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) _____

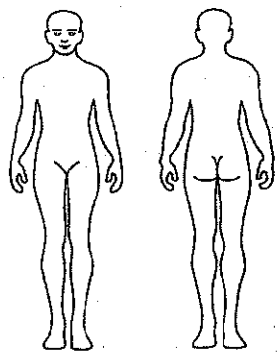
5 PATIENT CONDITION

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

6 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 condition _____

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 _____

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

AIDS/HIV ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No
Alcoholism ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	Measles ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No
Allergy Shots ☐ Yes ☐ No	Epilepsy ☐ Yes ☐ No	Migraine Headaches ☐ Yes ☐ No	Sexually Transmitted Disease ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Fractures ☐ Yes ☐ No	Miscarriage ☐ Yes ☐ No	Stroke ☐ Yes ☐ No
Anorexia ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Mononucleosis ☐ Yes ☐ No	Suicide Attempt ☐ Yes ☐ No
Appendicitis ☐ Yes ☐ No	Goiter ☐ Yes ☐ No	Multiple Sclerosis ☐ Yes ☐ No	Thyroid Problems ☐ Yes ☐ No
Arthritis ☐ Yes ☐ No	Gonorrhea ☐ Yes ☐ No	Mumps ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Gout ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No
Bleeding Disorders ☐ Yes ☐ No	Heart Disease ☐ Yes ☐ No	Pacemaker ☐ Yes ☐ No	Tumors, Growths ☐ Yes ☐ No
Breast Lump ☐ Yes ☐ No	Hepatitis ☐ Yes ☐ No	Parkinson's Disease ☐ Yes ☐ No	Typhoid Fever ☐ Yes ☐ No
Bronchitis ☐ Yes ☐ No	Hernia ☐ Yes ☐ No	Pinched Nerve ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Bulimia ☐ Yes ☐ No	Herniated Disk ☐ Yes ☐ No	Pneumonia ☐ Yes ☐ No	Vaginal Infections ☐ Yes ☐ No
Cancer ☐ Yes ☐ No	Herpes ☐ Yes ☐ No	Polio ☐ Yes ☐ No	Whooping Cough ☐ Yes ☐ No
Cataracts ☐ Yes ☐ No	High Blood Pressure ☐ Yes ☐ No	Prostate Problem ☐ Yes ☐ No	Other _____
Chemical Dependency ☐ Yes ☐ No	High Cholesterol ☐ Yes ☐ No	Prosthesis ☐ Yes ☐ No	
Chicken Pox ☐ Yes ☐ No	Kidney Disease ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	
		Rheumatoid Arthritis ☐ Yes ☐ No	

EXERCISE
☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY
☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS
☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

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

7 MEDICATIONS

_____

_____

_____

Pharmacy Name _____

Pharmacy Phone (____) _____

ALLERGIES

_____

_____

_____

_____

_____

VITAMINS/HERBS/MINERALS

_____

_____

_____

_____

_____

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 help 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	N/C-$25
Evaluation/ Management & Examination(s)	Ascertain the nature and severity of health problem. Assess & evaluate new or current health status determine an appropriate course of action.	First visit, new conditions, exacerbations, and reexamination.	$20-$120
Adjustment	Reduce the vertebral subluxation comples & help stabilize your spinal or joint proble.	As indicated by examination or evaluation	$28-$48
Therapy	Reduce inflammation and swelling, speed the healing process, and help provide relief.	As indicated by examination or evaluation.	$10-$20

FORMS OF PAYMENT - Patients are responsible for full payment at the tie 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 cre provider, Medicare, personal injury, such as an automobile 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. 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 of our miscellaneous charges.
We will not become involved in disputes with your insurance company regarding your deductibles, co-payments, 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 will be made for the reserved time.

BILLING - Any outstanding balances will be billed monthly and considered past due 10 days after the invoice date or when special arrangements are not met. Returned checks are subject to a $25.00 fee. Balances older than 30 days will accrue interest charges of 1.5% per month or a minimum $5.00 bookkeeping fee per month, plus any legal or collection fees.

PATIENT AGREEMENT
I have read, understood, agreed to, and received a copy of this agreement.

Patient/Responsible Party Signature Date

QUESTIONS
Please ask if you have any questions about this agreement or if your ability to comply with its provisions changes. We are here to help.

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

public or private entity to assist in disaster relief efforts.
Emergencies: We may use or disclose your protected health information in an emergency situation. If this happens, your physician shall try to obtain your consent as soon as possible after the emergency.

5. **Your Health Information Rights - You Have the Right to Inspect and Copy your Protected Health Information:** This means you may inspect and obtain a copy of protected health about you for as long as we maintain the protected health information.

