Creekside Chiropractic Center

PATIENT INFORMATION

Last Name:		**First:**			**Middle:**
Marital Status (Please circle one):	**Single**	**Married**	**Divorced**	**Widowed**	**Birth Date:**	**Sex: M F**
Social Security No:		**Home Phone:**			**Cell Phone:**
Street Address:					
City:			**State:**		**Zip Code:**
Patient's Email Address: (email address is for office use only)					

Family Physician: _____

Location: _____ _____

Permission to contact Y or N

ACCIDENT INFORMATION

Is this condition due to an accident Y N Date: _____

Type of Accident ☐ Auto ☐ Home ☐ Work ☐ Other

To whom have you made the report of incident?_____

Occupation:		**Employer:**		**Employer Phone:**
(Please circle work status):	**Full-Time**	**Part- Time**	**Full-Time Student**	**Part-Time Student**	**Not Employed**

Whom may we thank for referring you to us? _____ **Family/Friend** ☐ **Attorney** ☐ **Doctor** ☐

Insurance Provider Book/Web ☐ **Activator Website** ☐ **Small Yellow Pages (Gahanna)** ☐ **Other** ☐

INSURANCE INFORMATION

Name of Insured:	**Birth Date of Insured:**	**Is this person a patient here? Yes No**
Name of Insurance:	**Subscriber's Social Security No:**	**Subscribers Birth Date :**
Patient's relationship to subscriber:	**Self Spouse Child Other**	

Our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPPA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information release to family embers you must sign below. Signing this form will only give information to family members indicated below. I authorize Creekside Chiropractic Center, LLC to release my medical and/or billing information to the following individuals.

1. _____ **Relation to Patient:** _____
2. _____ **Relation to Patient:** _____
3. _____ **Relation to Patient:** _____

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	**Relationship to patient:**	**Home Phone:**	**Work Phone:**

Authorization and Release: I authorize payment of insurance benefits directly to Jodi L. Cooley, DC, Michael A. Fisher, DC or to Creekside Chiropractic Center LLC. I authorize the doctor to release all information necessary to communicate with personal physicians and other health care providers and payors to secure the payment of benefits. I understand that I am responsible for all cost 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, and 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%.

I understand and agree to allow Creekside Chiropractic Center LLC to use my protected patient health information for the purpose of treatment, payment, health care operations, and coordination of care. If you would like to review the complete notice of privacy practices before signing this form, it is avabilbe upon request at the front desk. If there is anyone you do not want to receive your medical records, please inform our office.

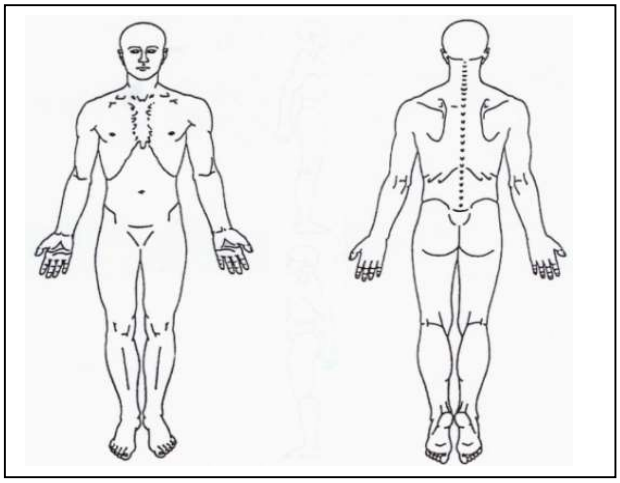
Patients or Authorized Person's Signature: The above information is true to the best of my knowledge. I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long-term authorization card. I authorize payment of medical benefits to Creekside Chiropractic Center LLC for services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing. I agree to pay for services not covered by insurance and understand that I am ultimately responsible for payment in full at this office.

Patient/Gardian Signature_____**Date**_____08/11/17 ked

Creekside Chiropractic Center Health History Questionnaire

Please Print Name: _____

1. Please **mark** where you are or have been experiencing pain:



No Pain Very Painful

2. **Circle** your pain intensity: 0---1---2---3---4---5---6---7---8---9---10

3. When did your symptoms start?_____

4. How did they occur? _____

_____

5. How often do you experience your discomfort?_____

_____

6. How would you describe your pain? **Please circle**: Sharp / Stabbing /Burning / Numbness / Tingling / Throbbing /Aching

7. What makes your pain worse?

_____

_____

8. What makes your pain better? _____

_____

9. Have you ever had chiropractic care? ☐ Yes ☐ No Last date of care? _____

10. List all current medications, including over the counter and nutritional supplements you are taking:

_____

_____

11. Have you had a major illness or have had surgery? Please explain:_____

_____

12. Please check items below that pertain to your health **(Check Past or Present) and (Circle all that apply)**

PAST / PRESENT			PAST / PRESENT		
		Smoking/Tobacco Use			Auto Immune Disorders
		Exercise			Respiratory Lung Disorders: (Bronchitis/Asthma/COPD)
		Weight Gain/Loss			Liver Disorders: (Hepatitis/Cirrhosis)
		Fatigue			Urinary Tract Disorders: (Kidney Stones / Chronic Urinary Tract Infection)
		Sleep Difficulties			Reproductive System Disorders
		Arthritis			(Gastrointestinal Disorders: Ulcer / Constipation / Diarrhea / IBS)
		Headache			Endocrine Disorders: (Thyroid / Diabetes / Other)
		Cancer			Please explain below:
		Allergies/Sinus			
		High Blood Pressure			
		Heart Disease			Other disorders not listed:
		High Cholesterol			
		HIV			

