Synergy Medical
16705 Square Drive Marysville, Ohio 43040

Patient Name____ **DOB:**________________ ☐ **Male** ☐ **Female**

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
SS#/ SIN_____________________________________
Email________________________________ Home Phone____________________ Cell Phone_________________
Patient's Address__________________________________ City________________ State______ Zip____________
Employer Name____
Spouse or Patients' Guardian Name__________________________ Spouse's Employer______________________
How did you hear about us?____
Emergency Contact____ Phone_____________________________

Responsible Party

Name of the person responsible for this account_______________________ Relationship to patient____________
Is the person currently a patient at our office? ☐ Yes ☐ No
Email_______________________________ Home Phone_____________________ Cell Phone_________________
Address____ City_________________ State______
Zip_____________
Driver's License # ____ Date of Birth__________________________

Do you have Medical Insurance? ☐ Yes ☐ No if yes, complete the following:

Name of the insured____ Relationship to patient_______________
Birthdate______________ SS#/SIN______________________________ Work Phone________________________
Name of Employer____
Employer Address_____________________________________ City________________ State______ Zip_______
Insurance Company_________________________________ ID #_________________ Group #_____________
Ins. Co. Address_____________________________________ City________________ State_______ Zip_______

In case of a medical emergency, if the patient is of school age 15+, it is ok to treat in my absence.

____ ___________________________

Parent or Guardian Date

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS Y PERSONAL REPRESENTATIVE
AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Buckeye Chiropractic and Wellness/Synergy Medical, Doctor Charita Cooper, Doctor Patrick Cooper, and Jennifer Roby CNP** as well as all employees, employers, representatives, and agents thereof (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that **have been or will be** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health Insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with the same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that the Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment and designation will remain in effect unless revoked by me in writing. It is my intent that the effective date of this document shall relate back to include all services, supplies, tests, treatments, or medications that have been previously provided by Healthcare Provider. A photocopy or scan or this document is to be considered as valid and as cnfarocable as the original.

Signed this_________ day of _____________, 20_____. X____
(Patient signature)

X____ X____

(Signature of Guardian if applicable) (Please print patient name)

Health History

Chief Complaint:____

History of Present Illness:

Location:_________________________________

(Where is the Pain/ Problem?)

Severity:__________________________________

(How severe is the pain/problem on a scale of 1-10 most severe?)

Timing:_____________________________________

(Does the pain/problem occur at a specific time?)

Associated Signs/Symptoms:_____________________

____

Have ____

(What other associated problems have you been having?)

Quality:______________________________________

(Example: Normal vs abnormal color, activity, etc..)

Duration:_____________________________________

(How long have you had this pain/ problem? being the When did it start?)

Context:______________________________________

(Where were you at the onset of this pain/problem?)

Modifying Factors:_____________________________

(What makes the pain/problem worse or better? you had previous episodes?)

Past Medical History

Have you ever had the following: (Please check all that apply)

☐ Anemia	☐ Back Trouble	☐ Hepatitis
☐ Bladder Infection	☐ High Blood Pressure	☐ Ulcer
☐ Epilepsy	☐ Low Blood Pressure	☐ Kidney Disease
☐ Whooping Cough	☐ Migraine Headaches	☐ Hemorrhoids
☐ Scarlet Fever	☐ Tuberculosis	☐ Bleeding Tendency
☐ Diphtheria	☐ Diabetes	☐ Asthma
☐ Smallpox	☐ Cancer	☐ Hives or Eczema
☐ Pneumonia	☐ Polio	Date of Last Chest X-Ray___________
☐ Rheumatic Fever	☐ Glaucoma	*Any Other Disease, (Please List):*
☐ Arthritis	☐ Hernia	__________________________________
☐ Venereal Disease	☐ Mitral Valve Prolepses	__________________________________
☐Stroke Chronic Bronchitis		
☐ Infectious Mono AIDS & HIV		

Previous Hospitalizations/ Surgeries/Serious Illnesses When? Hospital, City, State

____ ____________________ _______________________

____ ____________________ _______________________

____ ____________________ _______________________

Medication: *(include non prescription)*

____

____

Drug Allergies:

____

____

Sleep:

Average length of sleep (hours):__________

How many pillows do you sleep with? 1 2 3 4

Does pain affect sleep? ☐ NO ☐ YES

Energy level: ☐ Low ☐ Moderate ☐ Adequate

How has your mood been lately? ____

Patient Social History:

Use of Alcohol:	☐ Never	☐ Rarely	☐ Moderate	☐ Daily
Use of Tobacco:	☐ Never	☐ Rarely	☐ Moderate	☐ Daily

Use of Drugs: ☐ Never Type/Frequency:____

Excessive Exposure At home or at work to: ☐ Fumes ☐ Dust ☐ Solvents ☐ Airborne Particles ☐ Noise

Family Medical History:

	Age	Disease	If Deceased, Cause Of Death
Father	___________	___________________________	____
Mother	_________	___________________________	____
Sibling's	__________	___________________________	____
	___________	___________________________	____
	___________	___________________________	____
Spouse	___________	___________________________	____
Children	__________	___________________________	____
	___________	___________________________	____
	___________	___________________________	____

