PATIENT INFORMATION FORM (Please Print)

PATIENT NAME_____ DATE_____

STREET ADDRESS _____

MAILING ADDRESS (If different than Street Address) _____

CITY_____ STATE_____ ZIP_____ HOME PHONE_____

CELL PHONE _____ WOULD YOU LIKE TEXT ALERTS _____

AGE_____ DATE OF BIRTH_____ E-MAIL _____

EMPLOYER_____ WORK PHONE_____

EMPLOYER ADDRESS_____ OCCUPATION_____

SPOUSE NAME_____ DATE OF BIRTH_____

EMPLOYER_____ WORK PHONE_____

MEDICAL DOCTOR_____ LAST VISIT_____

In case of emergency, whom should be notified_____ PHONE_____

Whom may we thank for referring you_____

Who is financially responsible for this bill_____

Patient will be paying today by_____ CASH _____ CHECK _____ Visa/ MC

This case will be turned over to_____ Work. Comp. _____ P. I. _____ Ins.

- "I hereby give permission to the doctor to administer treatment and perform such general procedures as he may deem necessary in the diagnosis and/or treatment of my condition.
- "I hereby release and allow SHAFFER CHIROPRACTIC CENTER to examine and treat the above-named minor as I am the parent/guardian."
- "If applicable, I hereby give permission to the doctor to release any information requested by my insurance company acquired in the course of my examination and treatment. I am financially responsible for non-covered services."

SIGNED_____ DATE_____

"I have read and agree to the above statements as I am patient and/or parent/guardian."

SHAFFER CHIROPRACTIC CENTER
SCOTT M SHAFFER BS DC

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ Patient ID #: _____

I hereby acknowledge that I have received a copy of Shaffer Chiropractic Center's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

_____ _____
Signature of Patient or Legal Representative Date

_____
Printed Name of Patient's Representative (*if applicable*)

Relationship to Patient (*if applicable*)
- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date, _____ but acknowledgment could not be obtained because:

- ☐ Patient/representative refused to sign
- ☐ Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a later date)
- ☐ Communication barriers prohibited obtaining acknowledgement (Explain)

_____
_____
_____
_____
_____

- ☐ Other (Specify)

_____
_____
_____
_____
_____

SHAFFER
CHIROPRACTIC
CENTER
Scott M. Shaffer, B.S., D.C.

FINANCIAL AGREEMENT AND OFFICE POLICIES

The purpose of this agreement is to clarify your financial responsibilities so we can devote our efforts to helping you get the best results in the shortest amount of time. These are the most common services we provide:

PROCEDURE	PURPOSE	WHEN PERFORMED	FEE
Consultation	Discuss your health problems and review your case history.	First visit, new injuries, or new condition.	N/C
Evaluation/ Management (Examinations)	Ascertain the nature and severity of your health problems. Asses and evaluate your new or current health status and determine an appropriate course of action.	First visit, new conditions, exacerbations, and progress examinations.	$ 40.00- $100.00.
Chiropractic Manipulative Treatments (Adjustments)	Reduce the Vertebral Subluxation Complex and help stabilize your spinal or joint problems.	As indicated by examination or evaluation.	$ 35.00- $ 75.00.
Therapy (Ice Packs)	Reduce inflammation and swelling, speed the healing process, and help provide relief.	As indicated by examination or evaluation.	$ 5.00- $ 10.00.
Cervical Contour Pillows	Help maintain upper body stability and increase sleep.	As indicated by examination or evaluation.	$110.00- $140.00
Arch Support Orthotics	Help maintain lower body stability and strength.	As indicated by examination or evaluation.	$200.00- $350.00.
Nutritional/ Dietary Screenings	Help balancing nutritional needs.	As indicated by examination or evaluation.	$ 75.00- $ 100.00.

FORMS OF PAYMENT

Patients are responsible for full payment at the time of service. We accept cash, personal checks, and Visa/MC. Any credit arrangements must be authorized in advance.

Time of service self-pay cash discounts are available. Ask the front desk.

122 S. Main St., P.O. Box 541 * Utica, Ohio 43080-0541 * (740) 892-4622
www.shafferchiropractic.com * drscott@shafferchiropractic.com

SHAFFER CHIROPRACTIC CENTER

Scott M. Shaffer, B.S., D.C.

