Registration Information

Maxeiner Chiropractic and Muscle Therapy Clinic LLC

5791 Zarley St. New Albany, OH (614) 600-2225

Patient Information ---please print---

Patient _____ Date: _____
First Name Middle Initial Last Name

Birth date _____ Age____ Sex: ☐M ☐F

☐ Single ☐ Married ☐ Widowed ☐Separated ☐ Divorced Spouse's Name: _____

Race: ☐ White ☐ American Indian or Alaska Native ☐Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ Declined ☐Unknown/Unavailable

Ethnicity: ☐Not Hispanic or Latino ☐ Hispanic or Latino ☐Declined ☐Unknown/Unavailable

Primary Language: ☐English ☐Spanish ☐Other_____ ☐Declined

Address _____
Street City State Zip

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Preferred method of communication: ☐Home ☐Work ☐Cell ☐Email

Primary Care Physician: _____ City: _____

May we send your health information to this provider? Y / N

Occupation: _____ # of years ___ Employer Name: _____

Address _____
Street City State Zip

Employer Phone: _____ Best time to reach you: _____

Whom may we thank for referring you (where did you hear about us)? _____

IN CASE OF EMERGENCY, CONTACT

Name: _____ *Relationship:* _____

Home Phone: _____ *Work Phone:* _____ *Cell Phone:* _____

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Briefly describe your symptoms

_____

_____

How did your symptoms start?

_____

Average Pain Intensity(circle)

Last 24 hours: **no pain** 0 1 2 3 4 5 6 7 8 9 10 **worst pain**

Past week: **no pain** 0 1 2 3 4 5 6 7 8 9 10 **worst pain**

How often do you experience your symptoms?

☐ Constantly (76%-100% of the time) ☐ Frequently (51%-75% of the time) ☐ Occasionally (26% - 50% of the time) ☐ Intermittently (0%-25%)

How much have your symptoms interfered with your daily activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

In general, would you say your overall health right now is…

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

When did you first have these or similar symptoms?

☐ Never ☐ less than 6 months ☐ 6 months-1year ☐ over 1 year

Is your pain the result of a motor vehicle accident? ☐ No ☐ Yes => (rear, front, side) _____

Is your pain the result of a work related injury? ☐ No ☐ Yes

Have you filed a workman's compensation claim? ☐ No ☐ Yes

Have you been disabled from working during the past year? ☐ No ☐ Yes=>Date: From_____ to _____

Is your pain the result of a personal injury outside of work or a motor vehicle accident? ☐ No ☐ Yes

Have you filed a legal suit? ☐ No ☐ Yes=> Lawyer _____
Name Phone

List all prior injuries for which you received any medical or chiropractic evaluation or treatment. Include current condition.

1. _____

2. _____

List date and reason for any prior hospitalizations.

_____

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Have you had a problem with any of the following?

Yes	No		Explain
___	___	Eyes, Vision	_____
___	___	Ears, nose, throat	_____
___	___	Lungs, breathing	_____
___	___	Teeth/Mouth problems	_____
___	___	Digestion	_____
___	___	Difficulty swallowing	_____
___	___	Slurred speech	_____
___	___	Nausea	_____
___	___	Dizziness	_____
___	___	Bowel movement	_____
___	___	Bladder problem	_____
___	___	Diabetes	_____
___	___	High blood pressure	_____
___	___	Cardiovascular problems	_____
___	___	Painful calves	_____
___	___	Stroke	_____
___	___	Headaches	_____
___	___	Balance problems	_____
___	___	Blackouts/fainting	_____
___	___	Numbness/tingling	_____
___	___	Psychological problems	_____
___	___	AIDS	_____
___	___	Cancer	_____
___	___	Arthritis	_____
___	___	Other conditions not listed	_____
___	___	Alcohol	___ drinks/week
___	___	Smoking	___packs/day ____# of years ___ Never Smoked

Please list any allergies you are aware of: _____

Please list the medications you are currently taking.

Medication	Dose	Reason for medication

Please list any surgeries you have had.

