INTAKE FORM

DATE_________STAFF____________REFERRED BY__________________________________ACCT_____________________

NAME_________________________M_____LAST_________________________DOB___________

IS THIS AUTO ACCIDENT OR WORK RELATED? N Y STOP & RE-DIRECT

Did you go to the ER? Y N Did you go by Ambulance? Y N : CT MRI XRAYS

Need Proof of AUTO MED! Statement by the company to show amount of Auto Med!

Do you or will you have an Attorney and if so whom? ____

Address _______________________________________**City** _______________________**State**________**Zip**____________

Home Phone: ___________________________________**Mobile Phone:**____

Email____

QUESTIONS:

Have you been under chiropractic care in the past? N Y → WHERE? ____________________________________

What is your particular problem or complaint? ____

Do you have any current standing xrays or MRI? N Y→ Bring copies with you/***ATTACH DISC-COVERY FORM!***

BRINGING PAPERWORK? Y N

APPOINTMENT DATE: _________________________ TIME: _______________/_________________ DOCTOR: ________________

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

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

(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: ___________________

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AUTO INSURANCE VERIFICATION FORM

NAME____

APPOINTMENT DATE_____________________________ POWELL ACCT #__________________________

AS PREVIOUSLY EXPLAINED, OUR OFFICE POLICY IS TO BILL **YOUR** AUTO INSURANCE THROUGH THE MEDICAL PAYMENTS CLAUSE IN **YOUR** POLICY.

Did you go to the ER? Y N **Did you go by Ambulance?** Y N

Did you have? CT MRI XRAYS

YOU MUST PROVIDE US WITH THE FOLLOWING INFORMATION BEFORE BEING SEEN AT THE OFFICE

1. DATE OF ACCIDENT____

2. **YOUR AUTO INSURANCE INFORMATION:**

    a. COMPANY NAME____

    b. ADJUSTER NAME____

    c. INSURANCE MAILING ADDRESS FOR CLAIM _______________________________________

    ____

    d. INSURANCE PHONE#__________________________FAX #__________________________

    e. POLICY #_____________________________CLAIM # ______________________________

    f. AUTO MED AMOUNT ____

    (PLEASE ATTACH PROOF OF AUTO MEDICAL POLICY.)

Do you or will you have an Attorney and if so whom? ____

ASSIGNMENT AND AUTHORIZATION
PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE
(YOUR INSURANCE/AUTOMED INFORMATION)

I hereby request ____ to pay directly to POWELL
Name of Company

CHIROPRACTIC CLINIC, INC., 4867 Munson Street, NW, Canton, Ohio 44718 the **TOTAL AMOUNT OF**

MEDICAL CHARGES payable under the terms of Claim Number _________________, Policy Number

___________________ on account of claim commencing on or about _______________________.
Date

I specifically authorize that this assignment may be paid from disability benefits, medical payments, or from **ANY** benefits due to me under this claim. I understand and agree that any unpaid balances **not covered** by this policy will be paid by me.

I also authorize the above named Doctor/Clinic to release any information, pertinent to my case, to any insurance company, adjuster or attorney involved in the case.

Dated at Canton, Ohio this __________ day of ________________________, 20______.

____
Signature of Policy Holder

____
Witness

I hereby state and agree that a photocopy of this document will be deemed as valid and binding on all parties involved as the original copy.

PATIENT VERIFICATION

I have been advised by this Clinic that the preferred method for payment of treatment fees is for the fees to be paid directly by me as I receive treatment:

> I do not want my health insurance to be billed for treatment of my injuries, except in the case that my own liability insurer requires it as a condition to qualifying for medical payments coverage.

I authorize this Clinic to bill my own liability insurer for treatment fees I incur. I authorize this Clinic to send notice of the Assignment to my own liability insurer, to the liability insurer of the person I claim caused my injuries, and to the attorney representing me for My Claim. This document is made a part of the Assignment I have signed in favor of the Clinic.

______________________________________ ______________________________________

Name of Liability Insurer for *Person at Fault* Name of **My** Liability Insurer

____

Name of My Attorney, if applicable

I have received a copy of an Assignment which I have signed in favor of this Clinic and Schedule of Treatment Fees.

____ ______________________________

Signature of Patient, Parent, or Legal Guardian Date

____ ______________________________

Print or Type Name Staff Witness

PAYMENT FOR TREATMENT

(When Patient's Health Insurance Will Not Be Billed)

I have been injured. I do not have health insurance or do not want my health insurance to pay for the treatment fees. If my automobile insurance will cover my treatment fees, I authorize this Clinic to bill this insurer. Even if no other person is at fault for my injuries caused by an accident, agree to sign this Clinic's *Assignment* and related documents, and will provide any information required by the Clinic. I realize that any money which I receive from my automobile insurer for this Clinic's treatment fees must be immediately paid over to this Clinic.

If I believe that one or more persons are at fault for causing my injuries in an accident, I agree to sign this Clinic's *Assignment* and related documents, and will provide any information required by the Clinic.

