Essential Health and Wellness
1349 McNaughten Rd Columbus, OH 43232
(614) 864-3888 (p) ~ (614) 864-6668(f)

Date: _____

Confidential Patient Information

Patients Name: _____ Chief Complaint: _____

Address: _____ Home Phone: _____

City: _____ Zip: _____ Cell Phone: _____

SS#: _____ Email: _____

Date of Birth: _____ Marital Status: M S W D

Occupation: _____ Employer: _____

Address of Insured (if different than above): _____

Are your present systems or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) ___ Yes ___No

How did you hear of our office?

Ins. Company: _____ Ins. Phone #: _____

ID#: _____ Group #: _____

Name of Policy Holder: _____ Policy Holder DOB: _____

Policy Holders Employer: _____

Family Physician: _____ (Note: May we send your health information to this provider Y / N)

Person to contact in case of emergency (Name and Phone): _____

Have you ever been under Chiropractic Care? Y N If so, Who/When? _____

Have you had any SPINAL X-Rays / MRI's / CT's in the past? Y N If so, When/Where? _____

What surgeries have you had? _____ When? _____

Serious Illness: _____ When? _____

Infectious Diseases: _____ When? _____

Do you have a pace maker? Y / N Have you ever had any Hip or Knee Replacements Y / N

What medications or drugs are you taking? (check those that apply): Pain Killers ____ Insulin _____ Cholesterol Meds _____
Blood Pressure Meds ___ Muscle Relaxers ___ Birth Control ___ Other: _____

What is your goal in our office? _____

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 at clinic's request, and convey directly to Essential Health and Wellness 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 hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. 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 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 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 as the original. I have read and fully understand this agreement.

_____ _____
Signature of Insured / Guardian Date

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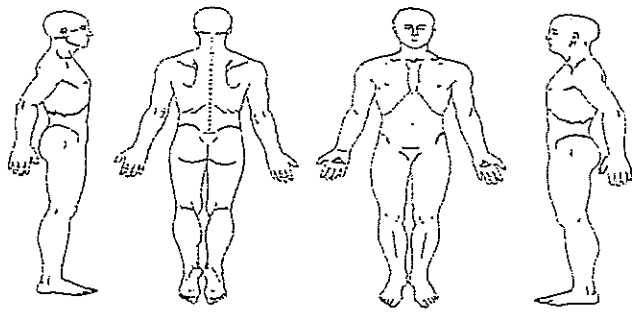
CASE HISTORY

Name: _____

1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain.

Condition / Problem	Severity (Minimal → Severe)	Frequency (% of week) (Occasional → Constant)
a. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
b. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
c. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
d. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
e. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

(Please mark the figures where you experience pain.)



2. Symptoms are worse in the:

-morning -Increase during the day
-during work -decrease during the day
-night -same all day

3. Symptom (a.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
4. Symptom (b.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
5. When did your symptoms begin (onset date)? _____
6. How did your symptoms begin? _____
7. Have you experienced these before? _____
8. Do your symptoms radiate? _____
9. Has your condition? ____ Improved ____ Gotten Worse ____ Stayed the same since it began
10. What increases your complaints? Bending - Lying down - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping - Other _____
11. Is there anything you can do to relieve/minimize the problems? __No __Yes Describe: _____
    If No, what have you tried that has not helped? _____
12. Have you been treated for this before? __No __Yes How long ago? _____
13. What treatment did you receive? _____
14. Results of previous treatment? __Good __Poor Comments: _____
15. Is this condition interfering with ____ Work ____Sleep ____Daily Routine ____Recreation _____Other
16. List any other major injuries you have had: _____
17. Any other Musculoskeletal problems? ____No ____Yes Neurological problems? ____No ____ Yes
    _____Additional information on back side of sheet.

I certify that the above information is accurate to the best of my knowledge.

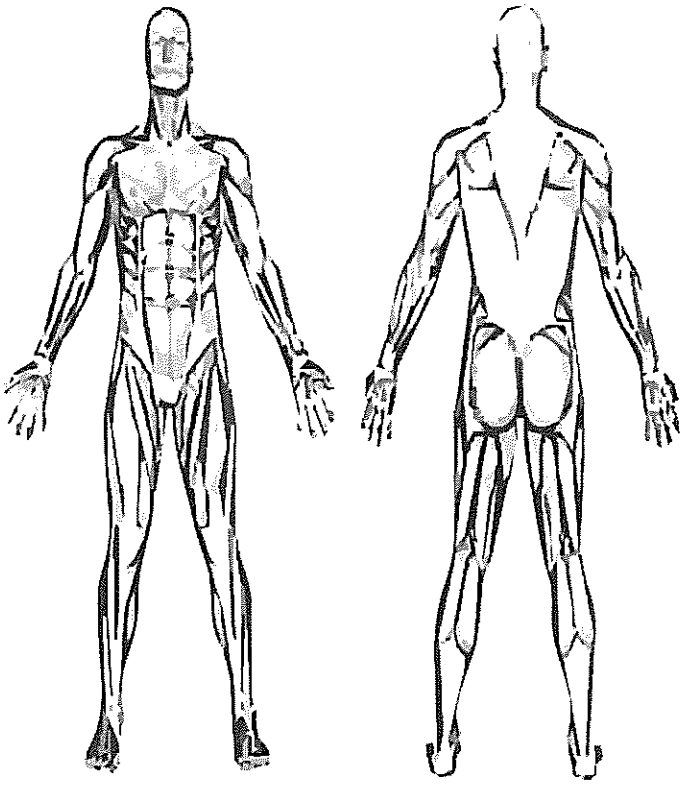
Patient/Guardian Signature _____ Date: _____

