Welcome to Perrysburg Chiropractic!

Chiropractic is considered a specialty in medicine and as such is reimbursed accordingly. Prior to or the time of your first visit, we will attempt to verify your chiropractic benefits with your insurance company and report that information to you. However, the benefits quoted to us by your insurance company are not a guarantee of payment and we strongly recommend that you verify your own benefits by calling the member services number on the back of your insurance card. 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. We are required by law to collect all co-pays which are due at time of service.

Billable to Insurance

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

Self Pay

• Spinal Treatment	$45
• Ultrasound/EMS Therapy	$5 (when combined with spinal treatment)
• Ultrasound/EMS Therapy	$10 (therapy only)
• Cold Laser Treatment	$20

Medicare/Medicare Products

• Ultrasound/EMS Therapy	$10

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

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

Insurance

Your insurance policy is an agreement between you and your insurance company. Our relationship is with you, not your insurance company. Therefore, all charges are ultimately your responsibility, regardless of your insurance status. Outstanding patient balances will be billed. Billing your insurance is a courtesy service we offer to our patients. We prefer to avoid extra costs and time it takes to process statements to our patients and appreciate your assistance in this by keeping your account current. Unpaid balances over 30 days will receive a 2% service charge to cover the expense of rebilling. We do not bill secondary insurance. Your health insurance and Medicare deductible renews annually. During your deductible period, services' provided will be applied to your deductible by your insurance carrier. Once we receive an Explanation of Benefits from your insurance company, we can better determine what their reimbursement rate is for you; balances are due at that time.

Automobile Accidents

It is our office policy that ALL Motor Vehicle Accidents be submitted to YOUR auto insurance's Med-Pay. We do not submit claims thru another at-fault party's auto insurance. Although we do submit claims to your auto insurance, you are ultimately responsible for your bill. Please notify our insurance department immediately if an attorney is representing you.

Methods of Payment

Accepted methods of payment include cash, check, MC, Visa, Discover and Debit Card. There is a minimum credit card charge of $5.00.

I, the undersigned, have read this financial agreement. I understand that I am personally responsible for co-pays or percentages of services at the time of treatment. In the event that my account is an automobile accident claim, and insurance carrier makes no payment or only partial payment on the claim, I understand that I am personally responsible for this entire balance due. I also authorize the release of any medical information necessary to process any 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

NERVOUS SYSTEM CODE

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

GENERAL CODE

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

GASTRO-INTESTINAL CODE

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO-URINARY CODE

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

C-V-R CODE

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

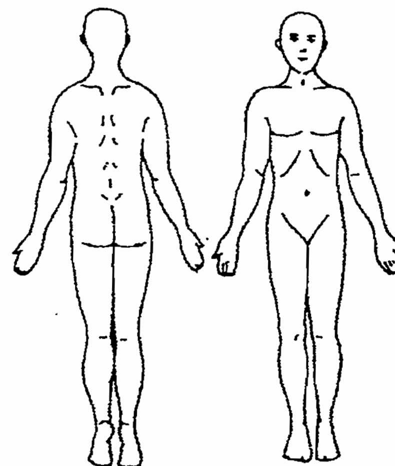
EENT CODE

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

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

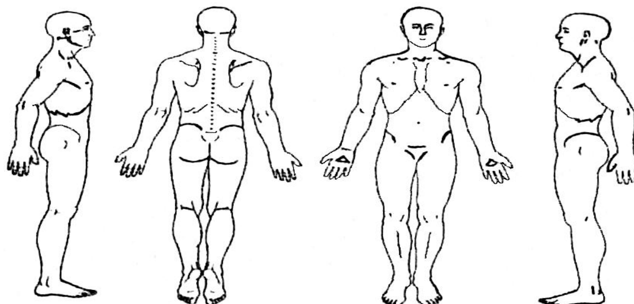
2. b.________________________________	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

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? ____

HIPAA NOTICE OF PRIVACY PRACTICES

2022

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

____________________	______________________________	__________
Print Your Name	Your Signature	Date

____

Your Email Address

Please list below the names of the persons that Perrysburg Chiropractic, Inc. has authorization to disclose your Protected Health Information:

____

Primary Family Member/Friend Name and Phone Number

____

Secondary Family Member/Friend Name and Phone Number

NOTICE OF PRIVACY PRACTICES

PERRYSBURG CHIROPRACTIC, INC.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose you protected health information (PHI) to carry out treatment, payment or health care operations (TPO) 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" is information about you, including demographic information, that may identify you and that relates to you past, present or future physical or mental health or condition and related health care services.

Uses and Disclosure of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required law.

Treatment

We will use and disclose your protected health information to provide, coordinate, or manage your health care and related services. This includes the management of your health care with a third party. As an example, your protected health information may be provided to a physician to who you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment

Your protected health information will be used as needed, to obtain payment for your health care services. For example, obtaining approval for additional physical medicine benefits may require that your relevant protected information be disclosed to the health plan to obtain approval for the additional visits.

Healthcare Operations

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose you protected health information to medical school students that see patients at our office, In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when the doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you about your appointment. We may use or disclose your protected health information in the following situations without your authorization. these situations include: as Required By Law, Public Health issues as required by law, legal proceedings, military activity and national security, worker's compensation. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with requirements of Section 164. 500.

Other Permitted and Required Uses and Disclosures

Will be made only with your consent, authorization or opportunity to object unless required by law.

Revoking Authorization

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information:
You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding and protected health information that is subject to law that prohibits access to protected health information.
You have the right to request a restriction of you 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 healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be 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 the physician believes it is in your best interest to permit use and disclosure of your protected health information, you protected health information will not be restricted You then have the right to use another Healthcare Professional.
You have the right to request to receive confidential communication from us by alternative means or at an alternative location You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.
You have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
We reserve the right to change the terms of this notice and will inform you of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to the Secretary of Health and Human Services or us if you believe your privacy right have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.