



Welcome!...We are honored you have chosen us to evaluate your health. So we may better serve you, please fill out the personal information below. If you need assistance, please inform a front desk team member. Thank you!!!

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ E mail \_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth Date \_\_\_\_\_

Marital Status: Married: \_\_\_\_\_ Single \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_ Children \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Occupation \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

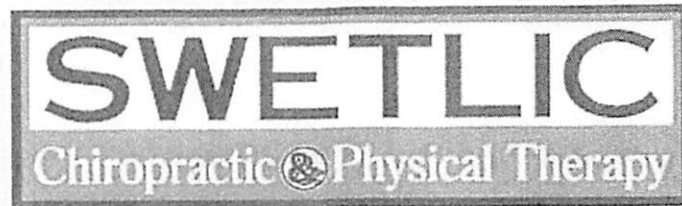
Name of Person on the insurance card \_\_\_\_\_ Birth Date \_\_\_\_\_

Name of Employer \_\_\_\_\_ City \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone Number \_\_\_\_\_

How did you hear about us \_\_\_\_\_ Facebook \_\_\_\_\_ Website \_\_\_\_\_ News Paper \_\_\_\_\_ Signage \_\_\_\_\_ word of mouth

Who can we thank for your referral \_\_\_\_\_



Patient Name: \_\_\_\_\_ 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.

Please read below and if you have, any questions please feel free to ask one of our staff members.

#### Informed consent:

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed "and involves your understanding and agreement regarding the care we recommend the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion; reduce swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur 3-4 of every 10,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in on in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death have been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include but not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

**Acknowledgement:**

I have read and fully understand the above statements

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Financial Agreement

Please remember that insurance is considered a method of reimbursing the patient for fees put to the doctor and is NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed allowances procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLE AT TIME OF SERVICE.

If this account is assigned to an attorney / outside agency for collection and/or suit, Swetlic Chiropractic and Physical Therapy Center. Shall be entitled to reasonable attorney's fees and for cost of the collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Insured's Signature

\_\_\_\_\_  
Date

### 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 and convey directly to Swetlic Chiropractic and Physical Therapy Center. all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor or clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance 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 upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. 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 names 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 and the original. I have read and fully understand this agreement.

\_\_\_\_\_  
Signature of Insured/Guardian

\_\_\_\_\_  
Date



## **Cancellation Policy/No Show Policy**

### ***1. Cancellation/ No Show Policy***

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

**If an appointment is not cancelled at least 24 hours in advance you will be charged a Twenty dollar (\$20) cash fee; this will not be covered by your insurance company.**

### ***2. Scheduled Appointments***

We understand that delays can happen however, we must try to keep the other patients and doctors on time.

**If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.**

### ***3. Account balances***

We will require that patients with self-pay balances do pay their account balances to zero (0) prior to receiving further services by our practice.

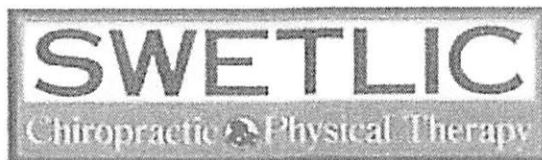
Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns.

Patients with balances over \$100 must make payment arrangements prior to future appointments being made.

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date



## PATIENT ACKNOWLEDGEMENT OF HIPAA NOTICE

### Notice to Patient:

We are required to offer you a copy of our HIPAA notice, which states how we may use and/or disclose your health information. Our HIPAA notice and office policies contain information regarding payment, health insurance, collections and other important information.

### OPTIONAL:

- |   |     |    |
|---|-----|----|
| 1) May we confirm your appointments by email, text or phone?  | Yes | No |
| 2) May we leave a message on your answering device at home or cell phone?   | Yes | No |
| 3) May we discuss your condition with any members of your family?   | Yes | No |
| If yes, provide names: _____  |     |    |
| 4) We utilize an open therapy room. We make good faith attempts to keep our conversations at a low level. We offer every patient the opportunity to be treated in a private room if requested. Are you comfortable being treated in an open room? | Yes | No |

### Patient Acknowledgement:

I acknowledge and agree to this office's HIPAA notice. I acknowledge that I have reviewed the HIPAA notice and have the right to obtain a paper copy of the HIPAA notice. I acknowledge that I may refuse to sign this acknowledgment if I wish.

\_\_\_\_\_  
Patient Printed Name

\_\_\_\_\_  
Patient Signature or legal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
If legal representative, state relationship

### FOR OFFICE USE ONLY:

We have made every effort to obtain written acknowledgment of receipt of our HIPAA notice from this patient but it could not be obtained because:

- \_\_\_ the patient refused to sign
- \_\_\_ we were not able to communicate with the patient
- \_\_\_ due to an emergency situation it was not possible to obtain a signature
- \_\_\_ other (please provide details):

\_\_\_\_\_  
Name of patient

\_\_\_\_\_  
Name of staff member

\_\_\_\_\_  
Signature of staff member

\_\_\_\_\_  
Date



Authorization for Release of Records

1. I authorize the professional staff of \_\_\_\_\_ to disclose the following patients' specified information to the professional staff of \_\_\_\_\_

