We want to thank you for choosing **EDISS CHIROPRACTIC.** Our goal is to provide the best state of the art alternative health care in the Douglas area. We appreciate your trust in us and look forward to serving your chiropractic needs.

To provide the best care possible, regardless of the area of complaint, Dr. Ediss conducts a complete examination on the first office visit in order to investigate and eliminate any possible underlying causes of problem areas. Because the body functions as a complete unit, something that may seem unrelated could actually be contributing to your symptoms.

The nature of the onset of symptoms, the duration of symptoms, your age, present and past health problems are all contributing factors affecting the duration of recovery as well as the amount of progress achievable. In some situations, patients may actually feel a little worse before they begin to feel better. This is because the body has been accustomed to being in a given position for weeks, months or even years. As corrections are made, the nervous system adapts to the body's new (corrected) position. This is very similar to the patient who experiences orthodontia work. Every time the doctor adjusts the braces, the patient experiences head pain until the nervous system adapts to the new position of the teeth. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometime the response is phenomenal.

In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions which do not respond to chiropractic care, may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

Dr. Ediss incorporates and utilizes many techniques in the care and treatment of his patients. When he is working with a patient it is at that time that he will make the decision on which technique he will utilize for your condition. (Please see our web-site for the different services we offer.)

Listed below are our charges as of **APRIL 1, 2015**:

FIRST OFFICE VISIT: MINIMUM OF $163.00. This includes a personal history evaluation and a chiropractic exam for $105.00 and a manipulation for $58.00. If x-rays, additional therapies or nutrition (supplements) are necessary they are extra over the $163.00 and **will be due** at the end of your first visit. Please ask about x-ray prices. The first office visit takes approximately an hour. For **children** the cost is slightly reduced. **Ages 5 and under** the minimum is $105.00 (and takes about 30 minutes). For **ages 6 to 12** it is $125.00 (and takes about 45 minutes).

The charges listed are for the services that are most commonly used in our office. If there is a service that is not listed and you would like to know the charge, please let us know.

Spinal Manipulation, 3-4 regions, $58.00
Spinal Manipulation, 1-2 regions, $42.00
Electrical Stimulation, laser, $25.00
Acupuncture, $55.00
Nutritional Evaluation, $45.00
Lumbar x-ray, 2 view, $82.00
Cervical x-ray, 2 view, $72.00

SUBSEQUENT OFFICE VISIT: These visits take approximately 15 minutes. **If additional time is needed by the patient, the doctor will charge for that time at $55.00 every 15 minutes.** To utilize your office visit efficiently please write down any questions you may have prior to your visit and then bring your questions with you.

We do require **full payment for everyone for the first office visit.** If you **do not** have insurance we ask that you make full payment at every visit. We do offer a "time of service" discount. We do accept Cash, Checks, Visa, MasterCard and Discover.

INSURANCE PATIENTS:

As a service to our patients we will bill your insurance but still require **payment in full** for the **FIRST OFFICE VISIT** including any therapies, x-rays and nutritional supplements. After we have received confirmation of coverage from your insurance carrier we will continue to bill your insurance and charge you only for your portion. If you have paid us and your Insurance carrier then pays us, **we will refund** any overpayment to you. **If there are services that are not covered by your insurance carrier you will be responsible for payment of those services.** ** We are a preferred provider with Blue Cross Blue Shield.**

MEDICARE PATIENTS:

As a service to our patients we will file your **MEDICARE CLAIMS.** We bill all **MEDICARE** as "Non-assigned". This means MEDICARE will send payment directly **TO YOU,** the beneficiary, and **NOT** to us, the provider. Keep in mind that according to the **MEDICARE MEDICAL POLICY;** reimbursement by **MEDICARE** is specifically limited to the **MANUAL MANIPULATION OF THE SPINE.** Bottom Line - MEDICARE pays **only for the manipulation** and NO other service that we provide. The patient will be responsible for payment of any services **NO**T covered by **MEDICARE.**

NUTRITIONAL SUPPLEMENTS:

Nutritional Supplements are to be **paid in full** at the time of purchase. Again, we accept: Cash, Checks, Visa, MasterCard and Discover.

We encourage all of our patients to ask questions. You may want to write them down as they arise so you won't forget. Feel free to call the office if you have any questions before or after your visit.