I understand that my automobile insurer, or an insurer representing someone I believe to be at fault for causing my injuries, or that persons' attorney, or an attorney representing me in a claim for injuries, may request reports, copies of records may require a physician from this Clinic to provide deposition testimony or testimony in court, or other information. I understand and agree that I am financially responsible to this Clinic to pay the Clinic's costs for these items, and that the Clinic may request payment in advance for some or all of these items, even if this Clinic's *Assignment* states otherwise.

I understand and agree that all of my records, including x-rays, are permanent records of this Clinic. I authorize the release of any information relevant to my treatment, including information regarding treatment fees, to insurers and attorneys who are involved with my claim and their respective representatives.

I HAVE READ THIS DOCUMENT AND I FULLY UNDERSTAND IT.

THIS DOCUMENT IS MADE A PART OF THE ASSIGNMENT I HAVE SIGNED IN FAVOR OF THE CLINIC.

I HAVE RECEIVED A COPY OF THIS DOCUMENT.

______________________________ Signature of Patient

______________________________ Date

______________________________ Print or Type Patient's Name

______________________________ Signature of Parent or Legal Guardian

______________________________ Print or Type Name of Parent or Legal Guardian

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Boehm, Kurtz & Lowry, Attorneys at law

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ASSIGNMENT

I was involved in an accident on or around ______________________ [date] in which I was injured for which I have or may have a claim against another person(s) for causing my injuries (including _____________________________) (referenced as "My Claim"), who is insured by_________________________.

Name of Person at Fault

In consideration of the agreement of Powell Chiropractic Clinic Inc. (referenced as the "Clinic") to delay billing me personally for medical treatment rendered until resolution of My Claim:

1. I now assign, without any right to later revoke a part of any proceeds from my claim equal to the fees incurred by me to this Clinic for all treatment and other services rendered by this Clinic. I am not assigning any legal cause of action in My Claim above, but only prospective proceeds. I also assign to the Clinic my right to enforce the obligation of any insurance company to pay settlement proceeds for any settlement agreement made by or for me in exchange for my signing such insurance company's release of claim. Prior to settlement or other disposition of My Claim, I understand and permit Clinic to pursue payment from any other source but me personally, including medical payments coverage in an automobile liability policy.
2. **This Assignment and related documents which I have signed in connection with it states the entire agreement and my complete understanding regarding the Clinic's fees. I have not relied on any statements by the Clinic or the Doctor or other information before making this Assignment. I understand that I remain responsible for any Clinic fees not paid out of My Claim.**

    ____

    Signature of Patient

3. **I understand that it is my responsibility during treatment to remain aware of my cumulative account balance for services rendered. I have received a schedule of treatment fees for this Clinic, or if I have not, will request this Clinic for one in writing.**
4. I understand that this is an express contract to pay for the services rendered by this Clinic. I agree to pay my account balance in full and/or direct its payment from My Claim proceeds regardless of whether any other person or entity attempts to or fails to fully reimburse me for it. If I dispute my account balance or treatment rendered, I agree that my remedy will be to resolve it with a separate action from My Claim.
5. **NOTICE: I DIRECT ANY INSURANCE COMPANY, ATTORNEY, OR OTHER PERSON WHO HOLDS OR LATER HOLDS ANY PROCEEDS FROM MY CLAIM TO APPLY ANY PROCEEDS FROM MY CLAIM TO MY TOTAL ACCOUNT BALANCE OUT OF THE TOTAL PROCEEDS HELD IN MY BEHALF, UNLESS THE CLINIC CONFIRMS PRIOR PAYMENT OF IT IN WRITING. "TOTAL PROCEEDS" HELD BY AN ATTORNEY FOR MY CLAIM SHALL MEAN PROCEEDS AFTER DEDUCTION OF ATTORNEY FEES.**
6. This Assignment is governed by Ohio law. Jurisdiction shall be in Ohio, and venue shall lie in the county in which the Clinic is located, unless required by applicable law to lie in a different county in which I reside.
7. **I REALIZE THAT I HAVE NOW GIVEN AWAY A PART OF ANY PROCEEDS FROM MY CLAIM. IF I RECEIVE ANY PROCEEDS FROM MY CLAIM, I AGREE TO IMMEDIATELY DETERMINE IF THIS CLINIC HAS BEEN SEPARATELY PAID IN FULL. UNLESS THE CLINIC CONFIRMS FULL PAYMENT IN WRITING, I REALIZE THAT ANY USE BY ME OF THESE PROCEEDS IS TAKING OR CONVERTING MONEY THAT IS THE PROPERTY OF THIS CLINIC.**
8. I HAVE READ THIS DOCUMENT AND I FULLY UNDERSTAND IT.

______________________________ Signature of Patient	______________________ Date
______________________________ Print or Type Patient's Name	This Assignment Has Been Signed On The Clinic Premises:
______________________________ Signature of Parent or Legal Guardian	______________________ Staff Witness

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PRACTICE'S REQUIREMENTS HIPPA

(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 1/1/2019. 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 Signature____Date:_________________

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