INTEGRATED health center LLC

LOUDONVILLE
419) 994-5222
226 E. Burwell Avenue
Loudonville, OH 44842

MT Vernon
(740) 830-6446
60 Parrot St
Mt Vernon, Oh 43050

Confidential Patient Information

First Name	M.I.	Last Name	Preferred Nickname, if any

Mailing Address	City	State	Zip Code

SSN	Marital Status	Primary reason for today's visit
	☐ M ☐ S ☐ W ☐ D	

Date of Birth

Race
☐ American Indian or Alaskan Native
☐ Black or African American
☐ Native Hawaiian or Pacific Islander
☐ Asian
☐ Other Race
☐ Prefer Not to Answer
☐ White

Ethnicity
☐ Hispanic
☐ Not Hispanic

Landline Number (including area code)

Cell Number (including area code)

May we mail you postcards or promotional material?
☐ Yes ☐ No

May we leave messages on voicemail or answering machine?
☐ Yes ☐ No

May we send appointment reminders via text messages?
☐ Yes ☐ No

Who is your cell phone *company*?_____

Email Address

May we contact you via email for:
☐ Appointments
☐ Requests to contact the office
☐ Newsletters

Emergency Contact Info

Name:_____

Phone Number:

Employer and Occupation:

Are your present symptoms or conditions related to – or the result of – an auto collision, a work-related injury, or other personal injury for which someone else will be responsible for payment? ☐ Yes ☐ No

Name of your primary care physician (PCP)

May we send your health information to your PCP?
☐ Yes ☐ No

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 healthcare benefits coverage with the above captioned, and hereby assign and convey directly to Integrated Health Center all medical benefits and/or insurance reimbursement (if any) otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or 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 information 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 of my insurance and/or employee healthcare 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 healthcare plan any claim, chose in action, or other right I may have to such insurance and/or employee healthcare benefits coverage under any applicable insurance policies and/or employee healthcare plan with respect to medical expenses incurred as a result of the medical services I received from the above named 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 pursue such claim, chose in action, or right against my insurers and/or employee healthcare plan, including (if necessary) bringing suit with such doctor and clinic against such insurers and/or employee healthcare 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 as the original. I have read and fully understand this agreement.

SIGNATURE OF PATIENT (OR GUARDIAN) _____ DATE _____

Continue to Page 2

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 that this document will clarify those issues for you. Please read the information below, and, if you have any questions, feel free to ask one of our staff members.

Informed Consent

A patient, in coming to the chiropractic physician, gives the doctor permission and authority to care for the patient in accordance with chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures - including physical therapy - are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures whether he/she is suffering from latent pathological defects, illnesses, or deformities that would otherwise not come to the attention of the chiropractic physician. The chiropractic physician provides a specialized, non-duplicating healthcare service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your healthcare regimen.

I understand that if I am accepted as a patient by a physician at Integrated Health Center I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved regarding chiropractic treatment will be explained to me upon my request.

Communication

Before we can discuss ***any*** of your healthcare information with another person, we must have your written permission. This includes, but is not limited to: billing issues, appointment information, and follow-up testing or instructions. Please tell us the name and relationship of individual(s) with whom we are authorized to communicate.

Name	Relationship
_____	☐ Spouse ☐ Child ☐ Parent/Guardian ☐ Other
_____	☐ Spouse ☐ Child ☐ Parent/Guardian ☐ Other
_____	☐ Spouse ☐ Child ☐ Parent/Guardian ☐ Other

Do not discuss my information with ***anyone***.

Applicable Fees

There is a possible $40 fee charged for all appointments that are not canceled *at least 3 hours* prior to scheduled visit.
There is a $35 fee for any check returned or not honored by your bank.

Acknowledgement

I have reviewed the notice of privacy practices (HIPPA) and have been provided an opportunity to discuss my right to privacy. Upon request, I will be given a copy of this document.

PRINT NAME _____ DATE _____

SIGNATURE _____

Consent to Evaluate and Treat a Minor

I _____, parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.