

LANCE MYLER, D.C.
62 ELM STREET ~ POTSDAM, NY 13676
PHONE (315) 265-1500 ~ FAX (315) 262-0403 ~ E-MAIL : dr@DrLanceMyler.com

Application for Treatment

Name First _____ MI _____ Home phone _____

Last _____ Work/Alt phone & ext _____

Nickname _____ Fax _____

Address _____ Cell Phone _____

City _____ State _____ Zip _____ Beeper _____

Social Security # _____ Email _____

Gender M F Work/Alt Email _____

Marital Status: Married, Widowed, Single, Divorced, Separated Emergency Contact _____

Spouse _____ Phone _____

Your Date of Birth _____ Patient Referral _____

Referral- Spouse, Staff Member, Dr., Office sign, NCTW, Mail, Yellow Pages, Attorney, TV, Watertown Times, Courier Observer.

Occupation _____

Employer _____ Phone _____

Employer Address _____ Fax _____

City _____ State _____ Zip _____ Email _____

Primary Physician _____ Address _____

May we send a summary of your care here? Yes No

Have you had Chiropractic care before? Yes No From Whom? _____ When? _____

Please describe your major Problem: _____

When were you first aware of this problem? _____

What caused it? _____

Was it related to: An Auto Accident _____ Other Accident _____ Work Related _____

Any other accidents or injuries? Yes No Has it been getting: Better? Worse? Staying the same?

What makes it better? _____

What makes it worse? _____

Have you missed any work as a result of this condition? _____ Dates: _____

Any chance you are pregnant? _____ Will we be billing your insurance? Yes No

I acknowledge that I have received a copy of the Notice of Privacy Practices, and had an opportunity to review it. I Understand that a copy of the current Notice will always be in a visible location in the office, and that I can always have a copy of the current Notice on request.

Signature _____ Date _____

Fees are payable at the time that services are rendered, unless other arrangements are made. Please provide any necessary insurance billing information.

Family and Personal Health History

Note: Please complete all information on this record. All information is treated in confidence and will not be released unless you grant permission.

Name _____ Today's date _____

Occupation _____ Allergies _____ Last physical _____

Family Record Check conditions and relationship of any relative who has or has had any of the conditions listed below.	YOU	SPOUSE	FATHER	MOTHER	BROTHER	SISTER	SON	DAUGHTER
Headaches								
Migraines								
Cluster Headaches								
Neck Problems								
Whiplash & Neck Injury								
Sinus Trouble								
Ear infections								
Shoulder Problems								
Arm pain, numbness or tingling								
Hand Problems								
Carpal Tunnel Symptoms								
Asthma								
Emphysema								
Digestion, Heartburn, Ulcers								
Low Back Pain								
Hip Problems								
Sacroiliac Problems								
Sciatica Problems								
Leg pain, numbness or tingling								
Spine & Disc Degeneration								
Muscle Spasm								
Arthritis & "Rheumatism"								
Stress								
Fibromyalgia								
Sports Injury								
Accident								
Injury								
Diabetes								
Cancer								
Heart disease								
Difficult Birth								
"Noisy bones"								
Foot turns in or out								
Joint pain								
Numbness or tingling								

Operations	Date
Spinal	
Appendix	
Gall Bladder	
Stomach	
Kidney	
Colon	
Thyroid	
Hernia	
Breast	
Uterus	
Ovaries	
Prostate	
Tonsils	
Other-	

Do You:	Amount
Smoke Y/N _____	Pkgs. Per day for _____ years
Alcohol Y/N _____	Servings per week
Recreational Drug Use Y/N	
Exercise: Type _____ Frequency _____	

X-RAYS	Date
Back	
Neck	
Hips	
MRI	
Bone Density	
Thoracic	
Lumbar	
CT Scan	

Medications Include Vitamins/Supplements		
Name _____	Dose _____	Frequency _____
Name _____	Dose _____	Frequency _____
Name _____	Dose _____	Frequency _____
Name _____	Dose _____	Frequency _____

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Financial Policy

We've learned that it is best if we explain our financial policies up front, so that we can focus of providing needed care.

Payment is due when services are rendered.

All patients are cash patients until we have all of the needed insurance documentation. We will attempt to contact the company and determine the nature of the coverage. Sadly, experience has shown that we cannot guarantee the accuracy of the information that they provide.

Once we have all of the necessary paperwork, we will bill most companies directly and accept your deductible and co-pay as payment until they have had time to process your claim. If we can't bill your company directly, we will tell you as soon as practical after we find out.

We are a Chiropractic office, and do not have a collections department. There is no one with the time to place all the calls, write the letters, and do the follow-up to necessary to service an overdue account. We simply do not have the manpower. Therefore, any account that is not paid fully and promptly, as agreed upon, will be referred out of the office for collections. Collection expenses will be the responsibility of the patient. In order to help defray the expenses associated with preparing and sending statements, there will be a 1.5% billing charge monthly on any outstanding balances.

We will do all that we can to see that you can get needed care. If you have any questions or concerns, please let us know. We look forward to taking care of you.

