



Urban Chiropractic Spine & Sports Clinic

Patient Information & History

Date: _____

PATIENT INFORMATION

Name: _____
(First) (Initial) (Last)

Address: _____

Date of Birth: _____ Age: _____ Male ___ Female ___

Social Security # _____/_____/_____

Occupation: _____

Employer: _____

Parent Name (if a minor): _____

Status: ___ Single ___ Married ___ Divorced ___ Widowed ___ Separated

Spouse's Name: _____ # of Children: _____ Name(s): _____

ACCIDENT INFORMATION

Is your condition due to an accident? ___ Yes ___ No Date: _____

Type of accident? ___ Automobile ___ Work ___ Home ___ Other

To whom have you reported the accident?

___ Insurance ___ Worker's Comp ___ Employer ___ Other _____

Attorney Name (if applicable) _____

INSURANCE

Who is responsible for this account? _____

Relationship to patient _____

Insurance Company _____

Insurance ID number _____

Group / Claim number _____

Is patient covered by additional insurance? ___ Yes ___ No

Insurance Company _____

Subscriber # and Name _____

Birth Date _____ Group# _____

****Please present insurance card(s) & driver's license to copy for our file.**

CONTACT INFORMATION

Home Phone _____

Cell Phone _____

Work Phone _____ Ext _____

Best way to reach you: ___ Home ___ Cell ___ Work ___ Email

Email _____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Home Phone _____ Cell _____

PATIENT CONDITION(S)

What is your major symptom/problem? _____

When did your symptoms begin? _____

Have you had this problem before? _____

Is your condition getting progressively worse? ___ Yes ___ No

Is this problem: ___ Constant ___ Comes and goes

How does it feel? ___ Burning ___ Sharp ___ Shooting ___ Dull ___ Aching ___ Stiff

___ Tingling ___ Throbbing ___ Swelling ___ Other _____

Circle below the severity of your pain on a scale of 0 to 10:

(No pain) **0 1 2 3 4 5 6 7 8 9 10** (Severe Pain)

What makes your condition better? _____

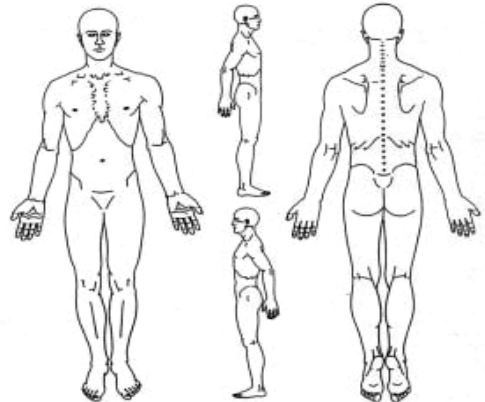
What makes your condition worse? _____

Does it interfere with your ___ Work ___ Sleep ___ Daily Routine ___ Recreation

Activities/movements that are painful to perform:

___ Sitting ___ Standing ___ Walking ___ Bending ___ Lying down ___ Driving ___ Reading ___ Getting Up

↓ Please mark where it hurts ↓



HEALTH HISTORY

What other treatments have you had for this condition?

Orthopedic Neurologist Physical Therapy Medication Surgery Chiropractic

Name of other doctors who have treated you for this condition _____

Describe the other doctor's treatment for your condition _____

Previous Chiropractic Care? Yes No Date: _____ Location _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ MRI _____

Spinal Exam _____ Dental X-Ray _____ CT-Scan _____

List any Medications you are taking _____

List Vitamins / Herbs / Minerals you are taking _____

Women: Are you Pregnant? Y N Due Date _____ 1st day of last menstrual cycle _____ Irregular Cycle? Y N

How many children do you have? _____ Date of last PAP? _____ Normal? Y N Last Mammogram? _____ Normal? Y N

