Allied Pain Relief Clinics

NEW PATIENT REGISTRATION FORM

Date: _____
File# _____

PATIENT INFORMATION	Primary Phsician Name:
Name:	Employer:
Address:	*How did you hear about APRC?*
City: State: Zip:	
Gender: M F Date of birth: Age:	
SS#:	**IS THE PATIENT A MINOR?**
Home #	Mother's Name: Ph:
Work #	Father's Name: Ph:
Cell#	Whom does minor reside with:
Email:	School Attended:
Marital Status Single Married Div Wid	**EMERGENCY CONTACT INFORMATION**
Spouse Name:	Name:
Date of birth: SS#	Phone:
Spouse Employer:	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 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."

APRC, Inc will make every reasonable effort to verify services provided are covered by the insurance policy. However, this does not guarantee coverage or release the patient from financial aliability for charges.

BENEFICIARY AGREEMENT:

I understand that my health insurance company may deny payment for services that my physician finds to be medically necessary to my care. I also agree to be personally and fully responsible for payment of non-covered services, co-pays, deductibles, and co-insurance amounts as determined by my insurance policy.

→ 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 important information on how we protect, use and/or disclose your health information.

APRC's Privacy Practices has been provided for review. I understand a may request a paper copy at anytime.

→ 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.

→ Signature: _____
Date

HISTORY OF PRESENT ILLNESS

Please indicate regions of complaint and the severity of symptoms when they are at their worst.

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

Using X, indicate area of pain below.

FRONT

BACK

Circle the words below that best describe the type of of pain you are experiencing.

A= Acute

B= Burning

S= Stabbing

N= Numbness

P=Pins/Needles

DIRECTIONS: Please complete all fields below. Circle Y or N for patient history; then circle M or F is the patient patient mother of father experienced the condition.

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	Y / N	M	F	Smoker	Y / N	M	F
Cancer	Y / N	M	F	Alcohol	Y / N	M	F
Diabetes	Y / N	M	F	Headaches/Migraines	Y / N	M	F
Heart Problems	Y / N	M	F	Other	Y / N	M	F
High Blood Pressure	Y / N	M	F	Birth Control Medications	Y / N		
Vascular Condition	Y / N	M	F	Currently Pregnant	Y / N		
Lung Problems	Y / N	M	F	Exercise Regularly	Y / N		
Usual Childhood Diseases	Y / N	M	F	xxxxxxxxxx			
Unusual Childhood Diseases	Y / N	M	F	xxxxxxxxxx			

DIRECTIONS: Please NONE for any section below that does not apply to you.

List of Medications

Surgery/Hospitalization

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?

REVIEW OF SYSTEMS **DO NOT WRITE BELOW THIS LINE. FOR CLINICAL STAFF ONLY**

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

Ohio | Bureau of Workers' Compensation

Notice to Change Physician of Record

The physician selected must be BWC certified or the injured worker will be responsible for payment.

Instructions for the injured worker

Part I

- Please complete all of Part I of the form.
- Sign in the space provided, and submit all copies to your managed care organization (MCO) to record your change of physician.

Injured worker's name	Date of injury	Claim number

Address	Phone number
	( )

City	State	Nine-digit ZIP code

Please change my physician of record for the above listed claim as follows:

From physician	Provider number

Address	Phone number
	( )

City	State	Nine-digit ZIP code

To physician	Provider number
Dr. John J. Clendenin	292669611-00

Address	Phone number
2400 Niles-Cortland RD SE	(330-652-4222

City	State	Nine-digit ZIP code
Warren	OH	44484

Reason for change

☐ Physician moved ☐ Physician no longer practicing ☐ I moved ☐ Physician is not a BWC-certified provider

☐ Physician terminated patient-provider relationship
Please explain: _____

☐ Dissatisfied with physician's treatment
Please explain: _____

☐ Other, please explain: _____

Have you been treated by the new physician for the condition(s) allowed in your claim? Yes ☐ No ☐ If yes give date of first treatment _____

Injured worker's signature	Date

Instructions for the MCO

Part II

- MCO to complete PART II.
- MCO must notify BWC via EDI (148) of change of physician within 24 hours of notification by the injured worker.
- Return signed copies per distribution listed below.