Indicate which of the below you have experienced in the last 1-2 months

1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes/Ears/Nose/Throat/Respiratory

Symptom	Rating
Asthma	1 2 3 4 5
Stuffy Nose	1 2 3 4 5
Hay Fever	1 2 3 4 5
Itching	1 2 3 4 5
Chronic Cough	1 2 3 4 5
Chest Congestion	1 2 3 4 5
Shortness of Breath	1 2 3 4 5
Wheezing	1 2 3 4 5

Muscular/Skeletal

Symptom	Rating
Muscle Aches	1 2 3 4 5
Fibromyalgia	1 2 3 4 5
Arthritis	1 2 3 4 5
Joint Pain	1 2 3 4 5
Low Back Pain	1 2 3 4 5
Neck Pain	1 2 3 4 5
Wrist/Hand Pain	1 2 3 4 5
Elbow Pain	1 2 3 4 5
Shoulder Pain	1 2 3 4 5
Hip Pain	1 2 3 4 5
Knee Pain	1 2 3 4 5
Ankle/Foot Pain	1 2 3 4 5
Pain b/t shoulder blades	1 2 3 4 5
Muscle Spasm	1 2 3 4 5

Neurological

Symptom	Rating
Headaches	1 2 3 4 5
Migraines	1 2 3 4 5
Dizziness	1 2 3 4 5
Numbness	1 2 3 4 5
Tingling	1 2 3 4 5
Pins/needles in hands/feet	1 2 3 4 5
Recent Vision Changes	1 2 3 4 5
Loss of Consciousness	1 2 3 4 5

General

Symptom	Rating
Fatigue	1 2 3 4 5
Malaise	1 2 3 4 5
Weakness, tiredness	1 2 3 4 5
Lightheadedness	1 2 3 4 5
Irritability	1 2 3 4 5
Constipation	1 2 3 4 5
Diarrhea	1 2 3 4 5
Feeling foggy	1 2 3 4 5
Forgetfulness	1 2 3 4 5
Insomnia/difficult sleeping	1 2 3 4 5

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

____ _____________________

Signature of the Patient, Parent or Guardian *Date*

Provider's Review

____ ______________________
Signature of Provider *Date*

BUCKEYE CHIROPRACTIC & WELLNESS
SYNERGY MEDICAL
CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic manipulation and manual therapy techniques and other chiropractic procedures, including various modes of physical therapeutic modalities and procedures and diagnostic X Rays, where warranted, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below.

I have had an opportunity to discuss with the doctor of chiropractic named below the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment and diagnostic services including but not limited to:

Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations and sprains.

Therapeutic Modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.

Radiographs: ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The doctor named below has additionally explained the risks associated with my refusal of treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient/Guardian Signature____ Date __________________

Witness Signature ____ Date__________________

Female Only

_____ I am NOT pregnant.

_____ I am pregnant.

Buckeye Chiropractic & Wellness/Synergy Medical
16705 Square Dr. Marysville, OH 43040
(937)642-4400 (p) ~ (937)642-4443 (f)

Protecting Your Health Information

New Regulation Passed

This new regulation is part of the Health Insurance Portability and Accountability Act or HIPPA and does three primary things:

1. It helps standardize and simplify the way healthcare organizations exchange health care data.
2. It provides consumers with additional protections for getting and maintaining health insurance coverage although, it does not guarantee coverage.
3. It creates new security rules to ensure the safety and privacy of individuals 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 the record 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 health care operations, we may disclose medical information for the following purposes: for a court order, subpoena, discovery request or other lawful process. We may disclose medical information to appropriate authorities if we reasonably believe that you are the victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose health information when authorized and necessary to comply with laws relating to worker's compensation, auto accidents, personal injury or similar issues.

If someone calls or comes by, they will not be given any information about your care and/or appointments unless otherwise specified and noted in your file.

We will also be publicly noting your name in our newsletter and/or picture in our lobby unless otherwise specified. Upon becoming a patient, we will be entering your name and email into our database and you may receive our monthly newsletter. If you do not wish to receive our newsletters, please contact our office and advise the receptionist of such. This list will not be sold to any outside agencies.

Your Rights

You have the right to look at or get copies of your medical records and to receive a list of all the times we shared your medical information for purposes other than treatment, payment and health care operations.

Open Adjusting Concept

Because of the open adjusting 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 include anything concerning the primary health care of that patient.

Notification by Mail or Phone

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

Complaints

If you feel that your rights have been violated, contact the Office Manager or the U.S. Department of Health

and Human Services.

Patient/Guardian Signature:____Date:_______________

Jennifer Roby, CNP **Charita N.Cooper, DC CACCP** **Patrick S. Cooper, DC CCEP**

When it comes to your health, chiropractors and medical doctors should be working together for your benefit!

I agree! I give you permission to inform my primary care physician of my condition, treatment and expected/actual response to care at this office.

Patient/Guardian Signature:____

Name (Please Print):____

Primary Care Physician:____

Physician's Address/Phone:____

____