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.

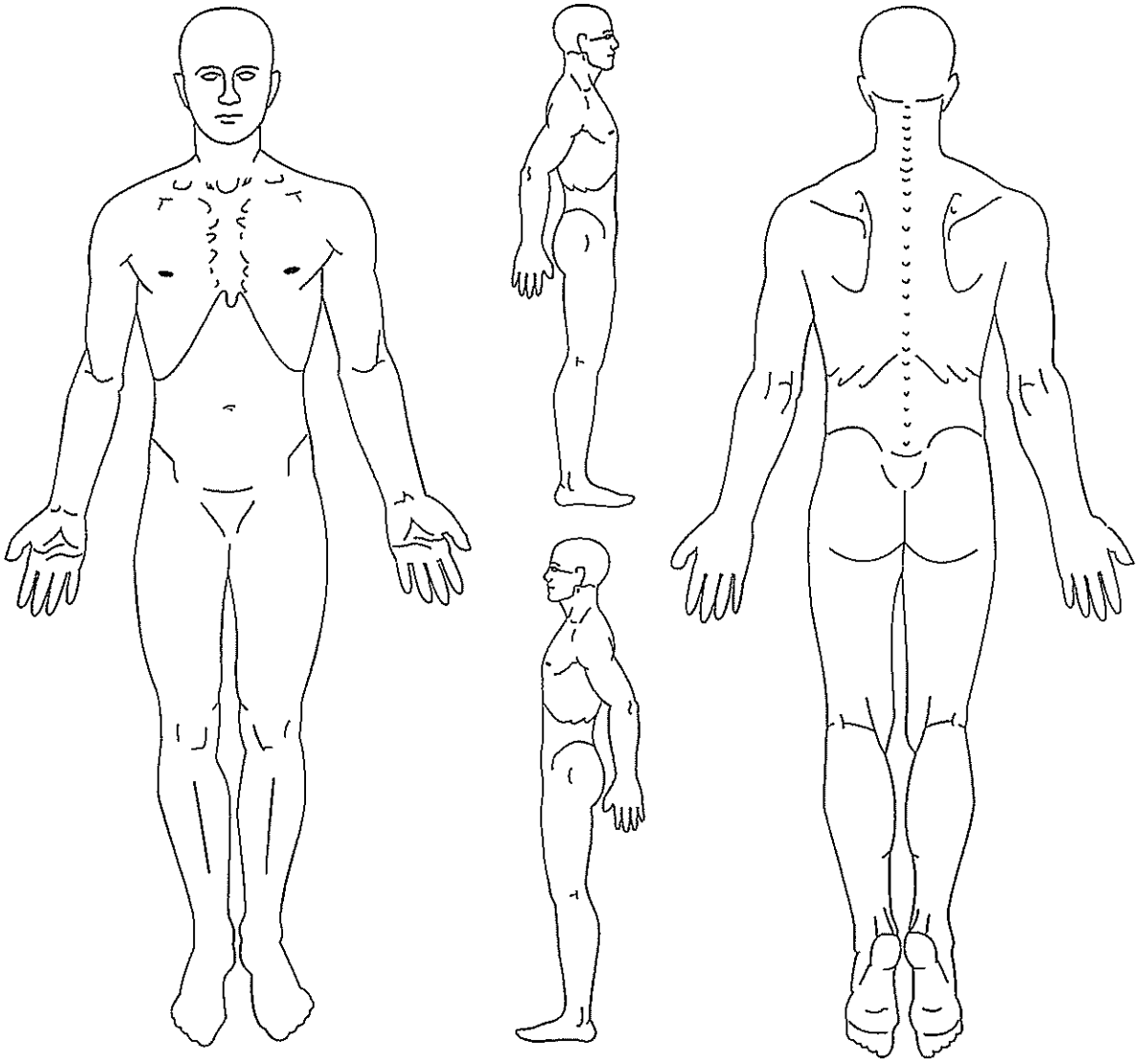
Patient or Other Legally Authorized Person: _____ Date: _____

Patient Name(Print)_____ Date_____

Patient ID #_____

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

D = Dull
B = Burning
N = Numb
S = Stabbing/Cutting
T = Tingling (Pins & Needles)
C = Cramping



On the scales below, please draw a vertical line representing your pain or discomfort:

Rate the pain you have right **now:**

No Pain — Unbearable Pain

Rate your pain at its **best** in the past week:

No Pain — Unbearable Pain

Rate your **average** pain in the past week:

No Pain — Unbearable Pain

Rate your **worst** pain in the past week:

No Pain — Unbearable Pain

EDISS CHIROPRACTIC

STEPHAN P. EDISS D.C., F.I.A.C.A.

DISCLAIMER

BY SIGNING THIS DOCUMENT I FULLY UNDERSTAND THAT DR. EDISS DOES NOT TREAT DISEASE WITH NUTRITION. BY USING THE NUTRITION THAT DR. EDISS MAY RECOMMEND I UNDERSTAND THAT HE IS SUPPORTING MY BODY'S FUNCTION, STRUCTURE AND/OR DEFICIENCIES.

X _____

(OVER)

1330 E. RICHARDS; P.O. BOX 902; DOUGLAS, WY. 82633 (307) 358-3147

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 August 15, 2022:

FIRST OFFICE VISIT: MINIMUM OF $190.00. This includes a personal history evaluation and a chiropractic exam for $125.00 and a manipulation for $65.00. If x-rays, additional therapies or nutrition (supplements) are necessary they are extra over the $190.00 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 $115.00 (and takes about 30 minutes). For ages 6 to 11 it is $135.00 (and takes about 45 minutes). For ages 12 to 16 it is $160.00 (and takes 45 minutes to an hour).

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, $65.00	Nutritional Evaluation, $45.00
Spinal Manipulation, 1-2 regions, $56.00	Lumbar x-ray, 2 view, $110.00
Electrical Stimulation, laser, $28.50	Cervical x-ray, 2 view, $90.00

Acupuncture, $42.00

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 $60.00 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. If you fail to cancel a visit you will be subject to a service charge equivalent to the cost of the visit. That does include the first office visit - If you miss your first visit and do not call to cancel you will be required to pay the $190.00 prior to re-scheduling your first visit.

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 and status of your deductible 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 NOT 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

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 an accident?***_____

List medications/vitamins currently taking:

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

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. Below, please mark the symptoms you have experienced or are currently experiencing with a P for in the PAST or with a C for CURRENTLY experiencing.

Gastro-Intestinal

_____ 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

_____ 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

_____ 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

_____ 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

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

Genito-Urinary

_____ 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

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

Miscellaneous

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

For Men Only

_____ Prostate trouble
_____ Urination problems
_____ Reproductive problems

Endocrine (Glandular)

_____ 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

_____ 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. _____

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 $65.00 service charge.

Signature _____ Date _____