Gillis Chiropractic Clinic
PERSONAL HISTORY

Date:_____

Name:_____ Social Security #:_____

Address:_____City:_____State:_____Zip Code:_____

Home Phone:_____Cell Phone:_____Business Phone:_____

Birthdate:_____Age:_____Sex:_____Height/Weight:_____

Name of your Employer:_____Type of Work:_____

Type of Insurance:_____Marital Status:_____Name of Spouse:_____

Spouse's Employer:_____Spouse's Social Security #:_____

Type of Insurance:_____Are you covered by this insurance?:_____

Name and Phone Number of Nearest Relative (Outside of your Home):_____

Who is responsible for your bill? (circle): Insurance Workman's Compensation Medicaid Medicare Self Auto Insurance Other:_____

Referred by (circle): TV Yellow Pages Previous Patient Internet Facebook

Friend:_____ Other:_____

PAST HEALTH HISTORY

SURGERIES: (Spinal or joint) _____

_____

ACCIDENTS OR FALLS: (Please Describe) _____

_____

FRACTURES OR DISLOCATIONS:_____

_____

HABITS: Sleep (hours):_____ Coffee:_____ Alcohol:_____ Exercise:_____
Tea:_____ Tobacco:_____

Are you taking any medications? (Please explain for what):_____

_____

Are you Pregnant (circle): Yes No If yes, how far along:_____ Pacemaker (circle): Yes No

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Gillis Chiropractic to release any information including diagnosis and the records of any treatment or examination rendered to my child or me during the period of such chiropractic care to third payers and/or health practitioners. I authorize and request my insurance company to pay directly to Gillis Chiropractic or chiropractic group insurance benefits otherwise payable to me. A fee schedule is available upon request. I understand that my chiropractic insurance carrier may pay less than the actual bill for services. I agree to be responsible for the payment of all services rendered on my behalf or my dependents.

_____ _____

Patient Signature Date

Name_____ Date of Birth_____ Date_____

WHEN DID SYMPTOMS APPEAR?_____

WAS THIS WORK OR AUTO RELATED?_____

HOW DID SYMPTOMS OCCUR?_____

_____

_____

SYMPTOMS

Please Circle All the Following Symptoms you have NOW.

	Side Pain 1-10		Side Pain 1-10	
Headaches		Pins/Needles in legs, feet, toes	R / L	Sinus Trouble
Neck Pain	R / L	Numbness in legs, feet, toes	R / L	Difficult Breathing
Stiff Neck	R / L	Pain in legs, feet, toes	R / L	Asthma
Fainting/Dizziness		Chest pain	R / L	Previous heart attack
Pins/Needles in arms, hands, fingers	R / L	High Blood Pressure/ Low Blood Pressure		Joint Swelling
Numbness in arms, hands, fingers	R / L	Pain between shoulder blades	R / L	Stomach Pain
Pain in arms, hands, fingers	R / L	Shoulder Pain	R / L	Bowel Changes
Mid Back Pain	R / L	Elbow Pain	R / L	Bladder Changes
Low Back Pain	R / L	Foot/Ankle Pain	R / L	Epilepsy
Hip Pain	R / L	Spinal Curve/ Scoliosis		Cancer

Other_____

Type of Pain (Circle): Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Cramps Stiffness Swelling Other

What aggravates your symptoms?_____

What gives you relief of your symptoms?_____

Are you presently being treated for any other condition? Yes No If yes, what?_____ _____ By who?_____

Have you ever had prior Chiropractic Care? Yes No If yes, who?_____

(For Doctor's Use Only)
ONSET:_____ ETIOLOGY:_____

HX OF BP:_____ PRIOR TX:_____

GILLIS CHIROPRACTIC CLINIC
Family Chiropractic Care Center, Inc
1905 Latham Avenue. Lima. Ohio 45805

NAME_____ DATE _____

AUTO ACCIDENT / ACCIDENTAL INJURY QUESTIONNAIRE

Date of Accident_____Location of accident _____

Auto / Other _____How did it occur: _____

In what exact area did you feel pain immediately? _____

List extent of injuries as you know them : _____

Did you require post accident care of hospitalization? Yes / No
Date:_____ Type of Treatment received: _____
Treating Physician _____

Did you receive any cuts / bruises ? Yes / No Where? _____

Was it hard for you to use any part of your body? Yes / No Where? _____

Check symptoms you have noticed since the accident:

_____Headache	_____Fainting	_____Loss of Smell
_____Neck Pain	_____Dizziness	_____Loss of Taste
_____Stiff Neck	_____Low Back Pain	_____Ears Ring
_____Pins/Needles in Arms	_____Nervousness	_____Sleeping Problems
_____Numbness in Fingers	_____Head Seems Heavy	_____Shortness of Breath
_____Mid back Pain	_____Loss of Memory	_____Chest Pain
_____Numbness in Toes	_____Loss of Balance	
_____Pins/Needles in Legs	_____Other_____	

