SWETLIC

Chiropractic & Physical Therapy

Welcome!...We are honored you have chosen us to evaluate your health. So we may better serve you, please fill out the personal information below. If you need assistance, please inform a front desk team member. Thank you!!!

First Name_____Middle_____Last_____

Address_____

City_____State_____Zip _____

Home Phone_____Cell Phone_____E mail_____

Social Security Number_____-_____-_____ Birth Date _____

Marital Status: Married:____Single____Widowed____Divorced_____Children _____

Employer_____Work Phone _____

Occupation _____

Spouse's Name_____Birthdate_____

Family Physician _____Phone_____

Name of Person on the insurance card_____Birth Date_____

Name of Employer_____City_____

Emergency Contact_____Phone Number_____

How did you hear about us____Facebook_____Website____News Paper____Signage____word of mouth

Who can we thank for your referral _____

SWETLIC
Chiropractic & Physical Therapy

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

Informed consent:

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed "and involves your understanding and agreement regarding the care we recommend the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion; reduce swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur 3-4 of every 10,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.
The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in on in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death have been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include but not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication tocare. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entirecourse of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Acknowledgement:

I have read and fully understand the above statements

Print Name: _____

Signature:_____Date:_____

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Financial Agreement

Please remember that insurance is considered a method of reimbursing the patient for fees put to the doctor and is NOT A SUBSITUTE FOR PAYMENT. Some companies pay fixed allowances procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLE AT TIME OF SERVICE.

If this account is assigned to an attorney / outside agency for collection and/or suit, Swetlic Chiropractic and Physical Therapy Center. Shall be entitled to reasonable attorney's fees and for cost of the collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

_____ _____

Patient Signature Insured's Signature

_____

Date

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 and covey directly to Swetlic Chiropractic and Physical Therapy Center. all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor or clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance 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 upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. 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 names 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 purse 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 and the original. I have read and fully understand this agreement.

_____ _____

Signature of Insured/Guardian Date

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Chiropractic & Physical Therapy

Cancellation Policy/No Show Policy

1. Cancellation/ No Show Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to Schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a Twenty dollar ($20) cash fee; this will not be covered by your insurance company.

2. Scheduled Appointments

We understand that delays can happen however, we must try to keep the other patients and doctors on time.

If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

3. Account balances

We will require that patients with self-pay balances do pay their account balances to zero (0) prior to receiving further services by our practice.
Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns.
Patients with balances over $100 must make payment arrangements prior to future appointments being made.

_____	_____	____/____/____
Printed name	Signature	Date

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PATIENT ACKNOWLEDGEMENT OF HIPAA NOTICE

Notice to Patient:
We are required to offer you a copy of our HIPAA notice, which states how we may use and/or disclose your health information. Our HIPAA notice and office policies contain information regarding payment, health insurance, collections and other important information.

OPTIONAL:

1) May we confirm your appointments by email, text or phone?	Yes	No
2) May we leave a message on your answering device at home or cell phone?	Yes	No
3) May we discuss your condition with any members of your family?	Yes	No
If yes, provide names: _____		
4) We utilize an open therapy room. We make good faith attempts to keep our conversations at a low level. We offer every patient the opportunity to be treated in a private room if requested. Are you comfortable being treated in an open room?	Yes	No

Patient Acknowledgement:
I acknowledge and agree to this office's HIPAA notice. I acknowledge that I have reviewed the HIPAA notice and have the right to obtain a paper copy of the HIPAA notice. I acknowledge that I may refuse to sign this acknowledgment if I wish.

_____ Patient Printed Name

_____ Patient Signature or legal representative

_____ Date

_____ If legal representative, state relationship

FOR OFFICE USE ONLY:
We have made every effort to obtain written acknowledgment of receipt of our HIPAA notice from this patient but it could not be obtained because:

___ the patient refused to sign
___ we were not able to communicate with the patient
___ due to an emergency situation it was not possible to obtain a signature
___ other (please provide details):

_____
Name of patient

_____
Name of staff member

_____
Signature of staff member

_____
Date

SWETLIC
Chiropractic & Physical Therapy

Authorization for Release of Records

1. I authorize the professional staff of_____to disclose the following patients' specified information to the professional staff of

Swetlic Chiropractic and Physical Therapy Center, Inc.
11301 Upper Gilchrist Road Suite A
Mount Vernon, Ohio 43050

Patient Name _____
Address _____
Date of Birth____/____/_____Phone number _____

2. Information to be released: O Please FAX (740) 392-0334 O Please mail hardcopy

___ Complete health record
___History and Physical Exam
___Progress Notes
___ Radiology Reports
___ Radiology Films
___Laboratory Reports
___ Other _____
____Discharge Summary
____MRI of _____
____Consultation Reports
____HIV Test Results
____Psychiatric Records
____Drug Screen, Blood, Alcohol

Dates of service_____to _____

I understand that if complete health record is checked all medical information will be released including psychiatric records, alcohol or drug screening and HIV test results.

