

CONFIDENTIAL HEALTH INFORMATION

Eddy Chiropractic Clinic Inc.
443 Highland Ave
Williamstown, WV 26187
304-375-6000

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?

No Yes When?

Whom may we thank for referring you?

If so, whom?

Gender

Male Female

Your Last Name

Your Social Security Number

Your First Name

Your Middle Name (or Initial)

Birth Date (MM/DD/YYYY)

Marital Status

Single Married Divorced
 Widowed Separated

Address

City

State/Province

ZIP/Postal Code

Home Phone

Spouse's Name

Email Address

Cell Phone

Child's Name and Age

Emergency Contact

Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

May we contact you at work?

Yes No

Address

State/Zip

Phone

Preferred method of contact?

Home Phone Cell Phone
 Work Phone Email

PRIMARY INSURANCE INFO

Insured's Last Name

Birth Date (MM/DD/YY)

Insured's Social Security #

Insured's First Name

Middle Name (or Initial)

Who carries this policy?

Self Spouse Parent

SECONDARY INSURANCE INFO

Insured's Employer

Employer's Phone

Insured's Last Name

First Name

Middle Initial

Birth Date

Social Security #

Address

City

State/Province

ZIP/Postal Code

Relationship to patient

CONFIDENTIAL HEALTH INFORMATION

PAGE
1/4

1. The symptom(s) that have prompted me to seek care today include: _____

ADDITIONAL INFO

2. And are the result of (darken circle): An accident or injury
 Work Auto Other _____
 A worsening long-term problem
 An interest in: Wellness Other _____

Height: _____

Weight: _____

3. Onset (When did you first notice your current symptoms?) _____

4. Intensity (How extreme are your current symptoms?) _____

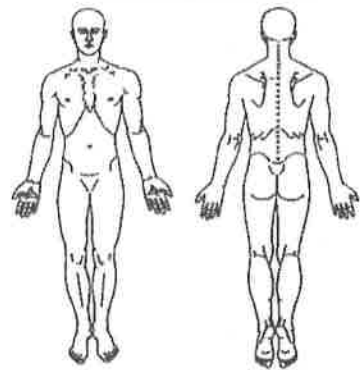


5. Duration and Timing (When did it start and how often do you feel it?)
 Constant Comes and goes. How Often? _____

6. Quality of symptoms (What does it feel like?)

- Numbness
- Tingling
- Stiffness
- Dull
- Aching
- Cramps
- Nagging
- Sharp
- Burning
- Shooting
- Throbbing
- Stabbing
- Other _____

7. Location (Where does it hurt?) Circle the area(s) on the illustration, "O" for current condition "X" for conditions experienced in the past



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.) _____

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem? _____
 What tends to lessen the problem? _____

10. Prior interventions (What have you done to relieve the symptoms?)

- Prescription medication Surgery Ice
- Over-the-counter drugs Acupuncture Heat
- Homeopathic remedies Chiropractic Other _____
- Physical therapy Massage _____

11. What else should Eddy Chiropractic Clinic know about your current condition? _____

12. How does your current condition interfere with your:

- Work or career: _____
- Recreational activities: _____
- Household responsibilities: _____
- Personal relationships: _____

13. Review of Systems
 Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've Had or currently Have and initial to the right. Are you currently treating with a Primary Care Physician Y N

