



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
Name:
Address:
City: State: Zip:
Gender: M F Date of birth: Age:
SS#: Drivers Lic#
Primary Phsician Name:
Employer:
Work Address:
City: State: Zip:
Marital Status Single Married Div Wid
Spouse Name:
Date of birth: SS#
Spouse Employer: Occupation:
EMERGENCY CONTACT INFORMATION
Name:
Phone:
Relationship:

CONSENT TO TREATMENT OF A MINOR CHILD

I hereby 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: _____

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

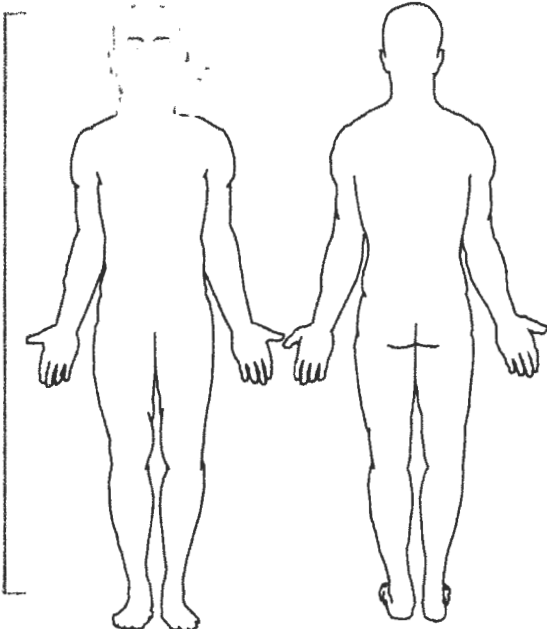
What was the nature of the injury? Describe in detail

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 apply)



Nature of Injury: _____ Months doing this job: _____

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



1160 Niles-Cortland Rd. Niles, OH 44446 Ph: (330) 652-4222 Fax: (330)

Workers Compensation Patient Financial Responsibility

I _____ understand that the staff of APRC,
(Print name)

Inc./Dr. John Clendenin, DC/Dr. Anthony J Clendenin, DC 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./Dr. Anthony J 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



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

• 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.

Part I

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
Address 1160 Niles-Cortland RD			Phone number (330)-652-4222
City Niles		State OH	Nine-digit ZIP code 44446
Reason for change			
<input type="checkbox"/> Physician moved <input type="checkbox"/> Physician no longer practicing <input type="checkbox"/> I moved <input type="checkbox"/> Physician is not a BWC-certified provider			
<input type="checkbox"/> Physician terminated patient-provider relationship <input type="checkbox"/> Dissatisfied with physician's treatment <input type="checkbox"/> Other, please explain: _____			
Please explain: _____			

Have you been treated by the new physician for the condition(s) allowed in your claim? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes give date of first treatment _____			
Injured worker's signature			Date

Instructions for the MCO

• 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.

Part II

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 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 not canceled 24 hours prior to scheduled appointment will be charged \$25 - \$50

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:** _____