# Noelle Nese Mercer, DC

**PATIENT INFORMATION**

Paperwork Version 3/26/26

Name

Address

City

State

Zip Code

Phone (AM)

Phone (PM)

Email Address

Emergency Contact

CDL#

Age

DOB

Sex

☐ M ☐ S ☐ W ☐ D (check one)

Marital Status

Occupation

Years Employed

Employer

Employer's Address

Spouse's Name

Spouse's Occupation

Person Responsible for this Account

Referred By

Have you ever had chiropractic care before?

If yes, when?

## CASE HISTORY

List your chief complaints in order of severity:

1. _____ How long? _____

2. _____ How long? _____

3. _____ How long? _____

What activities aggravate your condition? _____

Is this condition getting progressively worse? Y ❑ : N ❑ : Constant ❑ : Comes and goes ❑

Is this condition interfering with your: Work ❑ : Sleep ❑ : Daily Routine ❑ : Other _____

How long has it been since you really felt good? _____

List other Doctors consulted for this condition:

1. _____ Address: _____

2. _____ Address: _____

Is this injury or illness word-related? _____ Have you reported it to your employer? _____

Is this injury or illness related to an automobile accident? _____

If yes, complete the following:

_____ _____

Auto Insurance Company Policy #

_____ _____

Claim Number Agent

Are you now or have you recently been in pain? Yes ❑ : No ❑

If yes, describe the pain: Dull ❑ : Sharp ❑ : Aching ❑ : Stabbing ❑ : Burning ❑ : Throbbing ❑

Rate the pain on a scale of 1-10 (10 = unbearable): 1 2 3 4 5 6 7 8 9 10

Does the pain radiate? Y ❑ : N ❑ If yes: Down the arms ❑ : Down the legs ❑

Any numbness or tingling: Y ❑ : N ❑ If yes, where? _____

Does the pain come on: suddenly ❑ : gradually ❑

Have you had any past injuries or accidents: Y ❑ : N ❑

If yes, please list _____

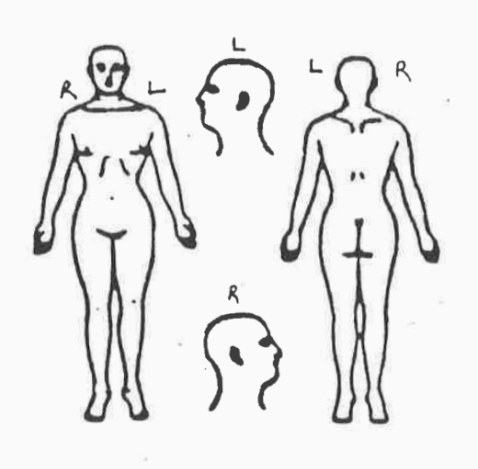
Have you ever experienced similar pain to which you now have: Y ❑ : N ❑

If yes, when? _____

Is there a specific incident which you think caused your condition: Y ❑ : N ❑

If yes, what incident? _____

Please mark on the figure the areas of pain:




## MEDICAL HISTORY

Circle any of the following if relevant to your medical history.

| | | | |
|---|---|---|---|
| Alcoholism | Concussion | German Measles | Muscular Dystrophy |
| Anemia | Convulsion | Heart Disease | Neuritis |
| Arthritis | Diabetes | Hepatitis | Polio |
| Asthma | Digestive Disorders | High Blood Pressure | Rheumatic Fever |
| Backaches | Dizziness | HIV | Tuberculosis |
| Cancer | Epilepsy | Multiple Sclerosis | Venereal Disease |

Describe any surgeries you've had: _____

Are you allergic to any medication: Y ❑ : N ❑

If yes, what kind? _____

Are you currently taking any medication: Y ❑ : N ❑

If yes, please list: _____

Are you pregnant: Y ❑ : N ❑ Date of LMP? _____

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as she deems appropriate through the use of Chiropractic Health Care and I give authority for these procedures to be performed. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient / Guardian's Signature _____ Date _____

# Noelle Nese Mercer, DC

**www.noellemercer.com**
**(213) 393-7035**

**Disclosure & Consent Form for Chiropractic Adjustments and Care**

Any procedure intended to help may also do harm. While chiropractic examination and therapeutic procedures (including spinal adjustment, ultrasound, heat application, electrotherapy and manual muscle therapy) are usually considered very safe and effective, please understand that occasionally there are complications. While the chances of experiencing any of these complications are small, it is the practice of this clinic to inform our patients about them. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so that you may give or withhold your consent to the procedure.

I understand and am informed that, in the practice of chiropractic, there are some risks to exam and treatment that include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, burns and temporary worsening of symptoms, fractures, disc injuries, strokes, dislocations, sprains, or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

I have read, or have been read to me, the above consent. I have had an opportunity to ask questions and all my questions have been answered fully and satisfactorily. By signing below, I consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and any further conditions for which I seek treatment.

To be completed by patient or by patient's representative (i.e. if patient is a minor, physically or legally incapacitated)

| | |
|---|---|
| Print Name | Print name of representative (if applicable) |
| Signature of patient | Signature of representative (if applicable) |
| Date | |

## Financial Policy and Summary of Fees:

- **New Patient (Exam + Treatment)** **$220**
- **Follow Up Treatment (20-30 mins)** **$120**
  (Adjustment + Tissue Work)
- **Adjustment only (10-15 mins)** **$85**
  (includes Children + Seniors)
- **Extended (50-60 min Follow Up Visits)** **$220**

### Payment and Insurance:

Dr. Mercer is considered an “out of network” provider for most PPO plans. This allows Dr. Mercer to provide the treatment needed, not what your insurance company dictates.

Fees will be collected at the time of service and a detailed receipt (aka “superbill”) will be provided upon request. The superbill can then be submitted by you for reimbursement from your insurance company.

Each plan varies so it is best to check for out of network reimbursement rates, deductible and other details.

In cases where your insurance plan is accepted, we will bill it for you. A credit card is required to be kept on file (click here) for any balances that may be due. This billing is done as a courtesy for you and in no way ensures payment. Ultimately your contract is between you and your insurance company.

**Cancellation Policy:**
Please respect my time and yours by canceling within 24 hours of your appointment time. Failure to do so may result in being charged in full for the session.