Howell Chiropractic, Inc.
1311 E. Stroop Rd. Kettering OH 45429
_(937)558-2824 (p) ~ (937)558-5679 (f)_

Welcome Sheet

Confidential Patient Information

Today's Date: _____

Patient Name: _____ Chief Complaint: _____

Address: _____ Home Phone: _____

City/State: _____ Zip:_____ Cell Phone: _____

SS#: _____ Email: _____

Date of Birth: _____ Age:_____ Marital Status: M S W D

Occupation: _____ Employer: _____

How were your referred to our office?: _____

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?): **Yes or No**

Ins. Company: _____ Ins. Phone #: _____

ID#: _____ Group #: _____

Name of Policy Holder: _____ Policy Holder DOB: _____

Policy Holder Employer: _____

Primary Care Physician: _____
(Note: May we send your health information to this provider? **Y or N**)

Person to contact in case of emergency (Name and Phone): _____

Have you ever been under Chiropractic Care? **Y or N** If so, Who? _____

Do you have a pace maker? **Y or N** Have you ever had any Hip or Knee Replacements? **Y or N** Are you pregnant? **Y or N**

What is your goal in our office? _____

Who is your mobile phone carrier for text reminders? _____

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 **Howell Chiropractic, 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.

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.

X_____ _____
Signature of Insured / Guardian Date

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HEALTH HISTORY

Patient Name: _____
Today's Date: _____

Name & address of other physician(s) who have treated you for your condition _____
_____

Date of last: Physical Exam _____ Blood Test _____ Urine Test _____ Physical Therapy_____

AIDS/HIV	Yes __ No __	Emphysema	Yes __ No __	Miscarriage	Yes __ No __	Scarlet Fever	Yes __ No __
Alcoholism	Yes __ No __	Epilepsy	Yes __ No __	Mononucleosis	Yes __ No __	Stroke	Yes __ No __
Allergy Shots	Yes __ No __	Fractures	Yes __ No __	Multiple Sclerosis	Yes __ No __	Suicide Attempt	Yes __ No __
Anemia	Yes __ No __	Glaucoma	Yes __ No __	Mumps	Yes __ No __	Thyroid Problems	Yes __ No __
Anorexia	Yes __ No __	Goiter	Yes __ No __	Osteoporosis	Yes __ No __	Tonsillitis	Yes __ No __
Appendicitis	Yes __ No __	Gonorrhea	Yes __ No __	Pacemaker	Yes __ No __	Tuberculosis	Yes __ No __
Arthritis	Yes __ No __	Gout	Yes __ No __	Parkinson's disease	Yes __ No __	Tumors, Growths	Yes __ No __
Asthma	Yes __ No __	Heart Disease	Yes __ No __	Pinched Nerve	Yes __ No __	Typhoid Fever	Yes __ No __
Bleeding Disorders	Yes __ No __	Hepatitis	Yes __ No __	Pneumonia	Yes __ No __	Ulcers	Yes __ No __
Breast Lump	Yes __ No __	Hernia	Yes __ No __	Polio	Yes __ No __	Vaginal Infections	Yes __ No __
Bronchitis	Yes __ No __	Herniated Disk	Yes __ No __	Prostate Problem	Yes __ No __	Venereal Disease	Yes __ No __
Bulimia	Yes __ No __	Herpes	Yes __ No __	Prosthesis	Yes __ No __	Whooping Cough	Yes __ No __
Cancer	Yes __ No __	High Cholesterol	Yes __ No __	Psychiatric Care	Yes __ No __	Other_____	
Cataracts	Yes __ No __	Kidney Disease	Yes __ No __	Rheumatoid Arthritis	Yes __ No __	_____	
Chemical Dependency	Yes __ No __	Liver Disease	Yes __ No __	Rheumatic Fever	Yes __ No __	_____	
Chicken Pox	Yes __ No __	Measles	Yes __ No __				
Diabetes	Yes __ No __	Migraine Headaches	Yes __ No __				

Are you Pregnant? **Yes** or **No** Due Date? _____

Have you had any **Spinal X-Rays/ MRI's/ CT's** taken in the last year? **Yes** or **No** If yes, Where? _____

Have you had any of the following? If so, please describe.

Falls	_____	Date: _____
Head Injuries	_____	Date: _____
Broken Bones	_____	Date: _____
Dislocations	_____	Date: _____
Surgeries	_____	Date: _____

EXERCISE
□ None
□ Moderate
□ Daily
□ Heavy

WORK ACTIVITY
□ Sitting
□ Standing
□ Light Labor
□ Heavy Labor

HABITS
□ Smoking Packs/Day _____
□ Alcohol Drinks/Week _____
□ Caffeine drinks Cups/Day _____
□ High Stress Level Reason _____

MEDICATIONS
_____
_____
_____

ALLERGIES
_____
_____
_____

VITAMINS/HERBS/MINERALS
_____
_____
_____

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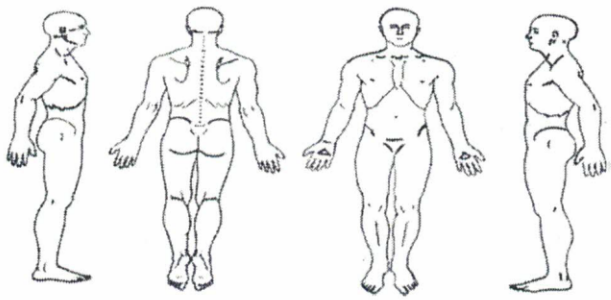
CASE HISTORY

Name: _____

1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% 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

(Please mark the figures where you experience pain.)