Name of Physician: _____						
a. Musculoskeletal						
Had Have <input type="radio"/> <input type="radio"/> Osteoporosis	Had Have <input type="radio"/> <input type="radio"/> Arthritis	Had Have <input type="radio"/> <input type="radio"/> Scoliosis	Had Have <input type="radio"/> <input type="radio"/> Neck pain	Had Have <input type="radio"/> <input type="radio"/> Back problems	Had Have <input type="radio"/> <input type="radio"/> Hip disorders	NONE <input type="radio"/>
<input type="radio"/> <input type="radio"/> Knee injuries	<input type="radio"/> <input type="radio"/> Foot/ankle pain	<input type="radio"/> <input type="radio"/> Shoulder problems	<input type="radio"/> <input type="radio"/> Elbow/wrist pain	<input type="radio"/> <input type="radio"/> TMJ issues	<input type="radio"/> <input type="radio"/> Poor posture	Initials _____
b. Neurological						
Had Have <input type="radio"/> <input type="radio"/> Anxiety	Had Have <input type="radio"/> <input type="radio"/> Depression	Had Have <input type="radio"/> <input type="radio"/> Headache	Had Have <input type="radio"/> <input type="radio"/> Dizziness	Had Have <input type="radio"/> <input type="radio"/> Pins and needles	Had Have <input type="radio"/> <input type="radio"/> Numbness	NONE <input type="radio"/>
						Initials _____
c. Cardiovascular						
Had Have <input type="radio"/> <input type="radio"/> High blood pressure	Had Have <input type="radio"/> <input type="radio"/> Low blood pressure	Had Have <input type="radio"/> <input type="radio"/> High cholesterol	Had Have <input type="radio"/> <input type="radio"/> Poor circulation	Had Have <input type="radio"/> <input type="radio"/> Angina	Had Have <input type="radio"/> <input type="radio"/> Excessive bruising	NONE <input type="radio"/>
						Initials _____
d. Respiratory						
Had Have <input type="radio"/> <input type="radio"/> Asthma	Had Have <input type="radio"/> <input type="radio"/> Apnea	Had Have <input type="radio"/> <input type="radio"/> Emphysema	Had Have <input type="radio"/> <input type="radio"/> Hay fever	Had Have <input type="radio"/> <input type="radio"/> Shortness of breath	Had Have <input type="radio"/> <input type="radio"/> Pneumonia	NONE <input type="radio"/>
						Initials _____
e. Digestive						
Had Have <input type="radio"/> <input type="radio"/> Anorexia/bulimia	Had Have <input type="radio"/> <input type="radio"/> Ulcer	Had Have <input type="radio"/> <input type="radio"/> Food sensitivities	Had Have <input type="radio"/> <input type="radio"/> Heartburn	Had Have <input type="radio"/> <input type="radio"/> Constipation	Had Have <input type="radio"/> <input type="radio"/> Diarrhea	NONE <input type="radio"/>
						Initials _____
f. Sensory						
Had Have <input type="radio"/> <input type="radio"/> Blurred vision	Had Have <input type="radio"/> <input type="radio"/> Ringing in ears	Had Have <input type="radio"/> <input type="radio"/> Hearing loss	Had Have <input type="radio"/> <input type="radio"/> Chronic ear infection	Had Have <input type="radio"/> <input type="radio"/> Loss of smell	Had Have <input type="radio"/> <input type="radio"/> Loss of taste	NONE <input type="radio"/>
						Initials _____
g. Skin						
Had Have <input type="radio"/> <input type="radio"/> Skin cancer	Had Have <input type="radio"/> <input type="radio"/> Psoriasis	Had Have <input type="radio"/> <input type="radio"/> Eczema	Had Have <input type="radio"/> <input type="radio"/> Acne	Had Have <input type="radio"/> <input type="radio"/> Hair loss	Had Have <input type="radio"/> <input type="radio"/> Rash	NONE <input type="radio"/>
						Initials _____

Eddy Chiropractic Clinic Inc.

21. Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Grocery shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising out of chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Household chores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Lifting objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Reaching overhead	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Showering or bathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Dressing myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Love life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a computer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Getting to sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in/out of car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving a car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking over shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Exercising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caring for family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Yard work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

22. What is the major stressor in your life? _____ 23. How much sleep do you average per night? _____ Hours

24. What is the type and approximate age of your mattress and pillow? _____ 25. What is your preferred sleeping position? _____

26. Describe your typical eating habits: Skip breakfast Two meals a day Three meals a day Snacking between meals

27. What would be the most significant thing that you could do to improve your health? _____

28. In addition to the main reason for your visit today, what additional health goals do you have? _____

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials _____ I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

Initials _____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials _____ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): _____

Initials _____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Initials _____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials _____ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

***CONSENT TO TREAT A MINOR CHILD**

Initials _____ I hereby authorize the doctors and assistants at EDDY CHOROPRACTIC, Inc. to administer care as deemed necessary to my (son / daughter) _____

If the patient is a minor child, print child's full name: _____

Signature _____

Date (MM/DD/YY) _____

CONSENT TO USE AND DISCLOSE OF HEALTH INFORMATION

By signing this form, you are granting consent to Eddy Chiropractic Clinic Inc. to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices (NPP) provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting us at (304) 375.6000. You have a right to request that we restrict how we use and disclose your protected health information for the purposes of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Authorization to Leave Messages with Household Members/Answering Machine

From time to time, it is necessary for representatives of Eddy Chiropractic Clinic Inc. to leave messages for patients. The purposes of these messages are to notify the patient that the doctor would like to discuss results, or to ask a patient to call Eddy Chiropractic Clinic, INC regarding an issue or concern, or to cancel/reschedule an appointment. At no time will a representative of Eddy Chiropractic Clinic discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Preferred phone number to be contacted: (_____) _____

_____ approval to leave a message with detailed information

_____ leave a message with call back number ONLY

Signature

Date

Patient Name (Please Print)

.....

