



# ALLIED INTEGRATIVE HEALTH & WELLNESS

4834 RICHMOND RD. WARRENSVILLE HTS. OH 44128

Patient Name \_\_\_\_\_ Date: \_\_\_\_\_ Email: \_\_\_\_\_

SS #/SIN \_\_\_\_\_ DOB \_\_\_\_\_  Male  Female Home phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Check appropriate Box:  Minor  Single  Married  Divorced  Widowed  Separated

Patient's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer Name: \_\_\_\_\_

Spouse or Patient's Guardian name \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Person to contact in case of an emergency \_\_\_\_\_ Phone \_\_\_\_\_

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

\_\_\_\_\_  
Parent or Guardian Date

### Responsible Party

Name of The Person responsible for this account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

E-Mail \_\_\_\_\_ Cell Phone \_\_\_\_\_

Driver's License # \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Is the person currently a patient at our office?  Yes  No

**Do you have any Medical insurance?**  Yes  No if yes, complete the following:

Name of the insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_ Name of Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Address of Employer \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Union or local # \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS AS WELL AS AN

#### APPOINTMENT AND/OR DESIGNATION AS MY 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 **WELNESSONE OF BEDFORD, LLC, ROBERT WHETSTONE, D.C., CHRISTOPHER MANACCI, DNP, SHELDON GOLD, PT, BENJAMIN LINKEL, DC**, 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 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 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 that 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, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan of this document is to be considered as valid and as enforceable as the original.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_.

X \_\_\_\_\_ (SEAL)  
(patient signature)

X \_\_\_\_\_ (SEAL)  
(signature of Guardian if applicable)

X \_\_\_\_\_  
(please print patient name)



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## Health History

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

**Chief Complaint:** \_\_\_\_\_

### History of Present illness:

**Location:** \_\_\_\_\_  
(Where is the pain/problem?)

**Quality:** \_\_\_\_\_  
(Example: normal vs abnormal color, activity, etc..)

**Severity:** \_\_\_\_\_  
(How severe is the pain/problem on a scale of 1-5 with 5 being the most severe?)

**Duration:** \_\_\_\_\_  
(How long have you had this pain/ problem? When did it start?)

**Timing:** \_\_\_\_\_  
(Does the pain/problem occur at a specific time?)

**Context:** \_\_\_\_\_  
(Where were you at the onset of this pain/problem?)

**Associated Signs/Symptoms** \_\_\_\_\_

**Modifying Factors** \_\_\_\_\_

(What other associated problems have you been having?)

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

### Past Medical History

(Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

Measles.....	NO	YES	Anemia.....	NO	YES	Back Trouble.....	NO	YES	Hepatitis.....	NO	YES
Mumps.....	NO	YES	Bladder Infection.....	NO	YES	High Blood Pressure.....	NO	YES	Ulcer.....	NO	YES
Chicken Pox.....	NO	YES	Epilepsy.....	NO	YES	Low Blood Pressure.....	NO	YES	Kidney Disease.....	NO	YES
Whooping Cough...	NO	YES	Migraine Headaches.	NO	YES	Hemorrhoids.....	NO	YES	Thyroid Disease.....	NO	YES
Scarlet Fever.....	NO	YES	Tuberculosis.....	NO	YES	Date of Last Chest X-Ray	_____	Bleeding Tendency.....	NO	YES	
Diphtheria.....	NO	YES	Diabetes.....	NO	YES	Asthma.....	NO	YES	Any Other Disease.....	NO	YES
Small pox.....	NO	YES	Cancer.....	NO	YES	Hives of Eczema.....	NO	YES	(Please List):	_____	_____
Pneumonia.....	NO	YES	Polio.....	NO	YES	AIDS & HIV.....	NO	YES		_____	_____
Rheumatic Fever...	NO	YES	Glaucoma.....	NO	YES	Infectious Mono.....	NO	YES		_____	_____
Arthritis.....	NO	YES	Hernia.....	NO	YES	Bronchitis.....	NO	YES		_____	_____
Venereal Disease...	NO	YES	Blood or Plasma			Mitral Valve Prolepses....	NO	YES		_____	_____
			Transfusion.....	NO	YES	Stroke.....	NO	YES		_____	_____

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

_____	_____	_____
_____	_____	_____
_____	_____	_____

**Medication:** (include nonprescription)

\_\_\_\_\_

Have you ever taken Fen-Phen/Redux?      NO      YES

Are you taking any medications (prescription or over the counter) for acid indigestion?

O yes   O no   if yes what type: \_\_\_\_\_

### Patient Social History:

Marital Status      Single: \_\_\_\_\_      Married: \_\_\_\_\_      Separated: \_\_\_\_\_      Divorced: \_\_\_\_\_      Widowed: \_\_\_\_\_

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: \_\_\_\_\_

**CLINICIAN SIGNATURE:** \_\_\_\_\_      **DATE REVIEWED:** \_\_\_\_\_

**PATIENT NAME:** \_\_\_\_\_      **DATE:** \_\_\_\_\_



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Name: \_\_\_\_\_ DOB \_\_\_\_\_ Date: \_\_\_\_\_

### Family Medical History:

	Age	Disease	If Deceased, Cause Of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
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

### Muscular/Skeletal

Asthma	1 2 3 4 5	Muscle Aches	1 2 3 4 5
Stuffy Nose	1 2 3 4 5	Fibromyalgia	1 2 3 4 5
Hay Fever	1 2 3 4 5	Arthritis	1 2 3 4 5
Sore throat	1 2 3 4 5	Joint Pain	1 2 3 4 5
Chronic Cough	1 2 3 4 5	Low Back Pain	1 2 3 4 5
Chest Congestion	1 2 3 4 5	Neck Pain	1 2 3 4 5
Frequent Sneezing	1 2 3 4 5	Wrist/Hand Pain	1 2 3 4 5
Itchy/Watery Eyes	1 2 3 4 5	Elbow Pain	1 2 3 4 5
Drainage	1 2 3 4 5	Shoulder Pain	1 2 3 4 5
Earache or Ear Infection	1 2 3 4 5	Hip Pain	1 2 3 4 5
Itching	1 2 3 4 5	Knee Pain	1 2 3 4 5
Hoarseness	1 2 3 4 5	Ankle/Foot Pain	1 2 3 4 5
Shortness of Breath	1 2 3 4 5	Pain b/t shoulder blades	1 2 3 4 5
Wheezing	1 2 3 4 5		

### Neurological

### General

Headaches	1 2 3 4 5	Fatigue	1 2 3 4 5
Migraines	1 2 3 4 5	Malaise	1 2 3 4 5
Dizziness	1 2 3 4 5	Weakness, tiredness	1 2 3 4 5
Numbness	1 2 3 4 5	Lightheadedness	1 2 3 4 5
Tingling	1 2 3 4 5	Irritability	1 2 3 4 5
Pins/needles in hands or feet	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

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

Doctor's Review

\_\_\_\_\_  
Signature of Doctor

\_\_\_\_\_  
Date

## **PATIENT HEALTH INFORMATION CONSENT FORM**

Patient Health Information Consent Form We want you to know 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 for 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 you Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this office to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care 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 us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for 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 in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of 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 providers at this office has the right to refuse to give care. I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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## 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 \_\_\_\_\_