PLEASE COMPLETE ENTIRE FORM **Today's Date:**______________________

Name ____ ***Date of Birth*** ___________________
First **Middle** **Last**

Address____ ______________
Street **Apt #**

____
City **State** **Zip**

Home Phone (______) ____________________ **Work Phone** (_____)______________________________

Cell Phone (______)_______________________**Email** ____

Please Circle: Single Married Other Gender: M / F Social Security #________________________________

Your Employer____________________________________ **Student** (Currently enrolled in classes) Yes /No

Employer's Address __________________________________
Street

____
City **State** **Zip**

Please allow _______________________to have access scheduling and requesting billing information regarding my account.
Spouse/ Parent- If the patient is over 18 years of age

Contact person in case of emergency_________________________ Phone Number _______________________

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

BILLING INFORMATION: **PAYMENT IS EXPECTED AT THE TIME OF VISIT!!**

1. Is this a **Worker's Comp.** Problem/injury? No Yes If yes: Date of injury ____________________________

Have you reported this injury? Yes No Worker's Comp. Claim # ______________________________

2. Is this problem/injury the result of an **accident**? No Yes If yes: Date of accident ________________________

3. Do you have an attorney? Yes No Name ____________________________ Phone __________________

Primary Insurance (the insurance company that pays first)

Name of Insurance ____

Whose name is it in? _______________________________________ Date of Birth ____________________

I.D. Number __________________________________ Group/Policy Number ___________________________

Secondary Insurance (the insurance that pays after primary insurance has paid)

Name of Insurance ____

Whose name is it in? _______________________________________ Date of Birth ____________________

I.D. Number __________________________________ Group/Policy Number ___________________________

Patient's Signature ____ Date ___________________________

Guardian or Spouse's Signature Authorizing Care;________________________________ Date ________________

NAME: ____

Patient Health History

Main Problem ____

How would you describe your chief complaint at this time? ____

Have you consulted any other doctors for these complaints? __________ **If yes, who?** ____________________________

Did you have x-rays taken? __________ **If yes, where?** ____

Where is the pain located? ______________________________ **When did it start (approx. date):** ______________

What makes it worse? ____________________ **Is the pain:** intermittent occasional frequent constant

How long did you have pain before you first sought treatment? ____________________

Who is your family doctor? ______________________________ **Contact Number:** ____________________

Current Medications: ____

Allergies: ____

Pregnant? Yes No Maybe *(signature)*______________________________________ *(date)* ______________

Do you now or have you in the past had any of the following?

Weight loss/gain	Yes	No	Ear infections	Yes	No
Fever/chills	Yes	No	Tinnitus/ringing in ears	Yes	No
Allergies	Yes	No	Hepatitis	Yes	No
Anemia	Yes	No	Kidney or bladder infection	Yes	No
Diabetes	Yes	No	Kidney stones	Yes	No
Cancer	Yes	No	Joint pain	Yes	No
Thyroid disease	Yes	No	Back pain	Yes	No
Poor memory	Yes	No	Neck pain	Yes	No
Headaches	Yes	No	Muscle spasms	Yes	No
Epilepsy/convulsions	Yes	No	Weakness	Yes	No
Stroke	Yes	No	Rash/skin lesion	Yes	No
Vision problems	Yes	No	Hair/nail changes	Yes	No
Heart attack	Yes	No	Anxiety	Yes	No
Blood clots	Yes	No	Depression	Yes	No
High blood pressure	Yes	No	Numbness/tingling	Yes	No
Indigestion	Yes	No	Menstrual/prostate problems	Yes	No
Vomiting/Diarrhea	Yes	No	Other________________		
Colon or bowel trouble	Yes	No	____________________		
Hemorrhoids	Yes	No	____________________		

Do you smoke? Yes No **If yes, how many packs per day** __________ **Do you drink alcohol?** Yes No **How much** __________

Family medical history (diabetes, cancer, heart disease)____

Past medical history (surgery, etc.)____

To be filled out by Doctor:
*Reviewed by*______________________________________ *Date* ______________

HEALTH CARE AUTHORIZATION FORM

Patient's Name ____

Patient's SS# ____________________________ Date of Birth ___________

THE PATIENT IDENTIFIED ABOVE AUTHORIZES Elite Chiropractic LLC TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS
(Please check boxes):

☐ I give permission to **Elite Chiropractic LLC** to use my address, phone number and clinical records to contact me with birthday cards, thank you cards, holiday related cards, newsletters, testimonials, and contact me about treatment alternatives or other health related information.

☐ I give **Elite Chiropractic LLC** permission to treat me in a closed exam room. If any therapies are provided to me, I may be treated in an open therapy room, (with curtains separating the therapy beds). I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with doctor at any time in private; the doctor will provide a room for these conversations.

