(Office use only) Acct Number _____

PATIENT INFORMATION

FIRST _____ **MI**_____**LAST**_____

Who can we thank for referring you_____ ***(Leave blank if returning patient)***

Address _____**City** _____**State**_____ **Zip**_____

Home Phone: _____ **Mobile Phone:**_____

DOB: _____**Social Security Number (used for billing purposes):** _____

Email_____

Employer: _____**Employer Phone:** _____

If Patient is a Minor: PARENT'S NAME _____

Person(s) to contact in case of emergency, questions concerning my treatment, and any questions concerning any account or account balance.

Name _____ Telephone_____

Relationship_____ Cell Phone: _____

Please Initial:

I give permission to leave a **message** on my home or cell phone: Yes_____ No_____

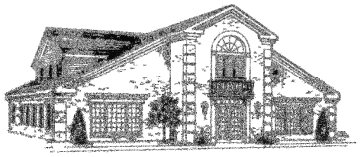
I give permission to leave a **detailed message** on my home or cell: Yes_____ No_____

I give permission to be contacted by **text** message: Yes_____ No_____

I acknowledge that the information listed above is true to my knowledge and if there are any changes, I understand that it is my responsibility to contact the office.

Print Full Name: _____ Date: _____

Signature: _____Date: _____



Powell Chiropractic Clinic, Inc.

Dr. James P. Powell • Dr. James D. Powell • Dr. Robert Powell • Dr. Walter B. Null IV • Dr. Abbey M. Crouse

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 Powell 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.

Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my provider in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived.

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.

Patient Signature _____ Date _____/_____/_____

Powell Chiropractic Clinic, Inc.
4867 Munson Street, NW
Canton, OH 44718

Phone: (330) 494-5533
Fax: (330) 494-8101
www.powellchiropractic.com

Powell Chiropractic Clinic, Inc.

Dr. James P. Powell • Dr. James D. Powell • Dr. Robert Powell • Dr. Walter B. Null IV • Dr. Abbey M. Crouse

PRACTICE'S REQUIREMENTS

The Practice:

(a) Is required by federal law to maintain the privacy of your Personal Health Information (PHI) and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

(b) Powell Chiropractic Clinic, Inc. adheres to Ohio law in those instances where Ohio law does not conflict with Federal law.

(c) Is required to abide by the terms of this Privacy Notice.

(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.

(e) Will distribute any revised Privacy Notice to you prior to implementation.

(f) Will not retaliate against you for filing a complaint.

EFFECTIVE DATE

This Notice is in effect as of 04/15/03. If you would like to review our HIPPA agreement, please advise our staff and we will supply you with detailed information.

PATIENT ACKNOWLEDGEMENT

By signing below, I acknowledge that I have read this Notice, and that I understand and agree to its terms.

_____

Patient Name

_____

Patient Signature

_____

Date

Powell Chiropractic Clinic, Inc.
4867 Munson Street, NW
Canton, OH 44718

Phone: (330) 494-5533
Fax: (330) 494-8101
www.powellchiropractic.com

MEDICATION/SUPPLEMENT UPDATE

We are in the process of updating our records to comply with federal standards, please answer the following questions:

Patient:_____ **Date:** _____
Last Name First Name Initial

Do you take vitamins or other supplements?

☐ Not currently taking any vitamins or supplements

☐ Yes… What? _____ _____ mg or times/day

What? _____ _____ mg or times/day

What? _____ _____ mg or times/day

Have you had recent tests showing high cholesterol and/or triglycerides? ☐ Yes ☐ No

Have you had recent tests showing high blood pressure? ☐ Yes ☐ No

Are you diabetic? ☐ Yes ☐ No **Are you taking insulin?** ☐ Yes ☐ No

Do you eat breakfast daily? ☐ Yes ☐ No

How many days/week do you skip one or more meals? ☐ 0-1 ☐ 2-3 ☐ 4 or more

How many servings of vegetables do you eat/day (average)? ☐ 0-1 ☐ 2-3 ☐ 4 or more

How many servings of fruit do you eat/day (average)? ☐ 0-1 ☐ 2-3 ☐ 4 or more

How many times do you eat fast-food or refined/processed foods a week (average)?

☐ 0-2 ☐ 3-5 ☐ 6-8 ☐ 9 or more

What are your average hours of sleep/night?