Swetlic Chiropractic and Physical Therapy Center, Inc.  
11301 Upper Gilchrist Road Suite A  
Mount Vernon, Ohio 43050

Patient Name \_\_\_\_\_  
Address \_\_\_\_\_  
Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone number \_\_\_\_\_

2. Information to be released:      O Please FAX (740) 392-0334      O Please mail hardcopy
- |  |  |
|--|--|
| <input type="checkbox"/> Complete health record    | <input type="checkbox"/> Discharge Summary           |
| <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> MRI of _____                |
| <input type="checkbox"/> Progress Notes            | <input type="checkbox"/> Consultation Reports        |
| <input type="checkbox"/> Radiology Reports         | <input type="checkbox"/> HIV Test Results            |
| <input type="checkbox"/> Radiology Films           | <input type="checkbox"/> Psychiatric Records         |
| <input type="checkbox"/> Laboratory Reports        | <input type="checkbox"/> Drug Screen, Blood, Alcohol |
| <input type="checkbox"/> Other _____               |  |

Dates of service \_\_\_\_\_ to \_\_\_\_\_

I understand that if complete health record is checked all medical information will be released including psychiatric records, alcohol or drug screening and HIV test results.

I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

3. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken thereon. This authorization is good for 1 year unless dates filled in below

From \_\_\_\_\_ To \_\_\_\_\_

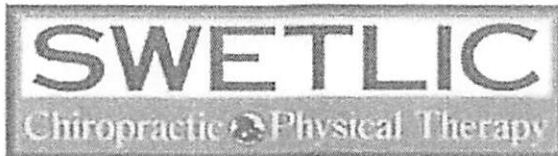
Access to medical information is the right of every patient; duplication and distribution is a service. Release are subject to copy and distribution cost. I understand the potentiality of charge for the service and release of medical information and accept financial responsibility.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name





Name \_\_\_\_\_ Date \_\_\_\_\_ Account \_\_\_\_\_

HISTORY OF ILLNESS/INJURY/PAIN

Chief Complaint and its location \_\_\_\_\_

Is the condition that brought you here today due to an automobile accident or on the job injury? \_\_\_\_ Yes \_\_\_\_ no

How often do you experience this pain? \_\_\_\_ 100% \_\_\_\_ 75% \_\_\_\_ 50% \_\_\_\_ 25% of the time I have this pain.

What do you think may have caused this problem? \_\_\_\_\_

When did your problem begin or when was the most recent occurrence \_\_\_\_/\_\_\_\_/\_\_\_\_

Over the past weeks/months this complaint is: \_\_\_\_ Improving \_\_\_\_ Getting Worse \_\_\_\_ About the same

On a scale of 0 to 10 with 0 representing no pain and 10 being the most severe pain imaginable, use the key below to rate the severity of your pain

0=none 1=Minimal 2=Very Mild 3=Mild 4=Mild to Moderate 5=Moderate 6=Moderate to severe  
7=Mildly Severe, Restricts Some Activity 8=Severe, Limits Most Activity 9=Very Severe 10=Excruciating

Sitting here today, right now, what is the intensity of your pain on a scale of 1-10 \_\_\_\_\_

What is the least intense the symptom has been on a scale of 1-10 \_\_\_\_\_

What is the most intense the symptom has been on the scale of 1-10 \_\_\_\_\_

If this pain radiates or travels, please identify where to: \_\_\_\_\_

How would you best describe the sensation of the pain/symptom:

\_\_\_\_ Dull \_\_\_\_ Stiff \_\_\_\_ Tight \_\_\_\_ Stabbing \_\_\_\_ Shooting \_\_\_\_ Tingling \_\_\_\_ Spasms  
\_\_\_\_ Annoying \_\_\_\_ Sore \_\_\_\_ Sharp \_\_\_\_ Burning \_\_\_\_ Pins & Needles \_\_\_\_ Cramps \_\_\_\_ Other

What aggravates the pain/symptom

\_\_\_\_ Sneezing \_\_\_\_ Lifting \_\_\_\_ Exercising \_\_\_\_ Looking up/down \_\_\_\_ Walking \_\_\_\_ Coughing  
\_\_\_\_ Sitting \_\_\_\_ Bending Forward \_\_\_\_ Looking side to side \_\_\_\_ Standing \_\_\_\_ Stress \_\_\_\_ Driving  
\_\_\_\_ Getting out of bed \_\_\_\_ Pushing \_\_\_\_ Pulling \_\_\_\_ Dressing \_\_\_\_ Carrying \_\_\_\_ Lying in Bed  
\_\_\_\_ Straining BM \_\_\_\_ Climbing Stairs \_\_\_\_ Getting in/out of car \_\_\_\_ Sitting to Standing  
\_\_\_\_ Sitting \_\_\_\_ Minutes \_\_\_\_ Standing \_\_\_\_ Minutes