HIPAA FORM

If you would like the option of being able to have your spouse, parent, or other individual to discuss your account with us please fill in the form below and sign. If our office does not have signed permission by you, we will be unable to honor any request for information from any of these parties. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Names authorized on account (list relationship), if no one is authorized, write N/A below, mark No Consent.

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

<input type="checkbox"/> Medical only
<input type="checkbox"/> Financial only
<input type="checkbox"/> All
<input type="checkbox"/> No Consent

Patient Signature

Date

Patient Name (print please)

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____

Patient Date of Birth: _____

SS Number: _____

I authorize the use and disclosure of the above individual's health information as described below.

The following individual or organization is authorized to make the PHI disclosure.

Physician/Facility

Address

The type and amount of information to be used or disclosed is as follows (include dates where appropriate):

- | | | |
|---|----------------------------------|---|
| <input type="checkbox"/> All medical records | from (date _____ to (date) _____ | <input type="checkbox"/> All dates of service |
| <input type="checkbox"/> Most recent history and physical | | |
| <input type="checkbox"/> Most recent discharge summary | | |
| <input type="checkbox"/> Office visits | from (date _____ to (date) _____ | |
| <input type="checkbox"/> Laboratory results | from (date _____ to (date) _____ | |
| <input type="checkbox"/> X-ray and imaging reports | from (date _____ to (date) _____ | |
| <input type="checkbox"/> X-ray and imaging disc | from (date _____ to (date) _____ | |
| <input type="checkbox"/> Consultation reports | from (date _____ to (date) _____ | |
| <input type="checkbox"/> Other _____ | | |

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and/or treatment for alcohol and drug abuse.

This information may be disclosed to and used by the following individual organizations:

Eddy Chiropractic Clinic Inc.
443 Highland Avenue, Williamstown, WV 26187
Phone: (304) 375.6000 Fax: (304)375.6043

The use or disclosure for which this request is made is: Review of medical records for diagnosis and/or treatment.

I understand that I may revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to Eddy Chiropractic Clinic. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. ***This authorization will expire one year from the date signed.***

I understand that authorizing the disclosure of this individually identifiable health information (PHI) is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed. I understand that, if the organization authorized to receive my PHI is not a health plan or health care provider, the released PHI disclosure of information carries with it the potential for an unauthorized redisclosure, and the information may not be protected by federal privacy regulations.

I hereby authorize the use or disclosure of my PHI as described below.

Signature of patient or patient's legal representative (Form MUST be completed before signing.)

Date

Printed name of patient's representative:

Relationship to the patient:



EDDY CHIROPRACTIC CLINIC, INC.

Exercise Wellness Center

Dr. Steven L. Eddy

443 Highland Ave., Williamstown, WV 26187 • (304) 375-6000 • Fax (304) 375-6043

GOOD FAITH ESTIMATE & FINANCIAL RESPONSIBILITY WAIVER

In this office, our major concern is to assist you in maintaining overall good health. As a patient with insurance coverage, you should be aware that insurance policies can vary greatly in terms of coverage, limitations, covered services and referral requirements. **We strongly recommend that each patient contact his/her own insurance company to verify their individual coverages.** Per our contract with your insurance carrier, it is required that you, the patient, be personally responsible for the payment of your deductibles/copays/co-insurance and charges that may exceed your coverage, prior to receiving treatment.

If at any time you fail to present our office with your current insurance card(s), fail to secure any necessary referral to be seen in our office, do not have current authorization on record for treatment in our office, exceed visit limitations, or receive non-covered services, the charges incurred will become your responsibility.

Please refer to the list below for the pricing of common services offered in our office so that you are aware of what charges will apply in the event you are responsible. This is not a complete list of services/supplies, pricing can be obtained from any of our staff should you have further concerns.

