Sunbury Chiropractic Center
123 State Route 3
Sunbury, OH 43074
P#: 740-965-4301

Johnstown Chiropractic Center
620 W. Coshocton St.
Johnstown, OH 43031
P#: 740-967-2225

Date: _____

Confidential Patient Information

Patient Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

City: _____ State/Zip:_____ Email: _____

SS#: _____ Preference for Phone Call: *Home* *Cell*

Date of Birth: _____ Marital Status: M S W D # children: _____

Occupation: _____ Employer: _____

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

Ins. Company: _____ Ins. Phone #: _____

ID#: _____ Group #: _____

Name of Policy Holder: _____ Policy Holder DOB: _____

Policy Holders Employer: _____ **Who is responsible for the bill?**_____

Person to contact in case of emergency: _____ Phone: _____

How did you hear about our office? _____

Preference for appointment reminders: *email* *text*

We may communicate with you regarding personal healthcare information including but not limited to your care, insurance billing and balance information via email or voicemail. If you do not allow us to communicate with you in this way, please indicate below.

- □ Opt out of email messages
- □ Opt out of voicemail

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 **Sunbury Chiropractic Center, 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. If I do not have insurance, I will pay at the time services are rendered.

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

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Patient Name_____ **DOB** _____

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

Condition / Problem	**Severity** Minimal — Severe	**Frequency (% of week)** Occasional — Constant
a. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
b. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
c. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
d. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
e. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

2. Symptoms are <u>worse</u> in the (circle what applies) *morning* *afternoon* *night*
   Increases during the day *same all day* *decreases during the day*
3. Has your condition? ____ Improved ____ Gotten Worse ____ Stayed the same since it began
4. When did your symptoms begin? _____
5. Is this condition interfering with ____ Work ____Sleep ____Daily Routine ____Recreation _____ Other
6. Circle the things that make your problems worse:
   Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping
7. How did your symptoms begin? _____
8. Have you experienced these before? _____
9. Do your symptoms radiate? _____
10. Is there anything you can do to relieve the problems? ____No ____Yes Describe: _____
    If No, what have you tried that has not helped? _____
11. Have you been in an auto accident: *Past year* *Past 5 years* *Over 5 years* *Never*
12. Have you ever been knocked unconscious? _____ If YES, when?_____
13. Have you ever fractured a bone? _____ If YES, where?_____
14. List all surgical operations and years: _____
    _____
15. List all medication, vitamins, or mineral supplements? (attach copy if necessary) _____
    _____
16. Do you have any allergies? _____ Food _____ Medication ____ Seasonal
17. Do you wear any of the following: *Heel lifts* *Arch Supports* *Back Brace* *Neck Brace* *Other:* _____
18. **Family Health History:** Many health problems are the result of hereditary spinal weaknesses; information about your family members give us a better picture of your total health.

Name	**Relation**	**Past and Present Health Problems**

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Patient Name_____ **DOB** _____

Please check any of the following symptoms which you now have or have had previously.

General		**Muscle & Joint**		**Respiratory**	
	Allergies		Arthritis		Chest pain
	Dizziness		Foot Trouble		Chronic cough
	Fainting		Low back pain		Difficult breathing
	Fatigue		Neck pain or stiffness		Spitting up blood
	Fever		Spinal curvature		Spitting up phlegm
	Headache				Wheezing
	Loss of Sleep	**Pain or Numbness**			
	Anxiety/depression		Shoulders	**Genito-Urinary**	
	Numbness		Arms		Bed Wetting
			Elbows		Blood in urine
Cardio-Vascular			Hands		Frequent urination
	Heart Disease		Hips		Inability to control Bladder
	High Blood Pressure		Legs		Kidney infection or stones
	Low Blood Pressure		Knees		Painful urination
	Pain over heart		Feet		Prostate Trouble
	Poor Circulation		Tailbone		
			Sciatica	**For Women only**	
Eyes, Ears, Nose & Throat					Cramps or backache
	Asthma	**Gastro-Intestinal**			Hot flashes
	Colds		Constipation		Irregular cycle
	Earache		Diarrhea		Menopausal symptoms
	Ear Noises		Difficult Digestion		Painful Menstruation
	Eye Pain		Gallbladder Trouble		**Pregnant? *Yes* *No***
	Failing vision		Hemorrhoids		
	Nosebleeds		Nausea	**Mental Health**	
	Sore Throat		Pain over stomach		Anxiety
	Sinus Infection		Vomiting		Depression
			Poor appetite		Bipolar