INSURANCE/CONTRACT SERVICES/ THIRD PARTY

Other options are available if your care is covered by group health insurance, Medicare, Medicaid, personal injury, or the result of an automobile accident. All professional services are rendered and charged to the patient receiving care and **not** to an insurance provider. We will submit statements, reports, or other documents to any involved third party. We will not become involved in disputes with your insurance company or third-party regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, "medical necessity", etc., other than to supply factual information.

We will accept assignment in the following cases:

- 100% on **approved**, personal injury, automobile accident or Medicaid cases. Approval must be sought through the front desk or the Doctor.
- The insurance co-payment on **approved** group health insurance and Medicare cases. Approval must be sought through the front desk or the Doctor.

CREDIT POLICY

To assist you in fulfilling the financial obligation associated with your care, our office will extend a credit limit of $_____.

SPECIAL ARRANGEMENTS

We have never denied anyone the benefits of chiropractic care due to their inability to pay our published fees. If financial hardship necessitates an Individual Consideration Contract, payment will be handled in the following manner:

_____

_____

BILLING

Any outstanding balances are billed monthly and may be considered past due 30 days after the invoice date or when special arrangements are not met. Returned checks are subject to a $35.00 collection fee. Balances older than 30 days may accrue charges of $15.00 per month, plus any legal or collection fees.

Patient Agreement

I have read, understood, agreed to, and received a copy of this agreement.

_____

Patient/Responsible Party Date

_____

Office Representative

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SHAFFER CHIROPRACTIC CENTER

Scott M. Shaffer, B.S., D.C.

INFORMED CONSENT
DOCTOR-PATIENT RELATIONSHIP FOR CHIROPRACTIC CARE

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

ANALYSIS

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment and mobility allow nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the doctor of chiropractic, 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 problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give chiropractic adjustment, or health care, if he is aware that such may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS

The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal. In most cases there is a more gradual but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we admit that conditions which do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT

Please discuss any questions or problems with the doctor **before** signing this statement of policy.

I have read and understand the foregoing.

_____ _____

Signature of patient or parent/guardian Date

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SHAFFER CHIROPRACTIC CENTER SCOTT M SHAFFER BS DC
P.O. Box 541, 122 S. Main Street, Utica, Ohio 43080-0541
Phone: (740)892-4622 Fax: (740)759-7104

Subjective Complaints

Explain WHEN and HOW it happened: _____

_____

_____

Complaints/Symptoms: ___ Come and go ___ Came on gradually ___ Came on suddenly VAS Score _____ / 10

Symptoms have persisted for: ___ Hours ___ 1 Day ___ Days ___ Weeks ___Months ___ Years

Symptoms developed from: ___ A work-related injury ___ Auto accident/personal injury ___ Other

Describe complaints (please give details):

Involving Neck & Head: _____

_____

Involving Mid-back / Shoulders / Arms & Hands: _____

_____

Involving Low back / Hips / Legs & Feet: _____

_____

What activities make condition WORSE? _____

What activities make condition BETTER? _____

Have you ever had this condition before? ___ Yes ___ No

If yes, when? _____

Give name of doctors previous seen for this present condition: _____

What MEDICATIONS are you presently taking? For what conditions? _____

_____

Symptoms are BETTER in: __ AM __ Midday __ PM Symptoms are WORSE in: __ AM __ Midday __ PM ___ No change with time of day.

Indicate ability to perform the following activities.
Use these codes: U = Unable P = Painful D = Difficult L = Limited N = Normal

___ Getting in and out of car ___Bending over forward ___ Lying on back
___ Walking short distances ___ Coughing or sneezing ___Sitting at a table
___ Lying on side with knees bent ___ Lying flat on stomach ___ Turning over in bed
___ Bending forward to brush teeth ___ Standing for more than 1 hour

___ Climbing ___ Kneeling ___Balancing ___ Dressing self ___ Sleeping
___ Pushing ___ Pulling ___ Reaching ___ Stooping ___ Gripping

Habits:
Hours of sleep _____
Coffee/Tea _____
Alcohol _____
Tobacco _____
Exercise _____
Hobbies _____

Check symptoms of nervous stress: Y = Yes N = Leave blank

___ Blurring vision ___ Convulsions ___ Loss of sleep ___ Muscle jerking ___ Confusion
___ Paralysis ___ Fainting ___ Low resistance ___ Numbness ___ Dizziness
___ Buzzing/ringing in ears ___ Depression/crying spells
___ Headaches - How often do you have headaches? _____

