



Buckeye Chiropractic and Wellness
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 Patient's Guardian name _____ Spouse's Employer _____

How did you hear about us? _____

Person to contact in case of an emergency _____ 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

E-Mail _____ Home Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Driver's License # _____ Date of Birth: _____

Do you have any 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 _____ Group # _____ Union or local # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

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

**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 Buckeye Chiropractic and Wellness/Synergy Medical 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)

Health History

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 1-10 with 10 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 _____
(What other associated problems have you been having?)

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

Past Medical History

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

- | | | |
|---|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Back Trouble | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Bladder Infection | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Bleeding Tendency |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Small pox | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hives or Eczema |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Polio | Date of Last Chest X-Ray _____ |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Glaucoma | Any Other Disease, (Please List): |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hernia | _____ |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Mitral Valve Prolapses | _____ |
| <input type="checkbox"/> Stroke Chronic Bronchitis | | |
| <input type="checkbox"/> Infectious Mono AIDS & HIV | | |

Previous Hospitalizations/Surgeries/Serious Illnesses

When?

Hospital, City, State

_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication: *(include nonprescription)*

Sleep:

Average length of sleep *(hours)*: _____

Does pain affect sleep? NO YES

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

Energy level: Low Moderate Adequate

How has your mood been lately? _____

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: _____

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

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

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

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

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 protecting it. We create a record of the care and services you receive at our office. We need the record to provide you with the 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 purpose: 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: _____

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: _____



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SynergyMedicalTeam.com