

Dr. Tyler J. Hammell

303 N. Main St. • Chamberlain, SD 57325 • (605) 234-6968

PLEASE PRESENT INSURANCE CARD AND DRIVER'S LICENSE TO FRONT DESK

Legal Name _____
First Middle Initial Last

Birthdate _____ Age _____ Sex M F Single Married Soc Sec# _____

Mailing Address _____ City _____ State _____ Zip _____

Physical Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Occupation _____ Supervisor _____

Family Physician _____ Phone _____

Spouse or Parent(s) Name _____ Cell Phone _____

Spouse or Parent(s) Employer _____ Work Phone _____

Spouse or Parent(s) Soc Sec.# _____ Driver's License # _____ State _____

Emergency Contact _____ Relationship _____ Phone _____

If you have Insurance and you are Not the policy holder, you must complete this section (If insurance is in spouse or parent name.)

Policy Holder (Name) _____ Relationship to Patient _____ Birthdate _____

Soc. Sec. # _____ Home Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Employer _____ Work Phone _____

METHOD OF PAYMENT: CASH/CHECK VISA, MC, DISCOVER INSURANCE

I authorize Dr. Tyler Hammell to release any information pertinent to my care or claims to my family and insurance and hereby release this clinic of any consequences thereof.

I authorize Dr. Tyler Hammell and his staff to perform services needed during the course of care. Chiropractic care is considered safe and effective. However, complications do arise. A Notice of Privacy Practices and Payment Policy & Insurance Billing Information are available in our waiting room and on our website ChamberlainChiro.com.

I understand that I am fully responsible for payment for all services received. No-Shows will be charged a fee!

I have read all the information on this form and have completed it correctly to the best of my knowledge.

Patient/Legal Guardian Signature _____ Date _____

Dr. Tyler J. Hammell

303 N. Main St. • Chamberlain, SD 57325 • (605) 234-6968

Name _____

Date _____

Today's main area of complaint to be evaluated and treated _____

How did pain start? Gradual - Pain got worse over time

Acute - Sudden Pain Chronic - Had pain for weeks or longer

My Pain Is

<input type="checkbox"/> 0 No Pain	<input type="checkbox"/> 1 Nagging Annoying	<input type="checkbox"/> 2 <input type="checkbox"/> 3 Moderate Pain	<input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 Disabling	<input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 Severe Pain
---------------------------------------	--	--	---	---

Reason for today's visit (check one)

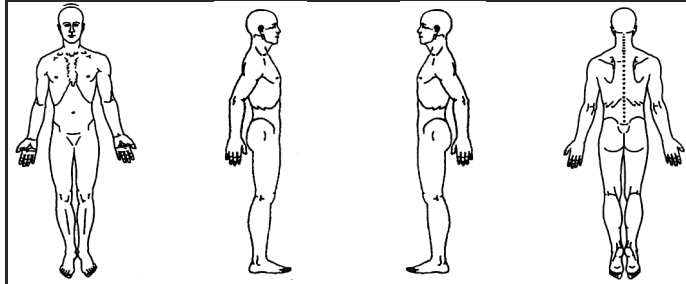
No Accident

Auto Accident Work Accident

Other Accident

Date of Accident _____/_____/_____

Explain what happened _____



Circle your pain

When are symptoms present? Morning Day Night

What makes it worse?(Circle)

lifting, bending, sitting, coughing, walking, standing

Does anything make it better? No

ice, heat, rest, stretching, walking, sitting, standing, medication

Does it affect work? No

Occasionally Frequently Constantly

Does it affect sleep? No

Occasionally Frequently Constantly

Who else have you seen for today's symptoms? No One

Name _____ Specialty _____ Date _____

Your diagnosis _____ Treatment received _____

Recommendation /Treatment plan: _____

What tests have you had for today's symptoms: None

X-rays Date: _____ Where: _____ MRI Date: _____ Where: _____

CT Scan Date: _____ Where: _____ Other Date: _____ Where: _____

I wear: None

Heel Lift

Arch Supports/Orthotics

Family History

None

Indicate below, if any, grandparents, parents, siblings, children has/had any of the following:

Rheumatoid Arthritis _____ Degenerative Arthritis _____ Diabetes _____ Heart Problems _____

