic

Patient Information

Today's Date _____ Chart #_____

Patient Name: _____

Address: _____

Street City State Zip

Home Phone: _____Work Phone: _____ Cell Phone: _____

Email Address: _____

Sex: M/ F Age: _____ Birth Date: _____ Patient SS#: _____

Height _____Weight _____ Race/Ethnicity [ ] African American [] Arabic [] Asian [] Caucasian [] Hispanic [] Native American

Brief Job Description: _____Company : _____

Emergency Contact: _____Phone Number: _____

Whom May We Thank for Referring you to our office? _____

Insurance Information

Is your condition related to any of the following: [ ] Auto Crash Date of Injury: _____

[ ] Health Insurance [ ] Self Pay: [ ] Other: _____

(Please provide the necessary Information to the Front Desk Staff)

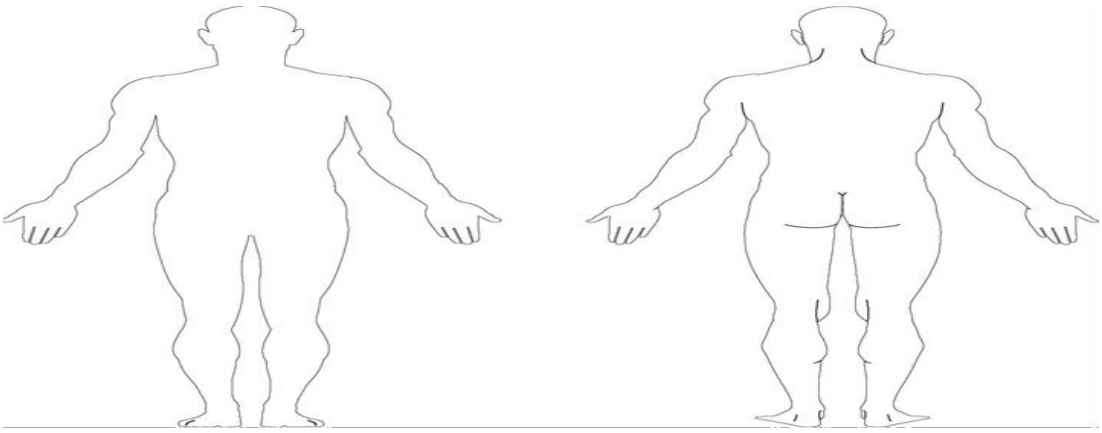
Purpose Of Visit Today (please list in order of importance)

Major Complaint/Reason for Visit	Date Condition Began	Have you had this before?	Injury related?
1._____	_____	[ ] Yes [ ] No	[ ] Yes [ ] No
2. _____	_____	[ ] Yes [ ] No	[ ] Yes [ ] No
3._____	_____	[ ] Yes [ ] No	[ ] Yes [ ] No

GENERAL SYMPTOMS CHART

Please use the following notations on the figures below to indicate the type and location of your symptoms, as it relates to the purpose of your visit today.

A = ACHE	G = STABBING	N = NUMBNESS
B = BURNING	M = SPASMS	P = PINS & NEEDLES
T = TINGLING	F = STIFFNESS	O = OTHER



Health Conditions

Your spine is the foundation of health and core strength in your body. Shifts in the vertebrae or sections of the spine will spread ultimately causing weakness and distortion to ALL the areas of the spine. These distortions are reflected in abnormal posture. Research shows abnormal posture leads to chronic pain, disease and possibly a shortened life span. Please answer the following questions accurately so we may determine the full extent of your child's condition.

History of Trauma/ Birth History

The below-listed traumas may lead to misalignment of the individual vertebrae, soft tissue injury to the supportive structures of the spine, as well as shifts and distortions in whole curves and sections of the spine. Please check any of the following if your child has experienced such (*if you check an item with an asterisk, please offer a detailed explanation*):

____ Fell from a height of two (2) feet or more as an infant
____ Experienced a fall that left a bruise or lump on their head or other resulting trauma*
____ Rough shaking as an infant
____ Were involved in a car accident (*if you check this item, please ask the front desk person for the corresponding form*)
____ Experience broken bones or debilitating injuries*
____ Difficult Birth (see below)
Explanation of (*) item(s):_____
_____
BIRTH EXPERIENCE:
How long was labor?_____
Describe any complications:_____
_____

Type of delivery: ☐ Vaginal ☐ C-Section ☐ Vacuum Extraction ☐ Forceps Assistance

Vaccination History

Are you up to date on vaccines? [ ] Yes [ ] No; Have you had any negative effects from vaccine? [ ] Yes [ ] No, Check below:

Please check any of the following responses your child experienced as a result of a vaccination (please indicate which vaccination caused the condition by writing the corresponding number next to that condition).

____ Swelling, redness, heat/hardness of site	____ Body rash or hives	____ High fever (over 103 degrees)
____ High-pitched screaming	____ Extreme sleepiness or unresponsiveness	____ Body twitching or paralysis
____ Breathing problems (asthma, etc.)	____ Excessive bleeding or anemia	____ Head banging
____ Excessive diarrhea or chronic constipation	____ Loss of memory/foggy state	____ Muscle weakness
____ Chronic ear or respiratory Infections	____ Vision or hearing disturbances	____ Joint pain
____ Crossing of eyes	____ Seizures	____ Other (please explain)

Explanation(s):_____
_____
_____

Health Conditions

Please Check any Problems you are currently experiencing:

General: [ ] Low Energy [ ] Sleep Disturbance [ ] Nausea [ ] dizziness [ ] headaches
[ ] TMJ/ clicking [ ] depression [ ] anxiety [ ] irritability [ ] snoring

