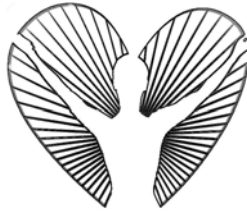


## Whole Health Clinic



**2819 Mahan Drive Ste. 102  
Tallahassee, FL 32308  
(850) 877-8980**

**(850) 671-1796 fax**

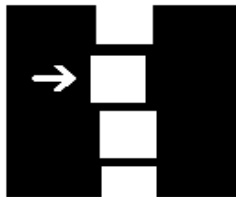
**WELCOME**

To Whole Health Clinic!

PLEASE TURN OFF YOUR CELL PHONE NOW.

*You are to be congratulated on your insight into health and your desire to live a healthier, happier, longer life. Many people with less understanding will see the dentist twice a year for good looks and prevention of tooth and gum disease; they will service their new cars every few thousand miles...but they neglect their spinal health! Consider: you can get false teeth or a new car...but your spine, muscles, meridians, and nervous system are irreplaceable!*

**WHAT IS A SUBLUXATION?** Every organ and structure, every muscle, bone, and blood vessel in your body is controlled and regulated by your nerves. And all of the nerves come from the spine. When a nerve is "short circuited", pinched, or compressed at the spine because the spine isn't working right, that is called a subluxation. Subluxations are often painful; sometimes they can cause numbness, tingling, headaches, spasms, twitches, and even problems with breathing, digestion, and other internal organs supplied by the affected nerve. Muscle imbalances and disturbances in *Chi* (energy) flow can cause these subluxations to become stubbornly entrenched.



**THE BIG IDEA:** Chiropractic as preventive health care: You, and every member of your family, need and deserve to have regular chiropractic checkups. Spinal injuries may begin in early childhood, even in the process of birth! Early childhood and adolescent falls and mishaps are responsible for a great many of the back, neck, and internal problems we experience as adults, sometimes without obvious reason.

Chiropractic adjustments have been shown to boost the activity of the body's immune cells. In short: ***Chiropractic is not just for your present need. It is lifetime preventive health care.***

## What Happens Next?

**ON YOUR FIRST VISIT**, you will receive a no-charge consultation with the doctor. After reviewing your present problem and the overall state of your health, the doctor will let you know what additional services are needed and what the fees will be.

**YOUR PRIVACY:** We will never release your personal information to anyone without your authorization.



It is our prime objective to restore your health. After a thorough consultation, examination, and X-rays (if necessary), **IF WE BELIEVE YOU ARE NOT A CHIROPRACTIC CASE OR THAT WE CANNOT HELP YOU, WE WILL ADVISE YOU AND WILL NOT TREAT YOU, NOR WILL WE CONTINUE TREATMENT IF AT ANY TIME WE BELIEVE WE CAN NO LONGER HELP YOU.**

**YOUR SECOND APPOINTMENT:** is the report, to you, of the doctor's findings. Your spouse or other family members are encouraged to come along. The doctor will explain your examination and X-ray and her recommendations before any treatment is begun. He or she will also answer any questions that will help you fully to understand your problem and your health.

**POST-TREATMENT INSTRUCTIONS:** You may feel happy, light, relaxed, even euphoric after your adjustment. This is your body's normal response to being able to function normally again. You may feel some muscle soreness, like you've been lifting weights with your spine, the next day. This is the normal response of the muscles, which have been inactive, suddenly beginning to work again.

1. Avoid heavy lifting or more strenuous than usual exercise until the doctor advises you that it is okay. Your normal exercise routine is desirable, as long as it is not painful.
2. Avoid rubbing, poking, or probing in the area(s) your doctor adjusts.
3. Avoid sudden twists and turns of movement beyond your normal range of motion, especially of your neck.
4. Do your exercises and home therapy as instructed! We want you well quickly!

**DAILY LIVING:** Set aside time each day for complete mental and physical relaxation and/or prayer and meditation. When sitting, choose a chair which is firm enough to support your weight and which your feet rest comfortably on the floor. Avoid too-soft, overstuffed chairs. If you sit in a recliner, be sure to support your lower spine with throw pillows.