Check any of the following conditions you have had:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Digestion Problems | <input type="checkbox"/> Intestinal Problems | <input type="checkbox"/> Poor Posture |
| <input type="checkbox"/> Alcoholism/ Drug Addiction | <input type="checkbox"/> Dizziness/ Fainting | <input type="checkbox"/> Irregular cycle | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diptheria | <input type="checkbox"/> Irregular Pulse | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Itching | <input type="checkbox"/> Rapid or Slow Heartbeat |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Dryness of Skin | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Rash Where: _____ |
| <input type="checkbox"/> Arm/Shoulder Pain | <input type="checkbox"/> Ear Discharge | <input type="checkbox"/> Joint Pain/ Swelling | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Ear Noise/ Ringing | <input type="checkbox"/> Kidney Problems/ Stones | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis/ Rheumatism | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Leg pain | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Asthma /Bronchitis | <input type="checkbox"/> Earache s | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Belching or Gas | <input type="checkbox"/> Ear Ringing | <input type="checkbox"/> Low back pain/Lumbago | <input type="checkbox"/> Sinus Infection |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Eczema | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Sore Throat |
| <input type="checkbox"/> Bloating Abdomen | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Malaria | <input type="checkbox"/> Spinal Curvature (Scoliosis) |
| <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Measles | <input type="checkbox"/> Stress Incontinence |
| <input type="checkbox"/> Bloody/ Tarry Stool | <input type="checkbox"/> Excessive Hunger | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Stomach Pain |
| <input type="checkbox"/> Boils | <input type="checkbox"/> Foot Trouble | <input type="checkbox"/> Migraines (with Aura?) | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Flu/ Common Cold | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Sweats |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Swelling/ Edema of: _____ |
| <input type="checkbox"/> Cancer: Type _____ | <input type="checkbox"/> Gallbladder Trouble | <input type="checkbox"/> Mumps | <input type="checkbox"/> Thyroid problem (Hyper/Hypo) |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Goiter | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Gout: Last Episode _____ | <input type="checkbox"/> Nasal Obstruction | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Gum Problems | <input type="checkbox"/> Nausea | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cholera | <input type="checkbox"/> Hardening of Arteries | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Neuralgia | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Pain/ Numbness in: _____ | <input type="checkbox"/> Venereal Disease: _____ |
| <input type="checkbox"/> Colitis/ Crohn's Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoporosis | Type: _____ |
| <input type="checkbox"/> Colon Trouble | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Vertigo/Dizziness |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Deafness | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Painful Defecation | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Dental Decay | <input type="checkbox"/> Hernia: Location _____ | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Weight Loss/ Gain |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Herniated Disk: Levels _____ | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Diabetes: Type _____ | <input type="checkbox"/> High Blood Pressure ___/___ | <input type="checkbox"/> Polio | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> High Cholesterol _____ | <input type="checkbox"/> Poor Appetite | |
| <input type="checkbox"/> Difficult Digestion | <input type="checkbox"/> Hives/ Allergies | | |

STRESSORS

Smoking Packs/Day _____
 Alcohol Drinks/Week _____
 Coffee/Caffeine Drinks Cups/Day _____
 High Stress Level Reason _____

EXERCISE

None _____
 Moderate _____
 Daily _____
 Heavy _____

INTENSITY

DURATION

Have you had any:

Description

Date

Automobile Accidents _____

Surgeries _____

Broken Bones _____

Falls/Head Injuries _____



Urban Chiropractic Spine & Sports Clinic

20102 Center Ridge Rd – Lower, Rocky River, OH 44116-3533

Phone: 440-895-9595 Fax: 440-895-9596

Notice of Privacy Practices

Keeping your medical records confidential – Urban Chiropractic: Spine & Sports Clinic is committed to providing you with high quality care and forming a relationship with you built on trust. That means respecting your privacy and the confidentiality of your medical information. We protect your privacy and confidentiality rights by creating and putting into practice specific policies and procedures that allow access to your personal medical information only for legitimate reasons.

Your medical record - As we provide your health care, we are required to maintain a complete copy of your medical history, current condition, treatment plan and all treatment given, including the results of all tests, procedures and therapies. Whether this information is stored in writing, on a computer, or other means, we will keep this information in a safe and secure way that protects your privacy and confidentiality. Of course, the physicians and other health care professionals who are involved in your care need to access this information in order to provide appropriate treatment for you.

