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

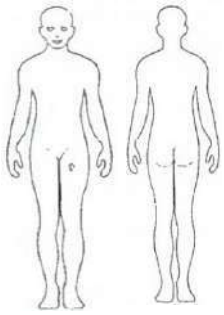
_____
Patient or Guardian Signature Date

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 Date

Patient Signature

General Patient Consent for Care Form

General Consent to Care: I, the undersigned, for myself or a minor child or another person for whom I have authority to sign, hereby consent to medical care and treatment, as ordered by a provider, while such medical care and treatment is provided through Allied Pain Relief Clinic on an outpatient/ office visit basis. This consent includes my consent for all medical services rendered under the general or specific instructions of a provider; including treatment by a mid-level provider (Nurse Practitioner or Physician Assistant), and other health care providers or the designees under the direction of a physician, as deemed reasonable and necessary. I agree and acknowledge that Allied Pain Relief Clinic is not liable for the actions or omissions of, or the instructions given by the physicians/providers who treat me while I am a patient. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations at Allied Pain Relief Clinic. Telemedicine I understand that telemedicine (defined as the use of medical information exchanged from one site to another via electronic communications for the health of the patient, including consultative, diagnostic, and treatment services) may be employed to facilitate my medical care. All electronic transmission of data will be restricted to authorized recipients in compliance with the Federal Health Insurance Portability and Accountability Act (HIPPA) and applicable state privacy laws.

To the Patient: You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

Signed Consent:
I hereby give my consent to treat minor child/children below, which is under the legal age of eighteen years of age, to receive medical care and/or treatment from the providers of Methodist Medical Group. Any care deemed medically necessary may be provided with or without my presence:

Child: _____ Date of birth _____
Child: _____ Date of birth _____
Child: _____ Date of birth _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ [ ] Patient under 18 years of age

_____
Signature of Patient or Legal Guardian Date

_____
Printed Name of Patient or Legal Guardian Relationship to Patient

This consent to medical treatment will expire if revoked in writing.

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

Cancellation /No Show Policy
For Doctor and Massage Appointments

1. *Cancellation/ No Show Policy for Doctor Appointment*

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a Thirty-dollar ($30) fee; this will not be covered by your insurance company

2. *Scheduled Appointments*

We understand that delays can happen however we must try to keep the other patients and doctors on time.

If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

3. Cancellation/No Show Policy For Massage

Due to the large block of time needed for Massage Therapy, last minute cancellations can cause problems and added expenses for the office.

If an appointment is not cancelled at least 24 hours in advance you will be charged a Thirty-dollar ($30) fee; this will not be covered by your insurance company

4. *Account balances*

We will require that patients with self pay balances do pay their account balances to zero (0) prior to receiving further services by our practice.

Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns.

Patients with balances over $100 must make payment arrangements prior to future appointments being made.

_____	_____	____/____/____
Print Name Patient	**Signature Patient/Guardian**	**Date**

Patient Account #_____
(Office Use Only)

A. Allied Pain Relief Clinic **B. Patient Name:**_____ **C. PT Num:**_____

(ABN) Advance Beneficiary Notice of Noncoverage

NOTE: Medicare/Medicaid doesn't pay for **(D.) 1--8** below. Medicare/Medicaid does not pay for everything, even some care that you or your health care provider may have good reason to think you need. We expect Medicare/Medicaid will not pay for the **D.) 1—8** below.

D.	E. Reason Medicare/Medicaid May Not Pay:	F. EstimatedCost
1. Exam: 99203-99204, 99211-99214	Statutorily Non-covered services	$25-$50
2. Spinal Adjustment: 98940-98942	Exceeds plan benefit/Statutorily NC	$30-$40
3. 97012-Manual Traction	Statutorily Non-covered services	$5
4. 97014-Electrical Stimulation	Statutorily Non-covered services	$5
5. Therapuetic Procedure: 97110, 97112	Statutorily Non-covered services	$26.00
6. Lumbar Belt	Statutorily Non-covered services	$20
7. SI Belt (s, m, l)	Statutorily Non-covered services	$14-$18
8. Deep Tissue Massage Therapy	Statutorily Non-covered services	$50-$60

WHAT YOU NEED TO DO NOW:

Read this notice, so you can make an informed decision about your care then ask us any questions

G. OPTIONS: THIS SECTION DOES NOT APPLY TO EXCLUDED BENEFITS.

☐ OPTION 1. I want the **D.**_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare/Medicaid by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ OPTION 2**.** I want the **D.**_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare/Medicaid is not billed.

☐ OPTION 3**.** I don't want the **D.**_____listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare/Medicaid would pay**.**

H.ADDITIONAL INFORMATION

According to the *Ohio Revised Code 5160-1-13.1,* services that are not covered by the MEDICAID program may be billed to the consumer when the consumer is notified in writing, prior to the service being rendered, that the provider will NOT bill Ohio Medicaid. The consumer must sign a written statement (this form) agreeing to be liable for payment of the non-covered services.

This notice also serves as a voluntary notice for all Medicare Part B beneficiaries. According to CMS Claims Processing Manual Publication 100-04, CH 30, S50, providers may notify beneficiaries of their financial liability for services Medicare never covers. Medicare will NOT be billed and you will be asked to pay for the services outlined above.

If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).
and the Medicaid Consumer hotline can be reached at 800-324-8680

Signing below means that you have received and understand this notice. You also receive a copy upon request.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

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

Your Name: _____

Your 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):

1) Name: _____

Relationship: _____

2) Name: _____

Relationship: _____

Patient Signature: _____ Date: _____

Or Signature of Patient's Representative: _____

Relationship: _____ Date: _____

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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:

1. **Request appointments via email**
2. **Confirm appointments via email**
3. **Receive text message appointment reminders**
4. **Submit patient satisfaction surveys**
5. **Refer your friends online**

- **I decline and DO NOT want to receive text messages.**
- **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:

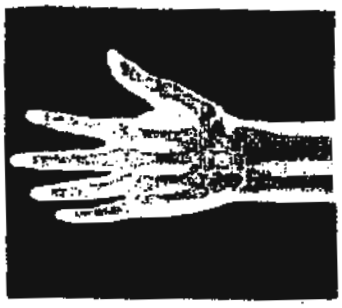
Home Phone: _____

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:** _____



Authorization To Release Chiropractic Information.

Allied Pain Relief Clinics
Combining Chiropractic & Medicine

John J Clendenin DC
PO Box 8607
Warren Ohio 44484

I,_____request the following information

___x-rays ___History ___Records ___Diagnosis

___Treatment ___Reports concerning my:

___Accident ___Injury ___Illness ___Other:_____

To be released to:_____

(Name of Ins. Atty, Dr. Hospital,Employer)

Address:
City, State, Zip _____

For the purpose of:_____

I understand that I have a right to receive a copy of this authoriztion upon my request._

Copy requested:___Yes___No
Copy received:___Yes___No

Date_____ Signed X_____

Signature is from: Patient ___ Spouse ___Parent ___Guardian

Allied Pain Relief Clinics
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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.**