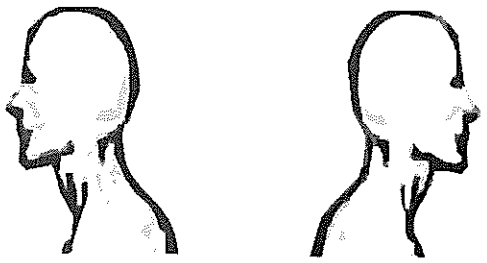
Have you ever suffered from:

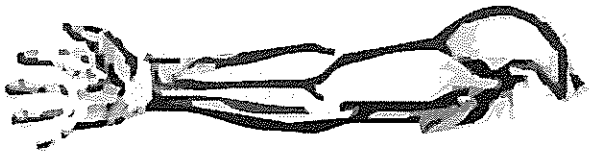
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chest Pain/Conditions
- ☐ Cold Extremities
- ☐ Constipation
- ☐ Cramps
- ☐ Depression
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Dizziness
- ☐ Ears Ring
- ☐ Excessive Menstruation
- ☐ Eye Pain or Difficulties
- ☐ Fatigue
- ☐ Frequent Urination
- ☐ Headache
- ☐ Hemorrhoids
- ☐ High Blood Pressure
- ☐ Hot Flashes
- ☐ Irregular Heart Beat
- ☐ Irregular Cycle
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Loss of memory
- ☐ Loss of balance
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Lumps In Breast
- ☐ Neck Pain or Stiffness
- ☐ Nervousness
- ☐ Nosebleeds
- ☐ Pacemaker
- ☐ Polio
- ☐ Poor Posture
- ☐ Prostate Trouble
- ☐ Sciatica
- ☐ Shortness of breath
- ☐ Sinus Infection
- ☐ Sleep problems or Insomnia
- ☐ Spinal Curvatures
- ☐ Stroke
- ☐ Swelling of ankles
- ☐ Swollen Joints
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Other: _____

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache **O**=Other
B=Burning **P**=Pins & Needles
N=Numbness **S**=Stabbing







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Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ Last Name:_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ Gender (Circle one): Male / Female Preferred Language: _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ I choose to decline receipt of my clinical summary after every visit *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Height: _____ Weight: _____ Blood Pressure: _____/_____

Patient Signature: _____

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

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures 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/she 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 what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at **Essential Health and Wellness**, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Women Only:

To the best of my knowledge I **am / am NOT** pregnant and **(give my permission / don't give permission)** to x-ray me for diagnostic interpretation.
(Circle one above) *(Circle one above)*

Consent to Evaluate and Treat a Minor:

I, _____ being the 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.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

No one: ____

May we leave messages regarding your personal healthcare information on any answering device, i.e. home answering machines or voicemails? Yes [ ] No [ ]

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____

Signature: _____ Date: _____

Essential Health & Wellness

Financial Policy

Insurance

If you have insurance, we will do our best to help you receive maximum benefits. Insurance is a contract between you and your insurance company. We are not party to this contract when possible, we will call your insurance company to verify your benefits. However, the benefits quoted to us by your insurance company are NOT a guarantee of payment. Through a third-party billing company, we will file insurance claims to your insurance carrier(s), if you have supplied us with all of the necessary information. 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., other than supply factual information as necessary. You are responsible for the terms listed above as well as 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 pocket network deductibles and copays. Per out office policy we do not bill any secondary insurance. We would be happy to provide you with statements to bill your secondary insurance. I understand that Essential Health & Wellness calls my health insurance company to receive a report of my benefits as a courtesy to me. **I understand that is it my responsibility to know and understand my own benefits and that my insurance company determines my policy benefits and that my charges will reflect this benefit.**

Referrals/Pre-Authorization

Is 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 lower or no payments from the insurance company. You would be responsible for any unpaid balances. You re ultimately responsible for knowing you insurance benefits.

Medicare

WE do accept assignments from Medicare. Medicare pay 80% of the allowable fee after your deductible has been met. **Medicare will cover chiropractic adjustment only for active conditions only.** Medicare does not cover chiropractic adjustments for maintenance or additional modalities or therapies. Medicare supplemental policies will cover only charges that Medicare allows. You are responsible for your Medicare deductable and all coinsurance

Cash Services

We request that 100% of payment is made at the time of service unless prior arrangements have been made. If your situation requires that you are a self pay patient (e.g. you have no insurance, your chiropractic health insurance benefits have been exhausted or your copay or out of network deductible is extremely high), please inquire with the front desk about our cash services policy.

Worker's Compensation

If you are injured on the job, your care may be under your employer's Worker Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of their insurance carrier. If your claim is not allowed, you will be responsible for all charges accrued during your care. Additionally, please let us know if you are working with a attorney.

Personal Injury

Please notify your auto insurance of your visit to our office immediately. Although you are ultimately responsible for any charges accrued during your care, we will wait for a settlement of our claim for up to 6 months after your care is completed. Once the claim is settled or if you suspend or terminate care all fee for services are due immediately. Additional, please let us know if you are currently working with an attorney. We do not accept any 3rd (third) party billing.

Financial Hardship

It is unlawful to routinely waive/fail to collect or discount co-payments, deductibles, coinsurance or other patient responsibility payments er 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 request will be kept confidential.

Return Check Policy

If your check is returned to Essential Health and Wellness for non-sufficient funds or other reasons, there will be a $25 fee.

Patient/Guardian Signature _____ **Date** _____