Dr. Jodi Cooley
Dr. Michael Fisher
Dr. Michelle A. Rogers
960 N Hamilton Rd, Suite 104
Gahanna, Ohio 43230

PATIENT INTAKE

PATIENT INFORMATION

Patient Name: _____
Last Name

_____
First Name Middle Initial

Address: _____

City: _____ State: _____

Zip Code: _____ Cell Phone: _____

Work Phone: _____

Email address: _____

Sex: ◯ Male ◯ Female Date of Birth: _____

◯ Married ◯ Widowed ◯ Single ◯ Minor

◯ Separated ◯ Divorced ◯ Partnered

Employer/School: _____

Occupation: _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____

Relationship: _____

Contact Phone Number: _____

Primary Care Physician: _____

Office Name: _____

Have you had any x-ray/MRI's taken in the last year? _____

Whom may we thank for referring you? _____

INSURANCE INFORMATION

We will collect payment in full for services rendered on the first visit.

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Name of Insurance Company: _____ Policy/Member ID Number: _____

Relationship to Policy Holder: _____ Do you have an HRA/HSA/FSA? ☐ Yes ☐ No ☐ Not sure

OFFICE FINANCIAL POLICY

Thank you for choosing Creekside Chiropractic Center, Inc. to be part of your healthcare team. We are committed to providing the best possible care for you. Please take a moment to read and understand our financial policy.

Insurance-As a courtesy, our office will attempt to verify chiropractic benefits covered by your insurance policy. The benefits quoted to us are not a guarantee of payment. We bill services promptly to the insurance company on your behalf and will collect any co-pay, co-insurance or deductible due at the time of service.

As with any medical provider, our relationship is with you, the patient, not the insurance company. We will assist you in providing necessary documentation for your insurance company when requested. Ultimately if your insurance deems a service to be "non-covered" or "not an eligible expense" you will be responsible for these services.

Cash Services - Time of Service (TOS) - If you are uninsured, underinsured, under preventative or maintenance care, we have out of pocket options available. Based on Federal and State insurance laws, it is unlawful to waive or fail to collect co-payments, deductibles or co-insurances. A good faith estimate is available upon request, as required by law.

Payment details: All patient balances are billed out on a monthly basis and are due upon receipt. Unpaid balances may result in appointment cancellation. We reserve the right to send outstanding balances to a collection agency.

Check return fee: Any bank service fees charged to Creekside Chiropractic Center, Inc. for checks returned for non-sufficient funds or a closed account will be passed on to you.

_____ _____
Print Name Date

_____
Sign

Communication

Informed Consent: By signing below, I am acknowledging that I have requested and consented to examination and treatment at Creekside Chiropractic Center, Inc. I understand that this includes chiropractic adjustments and/or physical therapy or soft tissue work. I understand that this will be performed by a Doctor of Chiropractic who will follow the laws for the State of Ohio as well as standards of care within the profession.

_____ _____

Print Name Date

_____

Sign

Communication: Would you like to designate a family member such as a spouse, parent or other family member to share medical and/or billing information with? Under HIPAA requirements, we are not allowed to give this information to anyone without your consent. If you wish to have your medical or billing information released to a family member, please fill out and sign below. If you do not wish to share this information, leave it blank.

By signing this form, I understand that I am giving Creekside Chiropractic Center, Inc. to release my medical and/or billing information to the following individual(s):

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

I understand that families are linked together for billing purposes. If I do not want to be linked to others in my household, I will discuss with the office staff. (please initial)

Texts and Emails: Your consent is needed for the use of e-mail/text for communication purposes. This includes appointment reminders, billing, office news, birthdays and other general communication. You are able to "opt in" and "opt out" at any time.

If you choose to "opt in" Creekside Chiropractic Center, Inc. will

-read and respond during open business hours. The response may not be immediate, so it is recommended that e-mail and text not be used for time sensitive communication such as a medical emergency.

-save all communications that are medical in nature into your confidential patient file (electronic medical records).

-forward the communication to the necessary staff member for completion of requests.

The patient will:

-not use text/email for time sensitive communications, nor in the case of a medical emergency

-inform Creekside Chiropractic Center immediately if there is a change in consent for "opt-in and opt out" of these services

-inform Creekside Chiropractic Center if there are changes in cell phone number or e-mail address

-follow up by phone if a response has not been received in a timely fashion (during normal business hours).

