Stromberg Chiropractic Center
757 Fife Ave.
Wilmington, OH 45177

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ____-____-_____ Work Phone: _____-_____-_____ Cell Phone: _____-_____-_____

At what number do you prefer to be reached? ☐ Home ☐ Work ☐ Cell

Email Address: _____ Occupation: _____

Date of Birth: _____ Social Security #: _____-_____-_____ Gender: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed ☐ Single

How did you hear about us? ☐ Website ☐ Facebook ☐ Instagram ☐ Search (ie Google/Bing)

☐ Referral: Who referred you? _____

Primary Care Physician (PCP): _____ PCP Phone: _____

Do we have your permission to share your medical records with your PCP? ☐ Yes ☐ No

Name of Insurance Company: _____

Policy #: _____ Group #: _____

Policy Holders Name: _____ DOB: _____

Social Security # of Policy Holder: _____-_____-_____

List any **Surgeries**:

☐ Brain ☐ Neck ☐ Shoulder ☐ Elbow ☐ Wrist/Hand ☐ Back
☐ Hip ☐ Knee ☐ Ankle ☐ Foot ☐ Neurological

☐ Other: _____

List any **Allergies**:
☐ Animals ☐ Bees/Stings ☐ Chocolate ☐ Dairy ☐ Eggs ☐ Shellfish
☐ Wheat ☐ Latex ☐ Rubber ☐ Soaps ☐ X-Ray Dye ☐ Dust
☐ Molds ☐ Ragweed/Pollen ☐ Seasonal Allergies
☐ Other: _____

Are you allergic to any medications: ☐ No ☐ Yes

If Yes, which?_____

List all **Medications** you are currently taking: (example: Ibuprofen – Pain)

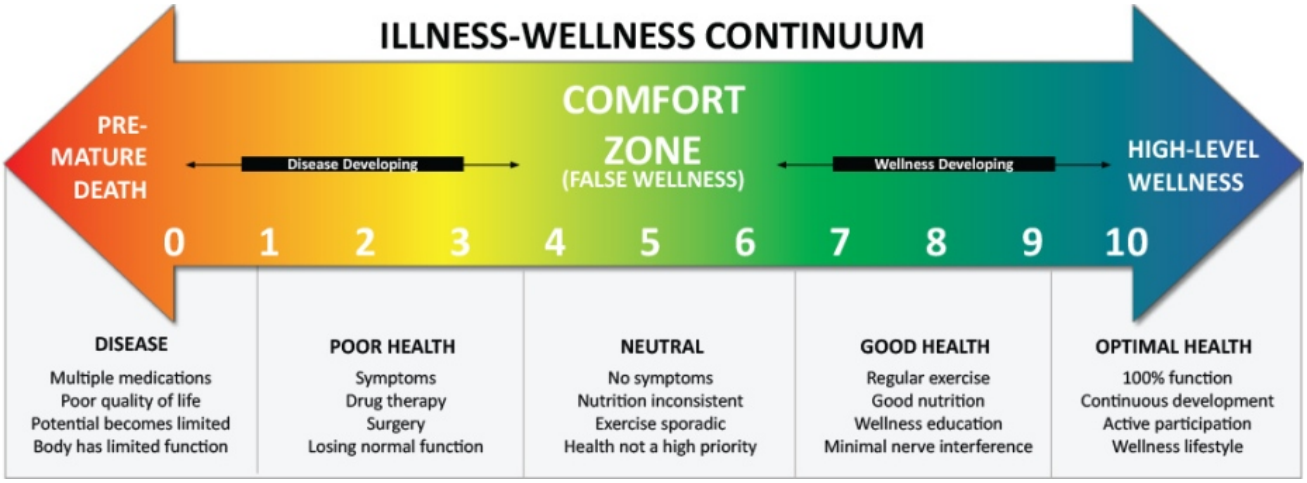
_____

_____

_____

_____

Wellness Assessment:



On the arrow diagram above:

- What number do you think represents your health today? _____
- In what direction is your health currently headed? _____

What are your health goals?

