CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Cell Phone (_____) _____ Home Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No 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 (if applicable) _____

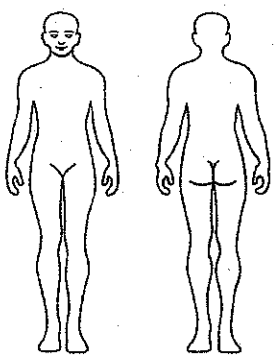
5 PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

PREBLE COUNTY CHIROPRACTIC
NUTRITION & SPORTS INJURY CENTER

Matthew D. Roberts, D.C. • Adam K. Pitsinger D.C.
Phone (937) 456-8368, Fax (937) 456-8369
450B Washington Jackson Rd., Suite 109 Eaton, OH 45320
preblecountychiropractic@gmail.com

Informed Consent

Patient Name: _____

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The Nature of the Chiropractic Adjustment.

The Primary treatment we use as Doctors of Chiropractic is spinal manipulative therapy. We will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures as necessary:

- Spinal Manipulative Treatment
- Range of Motion Testing
- Muscle Strength Testing
- Hot/Cold Therapy
- Palpation
- Orthopedic Tests
- Spinal Decompression
- Soft Tissue Work
- Vital Signs
- Basic Neurological Tests
- Ultrasound
- EMS

The Material Risks Inherent in Chiropractic Adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. We will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us.

Probability of Those Risks Occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and possible X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in 5 million cervical adjustments. The other complications are also generally described as rare.

The Risks and Dangers Attendant to Remaining Untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to the treatment.

_____ _____

Patient's Signature or Parent/Guardian (if a minor) **Date:**

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Financial Agreement

The purpose of this agreement is to clarify your financial responsibilities so we can devote our efforts to helping you get the best results in the shortest amount of time. These are the most common services we provide and when they are performed.

PROCEDURE	PURPOSE	WHEN PERFORMED	FEE
Consultation	Tour the office, meet the doctor, discuss your health Problem, and review your case history	First visit	$25-$50
Evaluation/ Management & Examination(s)	Ascertain the nature and severity of your health problem. Assess and evaluate your new or current health status and determine an appropriate course of action.	First visit, new conditions, exacerbations, and reexamination	$20-$120
X-rays	Visualize the location of spinal problems and confirm other examination findings.	First visit possible, re-injuries, certain progress exams	$25-$200
Adjustment	Reduce the Vertebral Subluxation Complex and help stabilize your spinal or joint problem.	As indicated by exam or evaluation	$28-$48
Therapy	Reduce inflammation and swelling, speed the healing process, and help provide relief.	As indicated by exam or evaluation	$10-$20

FORMS OF PAYMENT - Patients are responsible for full payment at the time of service. We accept cash, personal checks, MasterCard, Visa and Discover.

INSURANCE/CONTRACT SERVICES/THIRD PARTY – Other options are available if your care is covered by group health insurance, Worker's Compensation, a managed care provider, Medicare, personal injury, such as an auto accident. If you have qualifying medical insurance coverage, we will do the initial billing to your primary and secondary companies. BEYOND THAT, IT IS THE RESPONSIBILITY OF THE PATIENT TO WORK WITH THE INSURANCE COMPANY TO INSURE THAT PAYMENT IS MADE. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim or denies the claim. If it becomes necessary to write a report or copy records beyond the initial billing, you will be responsible for a minimum fee of $25. You may request a fee schedule f our miscellaneous charges. We will not become involved in disputes with your insurance company regarding your deductibles, co-payments, covered charges or non-covered charges, secondary insurance, "usual and customary" charges, etc.

SPECIAL ARRANGEMENTS – We have never denied anyone the benefits of chiropractic care because of their inability to pay our published fees. If financial hardship requires an Individual Consideration Contract, please let us know.

MISSED APPOINTMENTS – If unable to keep a scheduled appointment, kindly give a 24 hour notice, otherwise a $25.00 charge will be made for the reserved time.

FORMS OF PAYMENT - Patients are responsible for full payment at the time of service. We accept cash, personal checks, MasterCard, Visa and Discover.

PATIENT AGREEMENT
I have read, understand, agreed to this agreement.

Patient/Responsible Party Signature Date

QUESTIONS?
Please ask if you have any questions about agreement.

Office Representative Date

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FAMILY HEALTH HISTORY

Name: _____ Date_____

Please place a check mark () in the corresponding column for any family member who has been diagnosed with any of the following conditions.

M=mother; F=father; GM=grandmother; GF=grandfather; B=brother; S=sister

	M	F	GM	GF	GM	GF	B	B	B	S	S	S
Arthritis												
Cancer												
Diabetes												
Heart Disease												
Kidney Disease												
Lung Disease												
Migraine Headaches												
Neurologic Condition												
Osteoporosis												
Spinal Condition												
Stroke												
Thyroid Disease												

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PRACTICE'S REQUIREMENTS

The Practice:

(a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

(b) Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.

(c) Is required to abide by the terms of this Privacy Notice.

(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.

(e) Will distribute any revised Privacy Notice to you prior to implementation.

(f) Will not retaliate against you for filing a complaint.

EFFECTIVE DATE

This Notice is in effect as of 04/15/03.

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

_____
Patient

Date: _____

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MISSED APPOINTMENT PROCEDURE

Your appointment is important to us and to your wellness. If you miss an appointment, you may be delaying the treatment you need. You may also have to wait longer than you would like for a new appointment date.

In consideration for others who are waiting to be seen here, it is very important that you keep each appointment and arrive promptly at the scheduled time. If you must change your appointment, please call at least 24 hours in advance to cancel the appointment. You may leave a voice message. Failure to do so will result in a charge of $25. This charge is not covered by insurance and is to be paid before another appointment can be scheduled.