☐ I give **Elite Chiropractic LLC** permission to combine any mailings with my spouse/parent(s). I, also, give my spouse/parent(s) permission to call for and cancel my appointments.

By signing below I acknowledge receipt of a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of Elite Chiropractic LLC. The written notice must contain the following information: Your name, Social Security number, date of birth, a clear statement of your intent to revoke this AUTHORIZATION, the date of your request, and your signature.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by **Elite Chiropractic LLC** for its own use/disclosure of PHI. *(Minimum necessary standards apply.*

You have the right to inspect or copy the PHI to be used/disclosed.

* A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU UPON REQUEST*

____
Print Name of Patient

____
Signature of Patient

____
Date

EXPIRATION: The Authorization shall expire on the following date:____________

Medical Records Release Form

By signing this form, I authorize you to release confidential medical information about me, by releasing a copy if my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name:_____________________ Date of Birth:_______________

The information you may release subject to this signed release for is as follows:

Complete Medical Records
Hospital Reports
History and Physical
Lab Reports
Treatment Records
Medication Records
Progress Notes
Radiology Reports

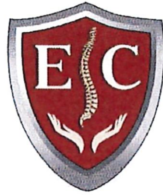
◊ Elite Chiropractic
4936 Wunnenberg Way
West Chester, Ohio 45069
513-860-5400
513-870-5752 fax

____
Signature

____ / /
Print Name Date of Birth

____
Street Address

____
City, State, and Zip



ELITE CHIROPRACTIC

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, 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 or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel 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, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. 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.

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 Signature_______________________ Date ________________

Guardian Signature ______________________________ Date____________

www.Elite-Chiro.com
4936 Wunnenberg Way • West Chester, Ohio 45069
(513) 860-5400 • (513) 870-5752 fax

ELITE CHIROPRACTIC

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Elite Chiropractic for your medical needs. We are committed to provide you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.
- Copays and Massage payments (if applicable) are due TIME OF SERVICE.
- Coinsurance, deductibles and non covered items are due 30 days after receiving a statement.
- Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:
    - Missed massage appointments-Full price of the massage
    - Missed chiropractic appointments-$25.00/appointment

These must be cancelled 24 hours BEFORE scheduled appointment time.

***If you call after hours, please leave a voicemail with the date and time of your call. Doing so may help avoid a late cancellation fee.**

By my signature below, I hereby authorize assignment of financial benefits directly to Elite Chiropractic and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.

Patient Signature ____

Date_____________ **Witness Signature** ________________________

DIAGNOSTIC IMAGING CONSULTANTS, INC.
3296 W STATE ROUTE 22-3
LOVELAND, Ohio 45140-9935
(513) 489-0055
FAX: (513) 489-4587

Assignment of Benefits For Radiographic

I understand that to ensure the highest quality of interpretation of my x-rays, the services of a certified chiropractic radiologist are being utilized. The fee is separate from that of the chiropractic clinic. I also understand that the fees for this service will be submitted to my insurance carrier, Worker's Compensation, or attorney in the case of personal injury.

I understand I may receive a billing statement for: insurance denial, professional fees that have been applied to my deductible or the balance due stated by my insurance company as my responsibility.

In the event that I receive payment for the services I agree to promptly remit payment to Diagnostic Imaging Consultants.

I acknowledge and give my consent to have my x-rays interpreted by Dr. Bryan Hosler. DACBR. I understand that any balance due is my responsibility.

Signature:____________________________ Date:____________________

Healthcare information is sensitive information. It is being sent to us after the appropriate authorization of the patient. We the recipient is obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure without additional patient consent of as permitted by law is prohibited. Unauthorized disclosure could subject penalties described in federal law.

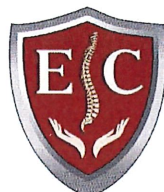
The following signature authorizes the release of medical information and also authorizes the assignment of benefits to:

Diagnostic Imaging Consultants, Inc.
3296 W State Route 22-3
Loveland, Ohio 45140-4587

Radiology Interpretation

I understand there is a fee of $25.00 for the radiology regarding that is separate from my insurance carrier that is due at the time of my x-rays.

Signature:____________________________ Date:____________________



ELITE CHIROPRACTIC

If you would like to receive appointment reminders via text message, please check the box below and provide your cell phone number. (Data and messaging rates may apply)

○

Cell Phone Number (________)________________________

We would love to hear from you!

Who referred you to our practice?

Please circle all that apply:

Ad
Existing Patient
Friend
Family
Provider
Internet/Website
Provider Manual

www.EliteHealthChiro.com
4936 Wunnenberg Way • West Chester, Ohio 45069
(513) 860-5400 • (513) 870-5752 fax