- Immediate: _____
- Short Term: _____
- Long Term: _____

List **<u>ALL Past Medical History/Conditions</u>**:

☐ Ankle Pain ☐ Arm Pain ☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Broken Bones
☐ Cancer ☐ Chest Pain ☐ Depression ☐ Diabetes ☐ Dizziness ☐ Elbow Pain
☐ Epilepsy ☐ Fainting ☐ Fatigue ☐ Foot Pain ☐ Hand Pain ☐ Headaches
☐ Hepatitis ☐ Hip Pain ☐ HIV ☐ Jaw Pain ☐ Knee Pain ☐ Leg Pain
☐ Neck Pain ☐ Polio ☐ Pacemaker ☐ Sprain/Strain
☐ Eye/Vision Problems ☐ Genetic Spinal Condition ☐ Hearing Problems
☐ High Blood Pressure ☐ Joint Stiffness ☐ Menstrual Problems
☐ Minor Heart Problem ☐ Mid-Back Pain ☐ Multiple Sclerosis
☐ Neurological Problems ☐ Parkinson's Disease ☐ Prostate Problems
☐ Significant Weight Change ☐ Shoulder Pain ☐ Stroke/Heart Attack
☐ Spinal Cord Injury
☐ Other: _____

List your **Family History**:

☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Cancer ☐ Depression ☐ Diabetes
☐ Epilepsy ☐ Polio ☐ Genetic Spinal Condition ☐ Heart Problems
☐ High Blood Pressure ☐ Multiple Sclerosis ☐ Neurological Problems
☐ Parkinson's Disease ☐ Prostate Problems ☐ Stroke/Heart Attack

Please list all family members who had/have any of the problems above (ex: Grandmother – Cancer):

_____ _____

_____ _____

_____ _____

Have you had any auto or other accidents in the past? ☐ No ☐ Yes
If Yes, please describe: _____

What was the date of your last physical examination: _____

Do you smoke? ☐ No ☐ Yes: How many per day? ___
If No, were you a former smoker? ☐ No ☐ Yes
Do you drink alcohol? ☐ No ☐ Yes: How many per day? _____
Do you drink caffeine? ☐ No ☐ Yes: How many per day? _____
Do you exercise? ☐ No ☐ Yes: What form and how often? _____

Have you ever had chiropractic care? ☐ No ☐ Yes Where? _____
Why? _____ When was your last visit? _____
Were X-Rays taken? ☐ No ☐ Yes

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform this office if I, or my minor child, ever have a change in health.

_____ _____
Patient Signature Date

Stromberg Chiropractic Center
757 Fife Avenue, Wilmington Oh 45177
(937) 382-1727

Protecting Your Health Information

New Regulation Passed

This new regulation is part of the Health Insurance Portability and Accountability Act or HIPAA 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 individual 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 this 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 a 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 other 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 also 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 Signature: _____ Date: _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to **Stromberg Chiropractic Center** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____/_____/_____

Signature of Insured / Guardian Date

Informed Consent

Chiropractic Treatment, as with any form of medical care, has certain risks that may occur during the course of treatment and which cannot be totally eliminated nor predicted. Among these risks are stroke and/or vascular injuries including, but not limited to dissection and transit ischemic attacks. Additional risks include, but are not necessarily limited to, aggravation of pre-existing disc herniation and rib fracture.

I understand that during the course of treatment I will receive chiropractic adjustments or manipulations and adjunctive therapies including, but not limited to, ice, heat and electric stimulation. By signing this Informed Consent form I understand that the proposed treatment carries with it the potential risks disclosed herein and I hereby consent to the proposed treatment.

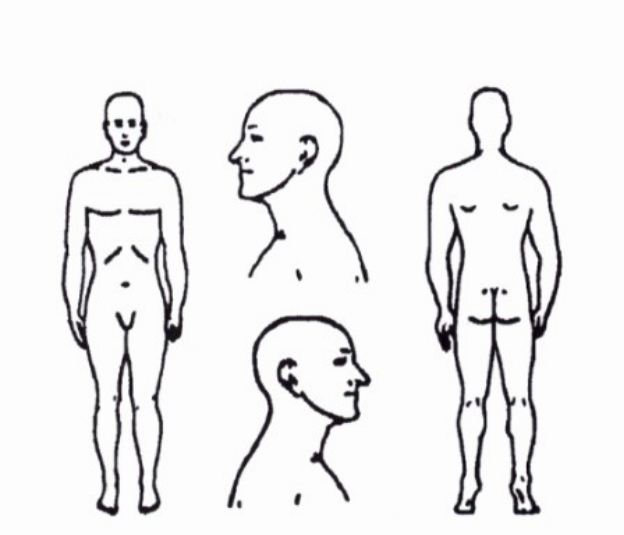
_____ _____

Date Patient's Signature

_____ _____

Date Witness

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM



Main reason for consulting the office:

- ☐ Become pain free
- ☐ Explanation of my condition
- ☐ Learn how to care for my condition
- ☐ Reduce symptoms
- ☐ Resume normal activity level

What do you wish you could do that your current condition keeps you from doing?