Have you lost any days off work? Yes / No Dates:_____
Any previous surgeries?_____
Any previous injuries?_____

DETAIL OF AUTO ACCIDENT:
Were You : Driver Passenger Pedestrian
Were you struck: yes / no Did you strike other car? Yes / No
Were you struck from: Behind Rt Side Left Side Front Parked
Was Seat Belt ON? Yes / No Seat Belt have shoulder harness? Yes / No
Headrest Position? Up / down / none Body position in Vehicle?_____
Loss of Consciousness? Yes / No Did you anticipate accident? Yes / No
Brake : On / Off Air Bag: Yes / No Did it inflate? Yes / No
Estimate of Vehicle Damage:_____

INSURANCE INFORMATION Policy# _____
Driver of other Vehicle_____ Driver of your vehicle_____
Insurance Co:_____ Adjuster Name: _____

Family Chiropractic Care Center, Inc
Dba Gillis Chiropractic Clinic

Lima Office : 419-228-0000 **Cridersville Office: 419-645-5555**

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

PRIVATE AND GROUP ACCIDENT/HEALTH INSURANCE/ATTORNEY

I hereby instruct and direct the _____ to pay by check made out and mailed directly to:

Family Chiropractic Care Center, Inc.
Dba Gillis Chiropractic Clinic
1905 Lathem Ave.
Lima, OH 45805

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

Family Chiropractic Care Center, Inc.
Dba Gillis Chiropractic Clinic
1905 Lathem Ave.
Lima, OH 45805

The professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS DIRECT ASSIGNMENT OF MY RIGHT AND BENEFITS UNDER THE POLICY. This payment will now exceed my indebtedness to the above-mentioned assignee. I fully understand that in Personal Injury claims I am directly and fully responsible to said doctor for all medical bills submitted. I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

Signature of Patient: _____ Date: _____

Witness Signature: _____

Attorney Signature (if applicable):_____

FAMILY CHIROPRACTIC CARE CENTER, INC
Dba Gillis Chiropractic Clinic

INFORMED CONSENT- CHIROPRACTIC OFFICE

Patient Name:_____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment: The primary treatment we use as a Doctor of Chiropractic is spinal manipulation therapy. We will use that procedure to treat you. The doctor may use his hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click" much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment: In addition to spinal manipulation, we may use a variety of other therapies and examination procedures. As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

Spinal manipulative therapy	Activator instrument spinal/extremity adjustment	palpation
Orthopedic testing	range of motion testing	vital signs
Basic neurological exam	muscle strength testing	hot/cold therapy
Postural analysis testing	x-ray/radiographic studies	electrical stimulation
Rehabilitation/core strengthening	manual traction adjustment	ultrasound
Cold laser therapy	spinal segmental traction	trigger point therapy

The material risks inherent in chiropractic adjustment. As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation (CMT) and therapy. However studies have shown that any observed association between vertebral artery dissection (VAD) and stroke with CMT is likely attributed to patients with an undiagnosed VAD who seek care for neck pain and headache before the onset of a stroke.(i) As a result we examine our patients thoroughly before initiaing any treatment to be sure that treatment is appropriate. The doctor, will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform the doctor.

The probability of those risks occurring. Chiropractic is a safe and comfortable form of health care for most people. If a potential risk is indentified, you will be informed and offered either treatment or a referral to the appropriate health care specialist for evaluation and care.

Soreness: It is not uncommon to experience some localized soreness following a manipulation. This type of soreness is usually minor and occurs most often following the initial few visits. It is similar to the soreness you experience after exercise.

Fracture: Fractures caused from spinal manipulation are extremely rare, so rare that an actual number of incidences per manipulation have never been determined. Patients suffering from bone weakening conditions like Osteoporosis are in a higher risk category. Alternative forms of spinal manipulation are utilized for this type of patient.

TIA/Stroke Overview: Spinal manipulation is clearly one of the safest forms of treatment for cervical spine pain. The incidence of serious events, strokes, or death is very rare.(ii) **Researchers found no evidence of excess risk of VBA stroke associated chiropractic care compared to primary care.(iii)** The risk was a low as 1.46 adverse events per 10,000,000 manipulations.(iv) The risk of artery dissection was a low as 1 per 5,846,381 cervical manipulations(v)

What about NSAIDS and Tylenol: To put it in perspective, non steroidal anti-inflammatory drugs (NSAIDS) kill approximately 16,500 people per year annually in the US.(vi) And Tylenol toxicity is now the leading cause of liver failure in the US.(vii,viii) Spinal manipulations is safer than NSAIDS by a factor of several hundred times. (ix)

Note: Screening tests are performed when necessary to rule out high risk patients. Alternative spinal adjusting is utilized when necessary to minimize potential risks.

