FRAME CHIROPRACTIC

3330 South Price Road, Suite D-110 Tempe, Arizona 85282 Phone: 480.345.2080 Fax: 480.345.2199

∞ W E L C O M E ∞

ABOUT YOU (please print)

Today's Date: _____
Patient Name: _____
DOB: _____ Age: _____ SS#:_____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Home Phone #: _____ Cell Phone #: _____
Work Phone #: _____ EXT #: _____
Minor___ Single___ Married___ Divorced___ Separated___ Widowed___
Spouse's Name: _____
Do you have any children: Yes___ No___ How many: _____
Referred By: _____

Employer: _____
Address: _____
City: _____ State: _____ Zip: _____
Occupation: _____

REASON FOR VISIT (please print)

The reason for this visit is a result of (circle one): **WORK SPORTS AUTO TRAUMA CHRONIC**
(Explain what happened):_____
_____
Explain the pain and location: _____
_____
When did it begin: _____ Is it getting worse: Yes___ No___ Other_____
Is this condition interfering with your: (circle one): **WORK SLEEP DAILY ROUTINE**
If so, please explain: _____
Have you been treated by a Medical Physician for this condition: Yes___ No___
If so, where? _____
Have you ever been treated by a Chiropractor before? Yes___ No____
If so, whom? _____ Phone #: _____

IN THE EVENT OF EMERGENCY(please print)

Who should we contact? _____
Relation: _____
Home Phone #:_____ Cell #:_____
Who is you Medical Doctor? _____ Phone #: _____

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HEALTH HISTORY (please print)

Are you taking any of the following medications?

- ❑ Nerve Pills
- ❑ Pain Killers (including aspirin)
- ❑ Muscle Relaxers
- ❑ Stimulants
- ❑ Tranquilizers
- ❑ Blood Thinners
- ❑ Other_____
  _____
  _____
  _____
  _____
- ❑ Insulin

Do you or have you ever had any of the following conditions (check all that apply)?

- ❑Heart Attack / Stroke
- ❑Congenital Heart Defect
- ❑Alcohol / Drug Abuse
- ❑HIV+ / Aids
- ❑Frequent Neck Pain
- ❑High/Low Blood Pressure
- ❑Severe / Frequent Headaches
- ❑Fainting / Seizures Epilepsy
- ❑Diabetes / Tuberculosis
- ❑Lower Back Problems
- ❑Heart Surg. / Pacemaker
- ❑Mitral Valve Prolapse
- ❑Venereal Disease
- ❑Shingles
- ❑Emphysema / Glaucoma
- ❑Psychiatric Problems
- ❑Kidney Problems
- ❑Sinus Problems
- ❑Difficulty Breathing
- ❑Artificial Bones / Joints
- ❑Heart Murmur
- ❑Hepatitis
- ❑Cancer
- ❑Anemia
- ❑Rheumatic Fever
- ❑Ulcers / Colitis
- ❑Asthma
- ❑Chemotherapy
- ❑Arthritis

Please list any other serious medical condition(s) you have or ever had: _____
_____

List previous surgeries/treatments with dates: _____
_____

List any **past** serious accidents with dates: _____
_____

Family Health History: _____
_____

Do you: Take Supplements or Vitamins? Yes___ No___ Exercise? Yes___ No___
Are you on a special diet: Yes___ No___ Since: _____
Do you smoke? Yes___ No___ How much? _____ How long? _____
Are you wearing: Heels Lifts___ Sole Lifts___ Inner Soles___ Arch Support___
What is the age of your mattress? _____ Is it comfortable? Yes___ No___
For Women: Are you taking Birth Control? Yes___ No___
Are you pregnant? No___ Yes/How Long? _____ Nursing: _____

FRAME CHIROPRACTIC
Dr. Paul Frame, D.C.
3330 S. Price Road, #D110
Tempe, Arizona 85282
Office # (480)345-2080

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

It is important that each patient understand both the objective and the method that will be used to attain it.

Your nervous system is made up of your brain, spinal cord & nerves. Your nervous system is in charge of directing, controlling, & coordinating every organ & system in your body. If you have a misaligned spinal or extremity bone, the nerves exiting through that bone are not operating at their best. I detect this, then gently and manually perform adjustments to remove nervous system interference. Once adjusted the nerve tracts are no longer compressed & your nervous system can work at its optimum. Ultimately homeostasis & health are restored naturally to every organ, system, tissue, & cell in your body.

Extremity Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral and extremity subluxation. Our chiropractic method of correction is by specific adjustments of the spine and extremities.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Extremity Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column and extremity joints which causes alteration of nerve function and interference to the transmission of impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

-Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct subluxation.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____
(signature) (date)

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ASSIGNMENT OF BENEFITS

I authorize Dr. Paul E. Frame, D.C., to receive direct payment from my insurance company(s) or attorney for all moneys due on my account. I understand that all coverages in effect will be billed and collected from, including group(s), medical payments and attorney liens.
Any overpayments will be promptly returned.

In the event that there is no valid coverage or that I have exceeded my annual insurance limit, I will remain responsible for all charges incurred. I agree to provide Dr. Paul E. Frame, D.C. with all valid insurance information forms and billing information within 5 days of my first visit.

Should I receive payments or settlements for services rendered, I agree to forward these to Dr. Paul E. Frame, D.C. within 5 days of receiving such materials.

I acknowledge that the assignment terms and fees have been reviewed with me and I agree to all of the above terms.

_____ _____
Signature (Patient) Date
(or legal guardian if applicable)

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FEE SCHEDULE APPLIED TO ALL INSURANCE COMPANIES

Usual and Customary Fees for Frame Chiropractic

Initial Examination: (1st & 2nd Visits) $60.60-$210.60

Patient conference, detailed review of case history, extended palpatory spinal examination, orthopedic & neurologic examination, correlation of findings. report of radiographic findings, doctor's recommendations, and introduction of care plan.

Intermediate Examination: $60.00-$77.40

A correlation of past and present findings with extended discussion of patient's health as a result of care to date to determine extent and frequency of continued care of dismissal. Includes examination procedures described above.

Spinal X-Rays/2 Views: (when deemed necessary)
$100.00

If radiographic films are taken, law requires all health care facilities to take a minimum of 2 (opposing) views.

Adjustment: $44.40-$73.80

A specific manual (by hand) or instrumental adjustment to correct Subluxations (a misalignment of a spinal/extra spinal joint causing nerve interference).

Heat or Ice Therapy: (as deemed necessary)
$25.00

A pack used for the reduction of muscle spasm and inflammation.

Interferential Current: (as deemed necessary)
$40.00

Electrical stimulation directed to muscles used for the reduction of inflammation.

Manual Therapy: (as deemed necessary)
$65.00

Manual traction therapy for stretching spinal joints/musculature to increase mobility and/or sustained pressure either instrumental or manual for increasing range of motion, reducing muscle spasm, avoiding scar tissue formation, and promotion of the healing process (based on 8-15 minute increments).

Therapeutic Exercise: (as deemed necessary and based on 8-15 minute increments).
$65.00

Patient Name (Printed): _____

Patient Signature: _____

Today's Date: _____ Witness: _____