Lupus _____ Cancer _____ Thyroid Disease _____ Depression _____

Osteoporosis _____ Alzheimer's _____ Epilepsy _____ Parkinson's _____

Other _____

Dr. Tyler J. Hammell

303 N. Main St. • Chamberlain, SD 57325 • (605) 234-6968

Name: _____

Date: _____

**You must provide us with your complete health history that would otherwise not come to the attention of a Chiropractic Physician.
This health information could have an important inter-relationship with the care you receive today.**

Please **X** any of the following that applies to you **NOW** and in the **PAST**

<input type="checkbox"/> None Musculoskeletal		<input type="checkbox"/> None Neurological	
<input type="checkbox"/> Fracture/Broken Bones _____ <input type="checkbox"/> Neck/Back Surgery _____ <input type="checkbox"/> Joint Replacement _____ <input type="checkbox"/> Osteoporosis/Osteopenia _____ <input type="checkbox"/> Joint Pain/Swelling/Stiffness _____ Other _____		<input type="checkbox"/> Headaches <input type="checkbox"/> Numbness/Tingling <input type="checkbox"/> Blurred/Double Vision <input type="checkbox"/> Speech Difficulty <input type="checkbox"/> Dizziness <input type="checkbox"/> Balance Difficulty <input type="checkbox"/> Nausea <input type="checkbox"/> Walking Difficulty Other _____	
<input type="checkbox"/> None Cardiovascular	<input type="checkbox"/> None Psychiatric	<input type="checkbox"/> None Neurological	<input type="checkbox"/> None Respiratory
<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Disease <input type="checkbox"/> Strokes/Mini Strokes <input type="checkbox"/> Blood Clot/Embolism <input type="checkbox"/> Carotid Artery Disease Other _____	<input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> ADHD <input type="checkbox"/> ADD Other _____	<input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Epilepsy <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Brain Tumor Other _____	<input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema/COPD <input type="checkbox"/> Chronic Cough Other _____
<input type="checkbox"/> None G. U. System	<input type="checkbox"/> None Endocrine	<input type="checkbox"/> None Musculoskeletal	<input type="checkbox"/> None Immunologic
<input type="checkbox"/> Kidney Problems <input type="checkbox"/> Bladder Problems <input type="checkbox"/> Prostate Problems Other _____	<input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid Problem <input type="checkbox"/> Hormonal Problem Other _____	<input type="checkbox"/> Degenerative (Osteo) Arthritis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Muscular Dystrophy Other _____	<input type="checkbox"/> AIDS or HIV <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Lupus/Scleroderma <input type="checkbox"/> Celiac Disease Other _____
<input type="checkbox"/> None Hematological	<input type="checkbox"/> None Gastrointestinal	<input type="checkbox"/> None E.E.N.T	<input type="checkbox"/> None Dermatologic
<input type="checkbox"/> Anemia <input type="checkbox"/> Leukemia <input type="checkbox"/> Vitamin B12 Deficiency Other _____	<input type="checkbox"/> Ulcer <input type="checkbox"/> Crohn's <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Diverticulosis/itis <input type="checkbox"/> Irr. Bowel Syndrome Other _____	<input type="checkbox"/> Hearing Loss <input type="checkbox"/> Upper Resp. Infection <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Swallowing Problems <input type="checkbox"/> Glasses/Contacts Last Eye Exam _____	<input type="checkbox"/> Eczema <input type="checkbox"/> Psoriasis <input type="checkbox"/> Rash Other _____
<input type="checkbox"/> None Cancer	<input type="checkbox"/> None Allergies	OBGYN (Females Only)	
<input type="checkbox"/> Bone/Skin <input type="checkbox"/> Breast/Prostate <input type="checkbox"/> Colon/Liver <input type="checkbox"/> Other _____	<input type="checkbox"/> Environmental _____ <input type="checkbox"/> Drug _____	Are you pregnant <input type="checkbox"/> No <input type="checkbox"/> Yes How far _____ Last menstrual period _____	

Listsurgerieswithdates: **None:** _____

List the Medications/Vitamins/Herbs you are taking (Please provide a list): **None:** _____



CHAMBERLAIN CHIROPRACTIC

Dr. Tyler Hammell
303 N. Main St.
Chamberlain, SD 57325
Tel: 605-234-6968

PAYMENT POLICY & INSURANCE BILLING INFORMATION

Patients with insurance are responsible for their copay/ estimated portion on each visit. Please read below for more detailed information that may apply to you.