Check the following conditions you have or had

	Alcoholism		Cold Sores		Influenza		Pleurisy		STD
	Appendicitis		Diabetes		Measles		Pneumonia		Stroke
	Arteriosclerosis		Eczema		Miscarriage		Polio		Tuberculosis
	Arthritis		Emphysema		Multiple Sclerosis		Rheumatic Fever		Ulcers
	Cancer		Epilepsy		Mumps		Scarlet Fever		Whooping Cough

Habits: Heavy/Moderate/Light/Never/Former

Alcohol_____Coffee_____Tobacco_____Drugs_____

Exercise_____

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Policy and Authorization

At Sunbury Chiropractic Center, Inc., our motto is "Relief First, Wellness Always." Our recommendations for care are based on a desire to see you get well and stay well with maintenance care. Chiropractic care is covered under many insurance plans, personal injury coverage, worker's compensation coverage, Medicare and Medicaid. All **medical** concerns are to be discussed with the doctor and all **financial** concerns are to be discussed with office staff. We accept Visa, Mastercard, Discovery, Care Credit and will be happy to extend a payment plan. We require a payment every month for any balance on the account. If you feel you might qualify for our financial hardship policy, please notify office staff for an application. Should payment be refused by your bank for a check written, the office will charge a fee of $12 to offset the charges we will incur. If bills remain unpaid by any insurance carrier, all patients will be asked to assist in getting bills processed when notified. The privilege of insurance assignment begins when our office receives and verifies your insurance information. This service is a courtesy to you and is not a guarantee of coverage. All patients whose treatment is considered maintenance is generally not a covered benefit and could be the responsibility of the patient.

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic adjustment, therapy, evaluation and/or diagnostic x-rays by any doctor or office staff.

Mother/legal Guardian:_____

Father/Legal Guardian:_____

I understand that some insurance plans consider spinal manipulation on children under the age of 2 years to be experimental and may not be covered. By signing this, you understand that your child's visit, if applicable, may be denied by the insurance company and you will be financially responsible for all denied services rendered.

Communications:

In the event that we would need to communicate your healthcare information, including but not limited to diagnosis, treatment plan and insurance/financial coverage, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

I do not give permission to speak with anyone: _____

Please complete the information below **IF** you allow us to use and disclose all health information to your Family Physician.

Physician Name/Practice Name:_____

Phone #: _____

I have read and fully understand the above statements.

Patient/Guardian Signature: _____ Date: _____

Patient Name: _____ DOB: _____

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Informed Consent

A patient gives the doctor permission and authority to care for them in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses, deformities, use of recreational drugs or use of CBD oil which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at **Sunbury Chiropractic Center, Inc.**, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request or new diagnosis. Today I consent to the adjustment, examination, diagnostic x-rays and therapy modalities if applicable.

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Massage Missed Appointments:

There is a fee charged for all **MASSAGE** appointments that are not canceled prior to a scheduled visit.
Any massage appointment that is not canceled 24 hours prior to scheduled appointment will be charged a $25 fee.

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I understand that my doctor may submit my x-rays to Professional Imaging Consultants, Inc. for radiological evaluation and analysis by a Radiologist. **There will NOT be a fee for this second opinion**, as Sunbury Chiropractic Center will cover all costs as a courtesy.

Benjamin Glass, DC, DACBR
Chiropractic Radiologist
8230 Crystal Creek Dr.
North Royalton, OH 44133

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I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy.

☐ **I have been given a copy of the Policy**
☐ **I have declined a copy of the policy**

Patient/Guardian Signature: _____ Date: _____

Patient Name: _____ DOB: _____