Please sign and date this form so we know that you have been informed. If you would like a copy for your reference please let us know.

_____ _____

PATIENT SIGNATURE DATE

Ediss Chiropractic, Inc.
1330 E. Richards St. - Douglas, WY 82633-2951
Phone: (307) 358-3147 • Fax:

Patient Information

Name: (First, Middle, Last) _____ Date of Birth: _____

Address: _____ (City, State, Zip): _____

Social Security #: _____ Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Preferred Name: _____

Maiden Name: _____ Employment Status: ☐ Employed ☐ Part-time Student ☐ Full-time Student ☐ Other

Employment Information

Employer: _____ Occupation: _____

Address: _____ (City, State, Zip): _____

Responsible Party Information

Name: _____ Date of Birth: _____

Address: _____ (City, State, Zip): _____

Social Security #: _____ Responsible Party's Phone #: _____ Relationship to Patient: _____

Occupation: _____ Employer: _____ Employer Phone: _____

Insurance Information

Name of Insured: _____ Relationship to Patient: _____

Insured's Date of Birth: _____ Social Security #: _____ Phone: _____

Insurance Company: _____ Group #: _____ ID Number: _____

Address: _____ (City, State, Zip): _____

Spouse Information

Name: (First, Middle, Last) _____ Date of Birth: _____

Address: _____ (City, State, Zip): _____

Social Security #: _____ Employer: _____ Employer Phone: _____

Relative to Contact in Case of Emergency

Name: _____ Phone: _____ Relationship to Patient: _____

Address: _____ (City, State, Zip): _____

Is Your Illness or Injury Related to Any of the Following?

☐ Employment ☐ Emergency ☐ Accident ☐ Auto Accident (State of Auto Accident) _____

If Employment related, has employer been notified? ☐ Yes ☐ No Employer Contact Name: _____

Employer Contact Phone and Extension: _____

How Were You Referred to Our Office?

☐ By an Attorney ☐ By a Doctor ☐ By a Patient ☐ Yellow Pages ☐ Other

Please print the name of your source: _____

Consent to Treatment / Financial Responsibility and Assignment of Benefits

I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examination, and treatment.

I hereby assign, transfer, and set over to Ediss Chiropractic, Inc. all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insuranc

I certify that I have read this form and understand its contents.

Patient or Other Legally Authorized Person: _____ Date: _____

EDISS CHIROPRACTIC

1330 E. RICHARDS ST. - DOUGLAS, WY 82633

NAME: _____ ***DATE:*** _____

Main complaint(s) that brought you to this office _____
List other doctors seen for this condition_____
When did this condition begin?_____ ***Due to accident?***_____

List medications/vitamins currently taking:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

List any injuries, operation or pertinent history:

1._____ ***Date*** _____
2. _____ ***Date*** _____
3. _____ ***Date*** _____
4. _____ ***Date*** _____

Instructions: **Below is a list of conditions, which may seem unrelated to the purpose of your appointment. However, there are many conditions that respond favorably when treatment is given that increases your body's ability to function correctly. This office specializes in such treatment and if you wish, an individualized program will be suggested. Please check the symptoms you have experienced in either or (both) of the CHRONIC (recurrent symptoms) or ACUTE (symptoms you have now).**

Gastro-Intestinal

Acute	Chronic	
_____	_____	Digestive complaints
_____	_____	Stomach pain
_____	_____	Ulcers
_____	_____	Frequent Heartburn
_____	_____	Nausea
_____	_____	Frequent diarrhea
_____	_____	Frequent constipation
_____	_____	Irritable bowel
_____	_____	Hemorrhoids
_____	_____	Frequent vomiting
_____	_____	Colitis/diverticulitis
_____	_____	Black or bloody stool
_____	_____	Gallbladder trouble
_____	_____	Frequent burping/belching

Structural/Neurological

Acute	Chronic	
_____	_____	Headaches
_____	_____	Muscle cramps/muscle spasms
_____	_____	Neck pain
_____	_____	Jaw pain
_____	_____	Dizziness
_____	_____	Back pain
_____	_____	shoulder/elbow/wrist pain (circle one)
_____	_____	Numbness/Tingling
_____	_____	Tremors in hands or feet
_____	_____	Knee pain/Hip pain (circle one)
_____	_____	Joint pain or loss of function
_____	_____	Osteoporosis/Osteomalacia
_____	_____	Current bone fracture or injury
_____	_____	Tendonitis/Bursitis