☐ 0-3 ☐ 4-5 ☐ 6-7 ☐ 8 or more

Do you need to take pills to sleep or be able to relax? ☐ Yes ☐ No

Have you received the full, standard profile of vaccinations? ☐ Yes ☐ No

Have you had the flu shot this year? ☐ Yes ☐ No

Have you had flu shots in the past? ☐ Yes ☐ No

Powell Chiropractic Clinic, Inc.
4867 Munson Street, NW
Canton, OH 44718

Phone: (330) 494-5533
Fax: (330) 494-8101
www.powellchiropractic.com

Office Financial Policy

It is our office policy that all services rendered are the responsibility of the patient, and that you are ultimately personally responsible for all payments regardless of whether or not this office accepts insurance assignment.

1. **Patients without insurance:**

   All payments are expected at the time of service, or preset a payment plan or program. Personal balances should not exceed $150 at any time, unless on a pre-arranged payment plan.

2. **Patients with insurance:**

   Deductibles and all co-payments are expected at the time of service, or preset on a payment plan. Your patient responsibility balance should not exceed $150, unless on a pre-arranged payment plan.

It is the policy of this office to extend to our patients the courtesy of assigning your insurance benefits directly to us. We are happy to extend this credit to you so that you can follow through with all of the care you may require. The following are important points of consideration to be aware of:

1. The privilege of insurance assignment begins when our office receives and verifies your insurance information.
2. As a courtesy to you, our office will pre-qualify your insurance coverage, in an effort to help you determine what coverage is available to you under your policy. We will help you make the *best estimate* of your coverage for the recommended services. *This service is a courtesy to you and not a guarantee of payment.*
3. As a courtesy, this office will submit secondary insurance, if necessary.
4. If your insurance has not paid on an assigned bill within 60 days, you will be notified. Since we do not own your policy, we may ask you to stay in communication with our office and take action with your insurance company at that time. If it remains unpaid within 90 days, the balance becomes due and payable immediately, and your assignment is revoked.
5. If your insurance benefits reach a maximum, you agree that any additional care you receive at Powell Chiropractic Clinic will be your financial responsibility.
6. All patients whose treatment visitation schedule is once per month or longer may not be eligible for insurance assignment as this level of care is rarely covered by insurance. Our office offers wellness plans to allow you to continue needed care.
7. No one can predict what an insurance company will pay for the usual and customary charges for services rendered. If we participate on your plan, you will not encounter balance billing above the stated fee schedule. If we do not participate, we will work with you to determine the amount of coverage and help estimate your responsibility.
8. Should you discontinue care for any reason; any and all balances will become due and payable at that time. If you are on a predetermined payment plan, that plan will continue to be in effect until your balance in zero, unless you fail to keep up with your payment plan.
9. If the patient being treated is a minor, a parent/guardian must be present at the time of the initial and report of findings appointment, which are the first and second appointments as a new patient. This is so treatment and financial arrangements can be explained to the parent/guardian. For services rendered to minor patients, the parent(s) or guardian(s) of the minor are responsible for payment.
10. The goal of our office is to provide you with the finest quality chiropractic care available. If you have any questions with regard to your health care or any of our policies, please let us know.

Signed:_____

Date:_____

Staff Initials:_____

Powell Chiropractic Clinic, Inc.
4867 Munson Street, NW
Canton, OH 44718

Phone: (330) 494-5533
Fax: (330) 494-8101
www.powellchiropractic.com

Billing Agreement

Our billing department will make every effort to ensure your claims get paid as quickly and easy as possible. Due to the fact that there are a lot of changes with insurance policies and multiple types of plan coverages, we are forced to follow their guidelines. Unfortunately, how they apply deductibles, copayments, payments, and denials is up to them, not us. At that time, if we see something is incorrect, we will appeal only once. **If it exceeds one appeal, we will contact you, and at that time you must get involved.**

Because insurance companies are continuously changing what they cover, how they cover, and what they make your responsibility, you, as the policy holder, are required to understand your insurance plan and be involved through the process. Remember, it is your insurance policy, not ours. We are the middle man, and cannot make decisions regarding what your insurance pays and what they do not.

You will receive an Explanation of benefits (EOB) from your insurance company. Please review them. If there is ever a time you feel like something is incorrect with what your insurance company paid, or what you feel is your responsibility, *YOU MUST* contact your insurance company.

One thing to keep in mind is that that each insurance policy has what is called a "Timely Filing." That means, they only allow us as the provider, and you as the policy holder, a certain amount of time to appeal or work with a claim. That time can range anywhere from 6 months to 2 years depending on the insurance company and your policy. Once that time is up, you will become fully responsible for all of the charges at full price.

