Boggs Chiropractic

4212 Town Crossing Blvd, Uniontown OH 44685
(330) 896-2424 (p) ~ (330) 896-3294 (f)
www.boggschiropractic.com

Date: _____ File #: _____ Initials

Confidential Patient Information

Patients Name: _____ Date of Birth: _____ Age: _____

Guardian's Name (if patient is a minor): _____

Address: _____ Chief Complaint: _____

City: _____ State:____ Zip:_____ Cell Phone: _____

SS#: _____ Email: _____

Address of Insured (if different than above): _____

Are your present symptoms or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) ☐ Yes ☐ No

Ins. Company: _____ Ins. Phone #: _____

ID#: _____ Group #: _____

Name of Policy Holder: _____ Policy Holder DOB: _____

Policy Holders Employer: _____

Place of Employment? _____

Family Physician: _____ (Note: May we send your health information to this provider? **Y**

Person to contact in case of emergency (Name and Phone): _____

Have you ever been under Chiropractic Care? Y N If so, where? _____

Have you had X-Rays / MRI's / CT's taken in the last year? Y N If so, Where? _____

What operations have you had? _____ When? _____

Currently Diagnosed Conditions?: _____

Do you have a pacemaker? Y N Have you ever had any replacement surgeries? Y N If so, what? _____

What medications or drugs are you taking? (check those that apply): Pain Killers ☐ Insulin ☐ Cholesterol Meds ☐

Blood Pressure Meds ☐ Muscle Relaxers ☐ Birth Control ☐ Other: _____

What is your goal in our office? _____

How did you hear about us? _____

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 **Boggs Chiropractic** 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

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Patient Name: _____ **Date: _____**

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at **Boggs Chiropractic**, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

X-Ray Permissions:

To the best of my knowledge I **AM / AM NOT** pregnant, and I **GIVE / DO NOT GIVE** permission for x-rays to be taken if necessary, for diagnostic interpretation.

Missed Appointments:

We will charge a minimum charge of $45 for all appointments that are not canceled 24 hours prior to scheduled visit.

Late Appointments:

There will be $15 charge and you will be asked to reschedule if you are more than 10 minutes late to your scheduled visit.

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.
Do we have permission to treat your child if you are not present? Y ○ N ○

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

No one: ☐ Spouse: ☐ Children: ☐ Others: _____

May we leave messages regarding your personal healthcare information on any answering device?
i.e. home answering machines or voicemails? Y ○ N ○

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____

Signature: _____ Date: _____