Patients without insurance are responsible for full payment on each visit.

Insurance: Most insurance don't pay 100%, you will be paying your estimated portion on each visit. Your remaining portion will be due in full upon receipt of our bill. Often times, we have already waited 60-90 days for your insurance to process your claim. We are an in-network provider for Wellmark BCBS, Sanford, Avera and DAKOTACARE.

Medicare: We send all claims to Medicare and Medicare Advantage Plans. Medicare will forward your claims to your supplement. Medicare will **only** pay for the spinal manual manipulation, and you must commit to Dr. Hammell's treatment plan as it's required by Medicare. If you want to come in when you want to that is considered maintenance and Medicare doesn't cover maintenance. Exams are required on patients. Medicare does not pay for it. Medicare sends payments to the patient for the spinal manual manipulation. Therefore, you will pay us on each visit.

Worker's Compensation: You should have reported the accident to your employer within 3 working days of the accident and filled out a First Report of Injury form from your employer. We will send all claims to your worker's compensation insurance that you or your employer has provided to us. They usually pay 100%. If an attorney is involved we need to know this right away.

Auto Accident: We will send the claims to **your** own auto insurance, even if it's the other driver at fault. They usually pay 100%. If the payment is sent to you-that payment needs to be brought in to us promptly. If an attorney is involved we need to know this right away.

Personal Injury: All personal injuries are treated as a cash patient; you pay on each visit. Examples are getting hurt by someone's animal, getting hurt in a store while shopping, getting in a fight etc.

We believe the best doctor-patient relationship exists when there is a complete understanding of your financial responsibilities.

Continued on back

Chiropractic is not all about pain ...it's about function! It only takes a small amount of pressure on a nerve, about the same pressure as the weight of a quarter on the palm of your hand to cut out 50% of the nerves ability to function normal. This is why it's important to have regular chiropractic care to keep the nervous system functioning normal which leads you to feeling better and being healthier. The Nervous System acts as the computer of your body. If it's not working properly than your body is going to malfunction. Chiropractic is about adjusting the spine, getting the nerves to function better in order to communicate more efficiently with the brain, and getting to the root cause of the problem.

There are different levels of Chiropractic Care that is available. If you just want to get out of pain even though your body could be healthier is the quickest but in the long run is more costly. Once you get out of pain then you go into the healthier stage and see us less often and the treatments are helping you with fewer illnesses, being more energetic, less stressful, less inflammation, longevity, balance and boost your immune system. Mobility and having your spine in line make your nerves function better therefore your body feels better, and you should be in less pain. You don't have to be in pain to be not healthy that's why chiropractic care is good for everyone! The other stage of care is "Maintenance" or "Wellness". This is when you are out of pain, are healthy, and you seek Chiropractic Care on a monthly basis. This is the most affordable plan once you reach this point.

We offer chiropractic services. Our relationship is with you-not with your insurance. We do not specialize in insurance. However, as a courtesy to our patients we will send claims to your insurance. The most misunderstanding in our office is the patient not knowing his/her insurance benefits. We rely on you to understand your insurance benefit that covers you. Each patient and each insurance policy is unique and confidential to you. If you have questions about your insurance or how they paid on a claim, please call them. You are ultimately responsible for payment for all the services received.

- * We recommend for you to follow the doctor's treatment plan that he has given to you for optimal care and to receive optimal results. Often times insurance companies play a part in this role.
- * As a courtesy to the doctor and other patients, kindly give us a 24-hour notice if unable to keep an appointment, **No-Shows** are not acceptable in our office and will be charged a fee.
- * Ask us about our referral program
- * Ask us about our Wellness program
- * We accept cash, checks, and credit cards
- * Returned check fee is \$45
- * Accounts past due will be charged a \$20.00 monthly late fee. You are responsible for any additional charges incurred from collections, court fees, attorney fees

If you have any questions, please ask!

For Emergencies Call 605-730-6968

**VISIT OUR WEBSITE: ChamberlainChiro.com.
Like Us on Facebook!**