Bowel and bladder Function: If you have had any change in your bowel or bladder function, do you:

[ ] Urinate more often [ ] Have loss of control or accidents [ ] Have a sense of urgency
[ ] Have a loss of sensation around the groin or buttocks [ ] Diarrhea
[ ] Constipation [ ] Recurrent bladder/ urinary tract infections

Neurological/ Orthopedic

[ ] Neck pain [ ] Shoulder pain [ ] Mid-back pain [ ] Low back pain
[ ] Pain in ribs/ chest [ ] scoliosis [ ] Muscular Cramps/ spasms
[ ] Numbness/ tingling into hands/ arms [ ] Pain into shoulders/ arms/ hands
[ ] Weakness into arms/ hands [ ] Numbness/tingling into legs/ feet
[ ] Pain into hips/ legs/ feet [ ] Weakness into the legs
[ ] Osteoporosis [ ] Arthritis [ ] Seizures

Other:

[ ] Immune problems [ ] Hearing disturbances [ ] Hearth murmurs [ ] Hypoglycemia
[ ] Infectious Disease [ ] Thyroid Conditions [ ] Asthma [ ] Gall Bladder

[ ] Pain with breathing [ ] High cholesterol [ ] Acid Reflux [ ] Dizziness/ Fainting
[ ] Sinusitis [ ] Kidney Disease [ ] Liver Disease [ ] Cold hands/ Feet
[ ] Heart palpitations [ ]Diabetes [ ] Bleeding disorder [ ] Sleep Apnea
[ ] Arthritis [ ]Shortness of breath [ ]Ulcers/ gastritis
[ ] Visual Disturbances [ ] High Blood Pressure [ ] Indigestion/ Heartburn [ ] Lung Disease
Please Explain Any of The Above: _____

General Healthcare Providers

Primary Care Provider—Name _____ Date of Last Visit: _____
Other Healthcare Providers—
Name _____ Specialty _____ Date of Last Visit_____
Name _____ Specialty _____ Date of Last Visit_____

Allergies (and reactions): _____

Previous Major Injuries or trauma and dates: _____
_____

Previous surgeries and dates: _____
_____

Previous hospitalizations or major conditions and dates: _____
_____

What other testing or treatments have you tried to date for present condition:_____
_____

Have you ever been diagnosed with cancer? [ ] Yes [ ] No If yes, explain _____
_____

Personal and Family Health History

Have YOU or any of your immediate family members ever had the following:

[ ] Mental health disease [ ] Neurological Problems [ ] Lung Disease [ ] Thyroid [ ] Arthritis
[ ] Circulatory problems [ ] Immune system problems [ ] Back pain [ ] Cancer [ ] Scoliosis
[ ] Heart Disease [ ] Stroke [ ] Kidney disease [ ] Diabetes [ ] Osteoporosis
[ ] Migraine Headache [ ] Digestive Disorders [ ] Infectious disease [ ] Seizures
[ ] Liver Disease [ ] Other:_____

Social and Lifestyle History

What activities does your child enjoying doing? _____
_____
What sports does your child play? _____
_____

Authorization of Care

*I authorize and agree to allow the doctor and/or his designated staff to work with my spine or the spine of the charge I represent through the use of spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal bio-mechanical and neurological function.
*I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.
*The Doctor and/or his staff will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another healthcare practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.
*I also clearly understand that if I do not follow the doctors and/or staff's specific recommendations at this clinic that I will not receive the full benefit from these programs; and that if I terminate my care prematurely that all fees incurred will be due and payable at that time.

Patient's Signature:_____ Date:___ /_____ /_____
Patient's Name Printed:_____

Guardianship

-If patient is a legal charge of limited capacity requiring guardianship for treatment, please complete the following:
Date Guardianship Awarded:_____ County, State of Guardianship:_____
I hereby authorize the doctor to administer care as deemed necessary to my charge as appointed to by the courts.
Guardian Signature:_____ Date:____/_____/____

Radiographic Consent

FOR FEMALE PATIENTS PREGNANCY STATEMENT

Patient Name: _____

□ I understand that if I am pregnant and have X-rays taken that expose my lower torso to radiation, it is possible to injure the fetus.
□ I have been advised that the 10 days following onset of a menstrual period are generally considered safe for X-ray exams (low risk of pregnancy during that time).

With those factors in mind, I am advising my doctor:

I am pregnant _____ Yes _____ No _____ Don't Know
I could be pregnant _____ Yes _____ No _____ Don't Know
My menstrual period is late _____ Yes _____ No _____ Don't Know
I am taking oral contraceptives _____ Yes _____ No _____ Don't Know
I have an IUD _____ Yes _____ No _____ Don't Know
I have had a tubal ligation _____ Yes _____ No _____ Don't Know
I have had a hysterectomy _____ Yes _____ No _____ Don't Know
I have irregular menstrual periods _____ Yes _____ No _____ Don't Know

My last menstrual period began _____
I have begun menopause _____ Yes _____ No

An X-ray may be performed on me with my consent, I authorize Midvalley Clinic physician(s) to perform **diagnostic imaging studies and diagnostic testing**, as deemed necessary or advisable during the course of treatment.

Signature: _____ _____ Date: _____

FOR MALE PATIENTS AND MINORS CONSENT TO DIAGNOSTIC TESTING

As the legal guardian of _____, who is _____ years of age, I _____, authorize MidValley Clinic physician(s) to perform **diagnostic imaging studies and diagnostic testing** on said minor as deemed necessary or advisable during the course of treatment.

Signature: _____ Date: _____

Name: _____ Date _____