Under federal law, there may be instances where you may not inspect or copy your protected health information. Depending on the circumstances, a decision to deny access may be reviewable. Please contact our privacy officer if you have any questions about access to your protected health information.
You have the Right to Request a Restriction of your Protected Health Information: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who maybe involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your Physician is not required to agree to a restriction that you may request. If your physician believes it is in the best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind please discuss any restriction you wish to request with your physician.

You have the Right to Request to Receive Confidential Communications from us by Alternative means or at an Alternative Location: We will accommodate reasonable requests. Please make this request in writing to our privacy officer.

You may have the Right to Request your physician to amend your Protected Health Information: This means you may request to have your protected health information changed for as long as we maintain this information. In certain cases, we may deny your request to have your protected health information changed. If we deny your request for a change, you have the right to disagree with us. Please contact our privacy officer if you have questions about making changes to your protected health information and how you can disagree with our decision.

You have the Right to Receive an accounting of certain disclosures we have made, if any, of your Protected Health Information: This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, family members or friends involved in your care or for notification purposes. It excludes disclosures made pursuant to a valid authorization. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the Right to Obtain a paper copy of this notice from us: If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our privacy officer.

6. **Complaints:** You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer of your complaint. We will not retaliate against you for filing a complaint.
You may contact our privacy officer, for further information about the complaint process.

7. **Change of Ownership:** In the event that DR. STEVEN E. SHAFER'S AND/OR DR. MATTHEW D. ROBERT'S practice is sold or merged with another organization, your protected health information/medical records will become the property of the new owner.

NOTICE OF PRIVACY PRACTICES

Matthew D. Roberts, DC, ATC
Adam K. Pitsinger, DC

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this notice, please contact our privacy officer.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information means health information, including demographic information, collected from you and created or received by your physician, another health care provider, health plan, your employer or a health care clearinghouse. This protected health information relates to your past, present or future physical or mental health condition and identifies you, or there is a reasonable basis to believe the information may identify you.

You will be asked by your physician's staff to acknowledge with your initials or signature that you received this Notice of Privacy Practices. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we may obtain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may obtain this by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. **Uses and Disclosures of Protected Health Information:** We will use or disclose protected health information for the following purposes:

Treatment: We will use or disclose protected health information to provide, coordinate, or manage your health care and any related services. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other

physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred.

Payment: Your protected health information will be used to obtain payment for your health care services. These may include certain activities that your health insurance plan may undertake before it approves or pays for your health care services, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for an office procedure may require that your protected health information be disclosed to the health plan before authorization is made.

Health Care Operations: We may use or disclose your protected health information in order to support the business activities of the practice. These activities include, but are not limited to, the day-to-day running of the practice, quality assessments, employee reviews, and training of chiropractic students.

For example, we may disclose your protected health information to chiropractic school students who see patients in our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may contact you to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use of disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information to provide you with information about treatment, alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products and services that we believe may be beneficial to you. You may contact our privacy officer to request that these materials not be sent to you. We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our privacy officer and request that these fundraising materials not be sent to you.

2. **Uses and Disclosures of Protected Health Information Based Upon your Written Authorization.** Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physicians practice has taken an action in reliance on the use or disclosure indicated in the authorization.

3. **Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object.** We may use or disclose protected health information in these following situations without your authorization. These situations include:

Required by Law: We may use and disclose your protected health information if the use or disclosure is required by law. The use or disclosure will be made in compliance with the law.

Public Health: We may disclose your protected health information to public health authorities for purposes rated to controlling disease, injury or disability. This includes:

•Communicable Diseases: We may disclose your protected health information to a person who has been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

•Health Oversight: We may disclose your protected health information for activities such as audits, investigations and inspections by government oversight agencies.

•Abuse or Neglect: We may disclose your protected health information to report child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence.

Food and Drug Administration: We may disclose your protected health information to report adverse events and product defects or problems; to enable product recalls; or to make repairs or replacements.

Legal Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceedings.

Law Enforcement: We may also disclose protected health information to a law enforcement official for purposes such as legal proceedings; request for identification and location of a suspect, fugitive, material witness or missing person; pertaining to victims of a crime; suspicion that death has occurred as a result of criminal conduct; that a crime has occurred on the premises of the practice; and medical emergency (not on the practice's premises) and it is likely that a crime has occurred.

Military Activity and National Security: We may use or disclose your protected health information to individuals who are armed forces personnel for activities deemed necessary by appropriate military command authorities, or for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits. We may disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including those for the provisions of protective services.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with Workers' Compensation laws and other similar legally-established programs.

Correctional Facilities: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

4. **Other Care Givers Involved in your Health Care:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. We may disclose protected health information to an authorized

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: ____ / ____