_____ _____

Patient Signature Date

Preble County Chiropractic

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name:**_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Smoking Start Date (Optional): _____

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date: _____

For office use only

Height: _____ Weight: _____ Blood Pressure: _____/_____

ACCT#_____ CLAIM #_____

Automobile Accident Questionnaire

Please answer all questions completely

Dear Patient: This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Name_____ Social Sec#_____

Address_____ City_____ State_____ Zip_____

Please explain in detail how your accident happened_____

_____

_____

_____

Insurance Co_____ Policy No_____ Claim No_____

Driver of other vehicle (if any)
Name_____ Insurance Co_____ Policy No_____

Driver of vehicle in which you were injured (if applicable)
Name_____ Insurance Co_____ Policy No_____

Name of insurance adjustor_____
Have you retained an attorney? ____Yes ____No
If so, his name and address_____
You were heading _____North ____East ____South ____West on_____Street or Highway
Other vehicle was headed ____North ____East ____South ____West on _____Street or Highway
Were police notified? ____Yes ____No
Were you knocked unconscious? ____Yes ____No If so, for how long?_____
You were struck from ____ Behind ____Front ____Left side ____Right side
You were ___Driver ___Passenger ___Front seat ___Back seat __using seat belt __Other protective devices
What were the time and date of present injury?_____

Where did you feel pain immediately after the accident?_____
Where were you taken after the accident?_____
What treatment was given?_____
Was any other doctor consulted after your accident? ____Yes ____No
If so, what was the doctor's name?_____ __D.C., __M.D., __D.O., __D.D.S.
What was the diagnosis?_____
What treatment was given?_____
How often did you see the doctor?_____
How long did you see the doctor?_____

Have you ever had any complaints in the involved area before? ____Yes ____No
If so, what were the complaints?_____
Before the injury were you capable of working on an equal basis with others your age? ____Yes ____No
Are your work activities restricted as a result of this accident? ____Yes ____No
Since this injury are your symptoms _____Improving? ____Getting worse? ____Same?

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ACCIDENT ASSIGNMENT

I was involved in an accident on or around _____ (date) in which I was injured for which I have or may have a claim against another person(s) for causing my injuries (including _____)(referenced as "My Claim"), who is insured by: _____ .

In consideration of the agreement of Preble County Chiropractic (referenced as the PCC) to delay billing me personally for medical treatment rendered until resolution of My Claim:

1. I now assign, without any right to later revoke, a part of any proceeds from my claim equal to the fees incurred by me to PCC for all treatment and other services rendered by PCC. I am not assigning any legal cause of action in My Claim above, but only prospective proceeds. I also assign to PCC my right to enforce the obligation of any insurance company to pay settlement proceeds for any settlement agreement made by or for me in exchange for my signing such insurance company's release of claim. Prior to settlement or other disposition of My Claim, I understand and permit PCC to pursue payment from any other source by me personally, including medical payments coverage in an automobile liability policy.
2. This Assignment and related documents which I have signed in connection with it states the entire agreement and my complete understanding regarding PCC's fees. I have not relied on any statements by PCC or the Doctor or other information before making this Assignment. I understand that I remain responsible for any PCC fees not paid out of My Claim.

_____
(Signature of Patient)

3. I understand that it is my responsibility during treatment to remain aware of my cumulative account balance for services rendered. I have received a schedule of treatment fees for PCC, or if I have not, will request to PCC for one in writing.
4. I understand that this is an express contract to pay for the services rendered by this PCC. I agree to pay my account balance in full and/or direct its payment from My Claim proceeds regardless of whether any other person or entity attempts to or fails to fully reimburse me for it. If I dispute my account balance or treatment rendered, I agree that my remedy will be to resolve it with a separate action from My Claim.
5. NOTICE: I DIRECT ANY INSURANCE COMPANY, ATTORNEY, OR OTHER PERSON WHO HOLDS OR LATER HOLDS ANY PROCEEDS FROM MY CLAIM TO APPLY ANY PROCEEDS FROM MY CLAIM TO MY TOTAL ACCOUNT BALANCE OUT OF THE TOTAL PROCEEDS HELD IN MY BEHALF, UNLESS PCC CONFIRMS PRIOR PAYMENT OF IT IN WRITING. "TOTAL PROCEEDS" HELD IN BY AN ATTORNEY FOR MY CLAIM SHALL MEAN PROCEEDS AFTER DEDUCTION OF ATTORNEY FEES.
6. This Assignment is governed by Ohio law. Jurisdiction shall be in Ohio, and venue shall lie in the county in which PCC is located, unless required by applicable law to lie in a different county in which I reside.
7. I REALIZE THAT I HAVE NOW GIVEN AWAY A PART OF ANY PROCEEDS FROM MY CLAIM. IF I RECEIVE ANY PROCEEDS FROM MY CLAIM, I AGREE TO IMMEDIATELY DETERMINE IF PCC HAS BEEN SEPARATELY PAID IN FULL. UNLESS THE CLINIC CONFIRMS FULL PAYMENT IN WRITING, I REALIZE THAT ANY USE BY ME OF THESE PROCEEDS IS TAKING OR CONVERTING MONEY THAT IS THE PROPERTY OF THIS CLINIC.
8. I HAVE READ THIS DOCUMENT AND I FULLY UNDERSTAND IT.

_____
(Signature of Patient)

_____
(Print or type patient name)

_____
(Signature of parent or legal guardian)

_____
(Date)

This Assignment has been signed on the Preble County Chiropractic premises:

_____
(Staff Witness)