



**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 insurance.  
 I certify that I have read this form and understand its contents.  
 Patient or Other Legally Authorized Person: \_\_\_\_\_ Date: \_\_\_\_\_

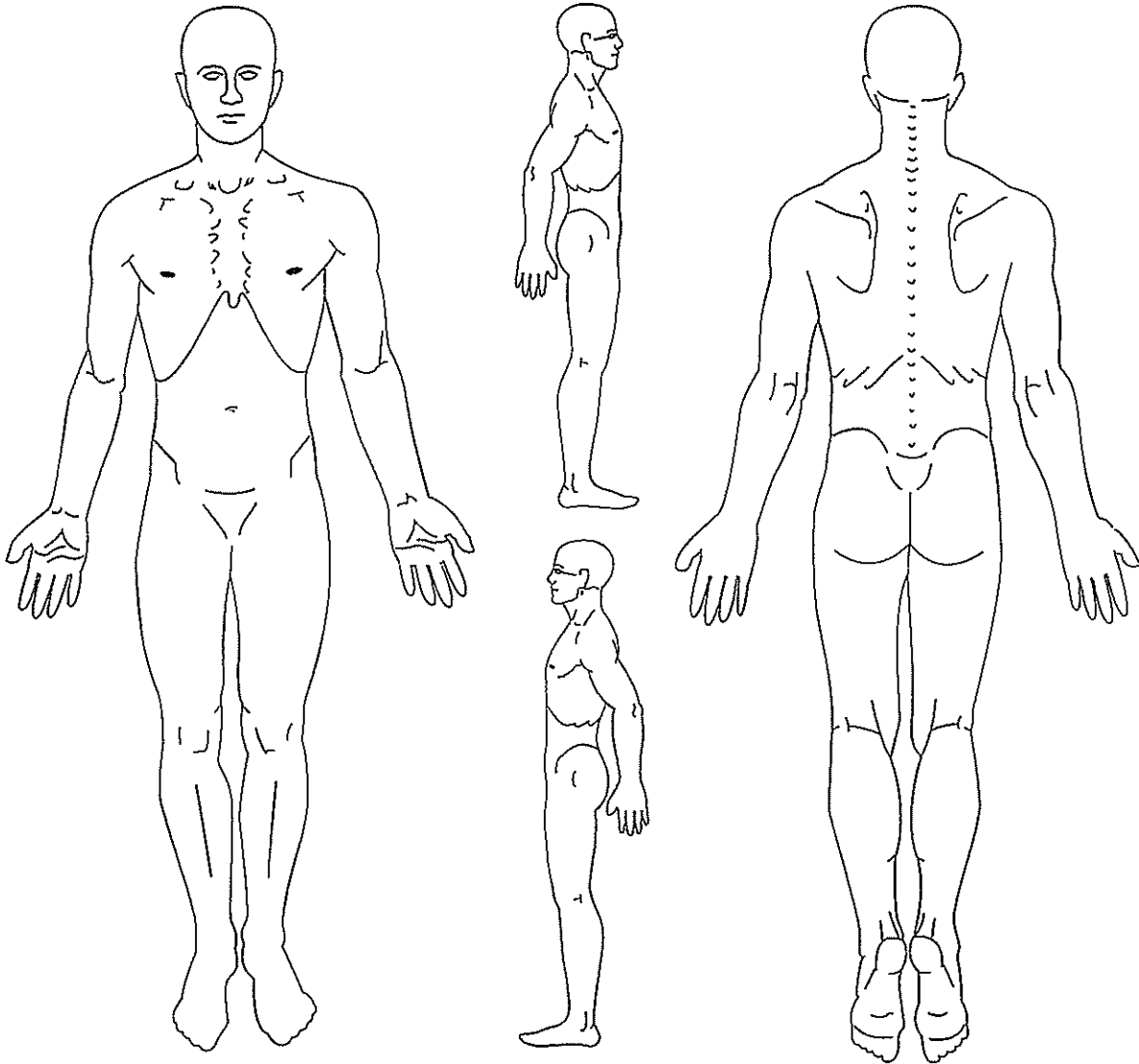
Patient Name(Print) \_\_\_\_\_ Date \_\_\_\_\_

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**:

