Shiepis Chiropractic Clinic

Dr. George Shiepis & Dr. Keric Shiepis

2756 Cleveland Ave. NW– Canton, OH 44709 - (330) 453-7733

Patients Name: _____ Chief Complaint: _____

Address: _____ Home Phone: _____ Cell Phone: _____

_____ Work Phone: _____

Social Security #: _____ Email: _____

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

Occupation: _____ Employer: _____

Spouse's Name:_____ Spouse's Employer:_____

Spouse's Employer's Phone #:_____ Name of Bank: _____

Referred By: _____

Primary Insurance: _____ ID#:_____

Secondary Insurance: _____ ID#:_____

Name of the Insured: _____ DOB: _____ Relationship: _____

Are you currently on any form of disability? Y / N If Yes please explain: _____

Is this condition a result of an **auto accident** or **work related accident**? (Circle One)

Family Physician: _____ Name of Facility: _____

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

What operations have you had? _____ When? _____

_____ When? _____

Serious Illness: _____ When? _____

_____ When? _____

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 and convey directly to Shiepis Chiropractic Clinic, 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 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.

I understand that there will be no fees charged if I give 24 hours notice to cancel or reschedule an appointment.

I understand that payment plans are mandatory unless balance can be paid in full. Finance charges will be applied to balances 60 days overdue at 1.5% and every 30 days thereafter

I understand that I will be responsible to pay for any and all Collections fees in the event the account becomes delinquent.

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: ______________________________

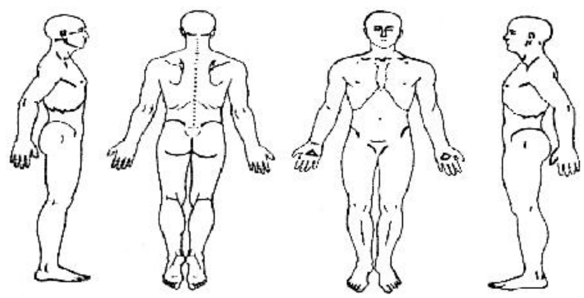
CASE HISTORY

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

(Please list your conditions on the lines below and rate them from top to bottom in the order of severity)

Condition	Severity	Frequency (% of day)
	Minimal Severe	Occasional Constant
______________	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
______________	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
______________	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
______________	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
______________	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
______________	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

Please circle the areas on the right figures where you experience pain.



2. When did your symptoms begin? ____
3. Has your condition? Improved ___ Gotten Worse ___ Stayed the same since its onset ___
4. Circle the things that make your problems worse:

   Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting
5. Is there anything you can do to relieve the problems? No ___ Yes ___ Describe: ______________________

   If No, what have you tried that has not helped? ______________________________________
6. Have you been treated for this before? No ___ Yes ___ How long ago? ____________________________
7. What treatment did you receive? ____
8. Results of previous treatment? Good ___ Poor ___ Comments ____________________________________
9. Is this condition interfering with Work ___ Sleep ___ Daily Routine ___ Recreation ___
10. Approximate date of last Chiropractic treatment? ____
11. Approximate date of last MD / DO treatment? ____
12. List any other major injuries you have had other that those that might have been mentioned above: ________________
____
13. To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or the present? Yes ___ No ___. If yes, Please explain ____

I certify that the above information is accurate to the best of my knowledge.
Patient's Signature ____ Date: ______________________________

Guardian's Signature ____ Date: ______________________________

Below is a list of problems that may be important for the Doctor to be aware of. Please check any that you may have had in the past 6 months:

- ❑ Upper Back Pain
- ❑ Midback Pain
- ❑ Low Back Pain
- ❑ Hip Pain
- ❑ Neck Pain
- ❑ Arm /Leg Pain
- ❑ Foot/Hand Pain
- ❑ Knee/Shoulder/Elbow/Wrist Pain
- ❑ Jaw Pain
- ❑ Numbness/Tingling
- ❑ Dizziness/Fainting/Vertigo
- ❑ Sleep Problems
- ❑ Fatigue
- ❑ Headaches/Migraines
- ❑ Stress/Anxiety
- ❑ Allergies
- ❑ Poor Appetite
- ❑ Excessive Thirst
- ❑ Nausea/Vomiting
- ❑ Diarrhea/Constipation
- ❑ Abdominal Pain
- ❑ Urinary Trouble
- ❑ Chest Pain
- ❑ Short Breath
- ❑ Blood Pressure Problems
- ❑ Lung Problems
- ❑ Stroke
- ❑ Ankle Swelling
- ❑ Earaches
- ❑ Menstrual Problems
- ❑ HIV/AIDS
- ❑ Cancer
- ❑ Tuberculosis
- ❑ Diabetes
- ❑ Heart Problems
- ❑ Epilepsy

Name _____

CC/Injury/MVA

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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 question please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic physician, 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 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 whatever 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 physician 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 Shiepis Chiropractic Clinic, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Women Only:

To the best of my knowledge I am NOT pregnant and give my permission to x-ray me for diagnostic interpretation.

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.

Communications:

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

Spouse: _____

Children: _____

Others: _____

May we leave messages on any answering device, i.e. home answering machines or voicemails? Yes [ ] No [ ]

I have read and fully understand all above statements.

_____ _____

Signature Date

Acknowledgement

I have been given the opportunity to view the notice of privacy practices (HIPPA) and have been provided an opportunity to discuss my right to privacy.

Print Name: _____

Signature: _____ Date: _____

S h i e p i s C h i r o p r a c t i c C l i n i c
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Protecting Your Health Information

New Regulation Passed

The new regulations are part of the Health Insurance Portability and Accountability Act or HIPPA 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 e very 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 be given general 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. Also upon becoming a patient, we will be entering your name into our database and you will 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.

Notification by Mail or Phone

Patients may be contacted by mail 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.