In Good Health,

Dr. Lance Myler, D.C., and staff

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Insurance Information and Authorization

Guarantor:

Name First _____ MI _____

Home phone _____

Last _____

Work/Alt phone & ext _____

Address _____

Phone _____

City _____ State _____ Zip _____

Fax _____

Social Security # _____

Email _____

Gender M F Date of Birth _____

Work/Alt Email _____

Insured: Child Self Spouse Other _____

Employer _____

Phone _____

Employer Address _____

Fax _____

City _____ State _____ Zip _____

Email _____

Insurance Company _____

Policy Information _____

Address _____

Payer % coverage _____

City _____ State _____ Zip _____

Co-payment _____

Phone _____ Ext. _____ Fax _____

Yearly Deductible _____

Group Name _____

Deductible remaining? _____

Group Plan _____

Policy ID _____

Claim _____

Effective date _____ Termination date _____

Have you ever had this problem, or similar problem, before? Yes No

Date? _____

Employment Status: FT student, PT student, Not a student, FT employed, PT employed, Not employed, Self employed, Retired, Active Military

Was patient in an accident? None, Auto, Work related, Other State _____ Date _____ Time _____

I hereby authorize Myler Chiropractic to release information concerning my condition and care to the insurance company. I also authorize and direct the insurance company to pay Myler Chiropractic directly for all care. I understand that all charges are my responsibility. A copy of this authorization shall be as the original.

Medicare covers at least 12 visits per year. The number of allowed visits depends on patients' condition. If visits exceed the number allowed by Medicare the patient understands that they are responsible for payment.

Workers' compensation-If case does not cover chiropractic care or treatments exceed the number allowed, the patient is financially responsible for payment.

I hereby give Dr. Myler permission to administer treatment and perform such general procedures as he may deem necessary in the diagnosis and/or treatment of my condition.

Patient Signature _____

Date _____

(I have read and agree to the above statements)

Name _____

Insured, if other than patient _____ Date _____

HEALTH STATUS QUESTIONNAIRE – RAND 36

Patient Name _____

Date _____

- | | |
|---|--|
| <p>1. In general, would you say your health is:
(circle one number)</p> <p>Excellent 1
Very Good 2
Good 3
Fair 4
Poor 5</p> | <p>2. Compared to one year ago, how would you rate your health in general now?
(circle one number)</p> <p>Much better now than one year ago 1
Somewhat better now than one year ago 2
About the same 3
Somewhat worse now than one year ago 4
Much worse now than one year ago 5</p> |
|---|--|

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

- | | | | |
|--|----------------------------------|-----------------------|------------------------|
| | (circle one number on each line) | | |
| | Yes, limited a lot | Yes, limited a little | No, not limited at all |
| 3. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports. | 1 | 2 | 3 |
| 4. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf | 1 | 2 | 3 |
| 5. Lifting or carrying groceries. | 1 | 2 | 3 |
| 6. Climbing several flights of stairs. | 1 | 2 | 3 |
| 7. Climbing one flight of stairs. | 1 | 2 | 3 |
| 8. Bending, kneeling or stooping. | 1 | 2 | 3 |
| 9. Walking more than a mile. | 1 | 2 | 3 |
| 10. Walking several blocks | 1 | 2 | 3 |
| 11. Walking one block | 1 | 2 | 3 |
| 12. Bathing or dressing yourself | 1 | 2 | 3 |

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?
(circle one number on each line)

- | | | |
|--|-----|----|
| | Yes | No |
| 13. Cut down the amount of time you spent on work or other activities. | 1 | 2 |
| 14. Accomplished less than you would like. | 1 | 2 |
| 15. Were limited in the kind of work or other activities. | 1 | 2 |
| 16. Had difficulty performing the work or other activities.
(for example, it took extra effort) | 1 | 2 |

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?
(circle one number on each line)

- | | | |
|--|-----|----|
| | Yes | No |
| 17. Cut down the amount of time you spent on work or other activities. | 1 | 2 |
| 18. Accomplished less than you would like. | 1 | 2 |
| 19. Didn't do work or other activities as carefully as usual. | 1 | 2 |

20. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?
(circle one number)

- | | |
|-------------|---|
| Not at all | 1 |
| Slightly | 2 |
| Moderately | 3 |
| Quite a bit | 4 |
| Extremely | 5 |

21. How much bodily pain have you had during the past 4 weeks?
(circle one number)

- | | |
|-------------|---|
| None | 1 |
| Very mild | 2 |
| Mild | 3 |
| Moderate | 4 |
| Severe | 5 |
| Very Severe | 6 |

22. During the past 4 weeks how much did pain interfere with your normal work (including both work outside the home and housework)?
(circle one number)

- | | |
|--------------|---|
| None at all | 1 |
| A little bit | 2 |
| Moderately | 3 |
| Quite a bit | 4 |
| Extremely | 5 |

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks . . .

(circle one number on each line)

	All of the time	Most of the time	A good bit of the time	Some of the time	Little of the time	None of the time
23. Did you feel full of pep?	1	2	3	4	5	6
24. Have you been a very nervous person?	1	2	3	4	5	6
25. Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
26. Have you felt calm and peaceful?	1	2	3	4	5	6
27. Did you have a lot of energy?	1	2	3	4	5	6
28. Have you felt downhearted and blue?	1	2	3	4	5	6
29. Did you feel worn out?	1	2	3	4	5	6
30. Have you been a happy person?	1	2	3	4	5	6
31. Did you feel tired?	1	2	3	4	5	6

32. During the past 4 weeks, how much of the time has your physical health or emotional health problems interfered with your social activities? (like visiting with friends, relatives, etc.)

(circle one number)

- All of the time 1
- Most of the time 2
- Some of the time 3
- A little of the time 4
- None of the time 5

How TRUE or FALSE is each of the following statements for you?

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
33. I seem to get sick a little easier than other people.	1	2	3	4	5
34. I am as healthy as anybody I know.	1	2	3	4	5
35. I expect my health to get worse.	1	2	3	4	5
36. My health is excellent.	1	2	3	4	5

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