Cross your legs only at the ankles, not at the knees.

Be sure to get enough sleep. Although the average is seven and a half hours, some people only need four hours, while you may be one of those who need ten. Don't feel guilty! Sleep is healthful and necessary for your tissues to regenerate. You should sleep during the same time each day, in a silent, dark room with no disturbances or interruptions. Sleep on as firm a mattress as you can tolerate, with 2-3" of foam or pillowtop padding if needed. Waterbeds are not recommended. Do not read or watch TV in bed with your head propped at a sharp angle. Sit in a chair instead, or at least prop yourself with a bed wedge or multiple firm pillows into a semi-sitting posture with a pillow under your knees.

**DIET:** Recently, the old model of high-carbohydrates, low-fat diets has been replaced by a fashion or fad of high-protein, limited carbohydrate diets. Many people thrive on either type of diet, but some do well on high carbohydrates, and others do well on high protein. Most overweight people, diabetics and hypoglycemics, should stay on the high-protein side, while many active, "hyper" people, or people with weaker kidneys, become irritable and cannot function well on such a diet. Age, activity level, stress level, climate, and child-bearing can all change the optimal nutrient balance for an individual.

Whether you go with the high- or low-carbohydrate, high- or low-protein, some general rules should be followed:

1. Eat food as close to its natural state as possible:
  - a. Whole wheat bread or pasta, instead of white.
  - b. Fresh vegetables, lightly steamed or grilled, not deep-fried nor boiled until soft.
  - c. Fresh fruits instead of cookies, pies or cakes.
2. Avoid artificial and partially-hydrogenated fats like margarine in favor of natural foods like butter, olive or safflower oil. Flax seed oil is even better, and virtually everyone can benefit from supplementation with 2-6 grams of fish oil for the Omega-3 fatty acids it contains.
3. Avoid foods with added sugar. Peanut butter, for example, should only contain peanuts and salt. Read labels and learn all the names for sugar, like corn-syrup, dextrose, maltose, sucrose, etc., etc.
4. Avoid Aspartame (Nutra-Sweet). There is evidence which links it to a variety of health problems in susceptible individuals. For more information on this subject, refer to several books on the subject available in the lending library of this clinic. For more specific dietary advice, ask the doctor. You may want to keep a diet diary that the doctor can review.

## **WHOLE HEALTH CLINIC FINANCIAL POLICY**

At Whole Health Clinic, it is our mission to provide exceptional-quality health care. At the same time, we try to keep our fee schedule reasonable. For this reason, we must ask you to be honest and cooperative in paying for your treatment, so that we can concentrate on health care. The following policies help us do so:

**1. All fees are due and payable when services are rendered unless prior arrangements have been made.**

The only time this is *not* true is when services are paid for under Worker's Compensation, which does not allow the patient to pay at all, or under Blue Cross/ Blue Shield PPC, Cigna, or Medicaid, which allow us by contract only to collect a specific co-payment.

We accept checks, money orders, cash, Visa, MasterCard, American Express, and Discover for payment of services. HSAs and MSAs normally reimburse for medically necessary services you receive here.

What about Insurance Coverage?

We will postpone payment and accept insurance assignment on any policy which has been verified by our office staff. Please do not ask us to accept assignment on an unconfirmed policy or to take your word against your insurance company's that you have met your deductible.

**We do not currently participate in any H.M.O. plans**

**2. Insurance assignment does not remove your responsibility for payment.**

Insurance companies are allowed by law 30 days to pay their claims. We recognize your contract with your insurance company by deferring the balance for 30 days.

**3. If the insurance company has not paid in 30 days, you are responsible for the balance.**

Since we are not a party to your contract with the insurance company, we cannot be responsible for their payment or non-payment.

Service is a high priority for our billing staff, and we will provide all the documents and information the insurance company needs. In return, we ask that you promptly pay when you receive a bill for unpaid services. If you cannot meet this obligation in a timely fashion, we recommend borrowing the money from a commercial lending institution, such as a bank, credit union, finance company or credit card like Discover, MasterCard, or Visa to clear the balance. Interest will be applied at 12% APR to all patient balances more than 60 days past due.

