Allied Pain Relief Clinics

NEW PATIENT REGISTRATION FORM

Date:
File#

Welcome to Allied Pain Relief Clinics. We ask that you complete this paperwork. It will help us to help you. We understand it can be difficult to complete paperwork, especially when you are in pain. If you need help, or have any questions, please ask. Thank you!

PATIENT INFORMATION			Home #
Name:			Work #
Address:			Cell#
City:	State:	Zip:	Email:
Gender: M F	Date of birth:	Age:	How did you hear about APRC?
SS#:	Drivers Lic#		**IS THE PATIENT A MINOR?**
Primary Phsician Name:			Mother's Name: Ph:
Employer:			Father's Name: Ph:
Work Address:			Whom does minor reside with:
City:	State:	Zip:	School Attended:

Marital Status Single Married Div Wid	**EMERGENCY CONTACT INFORMATION**
Spouse Name:	Name:
Date of birth: SS#	Phone:
Spouse Employer: Occupation:	Relationship:

CONSENT TO TREATMENT OF A MINOR CHILD

I hearby authorize Dr. John J. Clendenin, D.C. and whomever he may designate as assistants to administer treatment as deemed necessary to my (son, daughter, etc).

_____
Name of Minor

Signed: _____
Parent or Guardian Date

Witnessed: _____

INSURANCE DISCLAIMER

"A quote of benefits and/or authorizatin does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at the time of service."

INSURANCE LIABILITY FOR PAYMENT:

Your health insurance company will only pay for services that it determines to be "reasonable and necessary." Every effort will be made by APRC to have all services and procedures pre-verified by your health insurance company. If your insurance company determines that a particular service is not reasonable and necessary, or is not covered by your plan, your insurer will deny payment.

BENEFICIARY AGREEMENT:

I understand that my health insurance company may deny payment for services identified above, for the reasons stated. If my insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my insurance company does make payment for services, I will be responsible for any co-payment, deductible, or co-insurance that applies.

Print Name: _____ Date: _____

Signature: _____

HIPAA COMPLIANCE and NOTICE OF PRIVACY PRACTICES

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we protect, use and/or disclose your health information. The notice contains important information regarding your rights.

Please choose an option below. By signing this form, you are acknowledging one of the following:

_____ I have received a copy of APRC's Privacy Practices

_____ I am declining a copy of APRC's Privacy Practices and I understand that I may request and receive a copy at any time.

_____
Signature Date

AUTHORIZATION TO RELEASE MEDICAL INFORMATION/FINANCIAL AGREEMENT

I hereby authorize this office to release any information requested by my insurance company to document my claim for benefits.
I understand that I am personally responsible for full payment of all charges for my treatment. Services are payable at the time rendered

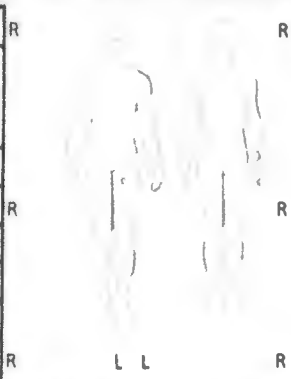
_____
Patient or Guardian Signature Date

Patient Name:

HISTORY OF PRESENT ILLNESS

Please indicate regions of complaint and the severity of symptoms.

Region	Mild Moderate Severe
Headache Pain	1 2 3 4 5 6 7 8 9 10
Neck Pain	1 2 3 4 5 6 7 8 9 10
Upper/Mid Back Pain	1 2 3 4 5 6 7 8 9 10
Low Back Pain	1 2 3 4 5 6 7 8 9 10
Shoulder/Elbow/Wrist/hand Pain	1 2 3 4 5 6 7 8 9 10
Other	1 2 3 4 5 6 7 8 9 10



Please use the letters below to indicate the *type* and *location* of your pain and sensations.

A= Acute
B= Burning
S= Stabbing
N= Numbness
P=Pins/Needles

Mark an X on the picture where you are continuing to have pain.

PATIENT PAST MEDICAL, FAMILY, SOCIAL HISTORY

Condition/Disease	Patient History (Y/N)	Family History Of (M=mother/F=father)		Condition/Disease	Patient History (Y/N)	Family History Of (M=mother/F=father)	
Arthritic Condition		M	F	Smoker		M	F
Cancer		M	F	Alcohol		M	F
Diabetes		M	F	Headaches/Migraines		M	F
Heart Problems		M	F	Other		M	F
High Blood Pressure		M	F	Birth Control Medications			
Vascular Condition		M	F	Currently Pregnant			
Lung Problems		M	F	Exercise Regularly			
Usual Childhood Diseases		M	F				
Unusual Childhood Diseases		M	F				

List of Medications	Surgery/Hospitalization Date
	Environmental/Medicinal Allergies

INJURY/CONDITION BACKGROUND

When did injury/cond start?