_____
_____
_____
_____

What is your MAJOR complaint (List only ONE)? _____ Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? ☐ GETTING BETTER ☐ GETTING WORSE ☐ NO CHANGE

Have you had this condition in the past? ☐ YES ☐ NO

How committed are you to correcting this issue? (0 = not committed, 10 = very committed)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How often do you experience your symptoms?
☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)
☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

Describe the nature of your symptoms:
☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Tingling
☐ Tightness ☐ Stabbing ☐ Throbbing ☐ Radiating pain
☐ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain, 10= excruciating pain):
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How do your symptoms affect your ability to perform daily activities such as working or driving?
(0= no effect, 10=unable to perform activities):
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What activities aggravate your condition (working, exercise, etc.)?

_____

_____

What makes your pain better (ice, heat, massage, etc.)? _____

What is your NEXT complaint (if none, put N/A)? _____Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? ☐ GETTING BETTER ☐ GETTING WORSE ☐ NO CHANGE

Have you had this condition in the past? ☐ YES ☐ NO

How often do you experience your symptoms?
☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)
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☐ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain, 10= excruciating pain):
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What activities aggravate your condition (working, exercise, etc.)?

_____

What makes your pain better (ice, heat, massage, etc.)? _____

What is your NEXT complaint? _____ Date problem began? _____

How did this problem begin (falling, lifting, etc.)? _____

How is your condition changing? ☐ GETTING BETTER ☐ GETTING WORSE ☐ NO CHANGE

Have you had this condition in the past? ☐ YES ☐ NO

How often do you experience your symptoms?
☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day)
☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

Describe the nature of your symptoms:
☐ Sharp ☐ Dull ☐ Numb ☐ Burning ☐ Shooting ☐ Tingling
☐ Tightness ☐ Stabbing ☐ Throbbing ☐ Radiating pain
☐ Other: _____

Please rate your pain on a scale of 1 to 10 (0= no pain, 10= excruciating pain):
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How do your symptoms affect your ability to perform daily activities such as working or driving?
(0= no effect, 10=unable to perform activities):
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What activities aggravate your condition (working, exercise, etc.)?

_____

What makes your pain better (ice, heat, massage, etc.)? _____

Functional Rating Index

In order to properly assess your condition, we must understand how much your **neck and/or back problems** have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

1. Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travel (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____
PRINTED

Total Score _____

_____
Signature

_____
Date

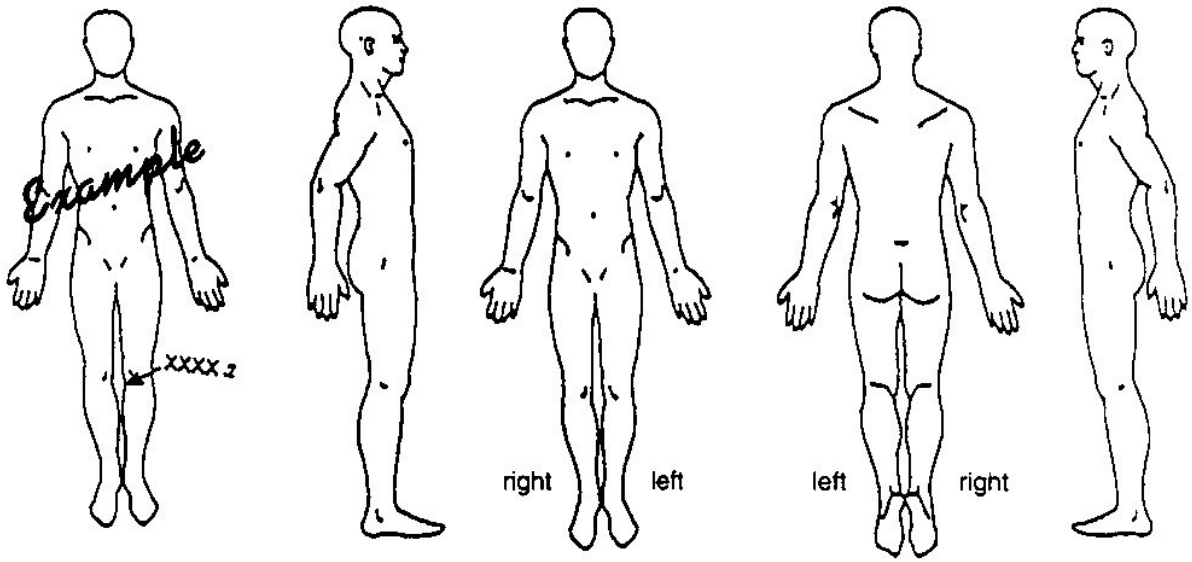
SHOW US WHERE IT HURTS

NAME: _____ DATE: _____

SIGNATURE: _____

Please mark area(s) of injury or discomfort as shown below in the example. Indicate the degree of pain **AT THIS TIME** using a scale of 1 (discomfort) to 10 (extreme pain).