Immune Response

Acute	Chronic	
_____	_____	Frequently sick
_____	_____	Frequent swollen glands/sore throats
_____	_____	Depression and/or anxiety
_____	_____	Achy joints/muscle pain
_____	_____	Headaches/migraines
_____	_____	Recurrent digestive complaints
_____	_____	Chronic fatigue
_____	_____	Food Allergies
_____	_____	Eczema or hives
_____	_____	Allergies (mild/moderate/severe)

Cardiovascular

Acute	Chronic	
_____	_____	Irregular heartbeat
_____	_____	Heart murmur/palpitations
_____	_____	High or low blood pressure
_____	_____	Chest pain
_____	_____	Previous heart trouble
_____	_____	Poor circulation
_____	_____	Previous heart surgery
_____	_____	Varicose or spider veins
_____	_____	Hands & feet cold all the time

Respiratory

Acute	Chronic	
_____	_____	Chronic Cough
_____	_____	Asthma
_____	_____	Emphysema
_____	_____	Recurrent head colds
_____	_____	Recurrent sinus infections
_____	_____	Recurrent bronchitis
_____	_____	Smoker

Genito-Urinary

Acute	Chronic	
_____	_____	Too frequent urination
_____	_____	Discolored or foul-smelling urine
_____	_____	Blood in urine
_____	_____	Recurrent kidney or bladder infections
_____	_____	Kidney stones
_____	_____	Bedwetting
_____	_____	Inability to control bladder

Eyes/Ears

Acute	Chronic	
_____	_____	Recurrent ear infections
_____	_____	Eye infection
_____	_____	Slowly losing vision
_____	_____	Floaters in eyes
_____	_____	Glaucoma
_____	_____	Macular degeneration
_____	_____	Cataracts
_____	_____	Diabetic retinopathy

Miscellaneous

Acute	Chronic	
_____	_____	Difficulty sleeping
_____	_____	Restless, uneasy sleep
_____	_____	Edema
_____	_____	Unusual swelling in arms or legs

For Men Only

Acute	Chronic	
_____	_____	Prostate trouble
_____	_____	Urination problems
_____	_____	Reproductive problems

Endocrine (Glandular)

Acute	Chronic	
_____	_____	Cold hands and feet
_____	_____	Low blood pressure
_____	_____	Weight problems (over or under)
_____	_____	Thyroid problems
_____	_____	Diabetes
_____	_____	Irritable if meals are missed
_____	_____	Anxiety/nervousness/irritability
_____	_____	Dizzy upon standing too quickly
_____	_____	Weak and shaky
_____	_____	Hyperactive behavior
_____	_____	Depression
_____	_____	Very susceptible to infections
_____	_____	Frequent headaches
_____	_____	Digestive complaints

For Women Only

Acute	Chronic	
_____	_____	Recurrent urinary tract infections
_____	_____	Yeast infections
_____	_____	Vaginal discharge
_____	_____	Menstrual irregularity
_____	_____	Cramping
_____	_____	Mood swing/depression
_____	_____	Pre-menstrual syndrome
_____	_____	Infertility
_____	_____	Frequent miscarriages
_____	_____	Hot flashes
_____	_____	Currently taking hormone meds
_____	_____	Currently taking birth control
_____	_____	Lumps in breast/s
_____	_____	Uterine cysts/ovarian cysts
_____	_____	Bladder leaks too easily
_____	_____	Endometriosis

List any other symptoms or unusual conditions that you feel are important:

1. _____
2. _____
3. _____

_____

I hereby give permission to the Doctor to release any information requested by my insurance company acquired in the course of my treatment. This will be done in compliance with HIPPA and this offices privacy standards.)
I hereby authorize and direct my Insurance benefits to be paid to the Doctor. I am financially responsible for the non-covered services. If this account is turned over for collection I agree to pay ALL costs and fees of collecting including any and ALL attorney fees. I hereby give consent to Stephan P. Ediss, D.C. to administer treatment and perform such general procedures, as he may deem necessary in the diagnosis and/or treatment of my condition. I am aware that if I fail to give a 24 hours cancellation notice I am subject to a $25.00 charge.

Signature _____ **Date** _____