OAK HILLS
BACK & NECK CARE CENTER, LLC

5981 HARRISON AVE., SUITE 3
CINCINNATI, OHIO 45248
PHONE: (513) 598-1693
FAX: (513) 598-1862

CONFIDENTIAL PATIENT HISTORY

Date_____

Name (including middle initial)_____ What You Prefer To Be Called_____

Male☐ Female☐ Marital Status: M☐ S☐ W☐ D☐

Address_____ No. of Children_____

City_____ ST_____ ZIP_____ Social Security Number_____

Age_____ Birth Date_____ Email Address_____

Home Phone #_____ Cell Phone #_____ Cell Phone Carrier_____
(For Appt. Text Reminders)

Occupation_____ Employer_____

Employer's Address_____

City_____ ST_____ ZIP_____ Work Phone #_____

Spouse's Name_____

Health Insurance Company _____

Insured's ID #_____ Group Number_____ Phone Number_____

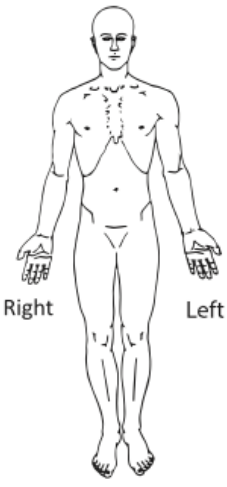
Insured's Name_____ Insured's Date of Birth_____

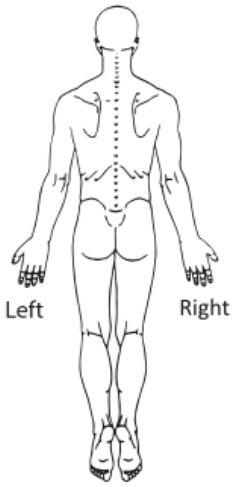
Payment Method: ☐Cash ☐Check ☐Credit Card Enter Card #_____ Exp. Date_____

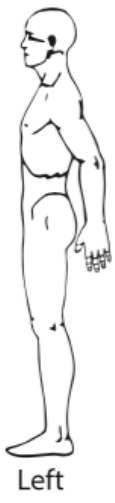
Whom may we thank for referring you?_____

Reason for this visit_____

MARK ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS. INCLUDE SYMPTOMS OF PAIN, NUMBNESS OR TINGLING, ETC.







Patient Name_____ Date_____

When did your problem begin? Specific date if possible_____

How did your problem begin?_____

_____

Have you experienced anything similar in the past? ☐Yes ☐No

Please explain_____

Please describe your pain. You may check more than one answer.

☐Sharp ☐Stabbing ☐Burning ☐Shooting ☐Aching ☐Sore

☐Weakness ☐Throbbing ☐Numbness ☐Dull ☐Constricting ☐Stiff

☐Other_____

On a scale from 0-10, with 10 being the worse pain you have ever experienced and 0 being no pain, what is your current pain level?

☐0 ☐1 ☐2 ☐ 3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

How often are your symptoms present?

☐Constant/100% of the time ☐Frequent/75% ☐ Intermittent/50% ☐Occasional/25%

Additional Comments_____

Is the pain: ☐Increasing ☐Decreasing ☐Not Changing ☐Varying

Pain is aggravated by: ☐Walking ☐Sitting ☐Standing ☐Riding in a car ☐Lifting

☐Bending ☐Stretching ☐Twisting ☐Running ☐Transitioning from sitting to standing

Other_____

Pain is reduced by: ☐Medicine ☐Exercise ☐Rest ☐Physical Therapy ☐Supplements

Other_____

What would you like to do, but can't, because of your pain?_____

_____

Are your complaints, in any way affecting your ability to work or be active?