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - -	OOOOO	^^^^^	xxxxx	●●●●●



Example Right Front Back Left

Please rate the SEVERITY of your pain by circling a number below:

AT ITS WORST

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

AT ITS BEST

0 1 2 3 4 5 6 7 8 9 10

STROMBERG CHIROPRACTIC

FINANCIAL POLICY

Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. Regardless of your coverage, we'll suggest the chiropractic care we think you need. We ask that you read and understand our policy as it applies to your particular situation.

Patient's Name:_____

Patient Signature: _____

Witness Signature: _____

GROUP OR INDIVIDUAL INSURANCE

Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers Chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. When possible, we will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge, and file them with your insurance company to help you collect. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles or co-pays. You may also pay the full amount due each day thereby qualifying for our Time of Service Reduction in fees. You may then submit the bill to your insurance carrier for reimbursement.

PATIENTS WITHOUT INSURANCE

We require that payment is to be paid at the time of the visit. Our cash/TOS visits are at a discounted rate that can only be paid on day of service. We are happy to accept your check, cash, MasterCard or Visa.

"ON THE JOB" INJURY (Worker's Compensation)

If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If your employer does not provide us with this information, if a settlement has not been made within 3 months, or if you suspend or terminate care, any fees and services are due immediately.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please present your auto insurance card, your health insurance card, and tell us if you have retained an attorney. There are four options available to the PI patient:

1. Pay cash for your care and we will submit reports whenever necessary.
2. We will bill (accept assignment) from the Med Pay portion of your auto insurance.
3. We will accept a Letter of Protection or Doctor's Lien from an attorney and await payment at the time of settlement as long as you remain an active patient.
4. We will bill your standard health insurance plan and you will be responsible for all co-pays and deductibles as they are incurred.

Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to (six) months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately. *In the event of late or nonpayment, there may be a nonpayment charge up to 50% of the total bill to cover collection efforts and fees.*

MEDICARE

We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%. All other services we provide are NON-COVERED. These services include, but are not limited to, x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services. Our office completes and files the forms for Medicare at no charge. *Maintenance visits need to be paid cash each time*

SECONDARY INSURANCE

Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

MANAGED CARE PLANS

□ You are required to pay a $_____co-pay at the time of service.

□ A referral from your primary care physician will be necessary. Out of network benefits are available if a referral is not obtained.

□ Benefits are available for up to _____visits per year. A $_____co-pay is due at the time of service.

□ Benefits allow adjustment and massage therapy to be done on the same day.

FLEX PLANS/MEDICAL SAVINGS ACCOUNTS

Please inform us if you have a medical savings account, sometimes known as a 'flex plan'. We will be happy to provide you with a statement of your charges for reimbursement. If you need to use an FSA or HSA card for this please do so. If you don't have your card with you, we are unable to credit back original credit card unless this is the same day of account being charged.

PATIENT OVERPAYMENTS

In the event of an overpayment on your account you will be notified of said overpayment and a refund will be issued to you or a credit will remain on your account that you can apply to future balances.

TERMINATION OF PROMOTION PACKAGES

Any early termination of any packages will result in the normal fees being assessed to the used portion of the packages and any refunds due will be deducted from total package price paid.

INSURANCE FORMS/PAYMENT

If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request of more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible. Occasionally, either by mistake, or due to provisions in your policy, the check issued by the insurance company for payment of services rendered in our office, may come to you instead of our office. If you should receive any unexpected check in the mail, please contact us to see if it does represent payment of your bill here.

I have read and understand the financial policy. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Stromberg Chiropractic and my insurance company. I request that Stromberg Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctors at Stromberg Chiropractic that fees will be due and payable immediately and may be charged to any payment method stored in the secure payment server. Balances not paid within 30 days may be subject to interest fees of 15%APR. In the event of late or nonpayment, there may be an additional nonpayment charge up to 50% of the total bill

_____

Patient's signature (or guardian if patient is a minor) Date

_____

Witness Date

STROMBERG CHIROPRACTIC

757 Fife Avenue | Wilmington, OH 45177 | 937.382.1727 | Fax 937.383.2597