

Innovative Medical Centers

55 Caren Avenue Suite 360, Worthington OH 43085

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 **Innovative Medical Centers** 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, tests, 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

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 1-10 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 _____

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 Prolapses...	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:** _____

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

- Asthma 1 2 3 4 5
- Stuffy Nose 1 2 3 4 5
- Hay Fever 1 2 3 4 5
- Sore throat 1 2 3 4 5
- Chronic Cough 1 2 3 4 5
- Chest Congestion 1 2 3 4 5
- Frequent Sneezing 1 2 3 4 5
- Itchy/Watery Eyes 1 2 3 4 5
- Drainage 1 2 3 4 5
- Earache or Ear Infection 1 2 3 4 5
- Itching 1 2 3 4 5
- Hoarseness 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

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 or feet 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

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

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PATIENT CONSENT FOR COMMUNICATION

We have the ability to call or text you, reminding you of your appointments. If you would like to receive this feature in the future, please read the consent below and sign. Patients in our practice may be contacted via phone/text message to be reminded of an appointment, to obtain feedback on an experience with our office, and to provide general health reminders/information.

1. I consent to receiving appointment reminders and other healthcare communications via telephone from Innovative Medical Centers. _____(initial)
2. I consent to receive text messages from Innovative Medical Centers on my cell phone and any number forwarded or transferred to that number. The cell phone number that I authorize to receive text messages for appointment reminders, feedback and general health reminders/information is (____)_____ - _____ . _____(initial)
3. I consent to emails to receive communications as stated above. The email that I authorize to receive email messages for general health reminders/feedback/information is: _____ . _____(initial)

I understand that this request to receive emails and/or text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing. _____(initial)

Signature: _____ Date: _____

PATIENT CONSENT TO TREAT:

I hereby authorize the Doctors/Nurse Practitioners of Innovative Medical Centers to treat my case as they deem appropriate through the use of lab testing, trigger point injections, durable medical equipment, rehabilitation, manual therapy, chiropractic manipulation of the spine, nutritional support, and diagnostic testing. I realize the goal of holistic health care is to strengthen the patient’s body in order to heal themselves. I also agree that I am responsible for all bills incurred at this office

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received Innovative Medical Centers Notice of Privacy Practices for protected health information

Name of Patient: _____ Date of Birth: _____

Signature of Patient/Personal Representative: _____ Date: _____

Documentation of Good Faith Effort to obtain written acknowledgement:

I made a good faith effort to obtain the patient’s written acknowledgement of our Notice of Privacy Practices for Protected Health Information by (check all that apply):

- Showing the patient the Notice of Privacy Practices available in our office
- Giving the patient a copy of the Notice of Privacy Practices
- Asking the patient to sign this acknowledge form
- Other (explain in detail) _____

I was unable to obtain the patient’s written acknowledgement because:

- The patient refused to sign because _____
- Other (explain in detail) _____

Staff Signature: _____ Date: _____

This written acknowledgement must be completed no later than the first date services or treatments are provided. This acknowledgement must be retained in the patient’s permanent record