(continued...)

#### **4. Medicare.**

We accept Medicare assignment for the only service Medicare covers at Whole Health: chiropractic adjustments necessary for treating a medical condition. Medicare may not even pay for this service, since their definition of “necessary” can be somewhat arbitrary. Medicare does not pay for massage, acupuncture, preparatory therapies, or adjustments for wellness care, so you will need to pay for these at the time of service.

#### **5. Charges for missed appointments.**

When you make an appointment, we are reserving a block of time to give you the best-quality holistic health care available. We ask for your courtesy in allowing another person to take that appointment if you cannot. *No charge is made for appointments cancelled with 24 hours' notice.*

We understand that emergencies happen, and all of us forget sometimes. However, if appointments are missed or canceled at the last minute without the presence of a bona fide emergency, you will be billed for a brief office visit beginning with the second missed appointment. Please note that insurance companies do not reimburse for missed appointments.

#### **6. If you truly can't afford to pay.**

At Whole Health Clinic, we recognize our obligation to provide care to those who lack the means to pay for life's necessities. If you or your child is in real physical distress and feel that you are in need of charitable or indigent care, please speak with Dr. Dwyer privately. Treatment for a token fee or sometimes even for free can be arranged.

## Fee Schedule

### Initial Consultation (by phone, by e-mail, or in person) .....NO CHARGE

THE PATIENT AND ANY OTHER PARTY RESPONSIBLE FOR PAYMENT HAS THE RIGHT TO REFUSE TO PAY, CANCEL PAYMENT, OR BE REIMBURSED FOR PAYMENT FOR ANY OTHER SERVICE, EXAMINATION, OR TREATMENT WHICH IS PERFORMED AS A RESULT OF AND WITHIN 72 HOURS OF RESPONDING TO THE ADVERTISEMENT FOR THE FREE, DISCOUNTED FEE, OR REDUCED FEE SERVICE, EXAMINATION, OR TREATMENT

**Please note these fees do not apply to managed care contracts such as Blue Cross Blue Shield PPC, which have their own contractual fee schedules.**

**Examinations:**

**New Patients:**

Infants (under age 1)	45.00
Brief	75.00
Moderate	180.00
Extended	210.00

**Established Patients:**

New Injury	35.00
Extended New Injury	87.00
Comprehensive/ Final	199.00

**Services and Therapies:**

**Adjustments:**

Spine 1-2 areas	45.00
Spine 3-4 areas	61.00
Spine 5 areas	79.00
Extremity	47.00
Heat/ Ice Packs	15.00
Electro Stimulation	24.00
Ultrasound	19.00
Kinetic Instruction	10.00-46.00
Hydrotherapy Bed	28.00
Acupuncture	65.00 + Exam

**Lab Tests:**

Lab tests are performed by Quest or LabCorp and are billed according to cost.

**Minimum Off-Hours Fee:** 75.00 (Plus services rendered)

**House Call (City Limit):** 200.00 (Plus services rendered)

**Phone Consult (over 2 min):**

2-10 minutes	10.00
10-20 minutes	20.00
20-30 minutes	40.00

**Braces, Orthotics & Supplies:**

Per Cost  
Fitting/ Testing 35.00-65.00

**Reports and Legal Testimony:**

Reports	35.00-350.00
Court Appearances	350.00/hr(Portal to Portal)
Legal Testimony	350.00/hr

**Massage Therapy:**

(By Licensed Massage Therapist)  
One Hour 197.44  
Thirty Minutes 98.72

**X-rays:**

Cervical Spine:	
AP & Lateral	63.00
Full Series	98.00
Thoracic AP/Lat:	80.00
Lumbosacral AP/Lat:	80.00
Lumbar w/ Obliques:	88.00
Single Views:	35.00
Read Outside Films	35.00
(per region read)	

