PERSONAL INFORMATION

PLEASE PRINT

First Name: _____ **M.I.**_____ **Last Name**: _____

Address:_____**City**:_____**State:**_____**Zip:**_____

Birthdate: _____/_____/_____ **Age**_____ Gender: □ Male □ Female □ Unspecified **SSN**: _____/_____/_____

Primary Phone: _____ Cell **Phone**: _____ Work **Phone**: _____

Home Email: _____

Preferred Contact Method: (check one) □ **Primary Phone** □ **Cell Phone** □ **Work Phone** □ **Home Email** □ **Work Email**

Emergency Contact: (Name, Relationship,) _____Phone #:_____

□ **Married** □ **Widowed** □ **Single** □ **Minor** □ **Separated** □ **Divorced** □ **Partnered for _____ years**

How did you hear about us? _____

Employer: _____ City:_____ Occupation: _____

Race: □ **White** □ **American Indian** □ **Asian** □ **African American** □ **Native Hawaiian** □ **Other** □ **Declined to Respond**

Ethnicity: □ **Hispanic/Latino** □ **Not Hispanic/Latino** □ **Declined to Respond**

INSURANCE OR PRIVATE PAY INFORMATION

Please provide insurance card(s) to receptionist.

Type of Insurance: □ Private Ins. □ Medicare □ Auto Ins. □ Worker's Comp □ Other_____

Primary Insurance Carrier: _____ Phone:

_____

ID#_____ Group #_____ Claim#_____

Name of Policy Holder: _____ Relationship to Patient: _____

Is patient covered by another insurance? □ Yes □ No **Secondary Insurance**: _____ID #:_____

ASSIGNMENT/AUTHORIZATION/RELEASE:

I certify that I, and/or my dependents, have insurance with the above named insurance company(s) and assign directly to Preferred Health of Marshall, PA all benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that "co pays" are payable at the time of each visit and that I am financially responsible for all charges whether or not paid by insurance. The above named provider's office may use my health care information and may disclose such information to the above named insurance company(s) and their agents for the purpose of obtaining payment for services and determining benefits payable for related services.

□ **Private Pay/Cash:** By checking this box, I acknowledge that I do not have insurance and understand that I am financially responsible for all services at the time they are rendered. Name of person responsible for this account: _____

X_____ DATE: _____

Signature of Patient, Parent or Legal Guardian (if minor)

REASON FOR VISIT

What is the reason for your visit today? □ Headache □ Neck Pain □ Mid-Back Pain □ Low Back Pain □Other_____

What caused this complaint(s)? _____

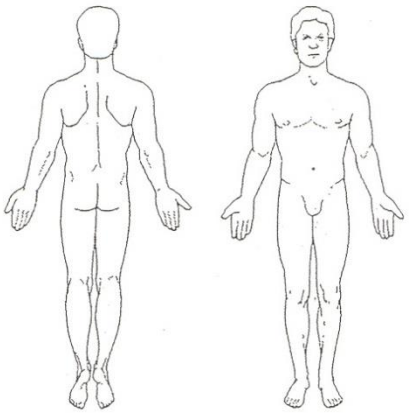
_____

When did this complaint begin? _____/_____/_____ is **it getting worse?** □ Yes □ No □ Constant □ comes and goes

Have you had this or similar complaint in the past? □ Yes □ No If "Yes", when? _____

What does your complaint (s) feel like? **Circle all** that apply: *Sharp / Dull / Sore / Stiff / Tight / Aching / Spasms / Throbbing / Stabbing / Shooting / Burning / Cramping / Nagging / Tingling / Numbness / Other*_____

Are you interested in learning more about Laser Therapy? □ Yes □ No



←**Please Circle or make an "X" on the body diagram to the left where you have pain or other symptoms.**

What area(s) does the pain radiate, shoot, or travel to? (If applicable)? _____

Area for notes:

Height: _____ Weight: _____ Blood Pressure:_____/_____

On the scale below, please circle the severity of your main complaint right now:

No Pain				***Moderate Pain***						***Worst Possible Pain***
0	***1***	***2***	***3***	***4***	***5***	***6***	***7***	***8***	***9***	***10***

HEALTH HISTORY

Please check **ALL** of the health conditions below that apply to **you** currently or in the past.

Medical History: □ Ankle Pain □ Arm Pain □ Arthritis □ Back Pain □ Broken Bones □ Cancer □ Chest Pain □ Diabetes □ Elbow Pain □ Epilepsy □ Fainting □ Fatigue □ Foot Pain □ Hand Pain □ Headaches □ Hearing Problems □ Hepatitis □ Hip Pain □ High Blood Pressure □ Jaw Pain □ Joint Stiffness □ Knee Pain □ Leg Pain □ Low Back Pain □ Mid Back Pain □ Minor Heart Trouble □ Multiple Sclerosis □ Neck Pain □ Neurological □ Pacemaker □ Parkinson's □ Polio □ Stroke □ Shoulder Pain □ Significant Weight Change □ Spinal Cord Injury □ Heart Attack □ Tumor □ Wrist Pain

Family History: □ Arthritis □ Autism □ Blindness □ Cancer □ Diabetes □ Epilepsy □ Heart Attack □ Mental Illness □ Muscular Disease □ Parkinson's □ Spinal Muscle Atrophy □ Stroke □ Tumor □ Thyroid □ MS □ Aids □ Alzheimer's □ COPD □ Pneumonia □ Kidney □ Declined to Respond

Known Allergies: _____

SURGERIES and/or HOSPITALIZATIONS (List and Date):

_____

_____

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? □ Yes □ No

List current prescription medications, including frequency and dosage if known. **If there are NO current medications, check here** □

Name of prescription medication	*Dosage/Start date*	4.	
1.		5.	
2.		6.	
3.		7.	