Patient Signature: _____ Date: _____

9/7/16 KED

Creekside
CHIROPRACTIC CENTER
Dr. Jodi L. Cooley
Dr. Michael A. Fisher
136 Mill Street, Suite 120
Gahanna, Ohio 43230
Phone 614-472-0992 / Fax 614-472-0994

www.creeksidechiropracticcenter.com

FINANCIAL POLICY

PLEASE READ & CHECK BY EACH BOX

☐ **Insurance;** If you have insurance, we will do our best to help you receive maximum benefits. Insurance is a contract between you and your insurance company. **We are not a party to this contract. As a courtesy,** we will verify your chiropractic benefits. However, the benefits quoted are an estimate and is not a guarantee of payment, upon receiving the explanation of benefits from your insurance**.**

☐ Through a third-party billing company, we will file insurance claims to your insurance carrier(s) if you have supplied us with all the necessary information. Our office will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than supply factual information as necessary. You are responsible for all services billed any services considered "not medically necessary" by your insurance company. We participate with most insurance companies; however, if we do not participate with your insurance company, you are responsible for all out of network deductibles and co pays at the time of service.

☐ **Cash Services - Time of Service (TOS):** We request that 100% of payment is made at the time of service. If your situation requires that you are a self pay patient (e.g. you are uninsured, chiropractic benefits have been exhausted or your co pay or out of network deductible is extremely high), please inquire with the front desk about our cash services policy.

☐ **Referrals / Pre-authorizations:** If your insurance requires a referral and/or pre-authorization for services, you are responsible for obtaining it. Failure to obtain a referral or pre-authorization may result in a denial of payment from your insurance company. You would be responsible for any unpaid balances.

☐ **You are ultimately responsible for knowing your insurance benefits.**

☐ **Medicare: We do accept assignment from Medicare. Medicare Part B only covers manipulation of the spine. Medicare pays 80% of the allowable fee after your deductible has been met.** Medicare will ONLY cover the chiropractic adjustment of the SPINE and for ACTIVE conditions only. **Medicare does not cover chiropractic adjustments for maintenance or additional modalities or therapies. Medicare supplemental policies will cover only those charges that Medicare also allows. You are responsible for your Medicare deductible and all coinsurance.**

☐ **Medicaid:** If you have Medicaid, most of your services, with the exception of supports/vitamins and supplies, will be covered 100% under you Medicaid plan. You will be required each MONTH to show proof of continued Medicaid coverage.

☐ **Workers Compensation/ Personal Injury**: If you are injured on the job, your care may be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of their insurance carrier. If your claim is not allowed, you will be responsible for all charges accrued during your care. Additionally, please let us know if you are currently working with an attorney.

☐ **Financial Hardship:** It is unlawful to routinely waive/fail to collect or discount co-payments, deductibles, coinsurance or other patient responsibility payments per the federal false claims act, federal anti-kickback statute, state and federal insurance fraud laws. It is also a violation of our managed care contracts. If you have a true financial hardship, please notify the front desk staff. You will need to provide appropriate documentation that shows you are unable to pay medical bills. All information relating to financial hardship requests will be kept confidential.

☐ **Payment Details:** All patients' balances are due immediately upon receipt. All dependents and spouses in the same household will be responsible for outstanding balances. Patients with upcoming appointments must pay their balance(s) in full prior to their next appointment.

By signing below, I agree that I have read and understand the Creekside Chiropractic Center, Inc., Financial Policy.

_____
Please Print

_____ _____
Please sign name for Patient &/or Guardian **Date**

1/11/17 KED

Creekside
CHIROPRACTIC CENTER
Dr. Jodi L. Cooley
Dr. Michael A. Fisher
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Gahanna, Ohio 43230
Phone 614-472-0992 / Fax 614-472-0994
www.creeksidechiropracticcenter.com

COMMUNICATION CONSENT

HOW WOULD YOU LIKE US TO COMMUNICATE WITH YOU?

Our Chiropractic office sends appointment reminders, information about treatment, payment, insurance and other communications. Please tell us how you would like to communicate with you.

Please Print Your Name: _____

Complete all that apply (please print clearly)

Please specify your Wireless Provider: _____

☐ Contact by text message at the following phone number: _____

☐ Contact me by email at the following e-mail address: _____

Signature: _____ Date: _____

Please inform us promptly if your address, email, or phone number changes!

☐ **We link patients in a household for statement purposes, to show credit and balance in the household. Please initial and sign if you authorize the transferring of credits from account (s) to another account(s) within a household.**

Signature: _____ Date: _____

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