Creekside Chiropractic Center

Dr. Jodi Cooley
Dr. Michael Fisher
Dr. Michelle Adkins
136 Mill Street, Suite 120
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? Yes

Whom may we thank for referring you? _____

INSURANCE INFORMATION

We will be happy to verify your insurance benefits and find out if you have any chiropractic coverage. However, we do 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

Insurance-As a courtesy to you, our office will attempt to pre-verify your primary insurance coverage for your Chiropractic care. Coverage information is obtained from your insurance company using information provided by you prior to your initial visit. We must emphasize that as medical providers, our relationship is with you, not the insurance company. Please be advised that the information provided by your insurance company is not a guarantee of payment, only an estimate of what might be covered under your policy at the time of inquiry. 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. You are responsible for all services billed and 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-payments 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.

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.

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.

Communication

Our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA, 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 members you must sign below. Signing this form will only give information to family members indicated below. By signing this, I understand that I give authorization to Creekside Chiropractic Center, Inc to release my medical and/or billing information to the following individuals. If I do not wish to release this information, I will leave it blank.

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

Patients must consent to the use of e-mail/text for patient communication. You may opt in (with signed consent form) or opt out (with written withdraw) of this service at any time. Consent to the use of e-mail/text includes agreement with the following conditions:

Creekside Chiropractic:

- will attempt to read and respond promptly to e-mail/text correspondence from patients. We cannot guarantee that e-mail/text messages will be read and responded to in a timely fashion. Therefore, it is recommended that this is not used for medical emergencies or other time-sensitive matters.
- will save all e-mails/text correspondence that is medical in nature as part of the patient's medical record. Because it is medical information, any individual authorized to access the medical record, such as staff and billing personnel, will have access to those e-mails/texts.
- may forward e-mails internally to office staff as necessary for diagnosis, treatment, reimbursement, and other handling. Creekside Chiropractic Center, Inc. will not, however, forward e-mail or share your information to independent third parties without the patient's prior written consent, except as authorized or required by law.
- Creekside Chiropractic Center, Inc. is not liable for breaches of confidentiality caused by the patient or any third party.

The patient:

- should not use e-mail/text for communication regarding sensitive medical information or for medical emergencies.
- is responsible for informing Creekside Chiropractic Center, Inc of any types of information the patient does not want to be sent by e-mail/text, in addition to those set out in the preceding paragraph.
- is responsible for protecting his/her password or other means of access to e-mail/text.
- must inform Creekside Chiropractic Center, Inc of changes in his/her e-mail address or text number.
- is responsible for following up with the office by phone or in person if e-mail/text requires a response from Creekside Chiropractic Center, Inc. and the patient has not received a response within a reasonable time period.

PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand the information Creekside Chiropractic Center, Inc has provided me regarding the risks of using e-mail and text messaging. I understand the risks and consent to the conditions outlined in this document. I agree to any other instructions that Creekside Chiropractic Center, Inc may impose regarding e-mail or text message communications. I agree that if I have any questions about this consent, or any other questions about text/email communication, I should contact Creekside Chiropractic Center, Inc.'s Privacy Officer at (614) 472-0992.

I would like to receive texts/emails for the following: (examples listed are not a full list of possible types of messages you may receive)

☐ Appointments (reminders, reschedules, etc.)

☐ Billing (emailed statements, receipts and link to web-pay)

☐ General (birthday greetings, office updates and news. No more than 2/month)

OR

☐ I do NOT wish to receive any text or emails from Creekside Chiropractic Center, Inc including text/email reminders. I understand that by checking this box, I will no longer receive appointment reminders if I currently receive them.

ACKNOWLEDGMENT AND CONSENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy on me (or on the patient named below, for whom I am legally responsible by the doctor of chiropractic who now or in the future work at this office, Creekside Chiropractic Center, Inc.

Also, by signing below, I have read and agree to the Office Financial Policy as well as the Communication Consent. I am aware that it is my responsibility to update any insurance, address or phone number changes to the office as quickly as possible. Changes in insurance that are not communicated with the office may result in full amount fees.

I understand that families are linked together for billing purposes and if I wish to not be linked with other members of my household, I am to make that change with the office staff.

_____ _____

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?_____

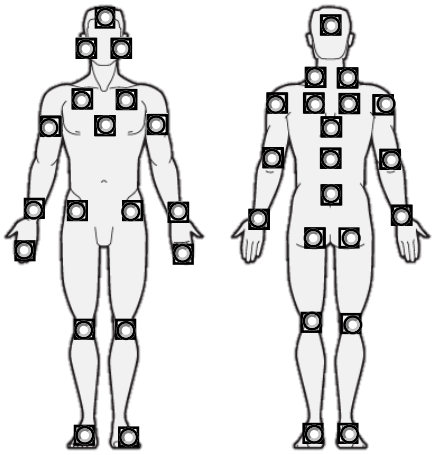
_____

Please list all areas of complaint_____

How intense are your symptoms? ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○

No Symptoms Intense Symptoms

Put an "X" on the picture where you have any issues, pain, numbness or tingling.



What does it feel like? (check all that apply)

- ☐ Numbness
- ☐ Tingling
- ☐ Stiffness
- ☐ Dull
- ☐ Aching
- ☐ Swelling
- ☐ Sharp/Stabbing
- ☐ Shooting
- ☐ Burning
- ☐ Throbbing
- ☐ Cramping
- ☐ Other_____

When did your symptoms start? _____

How did they occur?_____

How often do you experience your discomfort? _____

What makes the pain worse?_____

What makes the pain better?_____

Have you been to a chiropractor before? _____

Please list any surgeries/hospitalizations you have had _____

_____

MEDICATIONS, SUPPLEMENTS & ALLERGIES (Please attach separate list or provide list at first appointment if extensive)

Medications (list)	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
- ☐ Back Pain
- ☐ Elbow/Wrist/Hand Pain
- ☐ Foot/Ankle/Knee Pain
- ☐ Hip Pain
- ☐ Neck Pain
- ☐ Shoulder Pain
- ☐ TMJ
- ☐ Headaches/Migraines
- ☐ Vertigo/Dizziness
- ☐ Other_____

Exercise

☐ None ☐ Moderate ☐ Daily

Work Activity

☐ Sitting ☐ Standing ☐ Active

Habits

- ☐ Smoking/Vaping/Nicotine
- ☐ Alcohol

_____

Sign

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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.