### **THE FOLLOWING FEES ARE DISCOUNTED IF PAID IN FULL AT THE TIME OF SERVICE ONLY:**

Massage by Licensed Massage Therapist:	One Hour...65.00 <b>PAID IN FULL</b>
	30 minutes...45.00 <b>PAID IN FULL</b>
Unattended therapies:	15.00/ unlimited number <b>PAID IN FULL</b>
Spinal Adjustments, any number areas:	40.00 <b>PAID IN FULL</b>
Extremity Adjustments:	25.00 <b>PAID IN FULL</b>
Acupuncture/ Chinese Medicine:	Initial Visit...80.00
	Subsequent Visits...60.00

# PEDIATRIC APPLICATION FOR TREATMENT

Whole Health Clinic Tallahassee, Florida 850-877-8980

TODAY'S DATE: __/__/__	
<b>How Did You Hear About WHCC?</b>	
<b>NAME OF AUTHORIZED PARENT OR GUARDIAN COMPLETING THIS FORM:(PLEASE NOTE THAT AUTHORIZED PERSON <u>MUST</u> ACCOMPANY CHILD):</b>	
PHONE: home:	wk:

<b>CHILD'S INFORMATION:</b>				
Name: Last:		First:		Middle:
Sex: M F	Date Of Birth: __/__/__	Social Sec. #: -		-
Address:			Apt. #	
City:		State:	Zip Code:	
If Applicable: Driver's License #:		Occupation:		
Employer:		Work Phone:		

<b>PARENT OR EMERGENCY CONTACT:</b>	
Name:	Phone:
Relationship:	Address:

<b>PERSON RESPONSIBLE FOR BILL:</b>	
Name:	Address:
Telephone: Home:	Work:

<b>INSURANCE INFORMATION:</b>		
Name Of Insured:		Address:
City		State:
Zip:	Patient Relationship To Insured:	
Is Insured Employed & Covered By Employer's Health Plan? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Primary Insurance Company	Policy Or ID #:	Group #
Secondary Insurance Company:	Policy Or ID#:	Group #:
Other Insurance Company:	Policy Or ID#:	Group #:

<b>ACCIDENT INFORMATION</b>		
Is Patient Here As The Result Of An Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		A Work Injury? Yes <input type="checkbox"/> No <input type="checkbox"/>
Date Of Accident: __/__/__	Is This A Worker's Compensation Claim? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Type Of Accident: (Please Circle) AUTO WORK HOME RECREATION SPORTS OTHER NONE		

<b>FOR WORKER'S COMPENSATION CLAIMS:</b>		
Employer Name/Address:		Phone:
Date Of Injury:	Time: AM PM	
Reported To (Supervisor):		
Is There An Attorney Involved In This Claim? Y N		
If So, Name:	& Phone:	

**⇒ PLEASE READ OUR OFFICE FINANCIAL POLICY (BLUE PAPER) ⇐  
CAREFULLY TO AVOID ANY MISUNDERSTANDINGS!**

<b>PARENT OR GUARDIAN'S ACKNOWLEDGEMENT OF RESPONSIBILITY FOR PAYMENT:</b>
--

(please sign unless covered by Worker's Compensation **Only**):  
 I have read and understood Whole Health Clinic's financial policy. I understand that I am responsible for all services rendered by Whole Health Clinic, and that any insurance claims filed as a courtesy by the clinic are ultimately my responsibility. I agree to pay the charge in full for any insurance claim which has not been paid within 60 days of the filing of the insurance claim.  
 Date \_\_\_/\_\_\_/\_\_\_ Signed \_\_\_\_\_

**PARENT OR GUARDIAN'S CONSENT FOR TREATMENT OF A MINOR:**  
 I, \_\_\_\_\_, Am Parent Or Guardian Of The Minor Described Above, And I Consent To Permit Usual And Customary Chiropractic Examination And Treatment Procedures To Be Performed On Him/Her.  
 Signed, \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

**HEALTH HISTORY**

**What is (are) your child's current problem(s) or reason(s) for being here?** (Please List In Order Of Importance To You)