We have received and recorded your request for change of physician. You may bill only medical services and items related to the treatment of the allowed conditions and in accordance with the MCO medical-management guidelines to the MCO or the self-insured employer. The allowed conditions for this workers' compensation claim with corresponding ICD-9-CM codes are as follows: _____

MCO name	Phone number
	( )

MCO case manager	Date

Distribution: White–MCO Claim file • Yellow–Injured worker • Pink–Requested physician • Goldenrod–Former physician

Allied Pain Relief Clinics

2400 Niles-Cortland Rd S.E. • Warren, OH 44484 • Ph: (330) 652-4222 Fax:(330) 652-0574

Welcome to APRC! We are truly excited to introduce you to the benefits of chiropractic care. If this isn't your first encounter with chiropractic treatment, then we are glad to provide the very *best* in chiropractic care.

Dr. Clendenin is a valley native. He attended Ursuline High School and YSU before graduating with a degree in Health Sciences from Findlay University. Dr. C then went on to Chicago where he earned his degree of Doctor of Chiropractic at National College of Chiropractic, now the National University of Health Sciences. He has previously served as team doctor at multiple local high schools over the years, as well as served on the boards of several charitable organizations, including Big Brothers and Sister of the Mahoning Valley. He is truly invested in this community and its people.

A few things you can expect from us at APRC:

- Dr. Clendenin is passionate about chiropractic care and brings nearly 30 years of expertise to your care.
- Dr. Clendenin is a certified provider with the Ohio BWC. He takes pride in getting injured workers back to work.
- Dr. Clendenin offers sports physicals for our high school student athletes for a great cash price.
- We offer flexible scheduling hours that include late evenings and Saturday mornings to make chiropractic care fit into the hectic lifestyles that are all too common.
- We take your time seriously. It is our goal to get you into your appointment on time, every time. We also offer the ability to schedule multiple appointments ahead for weeks/months in advance, so you can lock in your preferred appointment time.
- We also accept same day appointments, schedule allowing, so don't be afraid to give us a call to get in!
- A complimentary benefit verification is a part of every new patient appointment. While this is not a guarantee of coverage or cost, we do our best to help each patient take full advantage of the benefits provided by the insurance policy.
- We offer flexible payment plans for those rising copays and deductibles, not to mention cash paying customers and friends whose insurance doesn't cover chiropractic care.
- APRC has a dedicated staff of licensed massage therapists. Dr. Clendenin prescribes clinical massage therapy on a case by case basis.
- We keep a small inventory of Standard Process vitamins and can order anything that isn't on our shelf.
- Visit our website www.alliedpainreliefclinics.com to learn even more about all that we have to offer!

Dr. John J. Clendenin, Chiropractic Physician

An Alliance of State-of-the-Art Chiropractic Care & Traditional Medicine

2400 Niles Courtland Road, Warren, Ohio 44484 · Phone (330) 652 4222 Fax (330) 652-0574

Patient Name: _____

Patient Address: _____

Date of Birth: _____

HIPPA Release of Information Authorization Form

I hereby authorize the following person(s) with access to any and all Health Information contained in my medical records pertaining to patient relationship with Allied Pain Relief Clinic (APRC Inc.) or any affiliate referral, or transitioning care.

I authorize the release of information via phone or in person.

Authorized person(s):

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Patient signature: _____ Date: _____

Or Signature of patient's Representative: _____

Relationship: _____ Date: _____

Allied Pain Relief Clinics
2400 Niles-Cortland Rd S.E.; Warren, OH 44484 Ph: (330) 652-4222 Fax:(330) 652-0574

NOTICE OF PRIVACY PRACTICE--EFFECTIVE 02/01/2017
Security Officer: Todd MacGregor
Email: aprcrelief1@yahoo.com

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. If you have any questions, concerns or complaints you can contact the security office above.

Please review the following information carefully.

Your Rights. You have the right to the following: Get a copy of your paper or electronic medical record;Correct your paper or electronic medical record; Request confidential communication; Ask us to limit the information we share; Get a list of those with whom we've shared your information; Get a copy of this privacy notice; Choose someone to act for you; File a complaint if you believe your privacy rights have been violated.

Your Choices. You have some choices in the way that we use and share information as we: Tell family and friends about your condition; Provide disaster relief; Include you in a hospital directory; Provide mental health care; Market our services and sell your information; Raise funds.