What relieves this pain/symptom

\_\_\_\_ Resting \_\_\_\_ Sleeping \_\_\_\_ Lifting \_\_\_\_ Exercising \_\_\_\_ Walking \_\_\_\_ Shower  
\_\_\_\_ Bending Forward \_\_\_\_ Lying Down \_\_\_\_ Lying with Knees bent \_\_\_\_ Stretching  
\_\_\_\_ Biofreeze/Icy Hot \_\_\_\_ Over the Counter Meds \_\_\_\_ Prescription Meds

Who have you seen in the past or currently for this problem? \_\_\_\_\_

When did you last see them? \_\_\_\_\_ Is it helping? \_\_\_\_\_

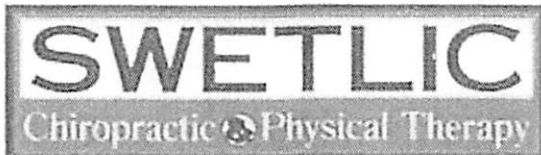
Have you seen any other Chiropractors in the past? \_\_\_\_ yes \_\_\_\_ No If so, who? \_\_\_\_\_

Is there a family history of back problems? \_\_\_\_ yes \_\_\_\_ No if yes, who? \_\_\_\_\_

Patient Signature \_\_\_\_\_

Doctor Signature \_\_\_\_\_





Name \_\_\_\_\_ Date \_\_\_\_\_ Account \_\_\_\_\_

Please List Past Surgeries: (if joint surgery please list side and type)

1. \_\_\_\_\_ Year \_\_\_\_\_
2. \_\_\_\_\_ Year \_\_\_\_\_
3. \_\_\_\_\_ Year \_\_\_\_\_
4. \_\_\_\_\_ Year \_\_\_\_\_

List any other key slips, falls, or accidents you've had from childhood to present date

1. \_\_\_\_\_ Date \_\_\_\_\_
2. \_\_\_\_\_ Date \_\_\_\_\_
3. \_\_\_\_\_ Date \_\_\_\_\_

Please list all of your medications or Provide a list for our records.

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_
4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

Please check all that apply: Have you ever taken or currently take:

\_\_\_\_ Insulin \_\_\_\_ Cortisone \_\_\_\_ Thyroid Medicine \_\_\_\_ Male/Female hormones \_\_\_\_ Blood Pressure Medication

\_\_\_\_ Tranquilizers/Sedatives \_\_\_\_ Birth Control \_\_\_\_ Blood Thinners

Pacemaker \_\_\_\_ yes \_\_\_\_ no Pregnant \_\_\_\_ yes \_\_\_\_ no

Known Allergies: \_\_\_\_\_

Major Hospitalizations: \_\_\_\_\_

Frequency of Exercise: \_\_\_\_ Never \_\_\_\_ Rarely \_\_\_\_ Occasionally \_\_\_\_ Moderately \_\_\_\_ Regularly

Intensity of Exercise: \_\_\_\_ Low Level \_\_\_\_ Medium Level \_\_\_\_ High Level \_\_\_\_ Competition Level

Sufficient Rest: \_\_\_\_ Never \_\_\_\_ Rarely \_\_\_\_ Occasionally \_\_\_\_ Moderately

Hours of Sleep: \_\_\_\_ 6 \_\_\_\_ 8 \_\_\_\_ 10 \_\_\_\_ More than 10

Well Balance diet: \_\_\_\_ Never \_\_\_\_ Rarely \_\_\_\_ Occasionally \_\_\_\_ Moderately

Do you smoke? \_\_\_\_ No \_\_\_\_ Occasionally \_\_\_\_ 1 to 2 \_\_\_\_ 2 to 3 \_\_\_\_ 4 to 5 \_\_\_\_ More than 5 Packs per day

Do you drink caffeinated beverages? \_\_\_\_ No \_\_\_\_ Occasionally \_\_\_\_ 1-2 \_\_\_\_ 2-3 \_\_\_\_ 3-4 \_\_\_\_ more than 5

Do you drink alcoholic beverages? \_\_\_\_ No \_\_\_\_ Occasionally \_\_\_\_ 1-2 \_\_\_\_ 2-3 \_\_\_\_ 3-4 \_\_\_\_ more than 5

Have you or a member of your family ever had: Please explain

Cancer \_\_\_\_\_ who \_\_\_\_\_

Stroke \_\_\_\_\_ who \_\_\_\_\_

Thyroid Problems \_\_\_\_\_ who \_\_\_\_\_

Asthma \_\_\_\_\_ who \_\_\_\_\_

Heart Attack \_\_\_\_\_ who \_\_\_\_\_

HIV \_\_\_\_\_ who \_\_\_\_\_

Angina/Chest Pain \_\_\_\_\_ who \_\_\_\_\_

Diabetes \_\_\_\_\_ who \_\_\_\_\_

Arthritis \_\_\_\_\_ who \_\_\_\_\_

Other \_\_\_\_\_ who \_\_\_\_\_

Back / Neck problems \_\_\_\_\_ who \_\_\_\_\_

Notes / Comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Women Only:**

To the best of my knowledge I am / am NOT (circle one) pregnant. If I am pregnant, I understand no x-rays will be taken for diagnostic interpretation.

Patient Signature \_\_\_\_\_

Doctor Signature \_\_\_\_\_