I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

3. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken thereon. This authorization is good for 1 year unless dates filled in below

From_____To_____

Access to medical Information is the right of every patient; duplication and distribution is a service. Release are subject to copy and distribution cost. I understand the potentiality of charge for the service and release of medical information and accept financial responsibility.

_____ _____
Signature Date

_____
Printed Name

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Name_____Date_____Account_____

HISTORY OF ILLNESS/INJURY/PAIN

Chief Complaint and its location_____

_____

Is the condition that brought you here today due to an automobile accident or on the job injury? ___Yes ____no

How often do you experience this pain?_____100%_____75%_____50%_____25% of the time I have this pain.

What do you think may have caused this problem?_____

_____

When did your problem begin or when was the most recent occurrence_____/_____/_____

Over the past weeks/months this complaint is:_____Improving_____Getting Worse_____About the same

On a scale of 0 to 10 with 0 representing no pain and 10 being the most severe pain imaginable, use the key below to rate the severity of your pain

0=none *1*=Minimal 2= Very Mild *3*=Mild *4*=Mild to Moderate *5*=Moderate *6*=Moderate to severe
7=Mildly Severe, Restricts Some Activity *8*=Severe, Limits Most Activity *9*= Very Severe *10*= Excruciating

Sitting here today, right now, what is the intensity of your pain on a scale of 1-10 _____
What is the least intense the symptom has been on a scale of 1-10_____
What is the most intense the symptom has been on the scale of 1-10_____
If this pain radiates or travels, please identify where to:_____

_____

How would you best describe the sensation of the pain/symptom:

_____Dull_____Stiff_____Tight_____Stabbing_____Shooting_____Tingling_____Spasms
_____Annoying_____Sore_____Sharp_____Burning_____Pins & Needles_____Cramps_____Other

What aggravates the pain/symptom

___Sneezing____Lifting____ Exercising ___Looking up/down____Walking____Coughing
___ Sitting____Bending Forward____Looking side to side____Standing____Stress____Driving
___ Getting out of bed____Pushing____ Pulling____Dressing____Carrying____ Lying in Bed
___ Straining BM____Climbing Stairs____Getting in/out of car_____Sitting to Standing
___ Sitting_____ Minutes ___ Standing____Minutes

What relieves this pain/symptom

____Resting_____Sleeping_____Lifting_____Exercising_____Walking_____Shower
____Bending Forward_____Lying Down_____Lying with Knees bent_____Stretching
____Biofreeze/Icy Hot____Over the Counter Meds_____ Prescription Meds

Who have you seen in the past or currently for this problem? _____

When did you last see them?_____Is it helping?_____

Have you seen any other Chiropractors in the past?____yes ___No If so, who? _____

Is there a family history of back problems?_____yes ___No if yes, who? _____

Patient Signature _____

Doctor Signature_____

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Name_____ Date_____ Account_____

Please List Past Surgeries: (if joint surgery please list side and type)

1._____Year_____
2._____Year_____
3._____Year_____
4._____Year_____

List any other key slips, falls, or accidents you've had from childhood to present date

1._____Date_____
2._____Date_____
3._____Date_____

Please list all of your medications or Provide a list for our records.

1._____ 2._____ 3._____
4._____ 5._____ 6._____

Please check all that apply: Have you ever taken or currently take:

_____Insulin_____Cortisone_____Thyroid Medicine_____ Male/Female hormones_____Blood Pressure Medication
____ Tranquilizers/Sedatives_____Birth Control___Blood Thinners
Pacemaker_____yes_____no Pregnant_____yes_____no
Known Allergies:_____
Major Hospitalizations: _____
Frequency of Exercise:_____ Never_____Rarely_____ Occasionally_____ Moderately_____ Regularly
Intensity of Exercise:_____Low Level_____Medium Level_____High Level_____Competition Level
Sufficient Rest:_____ Never_____ Rarely_____ Occasionally_____Moderately
Hours of Sleep:_____6_____8_____10_____More than 10
Well Balance diet:_____ Never_____ Rarely_____Occasionally_____ Moderately
Do you smoke?_____No_____ Occasionally_____1 to2___2 to 3_____ 4 to 5_____More than 5 Packs per day
Do you drink caffeinated beverages?_____ No_____Occasionally_____1-2_____2- 3_____ 3- 4_____more than 5
Do you drink alcoholic beverages?_____ No_____Occasionally_____1-2_____ 2- 3_____3- 4_____more than 5
Have you or a member of your family ever had: Please explain
Cancer_____who_____
Stroke_____ who_____
Thyroid Problems_____who_____
Asthma_____ who_____
Heart Attack_____ who _____
HIV_____ who_____
Angina/Chest Pain_____ who_____
Diabetes_____ who_____
Arthritis_____ who_____
Other_____ who_____
Back / Neck problems_____who_____
Notes / Comments:
_____
_____
_____

Women Only:

To the best of my knowledge I am / am NOT (circle one) pregnant. If I am pregnant, I understand no x-rays will be taken for diagnostic interpretation.

Patient Signature _____

Doctor Signature_____