

Write Legibly

Warren County Chiropractic

1248 Columbus Ave, Suite 5, Lebanon, OH 45036

Write Legibly

 New Address, Insurance, Etc? Please Check Box

Patient Name		Home Phone		Cell Phone	
Street Address		City		State	Zip Code

Date of Birth	Age	Social Security #	E-mail Address	Height	Weight
Occupation		Employer	Employer's Address & Phone		
Spouse's Name		Spouse's Occupation	Spouse's Employer	Spouse's Work Phone	

Primary Care Physician	City and Phone Number	How long has this been your PCP?
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Your signature is an acknowledgement that the information provided is true, you can be held liable for all charges incurred if correct information is or was **NOT** provided.

Patient Signature	Date of Signature
IF PATIENT IS A MINOR: Permission is hereby given by me to the doctor(s) of this office and whomever they designate to treat the patient. I am his/her legal guardian.	
Guardian Signature	Date of Signature

You **MUST** complete the following for our records, as well as provide a copy of insurance card(s)

Primary Insurance Company	Name of Policy Holder	Policy Holder's Date of Birth
ID Number	Relationship to Patient (if other than Self)	Policy Holder's Social Security#
Claims Mailing Address	City	State
		Zip Code

Secondary Insurance Company	Name of Policy Holder	Policy Holder's Date of Birth
ID Number	Relationship to Patient (if other than Self)	Policy Holder's Social Security#
Claims Mailing Address	City	State
		Zip Code

Health History:**Check only those conditions that apply**

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pace Maker |
| <input type="checkbox"/> Allergy shots | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Herpes | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Pinched Nerve |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fractures | <input type="checkbox"/> Measles | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gonorrhhea | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tumors, Growths |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Vaginal Infections | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Stroke | <input type="checkbox"/> Other _____ | |

Chiropractic Case History/Patient Information

Patient Signature: _____ Date _____
Guardian's Signature, if Applicable _____ Date _____

1. What is your major symptom? _____

2. What does this prevent you from doing or enjoying? _____

3. If this is a recurrence, when was the first time you noticed this problem? _____

How did it originally occur? _____

Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse ___

If yes, when and how? _____

4. How frequent is the condition? Constant ___ Daily ___ Occasionally ___ Night Only ___

How long does it last? All Day ___ Few Hours ___ Minutes ___

5. Are there any other conditions or symptoms that may be related to your major symptom?

Yes ___ No ___ If yes, describe _____

6. Describe the pain: Sharp ___ Dull ___ Numbness ___ Aching ___ Stabbing ___ Burning ___ Tingling ___

Other _____

7. Is there anything you can do to relieve the problem? Yes ___ No ___ . If yes, describe _____

_____. If no, what have you tried that has not helped? _____

8. What makes the problem worse? Sitting ___ Standing ___ Lying ___ Bending ___ Lifting ___ Twisting ___

Other _____

9. Have you had any broken bones? Yes ___ No ___ . If yes, please list and give dates _____

10. List any major accidents you have had other than those that might be mentioned above: _____

11. **WOMEN ONLY:** Are you pregnant or is there any possibility you may be pregnant? Yes ___ No ___ Uncertain ___

12. Remarks _____

No Symptoms-----Extreme Symptoms

Please place and "X" on the line above to indicate level of problem

Doctor's Signature _____ Date _____

Authorization and Release Form

Warren County Chiropractic
1248 Columbus Ave Ste5
Lebanon, OH 45036
513-932-2273

Date: _____

Patient: _____ Date of Birth: _____

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 16%

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorize Warren County Chiropractic to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Patient/Guardian Signature

Date

Financial Policy

We are committed to providing you with the best possible care. If you have insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for service is due at the time of services rendered unless arrangements have been made and approved in advance by our staff. We accept cash, checks, MasterCard, American Express, Discover, or Visa. We will be happy to help you process your insurance claims, but any such request must be accompanied by a completed assignment of benefits form as well as a simple agreement form.

We will ask to keep a credit card on file. Returned checks and or balances older than 30 days will be charged to this credit card unless previous arrangements have been made. Balances older than 30 days still outstanding will be subject to additional collection fees and interest of 1 ½ % per month. Charges may also be made for broken appointments and appointments cancelled without notice.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies that pay a percentage (such as 50% or 80%) of "UCR". UCR is defined as the Usual, Customary and Reasonable rates.

This statement does not apply to companies that reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area, which was freely chosen by you, the patient.

Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that, as chiropractic providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding your insurance coverage, PLEASE don't hesitate to ask us. WE ARE HERE TO HELP YOU!!

Patient/Guardian Signature: _____ Date: _____