

CHIROPRACTIC AND PHYSICAL THERAPY  
CENTERS OF OHIO, HILLIARD CLINIC

**PATIENT APPLICATION / INSURANCE FORM**

*WELCOME TO OUR CLINIC.* We specialize in assisting our patients to achieve their highest level of health through our *spinal and postural corrective programs*. Our approach is very unique and advanced from other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems.

Please fill out the following information thoroughly so the doctor or physical therapist can let you know if you are a case we can accept. Please feel free to ask any questions if you need assistance. We look forward to serving you.

\_\_\_\_\_  
Patient Signature:

\_\_\_\_\_  
Today's Date:

# PATIENT INFORMATION

Name: \_\_\_\_\_ (Age) \_\_\_\_\_ Gender: M F  
Home Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Email Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status: S M D W  
Names of Children: \_\_\_\_\_ Ages: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer Name: \_\_\_\_\_  
Spouse's Name: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_  
Spouse's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
How were you referred to this office? \_\_\_\_\_

## HEALTH INSURANCE INFORMATION

Name of *Your Health Insurance Co.* \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Address \_\_\_\_\_ Phone # \_\_\_\_\_  
Insured's Name if different than yours \_\_\_\_\_ Insured's SS# \_\_\_\_/\_\_\_\_/\_\_\_\_  
Relationship to Insured \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Employer \_\_\_\_\_

## SECONDARY INSURANCE INFORMATION

Name of *Your Health Insurance Co.* \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Address \_\_\_\_\_ Phone # \_\_\_\_\_  
Insured's Name if different than yours \_\_\_\_\_ Insured's SS# \_\_\_\_/\_\_\_\_/\_\_\_\_  
Relationship to Insured \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Employer \_\_\_\_\_

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. If this office chooses to bill any services to my insurance carrier that they are performing these services are strictly as a convenience to me. The Doctors office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and that I am ultimately responsible for any unpaid balances. Any monies received will be credited to my account.

I understand there could be some services that my insurance company does not cover, if this is the case are you willing to pay for these services [ ] YES [ ] NO

Patients Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian or Spouse's Signature Authorizing Care \_\_\_\_\_ Date \_\_\_\_\_

I hereby authorize Chiropractic & Physical Therapy Centers of Ohio to administer care as deemed necessary to my child, a minor under the age of 18 years old.

# EXPERIENCE WITH CHIROPRACTIC or PHYSICAL THERAPY

Have you seen a Chiropractor / Physical Therapist before? Yes No Who? \_\_\_\_\_ When? \_\_\_\_\_

Reason for visits: \_\_\_\_\_

How did you respond to care? \_\_\_\_\_

Did your previous Doctor of chiropractic take before and after x-rays? Yes No

Did you know posture determines your health? Yes No

And the most common postural weakness is **Forward Head Syndrome** (head and neck starting to bend forward and progressively moving downward weakening your whole body). Even less severe forms of this posture can cause many adverse affects on your overall health. Have you ever been told or felt like you carry your head forward, noticed a rounding of your shoulders or a developing “hump” at the base of your neck?  YES  NO

## HEALTH AND LIFESTYLE

Do you exercise?  Yes  No How often? 1X 2X 3X 4X 5X per week other: \_\_\_\_\_

What activities?  Running  Jogging  Weight Training  Cycling  Yoga  Pilates  Swimming  Other \_\_\_\_\_

Do you smoke?  Yes  No How much? \_\_\_\_\_

Do you drink alcohol?  Yes  No How much / week? \_\_\_\_\_

Do you drink coffee?  Yes  No How many cups / day? \_\_\_\_\_

Do you take any supplements (i.e. vitamins, minerals, herbs)? \_\_\_\_\_

Please list any medications you are currently taking \_\_\_\_\_

### CERVICAL SPINE (NECK):

Postural distortions from **subluxations**, (causing **Forward Head Syndrome**), in your neck will weaken/impinge the nerves into your arms, hands and head affecting these parts of your body. Do you experience any of the following conditions...?

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Neck Pain                           | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Sinusitis            |
| <input type="checkbox"/> Pain into your shoulders/arms/hands | <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Allergies/Hay fever  |
| <input type="checkbox"/> Numbness/tingling in arms/hands     | <input type="checkbox"/> Visual disturbances | <input type="checkbox"/> Recurrent colds/Flue |
| <input type="checkbox"/> Hearing disturbances                | <input type="checkbox"/> Coldness in hands   | <input type="checkbox"/> Low Energy/Fatigue   |
| <input type="checkbox"/> Weakness in grip                    | <input type="checkbox"/> Thyroid conditions  | <input type="checkbox"/> TMJ/Pain/Clicking    |