Please check the boxes for communication type that best fits your needs:

☐ I do NOT wish to communicate with Creekside Chiropractic Center via e-mails or text. By checking this box, I will no longer receive appointment reminders by text or e-mail. All communication will be via phone call or US mail.

or

I would like to receive communications via e-mail or text as follows:

☐ Appointment reminders

☐ Billing (electronic statements, receipts, links to web-pay)

☐ General (birthday greetings, office updates (ex, weather delays/closures), office news (we won't fill your in-box!)

Patient Acknowledgment and Agreement:

I acknowledge that I have read and understand the e-mail and text policy of Creekside Chiropractic Center, Inc. and that if questions arise about communicating via text and/or e-mail, I will address it with the staff. I also understand that I may reach out to the Privacy Officer of Creekside Chiropractic Center, Inc. for questions or concerns or further clarification.

_____ _____

Print Name Date

_____

Sign

For Office Use:

Received by: _____ Input: _____ Scanned: _____ Date:_____ Dr Initials: _____

Name:_____ Date:_____

Creekside Chiropractic Center, Inc **Health History Questionnaire**

What brings you in today? _____

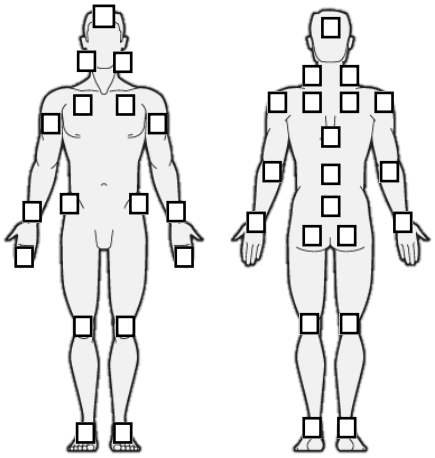
_____

_____

Have you been to a Chiropractor before? ☐ Yes ☐ No

Describe your pain:

☐ 0 No Pain ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Intense Pain



Describe your symptoms: (check all that apply) ☐ Throbbing/Burning ☐ Stiffness ☐ Sharp/ Stabbing/Shooting ☐ Swelling ☐ Numbness/Tingling ☐ Dull/ Aching

Daily Limitations: (check all that apply) ☐ Sitting ☐ Standing ☐ Walking ☐ Sleeping ☐ Bending ☐ Exercise ☐ Other: _____

When did your symptoms start? _____

How did they occur? _____

How often do you experience your discomfort? _____

What makes your pain worse? _____

What makes your pain better? _____

Please list any surgeries/hospitalizations you have had: _____

_____

MEDICATIONS, SUPPLEMENTS & ALLERGIES (Please attach separate list or provide list at first appointment if extensive. Put N/A if not applicable)

Medications/Supplements (list)	Medication/Supplements (list)	Allergies (list)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

HEALTH & ILLNESS HISTORY

☐ Cancer
☐ COPD/Lung
☐ Surgeries
☐ Heart Disease
☐ High Blood Pressure
☐ High Cholesterol
☐ Auto Immune Disorders
☐ Anxiety
☐ Depression
☐ Addiction
☐ Gastrointestinal Disorders
☐ Endocrine Disorders
☐ Reproductive System Disorders
☐ Arthritis
☐ Osteoporosis
☐ Allergies/ Sinus
☐ Ringing in Ears
☐ Blood Vessel Disease
☐ Diabetes
☐ TMJ
☐ Headaches/ Migraines
☐ Vertigo/ Dizziness
☐ Other

Exercise
☐ None ☐ Moderate ☐ Daily

Work Activity
☐ Sitting ☐ Standing ☐ Active

Habits
☐ Smoking/Vaping/Nicotine
☐ Alcohol

_____ Sign

_____ Date

Creekside Chiropractic Center

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Phone 614-472-0992 / Fax 614-472-0994
www.creeksidechiropracticcenter.com

CONSENT TO TREAT MINOR(S)

Consent to Treat Minor(s)

I hereby authorize Dr. Jodi Cooley/Dr. Michael Fisher/Dr. Michelle Adkins of Creekside Chiropractic Center Inc., or whoever is designated as assistants to administer treatment as the doctor deems necessary to my minor(s)

son/daughter, _____

son/daughter, _____

son/daughter, _____

son/daughter, _____

I ☐ **do** or ☐ **do not** authorize my minor child to schedule and come to appointments without a parent or guardian. I understand if I authorize this, they may incur charges that I will be billed for.

Parent/Guardian: _____
PLEASE PRINT

Parent/Guardian: _____
PLEASE SIGN

For those occasions when you may not be with your child, please list those individuals who may give us consent to see your child:

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

Date: _____

Thank you for your trust in our office.