☐No effect ☐Some physical restrictions ☐Unable to perform regular duties

Is there any dizziness associated with your symptoms? ☐Yes ☐No

Any fever or chills? ☐Yes ☐No

Any change in bowel or bladder (bathroom) function? ☐Yes ☐No

Are your complaints affecting your ability to sleep? ☐Yes ☐No Explain:_____

How many hours of sleep do you get per night?_____ Do you sleep through the night uninterrupted? ☐Yes ☐No

For your present complaint have you seen any other chiropractors or MD's or had any physical therapy? ☐Yes ☐No

If yes, who?_____ What treatment(s)?_____

Patient Name_____ Date_____

Family Doctor/Primary Care Physician_____

We normally keep your family doctor/ and or referring physician informed regarding your care at this office.

Is that okay? ☐Yes ☐No Please specify name and address:_____

_____

Medical History

☐Anemia
☐Artificial Joints/Bones
☐Cancer
☐Cardiovascular Problems
☐Pace Maker
☐High Blood Pressure
☐Low Blood Pressure
☐Depression
☐Dizziness/Fainting
☐Fractures
☐Headaches
☐Hepatitis/HIV
☐Kidney Problems
☐Respiratory Problems
☐Asthma
☐COPD
☐Seizures
☐Thyroid Problems
☐Diabetes
☐Other_____

Are you pregnant? ☐Yes ☐No If yes, when are you due?_____

Have you missed any days of work or school due to the current condition? ☐Yes ☐No

Have you ever broken any bones? ☐Yes ☐No Please Explain_____

Have you ever been in the hospital or had surgery for any reason? ☐Yes ☐No

Please explain:_____

_____

_____

Have you ever been in an accident? ☐Yes ☐No

Please explain: _____

_____

_____

What (if any) supplements are you taking? _____

_____

Do you consume alcohol? ☐Yes ☐No How much:_____

What is your exercise routine? _____

Other Health Concerns:_____

_____

Patient Name_____ Date_____

EHR Information

Smoking Status: ☐Every Day Smoker ☐Occasional Smoker ☐Former Smoker ☐Never Smoked

Height _____ ft_____ in Weight _____ lbs Most recent blood pressure reading_____

Are you currently taking any medications? (Please include all prescription and non-prescription)

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

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

Family medical history (record one diagnosis in your family and the affected relative)

Diagnosis	Father	Mother	Sibling	Offspring

Preferred Language_____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Decline to Answer

Race: ☐Black or African American ☐White (Caucasian) ☐Other ☐Decline to Answer

INFORMED CONSENT FOR CHIROPRACTIC CARE

CHIROPRACTIC EXAMINATION AND TREATMENT

On occasion, some patients experience increased discomfort following chiropractic care and examination. Chiropractic physical examination and treatment may involve bending and physically challenging joints and soft tissues (e.g. muscles and ligaments) of the spine and extremities, and it can possibly lead to temporary feelings of soreness or pain. During treatment, the Doctor of Chiropractic may use their hands or mechanical devices to move, adjust, or manipulate joints and mobilize soft tissues. With certain soft tissue therapies, light to moderate bruising may also occur. This is nearly always a temporary issue that occurs while the area under care is undergoing therapeutic change. Patients reserve the right to consent to, or refuse, certain aspects of care once therapeutic options have been presented.

RISKS OF CHIROPRACTIC CARE AND TREATMENT

I understand and have been informed that there are risks of side effects and complications anytime a healthcare provider is asked to intervene in an encounter with a patient. I have been informed of the following: that although the risk of serious complications from chiropractic treatment are rare and unlikely, events ranging from soreness, sprains and strains, to fracture or dislocation, to injuries of the spinal discs, nerves and cord have occurred. Cerebrovascular accidents, such as a stroke, have also been reported and that these have been estimated to occur in 1 in 2 million to 1 in 3.8 -5.8 million cervical manipulations, about the same probability of stroke occurring from turning your head or having your hair washed in a salon ("beauty parlor stroke"). It cannot be said with any certainty that the specific treatment caused the stroke or aggravated an underlying, pre-existing condition, or the treatment given was totally unrelated to the resulting stroke. You are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with cervical adjustment or manipulation is extremely remote.