Surgery	Year

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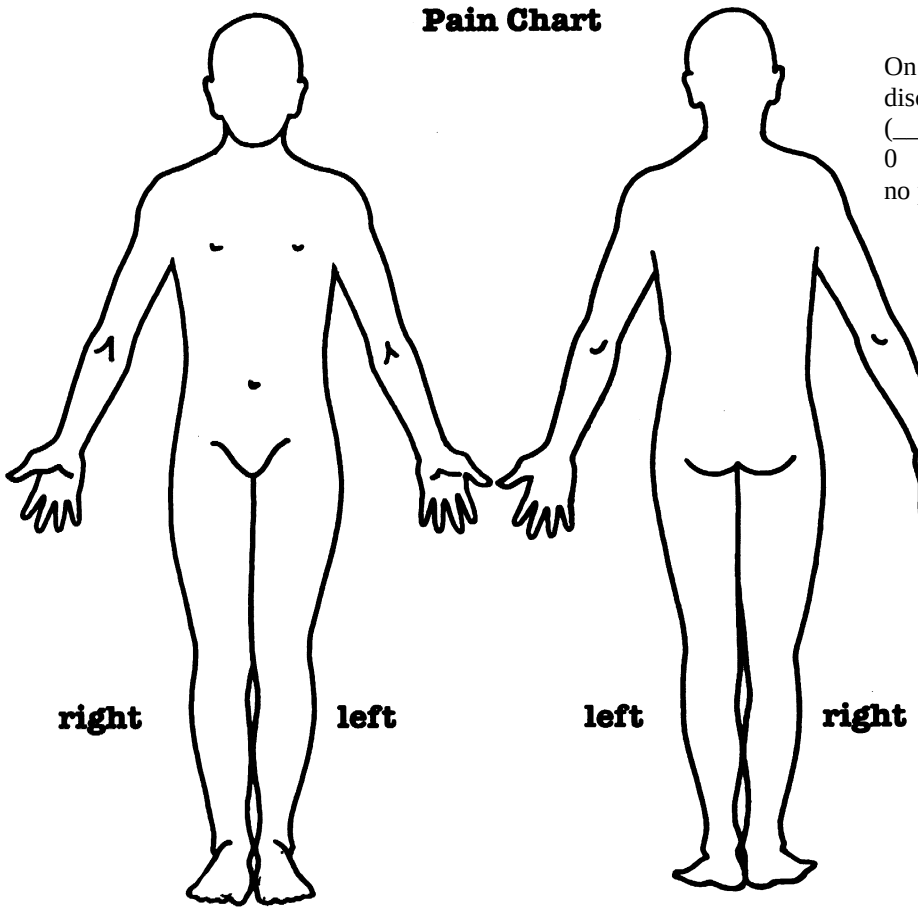
Area(s) of Pain

Please mark the areas of the body where you feel the described sensations.
Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

Numbness	Pins and Needles	Burning	Aching	Stabbing
----------	OOOOO	xxxxxx	******	///////////
----------	OOOOO	xxxxxx	******	///////////



Neck-Shoulder-Arm Pain
On a scale of zero to 10, I rate my discomfort as follows:
(_____)
0 10
no pain severe pain

Mid Back Pain
On a scale of zero to 10, I rate my discomfort as follows:
(_____)
0 10
no pain severe pain

Low Back and Leg Pain
On a scale of zero to 10, I rate my discomfort as follows:
(_____)
0 10
no pain severe pain

Date: _____ _____
Signature

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Consent to Professional Treatment

I certify that all information provided to this practice is true and correct, to the best of my knowledge. I hereby give consent to this practice and its health care providers, consultants, assistants, or designees to render care and treatment to me as they deem necessary. I recognize that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of evaluation and treatment. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. I acknowledge that I may refuse treatment at any time.

Initial ___

Assignment of Benefits and Release of Records

I hereby assign to this practice all of my medical and procedure benefits to which I am entitled, including major medical benefits. I hereby authorize and direct my insurance carrier(s), including Medicare and other government sponsored programs if applicable, private insurance and any other health plans to issue payment directly to this practice for medical services rendered. This assignment is irrevocable.

I hereby authorize this practice to release any medical or other information required by third party payors, including government agencies, insurance carriers, or any other entities necessary to determine insurance benefits or benefits payable for related services and supplies provided to me by the practice.

Initial ___

Financial Obligation

I hereby accept full financial responsibility for services rendered by this practice. I accept full responsibility for any fees incurred, regardless of insurance coverage. I understand that my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I further understand that I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. Should the account be referred to an attorney or collection agency for collection, I shall pay all fees, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. It is my responsibility to notify this practice of any changes in my health care coverage. You may direct any questions regarding this financial obligation to the clinic manager or physician.

Initial ___

Insurance or Self-Pay

This clinic participates with the following insurance providers. Please indicate your preferred method of paying for the services you receive.

☐ Self-Pay ☐ Aetna ☐ Humana ☐ Medical Mutual ☐ Medicare ☐ United Healthcare

Primary insured's name: _____ Date of Birth: _____

Group Number: _____ ID: _____

_____ _____

Signature Date

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Privacy Policy

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, the chiropractic physician has the right to refuse to give care.

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

_____

May we leave message regarding you personal healthcare information on an your answering machine or voice mail? ☐Yes ☐No

I have read and understand how my patient Health Information will be used and agree to these policies and procedures.

Name of Patient Date