SERVICES		STANDARD CHARGES (Insurance)	CHUSA DISCOUNT (\$49 enrollment fee)	PATIENT OPTIONS (no enrollment fee - 1/1/22)
Examinations	99202/99212	\$90.00/\$80.00	\$75.00/\$65.00	\$75.00/\$65.00
Detailed Examinations	99203/99213	\$140.00/\$115.00	(Worker's Compensation & Personal Injuries)	
X-rays	Multiple codes	\$110.00 and up	\$30.00 per view taken	\$30.00 per view taken
Spinal Manipulation	98940/98941/98942	\$50.00/\$60.00/\$70.00	\$40.00	\$40.00
Electrical Stim.	97014	\$35.00	\$20.00	\$20.00
Ultrasound	97035	\$35.00	\$20.00	\$20.00
Cold Laser	97039	\$35.00	\$20.00	\$20.00
Extremity Manipulation	98943	\$50.00	\$35.00	\$35.00

Charges may vary based on your diagnosis determined upon your visit. Our staff will be happy to assist you with any questions you may have about your insurance benefits.

I have read and agree to receive the care recommended and accept financial responsibility for services provided.

Patient Signature

Date

Witness Signature

Date



First Report of an Injury, Occupational Disease or Death

By signing this form, I:

- I elect to only receive compensation and/or benefits that are provided for in this claim under Ohio workers' compensation laws;
I waive and release my right to receive compensation and benefits under the workers' compensation laws of another state for the injury or occupational disease, or death resulting from an injury or occupational disease, for which I am filing this claim;
I agree that I have not and will not file a claim in another state for the injury or occupational disease or death resulting from an injury or occupational disease for which I am filing this claim;
I confirm that I have not received compensation and/or benefits under the workers' compensation laws of another state for this claim, and that I will notify BWC immediately upon receiving any compensation or benefits from any source for this claim.

WARNING:

Any person who obtains compensation from BWC or self-insuring employers by knowingly misrepresenting or concealing facts, making false statements or accepting compensation to which he or she is not entitled, is subject to felony criminal prosecution for fraud.

(R.C. 2913.48)

Injured worker and injury/disease/death info.

Form section for injured worker and injury/disease/death info, including fields for name, address, Social Security number, marital status, date of birth, wage rate, and description of accident.

Benefit application release of information - I am applying for a claim under the Ohio Bureau of Workers' Compensation Act for work-related injuries that I did not inflict. I affirm that I elect to receive compensation and benefits under Ohio's workers' compensation laws for my claim, and I waive and release my right to file for and receive compensation and benefits under the laws of any other state for this claim.

Treatment info.

Form section for treatment info, including fields for health-care provider name, telephone number, diagnosis(es), and whether the incident caused missed work.

Employer info.

Form section for employer info, including fields for employer policy number, telephone number, fax number, e-mail address, and employer signature.

WORKER COMPENSATION INFORMATION

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ Soc. Sec. # _____
Address _____
Street City State Zip
Home Phone (____) _____ E-mail _____
Cell Phone (____) _____ Occupation _____

EMPLOYER

Employer Name _____
Employer Address _____
Street City State Zip
Employer Phone (____) _____ Injury Verified by (For Office Use) _____
Contact Person _____ E-mail _____

WORKER COMPENSATION CARRIER (FOR OFFICE USE)

Worker Compensation Carrier _____
Carrier Address _____
Street City State Zip
Carrier Phone (____) _____ Coverage Verified by _____
Adjuster's Name _____ Claim Number _____

INJURY INFORMATION

Date of Injury _____ Time _____ AM PM Place of Injury _____

Accident reported to employer? Yes No Name of person you reported accident to _____

Give full description of how accident happened _____

Have you lost time from work? Yes No How much? _____

Other doctors seen for this condition: Doctor's Name _____

Diagnosis _____ Were X-Rays taken? Yes No Other Tests? Yes No

If yes, by whom? Please list test(s) and result(s) _____

Any previous Worker Compensation injuries? Yes No Date(s) of previous injuries _____

Describe previous Worker Compensation injuries _____

AUTHORIZATION

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for Worker Compensation benefits is denied. I understand that filing for Worker Compensation benefits does not relieve me from my responsibility for the payment of all charges.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient



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		Phone number ()	
City	State	Nine-digit ZIP code	
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 Please explain: _____	<input type="checkbox"/> Dissatisfied with physician's treatment Please explain: _____	<input type="checkbox"/> Other, 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