Your medical information is private and confidential – You, or anyone to whom you give written permission, or your legal representatives, have the right to read or get a copy of your medical information. Your medical record is the physical property of Urban Chiropractic: Spine & Sports Clinic.

How we assure your privacy – Urban Chiropractic: Spine & Sports Clinic has put in place detailed policies regarding access to medical records by our staff and employees and has carefully outlined the circumstances under which your medical information may be released to parties outside of this facility. The policies conform to state and federal law and are designed to safeguard your privacy. Our staff and employees are trained in the appropriate use of medical information and know that it is available to them only to continue to provide care to you or for other limited but legitimate reasons. A violation of confidentiality or failure of an employee to protect your information from accidental or unauthorized access will not be tolerated.

We ask your permission – We do not allow others outside of Urban Chiropractic: Spine & Sports Clinic access to any information unless we have the appropriate authorization to do so. We will respect your authorization to release information on your first visit. In addition, some laws prevent certain types of patient information from being released without specific patient permission. Examples include, but are not limited to: *confidential details of: Psychotherapy (treatment by a psychiatrist, licensed psychologist or psychiatric clinical nurse specialist. *Other professional services of a licensed psychologist * Social Work Counseling/Therapy * Domestic Violence Victims Counseling * Sexual Assault Counseling * HIV Test Results * Records pertaining to sexually transmitted diseases * Alcohol and drug abuse records - Please note, however, that the law requires some information to be disclosed under certain circumstances. This includes mandatory reports of the abuse of children, elderly or disabled persons. Also, subpoenas or court orders may compel the disclosure of confidential or privileged health information in the context of a lawsuit or administrative proceeding. Medical records are sometimes used for reasons other than patient care. For example, records are periodically reviewed to evaluate the quality of care, or to be sure that Urban Chiropractic: Spine & Sports Clinic follows the rules of regulatory agencies for the efficient and effective utilization of care such as Medicare, Department of Public Health or Department of Mental Health. Your insurance company may request information that we are required to submit in order to provide and bill for your care. Anyone reviewing records must follow the same confidentiality laws and rules required of all health care providers. Patient records are valuable tools used by researchers in finding the best possible treatments for diseases and medical conditions. All researchers must follow the same rules and laws that other health care workers are required to follow to insure the privacy of patient information. Information that may identify you will not be released to anyone outside Urban Chiropractic: Spine & Sports Clinic without your written approval. Concern for your privacy and well being is our first priority. If you have any questions about the privacy of your medical records, please speak with us. We will be happy to assist you.

Patient Acknowledgement of Privacy Practices

Patient Name _____ DOB _____

I have received this practice’s Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights and the practice’s legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, to make changes regarding all protected health information controlled by this practice. I understand I may obtain a current Notice of Privacy Practices upon request.

Signature _____ Date _____

Relationship to patient (if signed by a personal representative of the patient). _____



Urban Chiropractic Spine & Sports Clinic

20102 Center Ridge Rd – Lower, Rocky River, OH 44116-3533
Phone: 440-895-9595 Fax: 440-895-9596

Financial Agreement Patient Initials: _____

All payments are collected before time of service. In the instance that a payment is not collected at time of service, a %15 late charge will be applied when paid. We accept cash, personal checks, Visa, MasterCard, Discover, American Express & Care Credit (New Patient 1st office visit/ Evaluation = \$45.00- \$145.00

- Active Release Technique/ Adjustment office visit = \$45.00-\$75.00.
- Decompression Package (Light Therapy, Decompression, Adjustment, Exercise) = \$2,125.00
*This package includes 15 office visits during the first month of treatment.
- 1-on-1 Exercise Training –1st visit includes Exam & Functional Exam = \$125.00
Each additional visit is 1-on-1 Personal Training for 50 minutes, followed by ART®/ Chiropractic Adjustment = \$100.00.
*Includes functional training, vibration plate performance, core stability, flexibility, ART® & adjustments.
- There will be a \$30.00 fee added to your balance for any returned checks