What makes this condition worse?

What makes this condition better?

Have you received previous treatment?

Radiology Reports Performed?

MRI *CT SCAN* *XRAY*

Who have you seen for this condition?

DO NOT WRITE BELOW THIS LINE. FOR CLINICAL STAFF ONLY

REVIEW OF SYSTEMS

CONSTITUT'L	EYES	EAR, NOSE, THROAT		RESPITORY	CARDIO	MUSCULO		GASTRO	SKIN/BREAST	URINARY	NEURO
Hygiene	Pain	Nose bleed	Ringing in	cough	chest pain	muscle pain		diarrhea	lesions	incontinence	headaches
Fatigue	Redness	Stuffiness	ears	wheezing	palpations	joint pain		constipation	open sores	burning during	dizziness
Fever/chills	Flashing	Discharge	Ear pain	phlegm	faintness	neck pain		heartburn	wounds	urination	head injury
Weakness	Floaters	Dry mouth	Swollen	blood cough	tightness	neck injury		difficulty	rash	fruequent	
Weight loss	Blurry	Sore throat	Glands	shortness of		stiffness		swallowing	bruising	urgency	
Appetite Loss	cataracts			breath				hernia	lumps	blood in urine	
nausea	Vision Loss							abdominal	breast		
								pain	pain		
NEG	NEG	NEG	NEG	NEG	NEG	NEG	NEG	NEG	NEG	NEG	NEG

PHYSICAL EXAM

HT:	TEMP:	PULSE:	Eyes	Respiratory	Skin	GI	Muscoloskeletal	Psychological
WT:	BP:		ENT	Cardiovasc		GU	Neurological	Hem/Lymph

John Clendenin, DC
Anthony J. Clendenin, DC

Date

Patient Signature

Akron Pain Relief Clinics
1160 Niles-Cortland Rd Niles, OH 44446 Ph: (330) 652-4222 Fax: (330) 652-0574

Email and Text Messaging Program Consent Form

Your Name: _____

We are happy to provide our patients with the option to participate in our online patient communication system. Some of the features include the ability to:

- Request appointments via email
- Confirm appointments via email
- Receive text message appointment reminders
- Submit patient satisfaction surveys
- Refer your friends online

o I decline and DO NOT want to receive text messages.
o I accept and DO want to receive text messages. (fill out information below, sign and date)

You may choose to discontinue your participation in our online communication system at any time simply by clicking the "*unsubscribe*" link found at the bottom of each email, or by replying "*STOP*" to a text message from us. Standard text messaging rates may apply.

Please provide us with the following contact information:

Home Phone:

Cell Phone: (if you wish to receive text msg. reminders)

Email:

We use this information strictly for the purposes of communicating with you more efficiently. Our goal is to provide you with excellent treatment as well as overall service and satisfaction. We may disclose patient health information (PHI) to third parties that perform services for this practice in the administration of your benefits in accordance with HIPAA. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate that performs services for this practice in the administration of your benefits. Our affiliates do not sell, share or rent our users' personally identifiable information unless required by law, do not send any e-mail or other communications without your permission, and do not send spam

Signature: _____ **Date:** _____

Allied Pain Relief Clinics Inc.
1160 Niles Cortland RD Niles, OH 44446
330-652-4222 (p) ~ 330-652-0574 (f)

Patient Name: _____ **Date:** _____

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

Informed Consent:

A patient, in coming to the chiropractic doctor, 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/she 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 what 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 doctor 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 **Allied Pain Relief Clinics**, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Missed Appointments:

There is a possible fee charged for all appointments that are not canceled prior to scheduled visit.

Any massage appointment that is [illegible] to scheduled appointment will be charged [illegible]

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 whom may we do so?

Spouse: _____

Children: _____

Others: _____

No one:

May we leave messages regarding your personal healthcare information on any answering device:
i.e. home answering machines or voicemails? **Yes [ ]** **No [ ]**
May we contact you via email? **Yes [ ]** **No [ ]**

Acknowledgement and HIPPA rights to medical privacy

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy. Request copy (circle Y for a copy of HIPPA rights-**Y** **N**

Print Name: _____

Signature: _____ **Date:** _____