Prairie Ridge CHIROPRACTIC

DR. CHRIS WILLERS
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Patient Information

Date_____ Sex: □ M □ F Age: _____
Patient Name_____
Address_____
City_____ State____ Zip Code_____

Birth Date_____ Height_____Weight_____

□Single □Married □Widowed □Separated □Divorced

Occupation_____
Employer_____

Whom may we thank for referring you?_____

Email Address_____

□ Opt out of marketing, newsletters, and promotional materials. Email address will only be used for contact regarding appointment scheduling and information related to current treatment.

Insurance

Subscriber's Name_____
Birth Date _____
Relationship to Patient_____

Insurance Company_____
Member ID#_____
Group#_____

Is patient covered by additional insurance? □ Y □ N
Subscriber's Name_____
Birth Date _____
Relationship to Patient_____

Insurance Company_____
Member ID#_____
Group#_____

_____
Responsible Party Signature

_____
Relationship Date

Phone Numbers

Home_____Work_____Cell_____
Best time and place to reach you:_____
_____

IN CASE OF EMERGENCY, CONTACT:
Name_____Relationship_____
Home Phone_____
Work Phone_____Ext_____

Accident Information

Is condition due to an accident? □ Y □ N Date_____
Type of accident □ Auto □ Work □ Home □ Other

To whom have you made a report of your accident?
□ Auto Insurance □ Employer □ Worker Comp □ Other
Attorney Name/Phone # (if applicable)_____
_____

Health History

What treatment have you already received for your condition?
□ Medications □ Surgery □ Physical Therapy □ Chiropractic Services □ None
□ Other_____

Name and address of other doctor(s) who have treated you for your current problem:_____

Date of Last: Physical Exam_____ Spinal X-Ray _____Blood Test_____
Spinal Exam_____ Chest X-Ray _____ Urine Test_____
Dental X-Ray_____ MRI, CT-Scan, Bone Scan_____

Who is your primary care physician (First/Last Name)?_____
What is their address?_____
When was your last appointment with your primary doctor? _____
Was your last visit with your primary doctor related to your current problem? Yes No
May we contact your primary doctor regarding your condition? Yes No

Place a mark on "Yes" or "No" to indicate if you previously or currently have any of the following:

AIDS/HIV □ Y □ N
Alcoholism □ Y □ N
Anemia □ Y □ N
Anorexia □ Y □ N
Appendicitis □ Y □ N
Arthritis □ Y □ N
Asthma □ Y □ N
Bleeding Disorders
Breast Lump □ Y □ N
Bronchitis □ Y □ N
Bulimia □ Y □ N
Cancer □ Y □ N
Cataracts □ Y □ N
Chemical Dependency □ Y □ N
Chicken Pox □ Y □ N
Diabetes □ Y □ N
Emphysema □ Y □ N
Epilepsy □ Y □ N
Fractures □ Y □ N

Glaucoma □ Y □ N
Goiter □ Y □ N
Heart Disease □ Y □ N
Hepatitis □ Y □ N
Hernia □ Y □ N
Herniated Disc □ Y □ N
Herpes □ Y □ N
High Cholesterol □ Y □ N
Kidney Disease □ Y □ N
Liver Disease □ Y □ N
Measles □ Y □ N
Migraine Headaches □ Y □ N
Miscarriage □ Y □ N
Mononucleosis □ Y □ N
Multiple Sclerosis □ Y □ N

Mumps □ Y □ N
Osteoporosis □ Y □ N
Pacemaker □ Y □ N
Parkinson's Disease □ Y □ N
Pinched Nerve □ Y □N
Pneumonia □ Y □ N
Polio □ Y □ N
Prostate Problem □ Y □ N
Prosthesis □ Y □ N
Psychiatric Care □ Y □ N
Rheumatoid Arthritis □ Y □ N
Rheumatic Fever □ Y □ N
Scarlet Fever □ Y □ N
Stroke □ Y □ N
Thyroid Problems □ Y □ N

Tonsillitis □ Y □ N
TIA □ Y □ N
Tuberculosis □ Y □ N
Tumors Growths □ Y □ N
Typhoid Fever □ Y □ N
Ulcers □ Y □ N
Vaginal Infections □ Y □ N
Venereal Disease □ Y □ N
Whooping Cough □ Y □ N
Other_____
_____
_____
_____