Our Uses and Disclosures. We may use and share your information as we: Treat you; Run our organization; Bill for your services; Help with public health and safety issues; Do research; Comply with the law; Respond to organ and tissue donation requests; Work with a medical examiner or funeral director; Address workers' compensation, law enforcement, and other government requests; and Respond to lawsuits and legal actions

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Your Rights. When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

You can complain if you feel we have violated your rights by contacting us using the information on page 1. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775or at www.hhs.gov/ocr/privacy/hipaa/complaints/.

We will not retaliate against you for filing a complaint.

Your Choices. For certain health information, you can tell us your choices about what we share.
If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

Share information with your family, close friends, or others involved in your care; Share information in a disaster relief situation; Include your information in a hospital directory; If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

We never market or sell personal information. APRC periodically mails reminders and updates by way of postcard. You may tell us in writing if you prefer to receive this information in a sealed envelope.

Our Uses and Disclosures: How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.
For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as: Preventing disease; Helping with product recalls; Reporting adverse reactions to medications; Reporting suspected abuse, neglect, or domestic violence; Preventing or reducing a serious threat to anyone's health or safety.

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you: For workers' compensation claims; For law enforcement purposes or with a law enforcement official; With health oversight agencies for activities authorized by law; For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

- **We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.**

APRC, Inc. Worker's Comp Accident Report

Name of Injured Person: _____

Date of Birth: _____ / _____ / _____ Telephone #: ( ) _____ - _____

Address _____

City _____ State _____ Zip _____

(Circle One) MALE FEMALE

What part of the body was injured? Describe in detail

_____

_____

What was the nature of the injury? Describe in detail

_____

_____

Describe fully how the accident happened? What were you doing prior to the event?

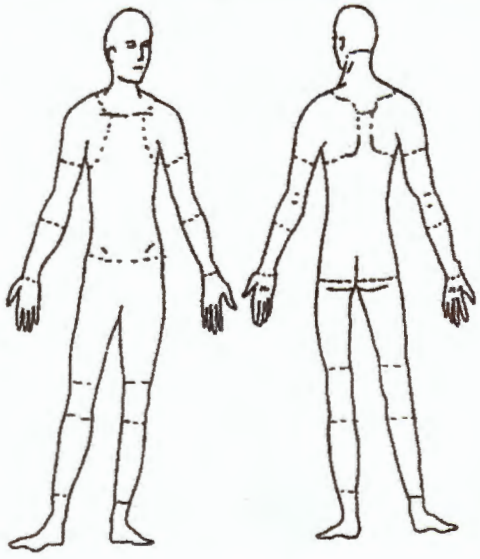
_____

_____

DATE OF ACCIDENT: _____ NATURE OF INJURY: _____

THIS REPORT IS BEING COMPLETED BY: _____

Part of Body affected (shade all that app;y)



Nature of Injury: Months doing this job: _____

- ☐ Abrasion, scrapes
- ☐ Broken bone
- ☐ Bruise
- ☐ Concussion (to the head)
- ☐ Crushing injury
- ☐ Hernia
- ☐ Illness, dizziness
- ☐ Sprain, strain
- ☐ Other _____

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2400 Niles-Cortland Rd S.E. Warren, OH 44484 Ph: (330) 652-4222 Fax: (330)

Workers Compensation
Patient Financial Responsibility

I _____understand that the staff of APRC,
(Print name)

Inc./Dr. John Clendenin has done all the necessary steps and submitted proper forms to gain authorized chiropractic treatment, however my current Worker's Compensation case MCO (Managed Care Organization) has not authorized further chiropractic treatment at APRC, Inc./Dr. John Clendenin, DC. I understand that by electing to receive treatment without authorization that it becomes my financial responsibility for treatment. Allied Pain Relief Clinics' Workers Compensation Specialist will continue to work diligently to expedite my continuation of care, by requesting authorized chiropractic and massage therapy treatments. However, during my continuation of care, if requested treatments are not-authorized, I understand, I will be responsible for a "cash patient" courtesy fee of $30 per visit and massage therapy visits of $55. I understand, that my signature below acknowledges that I am financially responsible for all accrued charges not covered in my workers compensation claim. Once authorization of my requested treatments, my financial responsibility will be managed under the BWC guidelines.

Also, it is my understanding that if I do not adhere to my approved treatment schedule, it is not the responsibility of APRC's Workers Compensation Specialist to retrieve my financial payment from the Bureau of Workers' Compensation.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

_____ _____
Signature of Patient or Guardian **Date**