### THORACIC SPINE (UPPER BACK):

- |   |   |
|---|---|
| <input type="checkbox"/> Heart Palpitations   | <input type="checkbox"/> Recurrent Lung Infections/Bronchitis |
| <input type="checkbox"/> Heart Murmurs        | <input type="checkbox"/> Asthma/Wheezing                      |
| <input type="checkbox"/> Tachycardia          | <input type="checkbox"/> Shortness Of Breath                  |
| <input type="checkbox"/> Heart Attacks/Angina | <input type="checkbox"/> Pain On Deep Inspiration/Expiration  |

### THOPRACIC SPINE (MID BACK):

- |  |   |
|--|---|
| <input type="checkbox"/> Mid Back Pain             | <input type="checkbox"/> Nausea   |
| <input type="checkbox"/> Pain Into Your Ribs/Chest | <input type="checkbox"/> Ulcers/Gastritis   |
| <input type="checkbox"/> Indigestion/Heartburn     | <input type="checkbox"/> Hypoglycemia   |
| <input type="checkbox"/> Reflux                    | <input type="checkbox"/> Tired/Irritable after eating or when you haven't eaten for a while |

### LUMBAR SPINE (LOW BACK):

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Pain into your hips/legs/feet       | <input type="checkbox"/> Weakness/injuries in your hips/knees/ankles | <input type="checkbox"/> Low back pain |
| <input type="checkbox"/> Numbness/tingling in your legs/feet | <input type="checkbox"/> Recurrent bladder infections                |  |
| <input type="checkbox"/> Coldness in your legs/feet          | <input type="checkbox"/> Frequent/difficulty urinating               |  |
| <input type="checkbox"/> Muscle cramps in your legs/feet     | <input type="checkbox"/> Menstrual irregularities/cramping (females) |  |
| <input type="checkbox"/> Constipation / Diarrhea             | <input type="checkbox"/> Sexual dysfunction                          |  |

Please list any health conditions not mentioned: \_\_\_\_\_

Please list any surgeries in the past 10 years: \_\_\_\_\_

Have you been tested HIV positive  YES  NO

# AUTHORIZATION OF CARE

I authorize and agree to allow the Doctor and/or physical therapist to work with my spine through the use spinal adjustments and rehabilitative exercises for the sole purpose of postural and structural restoration of normal biomechanical and neurological function.

I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges.

The Doctor and/or physical therapist will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions diagnosed at this clinic.

I also clearly understand that if I do not follow the Doctors and/or physical therapist specific recommendations at this clinic that I will not receive the full benefit from these programs, and that if I terminate my care prematurely that all fees incurred will be due and payable at that time. I authorize the assignment of all insurance benefits be directed to the Doctor and/or physical therapist for all services rendered.

\_\_\_\_\_  
Patient's Name Printed                      Date                      Patient's signature                      Date

\_\_\_\_\_  
Minors Name                      Guardian/Spouse's Signature of Authorizing care for minor                      Date

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## RADIOGRAPH CONSENT FORM

I \_\_\_\_\_ do hereby give my consent to allow Chiropractic and Physical therapy Centers of Ohio and it's representatives, as deemed by the examining physician to take radiographs of my spine and/or extremities.

I also hereby declare that to my knowledge that I am not pregnant \_\_\_\_\_ ( Initial )

Signature of Patient/or Guardian of said Minor \_\_\_\_\_ Date \_\_\_\_\_

### IN CASE OF EMERGENCY CALL:

Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_

## **HIPPA / HEALTH CARE AUTHORIZATION FORM**

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THE FOLLOWING AUTHORIZES **CHIROPRACTIC & PHYSICAL THERAPY CENTERS of OHIO** TO USE AND/OR DISCLOSE PROTECTED HEALTH CARE INFORMATION IN ACCORDANCE WITH THE FOLLOWING SPECIFIC AUTHORIZATIONS:

I give permission to Chiropractic & Physical Therapy Centers of Ohio to use my name, address, phone numbers and clinical records to contact me with birthday cards, holiday related cards, health related e-mails messages and information about treatment alternatives or other health related information as well as any advertisements, newsletters or patient of the week/month postings.

I give permission to Chiropractic & Physical Therapy Centers of Ohio to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protective health care information during the course of my treatment. Should I need to speak with a Doctor or Physical Therapist in private, the Doctor or Therapist will provide a private room for these conversations. By signing the following you are giving Chiropractic & Physical Therapy Centers of Ohio permission to use and disclose your protected health information in accordance with the directives listed above

### **ACKNOWLEDGEMENT OF RECIEPT & NOTICE OF PRIVACY PRACTICES**

I \_\_\_\_\_ on this date \_\_\_\_\_ understand and have been provided with a notice of information practices that provides me 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 care information for directory purpose
- \* The right to request restrictions as to how my health care information may be used or disclosed in this office to carry out treatment, payment, or health care operations

### **PLEASE READ THE FOLLOWING**

At this time, we ask that you hand your application into the front desk. They will now assistance you on how you will describe your **complaints *and/or* symptoms** on the Kiosks in the lobby. Please be sure to mark all areas of discomfort, one area at a time. Thank you.