Exercise	Work Activity	Habits	Yes	No	
□ Never	□ Sitting _____ hrs/day	□ Tobacco	□	□	⇒ Packs/Day_____
□ Occasionally	□ Standing____ hrs/day	□ Alcohol	□	□	⇒ Drinks/Week_____
□ Frequently	□ Light Labor	□ Coffee/Caffeine Drinks	□	□	⇒ Cups/Day_____
□ Daily	□ Heavy Labor	□ High Stress Level	□	□	⇒ Reason_____

Are you Pregnant? □ Yes □ No Date of last menstrual period_____ Due date_____
Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your spinal condition. Should x-rays be necessary, we would like to confirm that you are not pregnant at this time. _____
initial

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		
Car Accidents		

Medications/Uses	Allergies	Vitamins/Herbs/Minerals

Family History

If there is a family history of any of the following health conditions, please check the appropriate box corresponding to your maternal (mother's) or paternal (father's) side.

	Mother	Father		Mother	Father
Respiratory Disease	□	□	Cancer	□	□
Hypertension	□	□	Heart Disease	□	□
Gastro-Intestinal Disease	□	□	Osteoporosis	□	□
Diabetes	□	□	Thyroid Disease	□	□
Skin Disease	□	□	Degenerative Disc Disease	□	□
Neurological Disease	□	□	Stroke	□	□
Arthritic Disease	□	□	Genital-Urinary Disease	□	□

Please mark figures below in the location of your symptoms.

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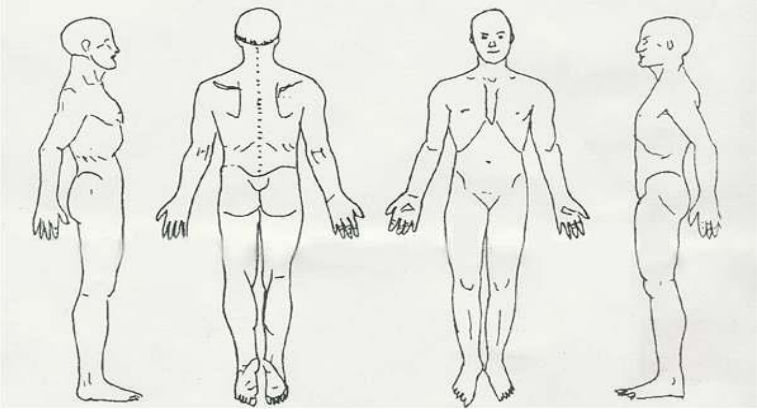

Have you seen any other physician of medical provider for your current complaint(s)? Yes No

Provider's name:_____
Location:_____

What was their diagnosis or impression of your condition?

_____

Primary Complaint

When did your symptoms begin? _____

Briefly describe how your symptoms began:_____

Location
- ☐ Neck
- ☐ Upper Back
- ☐ Low Back
- ☐ Shoulder
- ☐ Elbow
- ☐ Wrist
- ☐ Hand
- ☐ Hip
- ☐ Knee
- ☐ Ankle
- ☐ Foot
- ☐ Headache
- ☐ Hamstring

Side
- ☐ Left
- ☐ Right
- ☐ Bilateral
- ☐ Center

Radiating to
- ☐ Shoulder
- ☐ Arm
- ☐ Hand/Fingers
- ☐ Buttock
- ☐ Hamstring
- ☐ Quadricep
- ☐ Lower Leg
- ☐ Foot/Toes

Type/Onset
- ☐ New Injury
- ☐ Reoccurrence of existing problem
- ☐ Unknown Cause
- ☐ Exacerbation of previous injury
- ☐ Chronic Pain
- ☐ Motor Vehicle Accident

Description
- ☐ Achy
- ☐ Stiffness
- ☐ Sharp
- ☐ Dull
- ☐ Tight
- ☐ Sore
- ☐ Burning
- ☐ Numbness
- ☐ Tingling
- ☐ Throbbing
- Shooting
- Stabbing

