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 or 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)

- ☐ Anemia
- ☐ Bladder Infection
- ☐ Epilepsy
- ☐ Whooping Cough
- ☐ Scarlet Fever
- ☐ Diphtheria
- ☐ Small pox
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Arthritis
- ☐ Venereal Disease
- ☐ Stroke Chronic Bronchitis
- ☐ Infectious Mono AIDS & HIV
- ☐ Back Trouble
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Migraine Headaches
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Cancer
- ☐ Polio
- ☐ Glaucoma
- ☐ Hernia
- ☐ Mitral Valve Prolepses
- ☐ Hepatitis
- ☐ Ulcer
- ☐ Kidney Disease
- ☐ Hemorrhoids
- ☐ Bleeding Tendency
- ☐ Asthma
- ☐ Hives or Eczema

Date of Last Chest X-Ray_____

Any Other Disease, *(Please List):*

_____
_____

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:_____

Mechanism of Injury:

The injury was due to: _____ Date of accident: _____

FOR WORKMAN'S COMPENSATION-RELATED VISITS ONLY:

How did the injury occur? Choose all that apply.

- ☐ Bending
- ☐ Carrying
- ☐ Climbing
- ☐ Crawling
- ☐ Driving (driver)
- ☐ Driving (passenger)
- ☐ Job activity
- ☐ Jumping
- ☐ Kneeling
- ☐ Raising arm(s) above shoulder(s)
- ☐ Repetitive motion
- ☐ Running
- ☐ Sitting
- ☐ Squatting
- ☐ Standing
- ☐ Standing from a seated position
- ☐ Traveling (public transportation)
- ☐ Turning
- ☐ Twisting
- ☐ Typing
- ☐ Using computer
- ☐ Walking
- ☐ OTHER

FOR PEDESTRIAN ACCIDENTS ONLY:

As a pedestrian, what were you (or was the patient) doing at the time of the accident? _____

FOR AUTO ACCIDENTS ONLY:

Were you (or was the patient) wearing a seatbelt? ○ Yes ○ No ○ Don't know Did the airbag deploy? ○ Yes ○ No

Where in the vehicle were you (or was the patient) when the accident happened? _____

What interior vehicle part did you (or the patient) come into contact with? Choose all that apply.

- ☐ No interior parts were contacted at time of accident
- ☐ Airbag
- ☐ Armrest
- ☐ Dashboard
- ☐ Door
- ☐ Flying object(s) inside vehicle
- ☐ Headrest
- ☐ Seat
- ☐ Steering wheel
- ☐ Window
- ☐ Windshield

FOR MOTORCYCLE/BICYCLE ACCIDENTS ONLY:

Where on the vehichle were you (or was the patient) when the accident happened? ○ Operator ○ Passenger

What type of protection did you (or did the patient) have? Choose all that apply.

- ☐ Bicycle helmet
- ☐ Motorcycle Helmet- full face
- ☐ Motorcycle Helmet- open face
- ☐ Motorcycle Helmet- half helmet
- ☐ Protective eyewear
- ☐ Leathers
- ☐ Gloves
- ☐ Boots
- ☐ No protective wear
- ☐ OTHER

What did you (or the patient) come into contact with at the time of the collision? _____

Where were you (or was the patient) looking at the time of impact? _____

Did you (or the patient) come in contact with anything at the time of the collision? ○ Yes ○ No ○ Don't know

What part of your (or the patient's) body made contact? Choose all that apply.

- ☐ None made contact
- ☐ Back of head/neck
- ☐ Front of head
- ☐ Left arm
- ☐ Left chest/flank
- ☐ Left foot
- ☐ Left head
- ☐ Left knee
- ☐ Left leg
- ☐ Left shoulder
- ☐ Right arm
- ☐ Right chest/flank
- ☐ Right foot
- ☐ Right head
- ☐ Right knee
- ☐ Right leg
- ☐ Right shoulder
- ☐ OTHER

Did you (or the patient) receive an injury to the head? ○ Yes ○ No Did you (or the patient) lose consciousness? ○ Yes ○ No

What part of your (or the patient's) vehicle was impacted? Choose all that apply.