Health Insurance:

We accept certain insurance plans, and most insurance plans **DO** cover Chiropractic care. It is **YOUR** responsibility to give us the correct information about your present insurance company & follow the rules outlined by your insurance company. For example: referrals, deductibles, benefits, etc. As a courtesy, we will call your insurance company to verify your chiropractic coverage. This does NOT guarantee payment. We will collect any co-payment and/or deductible amounts quoted by your insurance at the time services are rendered. If there's any discrepancy when the claims are processed, you are responsible for any additional charges. *We advise you to contact your insurance company to verify benefits. If you are told different benefits, please advise our office ASAP.* We submit all claims for services rendered in our office which then bill's your insurance company. We feel the procedures performed in our office are medically necessary, yet some insurance companies, in an attempt to cut costs, will consider some services "non-covered" or "not medically necessary." Any denied services become **YOUR** responsibility. *Your insurance policy is an agreement between YOU & YOUR INSURANCE COMPANY, NOT BETWEEN YOUR INSURANCE COMPANY AND THIS OFFICE.* The amount paid varies from one policy to another.

Auto Accidents:

The patient **MUST** select which entity (personal health insurance, auto insurance "Med pay", at-fault party auto insurance) is responsible for reimbursement of services by conclusion of first visit. (Please ask the Doctor any questions during Consultation). A signed lien is a REQUIREMENT for treatment in this office. If you are dealing with an auto insurance company or involved in a lawsuit that affects the payment of the services rendered, please be advised that payment is due no later than 90 days of discharge from our office, whether or not your case has settled. It is **YOUR** responsibility to remain in contact with the at-fault party's auto insurance and/or your attorney.

Medicare Authorization:

I request that payment of authorized Medicare benefits be made directly to Urban Chiropractic: Spine & Sports Clinic, for any services furnished to me by Urban Chiropractic: Spine & Sports Clinic. I authorize any holder of medical information about me to release it to the Healthcare Financing Administration and its agent any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, Urban Chiropractic: Spine & Sports Clinic agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services.

Beneficiary Signature

Date

Worker's Compensation:

If you are injured on the job, your employer's worker's compensation insurance will pay for care that is APPROVED by the BWC. If your claim or treatment is denied, you are responsible for payment. You may be covered under your health insurance but any denied services become **YOUR** responsibility. **IMPORTANT:** Your injury must be reported to your employer **BEFORE** your first visit.



Urban Chiropractic Spine & Sports Clinic

20102 Center Ridge Rd – Lower, Rocky River, OH 44116-3533
Phone: 440-895-9595 Fax: 440-895-9596

Informed Consent to Chiropractic Treatment

Chiropractic treatment, including spinal adjustments, has been the subject of government reports and multi-disciplinary studies conducted over many years. It has been demonstrated to be an effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than those associated with many types of medical or other treatments, medications, and procedures performed for the same symptoms.

Doctors of Chiropractic who perform manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

- While rare, in some cases patients may experience short term aggravation of symptoms, rib fractures or muscles and ligament strains or sprains as a result of manual therapy techniques;
- There are reported cases of cerebral vascular accidents associated with many common neck movements. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently and estimated at one per million. However, you are being warned of this possible association because stroke sometimes causes serious neurological impairment, and may, on rare occasion, result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustments is extremely remote.
- There are rare reported cases of aggravation of existing disc conditions following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused by spinal adjustments or chiropractic treatment.

I acknowledge the if I have any questions regarding the nature and purpose of my chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the content of this consent I will ask my chiropractor in advance.

I consent to the chiropractic treatments offered or recommended to me by my chiropractor, including spinal adjustments; I intend this consent to apply to all of my present and future chiropractic care.

Dated this _____ day of _____, 20____

Patient Signature (or Legal Guardian)

Signature of Witness

Patient Name

Witness Name

Referral Information

Please let us know how you heard of our clinic and if we can thank someone for referring you here today: _____