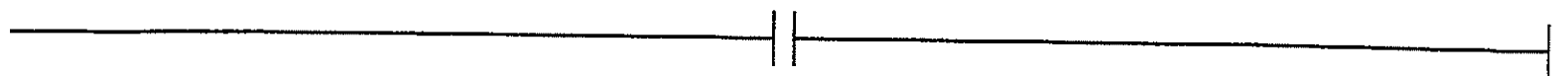
Rate your pain at its **best** in the past week:

No Pain

Unbearable Pain

No Pain

Unbearable Pain



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

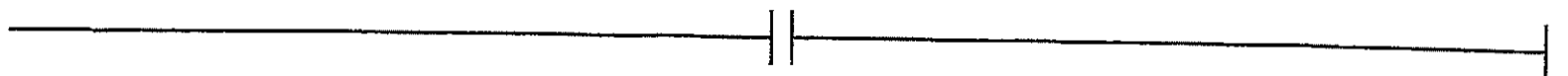
Rate your **worst** pain in the past week:

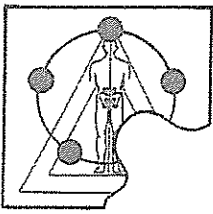
No Pain

Unbearable Pain

No Pain

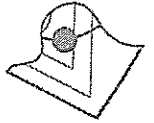
Unbearable Pain





# EDISS CHIROPRACTIC

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



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## 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)

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 **January 8, 2019**:

**FIRST OFFICE VISIT:** MINIMUM OF \$178.00. This includes a personal history evaluation and a chiropractic exam for \$116.00 and a manipulation for \$62.00. If x-rays, additional therapies or nutrition (supplements) are necessary they are extra over the \$178.00 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, \$62.00  
Spinal Manipulation, 1-2 regions, \$51.00  
Electrical Stimulation, laser, \$22.20  
Acupuncture, \$42.00

Nutritional Evaluation, \$45.00  
Lumbar x-ray, 2 view, \$89.00  
Cervical x-ray, 2 view, \$83.00

**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. 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 \$178.00 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.

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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.

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PATIENT SIGNATURE

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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	Structural/Neurological
<input type="checkbox"/> Digestive complaints	<input type="checkbox"/> Headaches
<input type="checkbox"/> Stomach pain	<input type="checkbox"/> Muscle cramps/muscle spasms
<input type="checkbox"/> Ulcers	<input type="checkbox"/> Neck pain
<input type="checkbox"/> Frequent Heartburn	<input type="checkbox"/> Jaw pain
<input type="checkbox"/> Nausea	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Frequent diarrhea	<input type="checkbox"/> Back pain
<input type="checkbox"/> Frequent constipation	<input type="checkbox"/> shoulder/elbow/wrist pain (circle one)
<input type="checkbox"/> Irritable bowel	<input type="checkbox"/> Numbness/Tingling
<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Tremors in hands or feet
<input type="checkbox"/> Frequent vomiting	<input type="checkbox"/> Knee pain/Hip pain (circle one)
<input type="checkbox"/> Colitis/diverticulitis	<input type="checkbox"/> Joint pain or loss of function
<input type="checkbox"/> Black or bloody stool	<input type="checkbox"/> Osteoporosis/Osteomalacia
<input type="checkbox"/> Gallbladder trouble	<input type="checkbox"/> Current bone fracture or injury
<input type="checkbox"/> Frequent burping/belching	<input type="checkbox"/> Tendonitis/Bursitis
<b>Immune Response</b>	<b>Cardiovascular</b>
<input type="checkbox"/> Frequently sick	<input type="checkbox"/> Irregular heartbeat
<input type="checkbox"/> Frequent swollen glands/sore throats	<input type="checkbox"/> Heart murmur/palpitations
<input type="checkbox"/> Depression and/or anxiety	<input type="checkbox"/> High or low blood pressure
<input type="checkbox"/> Achy joints/muscle pain	<input type="checkbox"/> Chest pain
<input type="checkbox"/> Headaches/migraines	<input type="checkbox"/> Previous heart trouble
<input type="checkbox"/> Recurrent digestive complaints	<input type="checkbox"/> Poor circulation
<input type="checkbox"/> Chronic fatigue	<input type="checkbox"/> Previous heart surgery
<input type="checkbox"/> Food Allergies	<input type="checkbox"/> Varicose or spider veins
<input type="checkbox"/> Eczema or hives	<input type="checkbox"/> Hands & feet cold all the time
<input type="checkbox"/> Allergies (mild/moderate/severe)	

**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 \_\_\_\_\_