Everett Health Center, Inc.
115 E. Ohio Ave. Sebring, OH 44672
(330)938-0001 p (330)938-2666 f

Date: _____

Confidential Patient Information

Patients Name: _____ Chief Complaint: _____

Address: _____ Home Phone: _____

City: _____ Zip:_____ Cell Phone: _____

SS#: _____ Email: _____

Date of Birth: _____ Marital Status: M S W D

Occupation: _____ Employer: _____

Address of Insured (if different than above): _____

Are your present systems 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: _____

Family Physician: _____ (Note: May we send your health information to this provider Y / N)

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

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

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

What operations have you had? _____ When? _____

Serious Illness: _____ When? _____

Infectious Diseases: _____ When? _____

Do you have a pace maker? Y / N Have you ever had any Hip or Knee Replacements Y / N

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? _____

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 **Everett Health Center, Inc.** 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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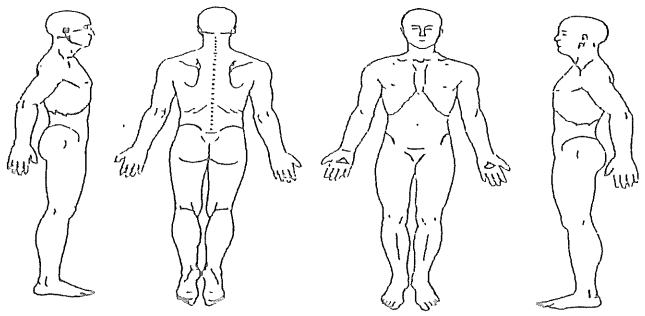
CASE HISTORY

Name: _____

1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain).

Condition / Problem	Severity (Minimal → Severe)	Frequency (% of week) (Occasional → Constant)
a. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
b. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
c. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
d. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
e. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

(Please mark the figures where you experience pain.)



2. Symptoms are worse in the (circle what applies)

-morning -Increase during the day
-afternoon -same all day
-night -decrease during the day

3. Symptom (a.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
4. Symptom (b.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
5. When did your symptoms begin (onset date)? _____
6. How did your symptoms begin? _____
7. Have you experienced these before? _____
8. Do your symptoms radiate? _____
9. Has your condition? ____ Improved ____ Gotten Worse ____ Stayed the same since it began
10. Circle the things that make your problems worse:

Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping

11. Is there anything you can do to relieve the problems? ____No ____Yes Describe: _____
    If No, what have you tried that has not helped? _____
12. Have you been treated for this before? ____No ____Yes How long ago? _____
13. What treatment did you receive? _____
14. Results of previous treatment? ____Good ____Poor Comments _____
15. Were you referred to our office by anyone? _____
16. Is this condition interfering with ____ Work ____Sleep ____Daily Routine ____Recreation
17. List any other major injuries you have had, other than those mentioned above: _____

_____

18. Any other Musculoskeletal problems? ____No ____Yes ...Neurological problems? ____No ____ Yes

_____Additional information on back side of sheet.

I certify that the above information is accurate to the best of my knowledge.

Patient/Guardian Signature _____ Date: _____

EVERETT HEALTH CENTER

BILLING, COLLECTION & FEE INFORMATION

_____INSURANCE PATIENTS: Please have current primary and secondary insurance cards at the time of your appointment. As a courtesy we will gladly file to your insurance company for your services in the office. We must remind you, however, that your insurance is a contract between you and the insurance company and/or employer. We will expect you to pay for all services not covered by your insurance agreement. You will be expected to pay any amount that is applied towards your deductible or co-insurance in a timely manner. Copays are due at the time of service and cannot be billed. If you do not have your copay at the time of service you may be asked to reschedule your appointment. Any patient balance over 30 days may be subject to a $7.00 statement fee.

Your insurance company may need you to supply additional information to them directly. It is your responsibility to comply with their request. Please be aware the balance of your claims is your responsibility whether or not your insurance company pays your claims.

_____NON-INSURANCE PATIENTS: We require 100% of all services to be paid at each visit. We will do our best to let you know approximately how much your visit will cost, but we cannot know your exact outcome until you see Dr. Everett and he has examined you. If you are not prepared to pay for additional costs towards your treatment plan it is your responsibility to inform Dr. Everett that you do not wish to proceed with services such as x-rays or therapy.

WE DO NOT BILL TO WORKERS COMP OR AUTO ACCIDENT CLAIMS

MISSED APPOINTMENTS: There will be a $50.00 charge for all missed appointments.

MEDICAL RECORDS: There is a minimum fee of $50.00, but could be more based on the size of your chart. There is no fee to send your records to anther physician.

RETURNED CHECK FEE: Returned checks will be subjected to a $30.00 NSF charge.

STATEMENT POLICY: After 3 monthly statements have been sent out with no attempt to make a payment we will send a letter notifying you that the account will be forwarded to our attorney for collection action.

X-RAYS: Please be aware that any imaging done by Dr. Everett will be sent to a board certified chiropractic radiologist for interpretation and a written report by Professional Imaging Consultants, Inc. There is a $25.00 reading fee and this is not covered by insurance. You will be expected to pay this fee at the time of service.

COMMUNICATIONS:

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

SPOUSE: _____

CHILDREN: _____

OTHERS: _____

NO ONE: _____

May we leave messages regarding your personal healthcare information on any answering device, such as home answering machines or voicemails? YES _____ NO _____

May we contact you via email? YES_____ NO _____

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 that 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 healthcare service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your healthcare regimen. I understand that if I am accepted as a patient by a physician at Everett Health Center, Inc. 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.

ACKNOWLEDGMENT:

I have read and fully understand the above statements. Upon request a notice of HIPPA will be provided.

Patient/Guardian Signature: _____ DATE: _____

OUR PRACTICE IS COMMITTED TO PROVIDING THE BEST TREATMENT TO OUR PATIENTS!