- ☐ Front right
- ☐ Front left
- ☐ Front head on
- ☐ Rear right
- ☐ Rear left
- ☐ Rear end
- ☐ Right side (passenger's side)
- ☐ Left side (driver's side)
- ☐ Unknown

In what direction was your (or the patient's) vehicle moving? _____

What was the estimated speed of your (or the patient's) vehicle? _____

What was the extent of the damage to your (or the patient's) vehicle? _____

What was the extent of the damage to the other vehicle? _____

In what direction was the other vehicle moving? _____

Mechanism of Injury (2):

What was the estimated speed of the other vehicle? _____

Was your (or the patient's) vehicle towed from the scene? ○ Yes ○ No Did police arrive at the scene? ○ Yes ○ No

Did Emergency Medical Services arrive at the scene? ○ Yes ○ No Was an accident report taken? ○ Yes ○ No

Were you (or was the patient) transported to a medical facility (ER or hospital)? _____

Have you (or has the patient) received any treatment since the accident? Choose all that apply.

- ☐ Admitted
- ☐ Examination was performed
- ☐ Home treatment with cold
- ☐ Home treatment with heat
- ☐ Home treatment with over-the-counter medication
- ☐ Home treatment with rest
- ☐ Medication was prescribed
- ☐ No treatment since accident
- ☐ Physical therapy
- ☐ Referred for further evaluation and treatment
- ☐ Referred to a chiropractor
- ☐ Referred to a neurologists
- ☐ Referred to orthopedists
- ☐ Referred to primary care provider
- ☐ Released
- ☐ Released that day
- ☐ Surgery
- ☐ X-rays were completed
- ☐ OTHER

What was the location of symptoms felt at the time of the accident? Choose all that apply.

Head:	☐ Front of head	☐ Back of head	☐ Right side of head	☐ Left side of head			
Neck:	☐ Front of neck	☐ Back of neck	☐ Right side of neck	☐ Left side of neck			
Back:	☐ Right mid back	☐ Left mid back	☐ Central mid back	☐ Right low back	☐ Left low back	☐ Central low back	
Trunk:	☐ Abdomen	☐ Chest	☐ Front of ribs	☐ Back of ribs	☐ Right side of ribs	☐ Left side of ribs	

Upper Extremity:	☐ Front of right upper extremity	☐ Rear of right upper extremity	☐ Front of left upper extremity	☐ Rear of left upper extremity
	☐ Front of right shoulder	☐ Rear of right shoulder	☐ Front of left shoulder	☐ Rear of left shoulder
	☐ Front of right upper arm	☐ Rear of right upper arm	☐ Front of left upper arm	☐ Rear of left upper arm
	☐ Front of right elbow	☐ Rear of right elbow	☐ Front of left elbow	☐ Rear of left elbow
	☐ Front of right wrist	☐ Rear of right wrist	☐ Front of left wrist	☐ Rear of left wrist
	☐ Front of right hand	☐ Rear of right hand	☐ Front of left hand	☐ Rear of left hand
Lower Extremity:	☐ Front of right lower extremity	☐ Rear of right lower extremity	☐ Front of left lower extremity	☐ Rear of left lower extremity
	☐ Front of right hip	☐ Rear of right hip	☐ Front of left hip	☐ Rear of left hip
	☐ Front of right thigh	☐ Rear of right thigh	☐ Front of left thigh	☐ Rear of left thigh
	☐ Front of right knee	☐ Rear of right knee	☐ Front of left knee	☐ Rear of left knee
	☐ Front of right leg	☐ Rear of right leg	☐ Front of left leg	☐ Rear of left leg
	☐ Front of right ankle	☐ Rear of right ankle	☐ Front of left ankle	☐ Rear of left ankle
	☐ Top of right foot	☐ Bottom of right foot	☐ Right side of right foot	☐ Left side of right foot
	☐ Top of left foot	☐ Bottom of left foot	☐ Right side of left foot	☐ Left side of left foot
	☐ OTHER			

Describe the discomfort felt at the time of the accident. Choose all that apply.

- ☐ Aching
- ☐ Burning
- ☐ Deep
- ☐ Diffuse
- ☐ Dull
- ☐ Heavy
- ☐ Numbness
- ☐ Pulling
- ☐ Sharp
- ☐ Shock like
- ☐ Shooting
- ☐ Stiffness
- ☐ Throbbing
- ☐ Tightness
- ☐ Tingling
- ☐ OTHER

Are there any additional symptoms which appeared since the accident happened? Choose all that apply.