I understand and I do not expect the Doctor of Chiropractic to be able to anticipate all the potential risks or complications. There may be problems or complications that might arise from treatment and recommendations other than those noted. These other events or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

I wish to rely on the Doctor of Chiropractic to exercise their best professional judgment during the course of the chiropractic examination and treatment, which the doctor feels is in my best interest, based upon the facts as then known at the time.

I will immediately notify a member of the office staff of any unanticipated side effects or adverse reactions associated with treatment. I also understand that if I become concerned about any post-treatment discomfort or, if I should develop any new or unrelated symptoms, I should call the practice for immediate attention. I also understand that if, for some reason, I am unable to reach or contact the practice, that I should telephone my personal primary care doctor or present myself to the nearest hospital emergency room.

ALTERNATIVE TREATMENTS AVAILABLE

I understand that there are reasonable alternatives to treatment including, but not limited to: rest, home application of therapy, prescription or over-the-counter medication, exercise, treatment and evaluation by another provider, and surgery. Each is associated with specific benefits and risks. I have the right to request a referral to another provider for further evaluation, assessment, and management of my presenting condition(s) at any time.

CONSENT

By affixing my signature below, I acknowledge that I have read and understood the above consent and have had the opportunity to ask questions about its content and meaning, if so desired, which have been answered to my satisfaction, **PRIOR TO MY SIGNING OF THIS CONSENT FORM.**

I, the undersigned, hereby request, consent to, and authorize Oak Hills Back and Neck Care Center to conduct physical examinations, perform testing procedures as are required, and administer treatment as deemed necessary or advisable for my presenting complaint(s) that are within the scope of the practice of chiropractic care. I attest that the information provided in regards to me or my dependents, current and past health history has been completed to the fullest extent and to the best of my knowledge and ability, and does not contain false or misleading information, or omission. I also certify that no guarantee or assurance has been made to me as to the results that may be obtained from any treatment rendered.

I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek examination and treatment for myself or my dependent.

_____

Signature (Patient, Parent, or Legal Guardian)

_____

Print Name (Patient, Parent, or Legal Guardian)

PRIVACY PROTECTION AND AUTHORIZATION FORRELEASE OF PROTECTED HEALTH INFORMATION

I understand that I have certain rights to privacy regarding my protected health information. I understand that this information
can and will be used to: plan, coordinate, and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and accreditation. This includes release of information and notification of care to my primary health care and/or referring provider.

I hereby authorize Oak Hills Back and Neck Care Center to release a complete report of services rendered including diagnosis, findings and details of treatment, and progress for the purpose of receiving payment for the services rendered to its authorized billing agents, my insurance carriers, employer's workers compensation insurance company, or other category of third party payers, the Social Security Administration under Title XVIII (18) of the Social Security Act, any Professional Review Organization, attorney, or other intermediaries responsible for payment of my charges and hereby release Oak Hills Back and Neck Care Center from any consequences thereof. I understand that I may revoke this consent at any time by giving written notice.

Please list below the names of and your relationship to individuals whom you authorize Oak Hills Back and Neck Care Center to release your protected health information.

Name and Relationship

_____

_____

_____

ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of the Notice of Privacy Practices and that I have read or declined the opportunity to read and understand the Notice of Privacy Practices. I understand that these privacy practices will be followed by Oak Hills Back and Neck Care Center to ensure the privacy of my protected health information. I understand that this acknowledgement will be placed in my electronic file and maintained for six years. A copy of this notice is available at any time upon request.

AUTHORIZATION TO ACQUIRE HEALTHCARE INFORMATION

I hereby authorize Oak Hills Back and Neck Care Center to obtain details regarding my current and/or prior health care status from my primary care provider, referring provider, and/or other providers to facilitate appropriate care. All health records, diagnostic imaging results, diagnostic testing results, surgical information, and any data that are held regarding my medical and health management are applicable for release. This release does NOT allow information pertaining to drug and/ or alcohol abuse, or mental health information to be included. I understand that I may revoke this consent at any time, except to the extent that action has already been taken, with written notice.

