



2705 S. Walton Blvd. Bentonville, AR 479.877.3471 morterwellness.com



Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email address \_\_\_\_\_ May we add you to our e-mail list? Yes \_\_\_ No \_\_\_

Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_ # of Children \_\_\_\_\_

People consult Morter Wellness Center with varied health objectives. Please check below those that apply to you.

- Relief of symptoms
- Correction of my underlying problem
- Better perform work or recreational activities
- Improve my health and enhance my quality of life
- Maximize my own, my family's and my community's health

What are your health objectives?

\_\_\_\_\_  
\_\_\_\_\_

Name of the last doctor who put you on a health development/wellness program?

\_\_\_\_\_

Were you able to stay on the program? \_\_\_\_\_ How long? \_\_\_\_\_

What were your results? \_\_\_\_\_

Were your results permanent? \_\_\_\_\_

Are you healthier today than you were 5 years ago? \_\_\_\_\_

If so, what did you do to improve your health? \_\_\_\_\_

If not, why do you think your health declined? \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Will you be healthier 5 years from now than you are today? \_\_\_\_\_

If so, what are you planning to do to improve your health and if not, what could you do to improve your health rather than have it continue to decline? \_\_\_\_\_

What would you like your health to be 5 years from now?

\_\_\_\_\_

This is about the HEALTH HISTORY of you and/or your family. Please mark each category accordingly.

You	Your Family	You	Your Family	You	Your Family
<input type="checkbox"/>	<input type="checkbox"/> Alcoholism	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Stroke
<input type="checkbox"/>	<input type="checkbox"/> Anemia	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/> Suicide Attempt
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Liver Disease	<input type="checkbox"/>	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/>	<input type="checkbox"/> Cancer/Tumor	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/> Lung Disease	<input type="checkbox"/>	<input type="checkbox"/> Digestive Issues
<input type="checkbox"/>	<input type="checkbox"/> Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/> Mental Illness	<input type="checkbox"/>	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/>	<input type="checkbox"/> Depression	<input type="checkbox"/>	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/>	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/> HIV
<input type="checkbox"/>	<input type="checkbox"/> Glaucoma	<input type="checkbox"/>	<input type="checkbox"/> Phlebitis	<input type="checkbox"/>	<input type="checkbox"/> Heart Disease
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Autoimmune	<input type="checkbox"/>	<input type="checkbox"/> Other _____

Past Surgical History (Please include dates):

\_\_\_\_\_  
\_\_\_\_\_

Current Medications: Include Birth Control Pills, Vitamins, and Supplements

Medicine name & reason taking

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies

\_\_\_\_\_

Approximate Date of Last Bloodwork? \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

This section is about symptoms you have personally experienced **within the past six months**. Please check any that apply.

**CONSTITUTIONAL**

- Weight Loss
- Fatigue
- Fever

**EYES:**

- Glasses/Contacts
- Eye Pain
- Double Vision
- Cataracts

**EAR, NOSE, THROAT:**

- Difficulty Hearing
- Ringing in Ears
- Vertigo
- Sinus Trouble
- Nasal Stuffiness
- Frequent Sore Throat

**CARDIOVASCULAR:**

- Murmur
- Chest Pain
- Palpitations
- Dizziness
- Fainting Spells
- Shortness of Breath
- Difficulty Lying Flat
- Swelling Ankles

**ENDOCRINE:**

- Loss of Hair
- Heat/Cold Intolerance
- Difficult Sleeping

**RESPIRATORY**

- Cough
- Coughing Blood
- Wheezing
- Chills

**GASTROINTESTINAL:**

- Heartburn/Reflux
- Nausea/Vomiting
- Constipation
- Change in BMs
- Diarrhea
- Jaundice
- Abdominal Pain
- Black or Bloody BM

**GENITOURINARY:**

- Burning/Frequency
- Nighttime
- Blood in Urine
- Erectile Dysfunction
- Abnormal Discharge
- Bladder Leakage

**ALLERGIC/IMMUNOLOGIC:**

- Hives/Eczema
- Hay Fever

**PSYCHIATRIC:**

- Anxiety/Depression
- Mood Swings

**HEMATOLOGY/LYMPH**

- Easy Bruising
- Gums Bleed Easily
- Enlarged Glands

**MUSCULOSKELETAL**

- Joint Pain/Swelling
- Stiffness
- Muscle Pain
- Back Pain

**SKIN:**

- Rash/Sores
- Lesions
- Itching/Burning

**NEUROLOGICAL:**

- Loss of Strength
- Numbness
- Headaches
- Tremors
- Memory Loss

**FEMALES ONLY:**

- Age Onset Periods \_\_\_\_\_
- Age Onset Menopause \_\_\_\_\_
- Periods Regular? Yes \_\_\_\_\_ No \_\_\_\_\_
- Number Pregnancies \_\_\_\_\_

Signature of Reviewing Physician \_\_\_\_\_

Date: \_\_\_\_\_



## Doctor – Patient Relationship in Chiropractic Informed Consent

### CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of Chiropractic, Osteopathy and Medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the Chiropractic Doctor's procedures often depends on environment, underlying causes, physical and spinal conditions of the patient. It is important to understand what to expect from Chiropractic health care services.