Ruptured/Herniated Dise: There have been some reports of herniated or ruptured discs caused by spinal manipulation. Alternative spinal adjusting methods are often utilized to minimize the risk and help the patient recover from serious disc-related pain.

Other complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns.

The availability and nature of other treatment options:

Other treatment options for your condition may include:
Self administered, over-the-counter may include:
Medical care and prescriptions drugs such as anti-flammatory, muscle relaxants and pain killers
Hospitalization
Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated or undertreated. Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed. Early intervention to restore normal function and compliance with the treatment program are both essential in an effort to prevent the condition from progressing to a chronic pain state. (x,xi,xii,xiii,xiv,xv)

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
I have read the above explanation of the chiropractic adjustment and related treatment. I will discuss it with Dr. Gillis, if I have any questions regarding the above information. **By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.**

Patient Name:_____

Patient Signature:_____ **Date**_____

Signature of Doctor:_____ **Date**_____

PATIENT TREATMENT CONSENT FORM

I authorize Gillis Chiropractic to release any medical or other information that may be necessary to process medical claims on my behalf to related physicians, rehabilitation counselors, social workers, insurance carriers or attorneys.
I authorize Gillis Chiropractic to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Financial Responsibility / Assignment of Benefits

I understand that I am responsible for paying my co-payments and deductibles at the time of service. I also understand that I am responsible for any balance due after payment by my insurance company.

I, the undersigned, understand that Gillis Chiropractic will bill my insurance company for services rendered upon verification of coverage by my insurance company. If my insurance company fails to render payment for services rendered, I hereby personally guarantee payment for medical care and services rendered. If your insurance company does not remit payment within 60 days, the balance will be due in full from you.

I hereby request that my insurance carrier make payment directly to Gillis Chiropractic for all services rendered by this facility. If my current policy prohibits direct payment to Gillis Chiropractic, I hereby instruct and direct my insurance company to make the check out in my name but send the check to the listed address of Family Chiropractic Care Center, Inc. 1905 Lathem Ave. Lima, OH 45805.

If my insurance carrier makes a payment to me, I agree to immediately pay over these funds to Gillis Chiropractic. I also authorize Gillis Chiropractic to deposit checks received on my account when made out to me.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

Charges related to Worker's Compensation injury shall be forwarded to the Worker's Compensation Insurance carrier. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you will be held responsible for the total amount of charges for services rendered to you.

Charges related to Personal Injury shall be forwarded to my attorney, or my car insurance carrier for payment. However, be advised that if your Personal Injury Claim is denied, you will be held responsible. I direct all payments from my insurance carrier/attorney to pay directly to Gillis Chiropractic for services rendered. Upon settlement of my personal injury claim, Gillis Chiropractic will be paid, or I assume all responsibility on my account.

I, the undersigned, acknowledge that by signing this form I authorize Gillis Chiropractic to submit charges via mail or internet to my insurance carrier. This is a "Signature on File" authorization.

Patient recognizes that Policy quotes are not a guarantee of payment by carrier and the patient is responsible for obtaining actual Policy benefits, limits from the carrier and, if needed, any referrals from primary care physicians or pre-authorization with insurance. All referrals or recommendations from our office have no confirmation of payment or benefits to referring providers.

I authorize my healthcare provider and/or entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging or other electronic communication to contact me for any reason by any telephone number, email address and/or mailing address provided. I authorize all my numbers that I have provided to the office in my file be able to accept phone and/or text message. I authorize stating a detailed message to all phone numbers that I have given Gillis Chiropractic.

List of prices (subject to change):
Chiropractic Adjustment: $40.00, $45.00
Examinations: $30.00, $55.00, $75.00
Therapy: $15.00-$20.00/each, Decompression $30.00
X-rays: $40-$105 each
Forms/Copies: $5.00-$20.00
Supports/Brace: Prices Vary

Acknowledgement of Receipt of Notice of Privacy Practices / Patient Consent

I certify that I was offered a copy of Gillis Chiropractic's Notice of Privacy Practices. The Notice of Privacy Practices describes the types and uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Gillis Chiropractic's health care operations. The Notice of Privacy Practices is also posted in the reception area.

Gillis Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requested a revised copy be sent in the mail or asking for one at the time of my next appointment.

I, the undersigned, state that I have read all the above and agree to the terms and conditions set forth.

Patient Name/Date

Patient/Guardian Signature/Date