ASSIGNMENT OF INSURANCE BENEFITS AND FINANCIAL POLICY

In consideration of all services provided, I hereby assign and transfer to Oak Hills Back and Neck Care Center all of my rights, title, and interest to healthcare reimbursement in accordance with the terms and benefits under my insurance policy or other health benefits otherwise payable to me for those services rendered, including Medicare Part B. I certify that the health insurance information that I have provided is accurate and that I am responsible for keeping it updated.

I understand that I will be fully responsible for payment of any and all charges not paid by health insurance. I understand that the balance of my account is due in full within 30 days of notice; unless a payment plan arrangement has been made in advance. In the event that a bill is disputed, notification must be made within 30 days; if I do not notify Oak Hills Back and Neck Care Center within that time, the bill will be presumed valid and due. All balances remaining unpaid after 30 days may be reported to a collection agency, and I will be responsible for all collection expenses including reasonable attorney's fees and court costs.

I hereby authorize Oak Hills Back and Neck Care Center to submit claims, on my or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I have provided, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Oak Hills Back and Neck Care Center directly for services rendered to me or my dependent.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from Oak Hills Back and Neck Care Center are paid in full. I also understand that I am responsible for all amounts not paid by my health insurance, including co-payments, coinsurances, and deductibles.

Oak Hills Back and Neck Care Center accepts cash, personal check, Visa, Discover, and MasterCard. I understand that I will have to pay a $30.00 fee for each check that is returned to Oak Hills Back and Neck Care Center for non-sufficient funds.

Prior balances considered delinquent must be paid prior to being seen for any further scheduled visits. Charges added to your account will be due in full when stated on the invoice.

ERISA AUTHORIZATION (EMPLOYEE RETIREMENT INCOME SECURITY ACT)

I hereby designate, authorize, and convey to Oak Hills Back and Neck Care Center to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan

(Including, but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. (2560.5031(b) (4)) with respect to any healthcare expense incurred as a result of the services I received from Oak Hills Back and Neck Care Center and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

NOTICE OF OFFICE PROCEDURES AND COMMUNICATIONS

Many areas of our office are an open concept. While we do our best to discuss information regarding your treatment and/or accounts privately, at times other patients may be able to overhear. We ask that if you would like to discuss something more privately that you let us know.

Communications from our office including but not limited to, patient bills, letters, thank you cards, and claims sent to insurance companies are all sent out in envelopes with our office name on them. It is the policy of Oak Hills Back and Neck Care Center to not leave messages via voicemail, e-mail, or with another party regarding your care, testing results, specific follow up instructions, or other situations involving your personal health or care provided in this office or elsewhere. When needed, communications will be limited in scope and nature with as little identifying or specific information as possible, often requesting a return phone call to discuss pertinent information. However, with your consent, detailed information can be left via the following methods:

I hereby authorize that Oak Hills Back and Neck Care Center can leave detailed messages regarding my healthcare.

Please check all that apply:

☐Cell ☐Home ☐Work ☐Email

I hereby authorize that Oak Hills Back and Neck Care Center can leave detailed messages regarding my healthcare via another person reached at the following phone numbers that I have provided:

☐Cell ☐Home

I, the undersigned, hereby certify that I have read, fully understand, and agree to be bound by these policies, assignment, and authorization pertaining to myself or my dependent. I have asked or have declined the opportunity to ask any pertinent questions regarding this information before applying my signature. A photocopy of this document shall be considered as effective as the original. I intend this certification to cover the entire course of treatment for my present condition and for any future conditions for which I seek examination and treatment for myself or my dependent.

_____

Signature (Patient or Responsible Party)

_____

Print Name (Patient or Responsible Party)

_____

Date

CONSENT TO TREAT A MINOR WITHOUT PARENT OR GUARDIAN PRESENT

I do hereby authorize and give my consent to Oak Hills Back and Neck Care Center to provide evaluation and treatment as needed and necessary to my minor child in my absence following initial consultation.