- ☐ None
- ☐ Anxiety
- ☐ Breathing difficulty
- ☐ Chest pain
- ☐ Depression
- ☐ Disbelief
- ☐ Dizziness
- ☐ Exhaustion
- ☐ Facial pain
- ☐ Genital pain
- ☐ Gluteal pain
- ☐ Headaches
- ☐ Irritability
- ☐ Loss of appetite
- ☐ Low energy
- ☐ Muscle spasm
- ☐ Numbness and tingling
- ☐ Rib pain
- ☐ Shock
- ☐ Sleeping difficulty
- ☐ Soreness
- ☐ Stomach pain
- ☐ Stress
- ☐ Stunned
- ☐ Tightness
- ☐ Tiredness
- ☐ OTHER

Mechanism of Injury (3):

Describe the status of your symptoms since the accident. Choose all that apply.

- ☐ Deteriorated daily functioning at home/work
- ☐ Disappeared
- ☐ Elicited less stiffness
- ☐ Elicited more stiffness
- ☐ Elicited less pain
- ☐ Elicited more pain
- ☐ Exacerbated
- ☐ Improved
- ☐ Improved daily functioning at home/work
- ☐ Lessened
- ☐ Shown no change in daily functioning at home/work
- ☐ Somewhat resolved
- ☐ Stayed the same
- ☐ Worsened
- ☐ Worsened quality of life
- ☐ OTHER

Goals for Your Care

People see a chiropractor for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ I want the Doctor to select the type of care appropriate for my condition

☐ Relief care: Symptomatic relief of pain or discomfort.

☐ Corrective care: Correcting and relieving the cause of the problem as well as the symptom

☐ Comprehensive care: Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic Care

Worker's Compensation

Who saw the accident? _____ Title: _____

Who reported the accident? _____ Title: _____

Type of windows: _____ Type of shop: _____

Do you use hand or foot levers? ○ Yes ○ No Do you work overhead? ○ Yes ○ No

Are you tired when you go home? ○ Yes ○ No

Describe the accident?

Do you lift from? ○ Ground ○ Bench ○ Platform ○ Box ○ Pallet ○ Other

Do you have to reach? ○ Yes ○ No Explain: _____

Is your work area cluttered? ○ Yes ○ No Explain: _____

Do you push or pull? ○ Yes ○ No Explain: _____

Do you pick up or lift? ○ Yes ○ No How Much: _____ How Often: _____

Do you lift in and out of a machine? ○ Yes ○ No If so, do you: ○ Sit ○ Stand ○ Kneel

Type of Floor: ○ Rough ○ Smooth ○ Wood ○ Concrete ○ Steel ○ Other

If other describe: _____

Type of ventilation: ○ Blower ○ Heat ○ Exhaust ○ None ○ Other

If other describe: _____

Type of lighting: ○ Fluorescent ○ Overhead ○ On Machine ○ Other

If other describe: _____

Is your work area: ○ Oily ○ Dirty ○ Slippery ○ Other

If other describe: _____

Do you have any other jobs? ○ Yes ○ No If yes, what type: _____

Has outside help been hired? ○ Yes ○ No If yes, why: _____

Do you use a cart? ○ Yes ○ No Type of Wheels: ○ Rubber ○ Steel ○ Plastic

Condition of cart: ○ Good ○ Bad ○ Other If other, explain: _____

# of carts being moved at once: ____ Weight moved per day: ____

From where to where: _____

Synergy Medical

ATTORNEY'S WE RECOMMEND FOR WORKERS COMP

Willis and Willis, Atty At Law
4653 Trueman Blvd #100
Hillard, Ohio 43026
614-586-7900

Cannizzaro, Bridges, Jillinsky & Streng LLC
302 S. Main
Marysville, Ohio 43040
937-303-4165

16705 Square Drive
Marysville, OH 43040
Phone: (937) 642-4400
Fax: (937) 642-4443
SynergyMedicalTeam.com

Rachel G. Frinak, MS APRN FNP-C 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: _____

_____

16705 Square Drive

Marysville, OH 43040

P. 937.642.4400 F. 937.642.4443

SynergyMedicalTeam.com