INTEGRATED health center LLC
CHIROPRACTIC & SPORTS REHAB

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

DANVILLE (740) 599-7562
6 E. Ross Street
Danville, OH 43014

Confidential Patient Information

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

Address	City	State	Zip Code

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

Date of Birth	Race	Ethnicity
	☐ American Indian or Alaskan Native ☐ Asian ☐ White ☐ Black or African American ☐ Other Race ☐ Native Hawaiian or Pacific Islander ☐ Prefer Not to Answer	☐ Hispanic ☐ Not Hispanic

Land line 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 e-mail 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 _____

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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 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.

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Protecting Your Health Information

The Regulations

The Health Insurance Portability and Accountability Act (HIPAA) does three primary things:

1. It helps to standardize and simplify the way healthcare organizations exchange healthcare data;
2. It provides consumers with additional protections for getting and maintaining health insurance coverage. It does not, however, guarantee coverage; and
3. It creates new security rules to ensure the safety and privacy of individual and medical records.

Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal, and we are committed to protecting it. We create a record of the care and services you receive at our office. We need this record in order to provide you with quality care and to comply with certain legal requirements. In addition, we have a policy in effect that makes every attempt to maintain the confidentiality of all patients' information.

Disclosure of Medical Information

In addition to disclosing your medical information for treatment, payment, and healthcare operations, we may disclose medical information for the following purposes: court order, subpoena, discovery request, or other lawful process. We may disclose medical information to the appropriate authorities if we reasonably believe that you are a victim of abuse, neglect, domestic violence, or the possible victim of other crimes. We may disclose health information when authorized to comply with necessary laws relating to worker's compensation, automobile accidents, personal injury, or other similar issues.

If someone calls us or stops by our offices, they will not be given general information about your care and/or appointments unless otherwise specified and noted in your file.

We may use your first name and last initial if you win any promotional contest offered at any Integrated Health Center Chiropractic and Sports Rehabilitation location. Your information will not be sold to any outside agencies.

Your Rights

You have the right to review, or obtain copies of, your medical records and to receive a list of the times we have shared your medical informational for purposes other than treatment, payment, and healthcare operations. You may request that we do not disclose information to your health plan for any services that was paid entirely out-of-pocket (self-pay). We are required to notify you of any breach of your protected health information. You may also request a copy of The Notice of Privacy Practices at the front desk for a more complete description of how your protected health information may be used or disclosed. Other uses and disclosures not described in The Notice of Privacy Practices (revised date 06/19/2013) will be made only by authorization of the individual.

Open Treatment Concept

Because of the open treatment concept in this office, it is possible for doctor/patient discussions to be overheard by other patients. Most discussions will involve spinal health, but may also include anything concerning the primary healthcare of that patient.

Notification by Mail or Phone

Patients may be contacted by mail or phone unless written notification is requested that contact only be made in person.

Complaints

If you feel that your rights have been violated, please contact the Privacy Officer or the U.S. Department of Health and Human Services.