WELCOME

MID OHIO CHIROPRACTIC & ACUPUNCTURE - Chiropractic Orthopedist Level

PATIENT INFORMATION

PATIENT _____ **DATE** _____

PO BOX, IF AVAILABLE: _____

ADDRESS _____
CITY **STATE** **ZIP**

SEX: ☐ **M** ☐ **F** ☐ **SINGLE** ☐ **MARRIED** **AGE**_____ **BIRTH DATE** _____

PATIENT SS# _____

OCCUPATION _____ **EMPLOYER** _____

EMPLOYER ADDRESS _____ **EMPLOYER** _____

**** IF PATIENT IS NOT INSURANCE POLICY HOLDER:**

POLICY HOLDER'S NAME _____ **POLICY HOLDER'S BIRTH DATE** _____

POLICY HOLDER'S S.S # _____ **POLICY HOLDER'S EMPLOYER** _____

MAY WE THANK FOR REFERRING YOU? _____

PATIENT CONTACT

CELL # _____ **HOME #** _____ **WORK #** _____

SPOUSE'S # _____ **Email:** _____

ALTERNATIVE ADDRESS _____

EMERGENCY CONTACT PERSON _____ **RELATIONSHIP** _____ **PHONE** _____

INSURANCE

ASSIGNMENT AND RELEASE

As a patient, I certify that I (or my dependent) have insurance coverage with _____ and assign directly to Mid-Ohio Chiropractic, Inc and Mid Ohio Chiropractic & Acupuncture, Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctors to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
RESPONSIBLE PARTY SIGNATURE **RELATIONSHIP** **DATE**

MEDICAL DOCTOR CONTACT

I request Mid Ohio Chiropractic to inform my medical doctor about my chiropractic diagnostic and treatment?
☐ **Yes or** ☐ **No**

If yes, MD is _____ **Phone** _____ **Address** _____
For the best interest of our patients, Mid Ohio Chiropractic prefers to have good communication with other health care providers. However, we will honor the wishes of the patients or other doctor's preference.

NON-COVERED SERVICES AGREEMENT

As a courtesy, our clinics bill your health insurance.

1. Under your health plan you are financially responsible for your co-payments, deductibles and co-insurance. By signing this form you are also agreeing to pay for all supplies, supplements, and orthotics. Any off shelf items that you obtain from this office will not be billed to your health insurance.

2. In some instances, your health plan may not cover office visits, therapy, x-rays, evaluations, acupuncture, orthotics, spinal decompression, casting for fracture, nerve conduction studies, extremity care, etc. You are responsible for the charges.

3. There will be an additional charge for after business hours care, Sundays, and holidays, or home-visits. The emergency charge will not be billed to insurance.

Due to hygiene and safety regulations, supplies or supplements can NOT be returned. It is the patient's responsibility to make sure that braces fit comfortably. By my signature, I agree to pay non-covered services and items.

SIGNATURE OF PATIENT OR PARENT / GUARDIAN: _____ DATE: _____

BILLING

Any outstanding balances are billed monthly and considered past due 10 days after the invoice date or when special arrangements are not met. Returned checks are subject to a $ 25 fee. We reserve the right to add interest charges of 1.5% per month on balances over 45 days, plus any late and legal fees. I agree to allow Mid Ohio Chiropractic, Inc. and Mid Ohio Chiropractic & Acupuncture, Inc. to bill my credit card that they have on file for any and all future that bills are more than 30 days past due.

The clinics can't guarantee and are not liable for any wrong information given by your insurance company.

SIGNATURE OF PATIENT OR PARENT / GUARDIAN: _____ DATE: _____

INFORMED CONSENT

Chiropractic adjustment, therapeutics modalities (ultrasound, heat, electrotherapy, infrared, decompression, traction and manual muscle therapy), and acupuncture are considered safe and effective method of care. While chances of complications are small, it is the practice of this clinic to inform our patients about them. These complications include but are not limited to: soreness, inflammation, soft tissue injury, dizziness, burns, worsening of symptoms. More serious complications are extremely rare and could include fracture if there is an underlying medical condition. If you have a condition that would otherwise not come to my attention it is your responsibility to inform the doctor.

Acupuncture complications include but are not limited to pain after insertion, stuck needle, and broken needle, pneumothorax or bleeding. Our office uses clean needle technique with sterile disposable needles. Other rare side effects could include heart, liver spleen or internal organ puncture, which may be from diseases such as cardiac disease, splenomegaly or hepatomogaly. Very rare organ injury could include brain, spinal cord or blood vessel injury.

For minor patients, parent or guardian hereby authorizes Mid-Ohio Chiropractic, Inc. and Mid Ohio Chiropractic & Acupuncture, Inc. to provide care in the future for their child without parent or guardian.

SIGNATURE OF PATIENT OR PARENT / GUARDIAN: _____ DATE: _____

NOTICE OF PRIVACY (HIPPA)

I, as a patient, received the Practice's Notice of Privacy and understand that my protected health information may be used by the practice as described in the notice. Upon my request, I will be given a copy.

SIGNATURE OF PATIENT OR PARENT / GUARDIAN: _____ DATE: _____