Have you had any of the following?: Y = Yes N = Leave blank

___ Pneumonia ___ Anemia ___ Arthritis ___ Rheumatic fever ___ Measles ___ Mumps
___ Venereal disease ___ Diabetes ___ Lumbago ___ Appendicitis ___ Mental disorders ___ Cancer
___ Epilepsy ___Tuberculosis ___ Polio ___ Pleurisy ___ Nervous disorder ___ Goiter
___ Chicken Pox ___ Alcoholism ___ Eczema ___ Influenza ___ Whooping cough

Operations / Spinal procedures: (Please list) _____

_____

Previous accidents, falls, unconsciousness: (Please describe fully) _____

_____

OVER

SUBJECTIVE COMPLAINTS - PAGE 2

Please check all of the appropriate symptoms that you now have or have had recently by frequency. We want all of the facts about your health before we accept your case. Your health report is confidential and is treated as such by our staff. Please letter the line beside the symptoms which pertain to you with an O = OCCASIONAL, F = FREQUENT or C = CONSTANT. If you do not have a symptom ***leave it blank***.

General Symtoms:
____ Headaches
____ Allergy headaches
____ Migraine
____ Tension
____ Fever
____ Chills
____ Fainting
____ Convulsions
____ Nervousness
____ Loss of weight
____ Obesity
____ Loss of sleep
____ Numbness / Pain in arms / hands
____ Numbness / Pain in legs / feet
____ Allergy
____ Wheezing

E.E.N.T.:
____ Failing vision
____ Near sightedness
____ Far sightedness
____ Eye pain
____ Deafness
____ Earache
____ Ear discharge
____ Nosebleeds
____ Nasal obstruction
____ Sore throat
____ Hoarseness
____ Hay fever
____ Asthma
____ Frequent colds
____ Enlarged thyroid
____ Tonsilitis
____ Sinus infection
____ Enlarged glands

Skin:
____ Skin eruptions
____ Psoriasis
____ Eczema
____ Itching
____ Bruise easily
____ Dryness
____ Varicose veins
____ Hives/allergy

Respiratory:
____ Chronic cough
____ Spitting up phlegm
____ Spitting up blood
____ Chest pain
____ Difficulty breathing

Cardiovascular:
____ Rapid heart beat
____ Slow heart beat
____ High blood pressure
____ Low blood pressure
____ Pain over heart
____ Swelling of ankles
____ Poor circulation

For Women Only:
____ Lumps in breast
____ Congested breast
____ Vaginal discharge
____ Painful menstruation
____ Pre-menstrual headache
____ Excessive flow
____ Irregular cycle
____ Hot flashes
____ Menopausal symptoms
____ Infertility
____ Previous discharge
____ **CURRENT pregnancy**
Last menstrual cycle was: _____

Genitourinary Symptoms:
____ Frequent urination
____ Painful urination
____ Blood in urine
____ Kidney/bladder infection
____ Bed wetting
____ Inability to control bladder
____ Prostate trouble
____ Inability to start urination

Gastrointestinal:
____ Poor appetite
____ Difficult digestion
____ Excessive hunger
____ Belching/gas
____ Nausea
____ Vomiting
____ Vomiting of blood
____ Pain over stomach
____ Distension of stomach
____ Constipation
____ Diarrhea
____ Colon trouble
____ Hemorrhoids
____ Liver trouble
____ Gall bladder trouble
____ Jaundice
____ Colitis

Muscle / Joint Symptoms:
____ Hernia
____ Arthritis
____ Swollen Joints
____ Painful joints
____ Difficulty walking
____ Backache / Sciatica
____ Painful tailbone
____ Neck pain / stiff neck
____ Pain between shoulders
____ Muscle spasms

To help us better explain chiropractic and how we may be able to help you, please check the one best answer for each statement below:

1. I remember important things in my life by what I _____.
   ___ see ___hear ___ feel
2. The primary reason I brush my teeth is to _____.
   ___ avoid tooth decay and gum disease
   ___ make sure I have healthy teeth and gums
3. When I make decisions I generally _____.
   ___ gather the facts and weigh the evidence
   ___ make the right choice instantly
   ___ consult my friends and family
   ___ depends on how I feel about it
4. When I get in an automobile, I put on my seatbelt _____.
   ___ every time ___ most of the time ___ some of the time

Name:_____

Age: _____ Occupation: _____

File #: _____ Today's date: _____