You will receive monthly statements ONLY if you have a current balance. Please remember that it can take weeks to hear back from your insurance company, and sometimes statements and EOB's can cross paths.

When you make payments on your account, we apply that payment to the oldest date of service with an outstanding balance, to avoid sending those claims to collections. It WILL NOT affect your balance total if what you thought you paid for and what it was applied to do not match.

We apologize for any inconvenience that this may cause, but appreciate your understanding and patience. Please know we only have the best interest of our patients and we will try our best to make this process as easy as possible.

Thank you,
Amanda Deeser
Billing Department

Amy Marceric
Office Manager

Print Name _____ Date _____

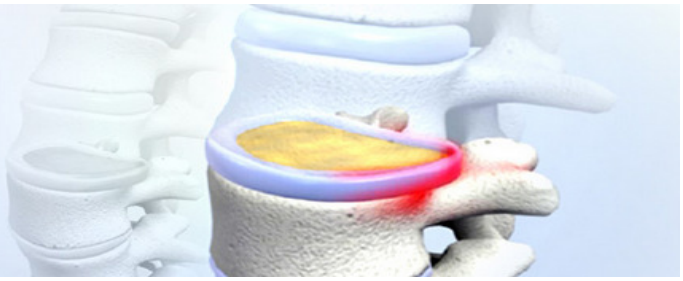
Signature _____

Powell Chiropractic Clinic, Inc.
4867 Munson Street, NW
Canton, OH 44718

Phone: (330) 494-5533
Fax: (330) 494-8101
www.powellchiropractic.com

DISC-covery

Disc Recovery Program



Name: _____ **DOB**:_____ **Date:**_____

What is your chief complaint? Neck pain Arm Pain (Right Left) Low Back Pain Leg Pain (Right Left)

Other: _____

How long have you suffered with these symptoms? _____

How would you describe your pain? Aching Dull Numbing Sharp Shooting Throbbing Tingling

Please describe your symptoms:_____

Does it radiate or travel into another part of the body? Yes No If so, where:_____

Pain scale evaluation (Circle your pain level): No Pain 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Intense Pain

When is the pain worst (Circle your response): Morning Mid-day Evening

Family history of similar conditions? Yes No

Any weakness in arms or legs? Yes No Arms Legs Right Left Both

Poor circulation in arms or legs? Yes No Arms Legs Right Left Both

Blurred vision or change in eye function? Yes No Right Left

Dizziness or balance issues? Yes No Dizziness Poor balance Both

Do you suffer from any of the following: ***Circle all that apply***

Chronic sinus issues Low grade fever Unexplained Weight loss Night sweats Issues with fatigue Bowel/bladder changes or loss of control Male/Female disorders

Other/Details: _____

Previous Care:	**Date/Details**		**Date/Details**
Pain Management:	_____	Surgery:	_____
Physical Therapy:	_____	Chiropractic:	_____
Medication:	_____	Acupuncture:	_____

Other: _____

Any treatment success? _____

Other information we should know:_____

_____

_____

Patient Signature: _____

Powell Chiropractic Clinic, Inc.
4867 Munson Street, NW
Canton, OH 44718

Phone: (330) 494-5533
Fax: (330) 494-8101
www.powellchiropractic.com

Powell Chiropractic Clinic, Inc.

Dr. James P. Powell • Dr. James D. Powell • Dr. Robert Powell • Dr. Walter B. Null IV • Dr. Abbey M. Crouse

4867 Munson Street NW • Canton, Ohio • 44718

(330) 494-5533 Fax: (330) 494-8101

Name: _____ Date: _____

Chart Number: _____

PLEASE FILL OUT ALL AREAS

Primary Care Physician: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

Have you had blood work within the last year? _____

Do we have your permission to request Records from the office? _____

Patient Name: _____
Date of Birth: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:

Name: POWELL CHIROPRACTIC CLINIC, INC
Address:4867 Munson ST NW
City: Canton State: Ohio Zip: 44718
Phone Number: 330-494-5533 Fax Number: 330-494-8101

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).
   - _____ Complete Health Records
   - _____ Physical Exam
   - _____ Immunization Record
   - ___X___ Lab Results/X-ray Reports
   - _____ Consultation Reports

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
5. *This information may be disclosed to and used by the following individual or organization:*
6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: 12 months from signing date.
7. If I fail to specify an expiration date, event, or condition, this authorization will expire in 60 days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact:

_____
Privacy Officer for _____

_____ _____
Signature of patient or legal representative Signature of witness
Date: _____ Date: _____