☐Yes ☐No

My child will be accompanied by (check all that apply) :

Himself or Herself

Other: _____

Other: _____

_____

Signature (Parent or Responsible Party)

EXTENDED FINANCIAL POLICY

Please read our financial policy in its entirety. If you have any questions or concerns please feel free to ask. Your clear understanding of our Patient Financial Policy is important to our professional relationship.

INSURANCE

It is the patient's responsibility to provide our office with current insurance information. We will ask for your insurance card at your first visit and will copy for our records. We will request a copy at each annual office visit, or if you have not been seen in the past six months. If your insurance information changes at any time during your treatment, it is ultimately your responsibility to provide us with the new information as soon as it becomes active. If current information is not obtained at the time of service it will be the patient's responsibility to pay the entire balance until current information is provided to our office. It is the patient's responsibility to know their benefits and coverage. Your insurance policy is a contract between you and the insurance company. As a courtesy and pursuant to contractual obligations we will file all your claims for you. However, we will not become involved in any disputes between you and your insurance carrier. This includes, but is not limited to, deductibles, copays, and non-covered charges.

REFERRALS

Some insurance policies require you as the policy holder to obtain a referral from your primary care physician, or student health center prior to receiving treatment at our office. It is your responsibility to obtain this documentation and present it to our office at the time of service. If this information is not obtained, you will be responsible for the entire balance of your account.

COPAYS

Copays are due at the time of service. Copays are usually collected PRIOR to you seeing the doctor but may sometimes be collected after you have received treatment.

MEDICARE

If you are a Chiropractic Medicare patient you will be responsible to pay for your exam on your first visit, at the time of service. Medicare requires an exam but does not cover it. Exams are typically $70. X-rays are also NOT covered by Medicare and the cost would be your responsibility and would also be due at the time of service. Medicare does NOT cover physical therapy, vitamins, supports, supplies, and manipulation of non-spinal regions, for example the knee, elbow, etc. Further, Medicare does not pay for treatment considered to be maintenance therapy.

CASH PLANS

Cash plans are available for patients who do not have insurance or wish to not bill to insurance. These plans differ and can be discussed with your doctor. Cash plan payments are due at the time of service.

SUPPLEMENTS/MERCHANDISE

Payments for supplements and merchandise purchased in our office are due at the point of sale. We cannot bill insurance, worker's compensation, or personal injury accounts for these items. These charges are the patient's responsibility and are not covered by any insurance carrier. These items include but are not limited to orthotics, supplements, pillows, braces, heel lifts, and cold packs.

UNPAID/OUTSTANDING BALANCES

We ask that full payment be made at the time of service unless prior arrangements have been made, either with your doctor or our billing office. Deductibles and copays and co-insurance payments are to be paid at the time of service. Prompt and timely payment is appreciated. You may call our billing office to set up a payment plan if necessary. Any overdue balances will be considered for collections.

RETURNED CHECKS

The charge for a returned check is $30. This can be paid by cash, money order, or charge. This will be applied to your account in addition to the original amount owed.

MISSED APPOINTMENTS

We ask that you keep all scheduled appointments. In the event that you are unable to keep your appointment we ask that you provide at least a 4 hour notice for Chiropractic appointments and 24 hours for Massage Therapy appointments.

CREDIT BALANCES

From time to time you may accrue a credit balance. Credit balances will be refunded at the patient's request. Refunds are made by check. After the request for a refund has been made, please allow time for review of your entire account and processing through our accounting department. Once approved please allow 30-45 days for your refund check to arrive.

I have read Oak Hills Back and Neck Care Center's Patient Financial Policy and acknowledge my responsibility with my signature below.

_____

Signature (Patient, Parent, or Legal Guardian)

_____

Print Name (Patient, Parent, or Legal Guardian)

_____

Oak Hills Back & Neck Care Center Staff Witness

_____

Date

A photo copy of this document will be treated as an original