### ANALYSIS

A Doctor of Chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of a Vertebral Subluxation Complex (VSC). When VSCs are found, Chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the Chiropractic premise that spinal alignment allows nerve transmission throughout the body, and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no Doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

### DIAGNOSIS

Although Doctors of Chiropractic are experts in Chiropractic diagnosis, the VSC, they are not internal medical specialists. Every Chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your Doctor of Chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

### INFORMED CONSENT TO CHIROPRACTIC CARE

A patient, in coming to the Doctor of Chiropractic, gives the Doctor permission and authority to care for the patient in accordance with the Chiropractic tests, diagnosis and analysis. The Chiropractic adjustment or clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The Doctor, of course, will not give a Chiropractic adjustment if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or learn from healthcare procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention to the Doctor of Chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Doctor of Chiropractic provides a specialized, non-duplicating health service. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

### RESULTS

The purpose of Chiropractic services is to promote natural health through reduction of the VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the Chiropractic procedures. Sometimes 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 that 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.

### TO THE PATIENT

Please discuss any questions or problems with the Doctor **BEFORE** signing this statement of policy.

I have read and understand the above.

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Date

Signature: Patient/Guardian/Parent



## Consent for Purposes of Treatment, Payment & Healthcare Operations (3/03)

In this document, "I" and "my" refer to the patient, and "Chiropractor" refers to Morter Wellness Center.

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor.

I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is also posted in the waiting room at 2905 S. Walton Blvd, Suite 17 Bentonville, AR 72712. This Notice of Privacy Practices also addresses my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Date of Signing

\_\_\_\_\_  
Description of Personal Representative's Authority



## Our Financial Policy

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We are a “fee for service” practice. Payment is expected at the time of service unless otherwise stated. In order to best serve you and to provide accurate charges and insurance information, we recommend all new patients take advantage of our “complimentary consultation” policy where you and the doctor can sit and discuss your concerns and goals. At that time, pricing and recommendations can be discussed based on your personal road to wellness.

Because we are a wellness-based practice, we have chosen not to become an in-network provider for insurance providers. We have done this to keep our rates affordable for the time we spend with patients and the comprehensive services we offer. We are happy to provide the necessary forms needed for you to submit claims to your insurance carrier for reimbursement.

Our fee schedule is based on the time spent with our patients, the complexity of the problem assessed, and the number of problems addressed. If a visit addresses several items, each of which would normally be the focus of a single visit, this will be reflected in the overall charge. Since we evaluate your health concerns in a holistic manner, our appointments require more time. Our prices reflect the amount of time and focus we spend on your individual case. If you are looking for a brief 5 minute visit for the price of a co-pay, we would be happy to refer you to an office that better fits your health goals.

We accept the following methods of payment:

- Cash
- Check
- Visa
- Mastercard
- HSA checks/cards
- Flex Spending Account Funds

### Our Insurance Policy

We are an out-of-network provider for all insurance carriers. However, you may still use your insurance to assist in paying for your care. Keep in mind, we will always make treatment recommendations based on what you need, rather than what your insurance covers.

For those that wish to use their insurance for care, you are held to the same financial responsibilities as cash patients, as your insurance policy coverage is an agreement between you and your carrier, not the providing doctor. All care must be paid for at the time services are rendered whether insurance claims are being sent or not. We will provide the necessary paperwork for you to submit the claims in a quick, easy way to your insurance carrier. If you are eligible for reimbursement, your carrier will mail a check directly to you. If you wish to submit your claims to your insurance provider, please ask for our Insurance Verification form that will help you with the process.

We apologize for any inconvenience and will do our best to answer any questions you may have regarding our insurance policy.

### Our Payment Plans

We offer pre-paid bundled care plans that provide discounted rates for 12- and 24 visit treatment plans. Please see the **Smart Care** insert in your new patient paperwork for more information.

For those who wish to get the care they truly need and deserve, but cannot afford the upfront investment, we offer several very affordable payment plan options to fit your financial needs.

Through CareCredit, we are able to offer qualifying patients with no interest payments to keep your care within your financial comfort. For more information on CareCredit, please call them directly at 1-866-893-7864.

### **Our Cancellation Policy**

We do our best to get new patients in the same day. In order to serve others, we ask that you offer a courtesy call if you cannot keep your allotted appointment time. **A twenty-four hour notice is required for cancellation of appointments without acquiring a “no-show” charge. Patients that do not adhere to our policy may be charged the full fee for the scheduled services. This includes new patients. Please be considerate!**