- 1. \_\_\_\_\_ Since when? \_\_\_\_\_
- 2. \_\_\_\_\_ Since when? \_\_\_\_\_ 3. \_\_\_\_\_
- \_\_\_\_\_ Since when? \_\_\_\_\_
- 4. \_\_\_\_\_ Since when? \_\_\_\_\_

**Has child ever had the same or a similar problem before?** Yes  No   
 (If Yes, Please Explain):

**HAS CHILD SEEN ANY OTHER HEALTH CARE PROVIDER CONCERNING THESE CONDITIONS?** Yes  No   
 (If Yes, Please List Names, Phone Numbers &/Or Addresses)

Please list your family doctor/pediatrician and family or previous chiropractor, if applicable:		
D.C.	Address:	Phone:
M.D.:	Address:	Phone:
Other:	Address:	Phone:

**CHILD'S BIRTH HISTORY:**

UNKNOWN (Adopted, e.g.)

Mom stressed when pregnant?

Mom drugs when pregnant?

Pregnancy complications?

Full Term Baby? Yes  No  If No, How Many Weeks? \_\_\_\_\_

Mother's First Birth? Yes  No  Approximate Length Of Pushing Stage: \_\_\_\_Hours \_\_\_\_Minutes.

Please Circle All That Are True:

Vaginal ("Normal") Delivery  Forceps  Suction  Epidural  C-section

Child's Birth Weight: \_\_\_\_lb. \_\_\_\_oz. Length \_\_\_\_in. Apgar score at birth: \_\_\_\_\_  
Apgar score at 5 minutes: \_\_\_\_\_

Cesarean Delivery: Emergency?  Reason(s): \_\_\_\_\_  
Scheduled?  Epidural?  Or Asleep?

Was/is Child Breast-Fed? Yes  No  For How Long? \_\_\_\_Years \_\_\_\_Months \_\_\_\_Weeks

**PLEASE LIST ANY OF THE FOLLOWING WHICH CHILD HAS, TO YOUR KNOWLEDGE, TAKEN WITHIN THE LAST SIX MONTHS:**

ASPIRIN, TYLENOL, OR OTHER OVER-THE-COUNTER DRUGS:

CAFFIENATED BEVERAGES (Cups/Drinks/Day\_\_\_\_)

VITAMINS &/OR MINERALS:

ESTROGEN OR BIRTH CONTROL PILLS

ALCOHOLIC DRINKS (# PER WEEK\_\_\_\_)

TOBACCO (TYPE\_\_\_\_)(#\_\_\_\_/DAY)

PRESCRIPTION DRUGS:

Drug \_\_\_\_\_ Rx.By Dr. \_\_\_\_\_ For \_\_\_\_\_

Drug \_\_\_\_\_ Rx.By Dr. \_\_\_\_\_ For \_\_\_\_\_

Drug \_\_\_\_\_ Rx.By Dr. \_\_\_\_\_ For \_\_\_\_\_

Drug \_\_\_\_\_ Rx.By Dr. \_\_\_\_\_ For \_\_\_\_\_

**PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS WHICH YOUR CHILD HAS NOW OR HAS HAD IN THE PAST:**

Diabetes	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Heart Or Valve Disease	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	Any Nerve Or Muscle Disorder	<input type="checkbox"/>	Sleep Apnea/Near-SIDS Attacks	<input type="checkbox"/>
ADD/ADHD	<input type="checkbox"/>	Eating disorder	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	Surgery(type?)	<input type="checkbox"/>	Stomach or Intestinal disease or Ulcer	<input type="checkbox"/>

**PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS WHICH APPLY TO BLOOD RELATIVES INCLUDING PARENTS, SIBLINGS, GRANDPARENTS, UNCLES/AUNTS:**

Unknown (Adopted, e.g.)	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>			High Blood Pressure	<input type="checkbox"/>
Rheumatoid arthritis	<input type="checkbox"/>	Birth defects or hereditary disorders	<input type="checkbox"/>			Sickle Cell	<input type="checkbox"/>
Nerve Or Muscle Disease	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>