Patients Name: ______________________

Address: __________________________

City:_______________________Zip: ______

SSN: _______________________________

Date of Birth: _______________________

Occupation: ________________________

Born as a Male ☐ Female ☐

Chief Complaint: ____________________

Home Phone: ______________________

Cell Phone: ________________________

Email: ______________________________

Marital Status: M S W D

Employer: ___________________________

Address of Insured (if different than above):

____

Office Use Only

Are your present symptoms 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?)

Y N

CLAIM#	MCO:	AUTO INS:
ATTY:		MED PAY:

Family Physician:____

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

How did you hear about our office?

____

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 / CTs taken in the last year? Y / N

If Yes, Where?____

What operations, infectious diseases, or serious illnesses have you had and 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 here if not taking any_______

Example: Pain Killers, Insulin, Cholesterol Meds, Blood Pressure Meds, Muscle Relaxers, Birth Control

Medication Name	# of Refills Used	Quantity of Pills	Strength of Medication (mg)	Dose Form (capsule/tablet/etc)	Frequency

Are you allergic to any medications? Check here if none_________

Name of Drug	Symptom

Have you been diagnosed with (circle any that apply) Asthma Diabetes ?

Smoking Status: Include amount of cigarettes/cigars/packs

Smoke Every Day	Smokes Some Day	Former Smoker	Never Smoked

What is your goal in our office?

____

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 Tuscarawas County Chiropractic Clinic, 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 patients. 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 docu1nents, 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 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 1ny 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___________

TERMS OF ACCEPTANCE

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient 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 or deformities 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 Tuscarawas County Chiropractic Clinic, 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.

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 care.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?
Name:____Relationship:______________________
Name:____Relationship:______________________
Name:____Relationship:______________________

May we leave messages regarding your personal healthcare information on any answering device?
i.e. home answering machines, computer e-mail or voicemails? Yes [ ] No [ ]

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected medical information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed out notice before signing this consent.
The terms of the notice may change, if so you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected medical information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The **HIPAA** (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected medical information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected medical information may be disclosed or used for treatment, payment, or medical operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text message to you to confirm your appointments? **YES** **NO**

May we leave a message on your answering machine or voicemail? **YES** **NO**

May we discuss your medical condition with any member of your family? **YES** **NO**

IF YES, please name members allowed:
____

This consent was signed by:____________________________________
(Please Print Name)

Signature:____ Date:_________________

Witness:____ Date:_________________