2. Symptoms are worse in the (circle what applies)

-Morning -Increase during the day
-Afternoon -Same all day
-Night -Decrease during the day

3. Symptom (a.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
4. Symptom (b.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
5. When did your symptoms begin (onset date)? _____
6. How did your symptoms begin? _____
7. Have you experienced these before? _____
8. Do your symptoms radiate? _____
9. Has your condition? ____ Improved ____ Gotten Worse ____ Stayed the same since it began
10. Circle the things that make your problems worse:

Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping

11. Is there anything you can do to relieve the problems? ____No ____Yes Describe: _____
    If No, what have you tried that has not helped? _____
12. Have you been treated for this before? ____No ____Yes How long ago? _____
13. What treatment did you receive? _____
14. Results of previous treatment? ____Good ____Poor Comments _____
15. Were you referred to our office by anyone? _____
16. Is this condition interfering with ____ Work ____Sleep ____Daily Routine ____Recreation
17. List any other major injuries you have had, other than those mentioned above: _____

_____

18. Any other Musculoskeletal problems? ____No ____Yes …Neurological problems? ____No ____ Yes
19. Any additional information, in addition to the above listed problems, may be listed on the back side of this sheet.

I certify that the above information is accurate to the best of my knowledge.

Patient/Guardian Signature _____ Date: _____

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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 the information below and if you have any questions please feel free to ask one of our staff members.

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 **Howell Chiropractic, 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.

Women Only:

To the best of my knowledge I **am / am NOT** pregnant and (**give my permission / don't give permission**) to x-ray me for diagnostic interpretation.
(Circle one above) *(Circle one above)*

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. For future visits I authorize my minor child to receive treatment without my presence if needed.

Communications:

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

Spouse: _____

Children: _____

Others: _____

No one: _____

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

Acknowledgement

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. Upon request I will be given a copy.

Print Name: _____

Signature: _____ Date: _____

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OFFICE POLICY

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best professional care. Your clear understanding of our Office Policy is important to our relationship. The following is a statement of our Financial Policy, which we require that you read and sign prior to any treatment:

- **All patients are required to bring their health insurance card to each visit in order to be seen for treatment that day.**
- **All patients must have all necessary paperwork completed before seeing the doctor.**
- **A parent or legal guardian must accompany a minor patient for the initial exam/treatment visit.**
- **We accept Cash, Check, Money Orders, Visa, Master Card and Discover.**

***Insurance**

- Once we are given correct policyholder's personal information, including name, birth date, and social security number, as a courtesy we will file health insurance claims for you at no charge. If such personal information is not given we will not be able to file any claims and account will be set at a self-pay and payment will be collected at the time of service. However, we must ask you to be responsible for tracking claims for timely payment. We will also expect you to **know your maximums, exclusions and policy limitations, prior to treatment.** We cannot accept responsibility of knowing all details about your personal policy. Any amount not paid by your insurance is your responsibility regardless of any estimation of benefits made by our office.
- Your insurance policy is a contract between you and your insurance company. We are not a party to the contract. **If your insurance has not paid a claim within 60 days, the balance of the claim will automatically transfer to you.**
- Please be aware that some, and perhaps all, of the services provided may be a "non-covered" benefit and/or not considered reasonable and customary under the Medicaid and/or Medicare Programs or any other health insurances.

***Accounts**

- Our office does not get involved with third party billing. **The legal guardian that brings a child in for a visit is responsible for the payment in full that day.**
- Returned checks are subject to a $40.00 service fee and then will become a cash only account after that point.
- Past due balances may be subject to additional collection fees and interest will also apply each month an account goes unpaid.
- Should you allow your account to become delinquent and placed with a collection agency, you will be responsible for all Collections or a Bankruptcy Chapter is filed for account balance, we will inactivate your account with our office and will no longer continue to see family members.

All Accounts must be current to enable scheduling without delays.

***Late arrivals/ Missed Appointments**

- A 48-hour notice is appreciated for any changes in appointments with us. A 24-hour notice is required if you need to change your appointment date and/or time to avoid a **$45.00** charge per appointment that is scheduled. You may call and leave a message at our office 24 hours a day.
- Once there is a record of 3 missed appointments on your account, the entire account will be made inactive, and services will no longer be rendered here for all patients on your account.
- Patients are asked to arrive prior to appointment time. This will allow for ease with the check-in process. Late arrivals, after appointment time, may be asked to reschedule.

****Please help us serve you better by keeping scheduled appointments****

Thank you for understanding our Office Policy. Please let us know if you have any questions or concerns.
"I understand and agree that regardless of my insurance status or state coverage, I am ultimately responsible for the balance on my account."

Patient Name (PRINT): _____

Signature Insured/ Guardian: _____ Date _____