Frequency
- ☐ Occasional
- ☐ Intermittent
- ☐ Frequent
- ☐ Constant
- ☐ With Activity

Progression
- ☐ Getting Better
- ☐ Getting Worse
- ☐ Staying The Same

Aggravate
- ☐ Activity
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Running
- ☐ Bending
- ☐ Getting Up From Sitting
- ☐ Getting Up
- ☐ Lying Down
- ☐ Work Tasks
- ☐ Neck Movements
- ☐ Daily Activities

Alleviate
- ☐ Rest
- ☐ Ice
- ☐ Heat
- ☐ Exercise
- ☐ Medication
- ☐ Stretching
- ☐ Massage
- ☐ Topical Ointments
- ☐ Chiropractic Care

Pain Scale 0-10
Current_____
Average_____
Worst _____

Other Symptoms
- ☐ Lightheaded
- ☐ Dizzy
- ☐ Fevers
- ☐ Night Sweats
- ☐ Nausea
- ☐ Weakness
- ☐ Visual Abnormalities
- ☐ Bowel/Bladder Changes
- ☐ Weight Loss/Gain

Secondary Complaint

When did your symptoms begin? _____

Briefly describe how your symptoms began:_____

Location
- ☐ Neck
- ☐ Upper Back
- ☐ Low Back
- ☐ Shoulder
- ☐ Elbow
- ☐ Wrist
- ☐ Hand
- ☐ Hip
- ☐ Knee
- ☐ Ankle
- ☐ Foot
- ☐ Headache
- ☐ Hamstring

Side
- ☐ Left
- ☐ Right
- ☐ Bilateral
- ☐ Center

Radiating to
- ☐ Shoulder
- ☐ Arm
- ☐ Hand/Fingers
- ☐ Buttock
- ☐ Hamstring
- ☐ Quadricep
- ☐ Lower Leg
- ☐ Foot/Toes

Type/Onset
- ☐ New Injury
- ☐ Reoccurrence of existing problem
- ☐ Unknown Cause
- ☐ Exacerbation of previous injury
- ☐ Chronic Pain
- ☐ Motor Vehicle
- ☐ Accident

Description
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- ☐ Tight
- ☐ Sore
- ☐ Burning
- ☐ Numbness
- ☐ Tingling
- ☐ Throbbing
- ☐ Shooting
- ☐ Stabbing

Frequency
- ☐ Occasional
- ☐ Intermittent
- ☐ Frequent
- ☐ Constant
- ☐ With Activity

Progression
- ☐ Getting Better
- ☐ Getting Worse
- ☐ Staying The Same

Aggravate
- ☐ Activity
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Running
- ☐ Bending
- ☐ Getting Up
- ☐ From Sitting
- ☐ Getting Up
- ☐ Lying Down
- ☐ Work Tasks
- ☐ Neck Movements
- ☐ Daily Activities

Alleviate
- ☐ Rest
- ☐ Ice
- ☐ Heat
- ☐ Exercise
- ☐ Medication
- ☐ Stretching
- ☐ Massage
- ☐ Topical Ointments
- ☐ Chiropractic Care

Pain Scale 0-10
Current_____
Average_____
Worst _____

Other Symptoms
- ☐ Lightheaded
- ☐ Dizzy
- ☐ Fevers
- ☐ Night Sweats
- ☐ Nausea
- ☐ Weakness
- ☐ Visual Abnormalities
- ☐ Bowel/Bladder Changes
- ☐ Weight Loss/Gain

For additional complaints use the back side of this page.

Prairie Ridge
CHIROPRACTIC

CHIROPRACTIC INFORMED CONSENT

I hereby give my consent to the performance of diagnostic tests and procedures and chiropractic treatment or management of my condition(s).

Chiropractic treatment or management of conditions includes the chiropractic adjustment, a specific type of joint manipulation. Like most health care procedures, the chiropractic adjustment carries with it some risks. Unlike many such procedures, the serious risks associated with the chiropractic adjustment are extremely rare. **Following are the known risks: Temporary soreness or increased symptoms or pain**. It is not uncommon for patients to experience temporary soreness or increased symptoms during or after your care.