List any know allergies you have had to prescription medications. If NO medication allergies are known, check here □

1._____ 2._____

SOCIAL HISTORY

Do you exercise? □ Yes □ No **Times per week?** **Intensity?** □ Light □ Moderate □ Strenuous Type?

Do you currently smoke tobacco of any kind? □ Yes □ Former smoker □ Never been a smoker

If "Yes", how often do you smoke: □ Current every day smoker □ Current sometimes smoker **Circle level below ↓:**

If "Yes", what is your level of interest in quitting smoking? (0 = NO interest, 10=very interested) **0 1 2 3 4 5 6 7 8 9 10**

NAME:_____ DATE:_____

AMERICAN FAMILY CHIROPRACTIC * 513-398-6300 * Fax 513-398-6363

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Authorization for Use/Disclosure of Information:

I voluntarily consent to authorize my health care provider _____ to use or disclose my health information during the term of this Authorization to American Family Chiropractic.

Information to be disclosed:

I authorize the release of the following health information: (check the applicable box below)

- ☐ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.[1]

- ☐ Only the following records or types of health information: _____.

_____ Date_____
Print Name

_____ _____
Signature Signature of Witness

_____ _____
Name of Guardian/ Legal Relationship

[1] **NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris-Short Act.**

PHI Use and Disclosure Authorization

If you wish to have your medical or billing information released to family members you must fill out the information and sign below. I hereby authorize American Family Chiropractic disclosure of my individually identifiable health information to the individuals listed:

1. Name _____ Relationship to Patient _____

2. Name _____ Relationship to Patient _____

Authorization to:

- ❑ Disclose treatment plans and test results
- ❑ Billing information including statement balances

Consent, NPP, Assignment, Financial Policy

Thank you for allowing American Family Chiropractic to serve you. Please complete the following and provide proper proof of insurance in order to receive services.

CONSENT FOR TREATMENT

I hereby give my consent to receive chiropractic treatment services from American Family Chiropractic. I further authorize any health professional employed by AFC to provide necessary treatments for the medical evaluation and management of my health care.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign/authorize payment of all my health, sick, Medicare and/or auto/work comp benefits due because of liability of a third-party, payable by any party directly to American Family Chiropractic. This is a direct assignment of my rights and benefits under my policy. I understand that I am solely responsible for any charges not covered by my insurance.

PROMISE TO PAY

I understand that I am obligated to pay in full for any services received in accordance with the regular rates and terms of American Family Chiropractic. If I fail to make payment when due and it becomes delinquent or sent to collections, I agree to pay all charges incurred due to my delinquency. I also agree that any overpayments on my account may be applied directly to any balance for which I am responsible.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the American Family Chiropractic Notice of Privacy Practices and signed the Protected Health Information form.

I understand that I may revoke this authorization to disclose information at any time by notifying American Family Chiropractic in writing (*Termination of Disclosure Form* provided on request). If I choose to do so, I am aware that my revocation will not affect any actions taken by American Family Chiropractic until the termination request is received in writing and processed.

_____ _____

Patient Name (print) Patient's Date of Birth

_____ _____

Patient Signature Date

DIAGNOSTIC IMAGING CONSULTANTS

1123 Montgomery Road
Cincinnati, Ohio 45249
Phone: (513) 489-0055
Fax: (513) 489-4587

I understand the services of a qualified radiologist are being utilized for the interpretation of my x-rays. This fee is separate from the services performed at American Family Chiropractic Clinic. I also understand there is a fee of $45 for the interpretation of my x-rays.

My signature is acknowledgment that I have given my consent to have my x-rays examined and reviewed by Dr Bryan Hosler, DACBR.

PATIENT: _____

SIGNATURE:_____

DATE:_____

PAYMENT DUE AT THIS TIME: $45

Payable by cash, credit card, or check

*made payable to American Family Chiropractic

Thank you

☐ Please check this box if you are declining xrays.

AMERICAN FAMILY CHIROPRACTIC

MASSAGE CANCELLATION AGREEMENT

*MASSAGE PACKAGES EXPIRE 1 YEAR FROM DATE OF PURCHASE.

Massages between 9:00am – noon must be cancelled by noon the previous business day. Massages after noon MUST be cancelled prior to 5pm the previous day.

You will be charged $19.50 for a half hour, $35.50 for an hour, and $52.50 for an hour and a half, if not cancelled in the specified time frame per this agreement. If you have a package, you will lose the equivalent.

Your insurance company including auto does not cover massage no show or cancellation fees. Therefore, you will be held responsible for the payment of any missed massage appointments that weren't cancelled as described in this agreement.

Should you no call no show for your massage, you will be charged the full amount of that massage.

Since this time is reserved exclusively for each patient, and the massage therapist is only paid if the massage is performed, proper notification must be given. We appreciate your cooperation in advance.

_____ _____

Patient's Signature *Date*

_____

Witness of Signature