Welcome to Perrysburg Chiropractic!

Chiropractic is considered a specialty in medicine and healing.

We will attempt to verify your chiropractic benefits with your insurance. However, the benefits quoted to us are not a guarantee of payment and we strongly recommend that you verify your own benefits with your insurance company. We hope you understand that our financial policies are established to assure the financial resources needed to maintain this chiropractic office for all of our patients.

Insurance

Your insurance policy is an agreement between you and your insurance company. Our relationship is with you. Therefore, all charges are ultimately your responsibility. Unpaid balances over 90 days will receive a 2% service charge to cover the expense of rebilling. Once we receive an Explanation of Benefits from your insurance company, balances are due at that time or can be paid on our Online Portal.

We do not bill secondary insurance and are required by law to collect all co-pays at time of service.

Methods of Payment

We accept cash, check, MC, Visa and Discover. Minimum credit card charge is $5.00.

Billable to Insurance

• Initial Consultation and Examination	$125 - $150
• Spinal Treatment	$45 - $56
• Extremity Treatment	$20
• Ultrasound/EMS Therapy	$20

Self Pay

• Initial Consultation and Examination	$125
• Spinal Treatment	$45
• Ultrasound/EMS Therapy	$10
• Cold Laser Treatment	$20

Medicare/Medicare Products

• Ultrasound/EMS Therapy	$10

Federal Medicare guidelines only cover chiropractic spinal adjustments. You will be provided an Advanced Beneficiary Notice that is required for all recipients to sign acknowledging what services are not covered.

MISSED APPOINTMENT POLICY - PREVENTING OTHERS FROM RECEIVING CARE

CANCEL OR RESCHEDULE WITH 24 HOURS' NOTICE - NO CHARGE

NEW PATIENT APPOINTMENT NO SHOW - $45

MISSED APPOINTMENT - $25

I have read and understand this financial agreement and authorize the release of any medical information necessary to process claims.

Print Name	Signature	Date

Perrysburg Chiropractic, Inc.

139 W. Indiana Ave., Suite 102, Perrysburg, OH 43551
(419) 874-4463 (p) ~ (419) 874-5244 (f)

Date: _____

Confidential Patient Information

Patient Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

City/State: _____ Zip:_____ Email: _____

SS#: _____ Occupation: _____

Date of Birth: _____ Age:_____ Employer: _____

Marital Status: M S W D Employer Phone: _____

Address of Insured (if different than above): _____

Are your present systems or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) ___ Yes ___No

Chief Complaint: _____

Family Physician: _____ (Note: May we send your health information to this provider Y / N)

Person to contact in case of emergency (Name and Phone): _____

Have you ever been under Chiropractic Care? Y / N If so, Who? _____

Have you had any SPINAL X-Rays / MRI's / CT's taken in the last year? Y / N If so, Where? _____

What operations have you had? _____ When? _____

Serious Illness: _____ When? _____

Infectious Diseases: _____ When? _____

Do you have a pace maker? Y / N Have you ever had any Hip or Knee Replacements? Y / N

What medications or drugs are you taking? (check those that apply): Pain Killers ____ Insulin ____ Cholesterol Meds _____
Blood Pressure Meds ___ Muscle Relaxers ___ Birth Control ___ Other: _____

What is your goal in our office? _____

Initial visit paid by cash ( ) check ( ) Mastercard/Visa or Discover ( )

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to **Perrysburg Chiropractic, Inc.** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____
Signature of Insured / Guardian Date

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorder
- ☐ Lumbago
- ☐ Eczema

INTAKE

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White Sugar

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS;

MUSCULO-SKELETAL CODE

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness

- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO-URINARY CODE

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

NERVOUS SYSTEM CODE

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

C-V-R CODE

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

GENERAL CODE

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

EENT CODE

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

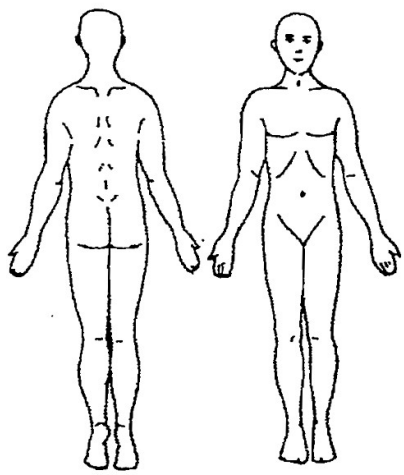
GASTRO-INTESTINAL CODE

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps

MALE/FEMALE CODE

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain/Infections
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction

Please outline on the diagram the area of your discomfort.



FEMALES ONLY:
When was your last period? _____

Are you Pregnant?
☐ Yes ☐ No ☐ Not Sure

DO NOT WRITE BELOW THIS LINE

CHIROPRACTIC ANALYSIS:

Perrysburg Chiropractic, Inc.

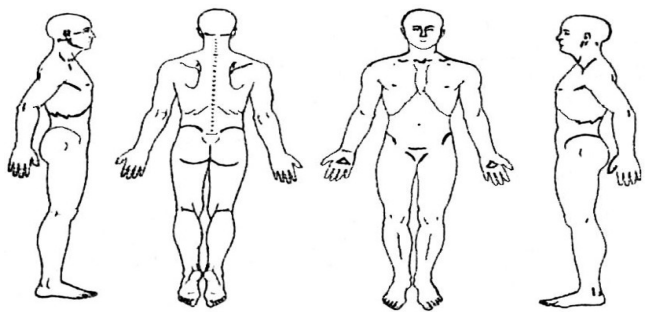
CASE HISTORY

Name: _____ Height: _____ Weight: _____

Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain).

	One Symptom per line	**Severity**	**Frequency (% of week)**
		Minimal Severe	Occasional Constant
1.	a._____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
	Symptom (a.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles		
2.	b._____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
	Symptom (b.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles		
3.	c._____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
	Symptom (c.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles		

(Please mark the figures where you experience pain.)



4. Symptoms are worse in the (circle what applies)

-Morning -Increase during the day
-Afternoon -Same all day
-Night -Decrease during the day

5. When did your symptoms begin (onset date)? _____
6. How did your symptoms begin? _____
7. Have you experienced these before? _____
8. Has your condition? ____ Improved ____ Gotten Worse ____ Stayed the same since it began
9. Do your symptoms move up or down your legs or arms? _____
10. Circle the things that make your problems worse:
    Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping
11. Is there anything you can do to relieve the problems? ____No ____Yes Describe: _____
    If No, what have you tried that has not helped? _____
12. Have you been treated for this before? ____No ____Yes How long ago? _____
13. What treatment did you receive? _____
14. Results of previous treatment? ____Good ____Poor Comments _____
15. Is this condition interfering with ____ Work ____Sleep ____Daily Routine ____Recreation
16. List any other major injuries you have had, other than those mentioned above: _____

_____

16. Who referred you to our office? _____