Dizziness, nausea, flushing. These symptoms are relatively rare. It is important to notify the chiropractor if you experience these symptoms during or after your care.

Fractures. When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your chiropractor if you have been diagnosed with a bone weakening disease or condition. If your chiropractor detects any such condition while you are under care, you will be informed and your treatment plan will be modified to minimize risk of fracture.

Disc herniation or prolapse. Spinal disc conditions like bulges or herniations may worsen even with chiropractic care. It is important to notify your chiropractor if symptoms change or worsen.

Stroke. A certain extremely rare type of stroke has been associated with chiropractic care. Although there is an association between this type of stroke and chiropractic visits, there is also an association between this type of stroke and primary care medical visits. According to the most recent research, there is no evidence of excess risk of stroke associated with chiropractic care. The increased occurrence of this type of stroke is associated with both doctors of chiropractic and primary care medical doctors before or during their stroke.

Other risks associated with chiropractic treatment include rare burns from physiotherapy devices that produce heat.

Bruising. Instrument assisted and manual soft tissue manipulation may result in temporary soreness or bruising.

I understand that the practice of chiropractic, like the practice of all healing arts, is not an exact science, and I acknowledge that no guarantee can be given as to the results or outcome of my care.

I agree to adhere to my treatment plan. By not doing so, I would release Prairie Ridge Chiropractic, LLC from any consequences that could result from my own actions.

I certify that I provided my current insurance card and/ or all insurance information. I assign all insurance benefits payable to my treating physician at Prairie Ridge Chiropractic, LLC. I understand that I am financially responsible for all charges whether or not paid and/or covered by my insurance plan. I have read and agree to the terms of the financial policy. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize this signature on all insurance submissions.

I agree to be personally responsible for my own property (including children).

I certify that the statements on these forms are accurate to the best of my knowledge and I have left nothing out.

I have read or had read to me this informed consent document. I have discussed or been given the opportunity to discuss any questions or concerns with my chiropractor and have had these answered to my satisfaction prior to my signing this informed consent document. I have made my decision voluntarily and freely.

PATIENT'S NAME (print)_____ **Date of Birth**_____

_____ _____

(PATIENT/GUARDIAN SIGNATURE) **(DATE)**

Prairie Ridge CHIROPRACTIC

Financial Policy

Effective Date: 1/1/2026

1. Introduction

Welcome to Prairie Ridge Chiropractic. To ensure clear communication and understanding of our financial practices, we have established the following financial policy. Your understanding and cooperation are essential to providing the best possible care.

2. Payment Methods

We accept the following forms of payment:

- Cash
- Personal Checks
- Credit Cards (Visa, MasterCard, American Express, Discover)
- Debit Cards
- Health Savings Accounts (HSA) and Flexible Spending Accounts (FSA)

3. Payment Due at Time of Service

- Payment is expected at the time services are rendered unless other arrangements have been made in advance.
- If you have insurance coverage, co-pays, deductibles, and non-covered services are due at the time of service.

4. Insurance

- As a courtesy, we will verify your insurance benefits and submit claims on your behalf. However, it is your responsibility to understand your insurance policy and benefits.
- You are responsible for any charges not covered by your insurance, including co-pays, deductibles, and non-covered services.
- If your insurance company has not paid your account in full within 30 days, the balance will be automatically billed to you.

5. Financial Agreements

- For services that are not covered by insurance, we offer several payment options. Please speak with our office staff to discuss a financial agreement that works for you.
- We also offer payment plans for patients who need to finance their care. Payment plans must be arranged before services are rendered.

6. Refunds

- Refunds for overpayments will be issued within 30 days of discovering the overpayment.

7. Returned Checks

- A fee of $45 will be charged for any returned checks. After two instances of returned checks, we will no longer accept personal checks from you.

8. Collection Policy

- Accounts that are past due by 60 days will receive a courtesy reminder call or letter.
- Accounts past due by 90 days will be sent to a collections agency. You will be responsible for any additional fees associated with the collection process.

9. Interest on Unpaid Balances

- Unpaid balances past due by 90 days will incur interest at a rate of 1.5% per month.
- Interest will be applied to the outstanding balance at the beginning of each month until the balance is paid in full.