5812 Wilmington Pike
Centerville, OH 45459

T: 937-886-7474
F: 937-886-7475

GEM CITY CHIROPRACTIC

Patient Demographics

Name: _____ Date: _____
Last First Middle Initial

Preferred Name: _____ Date of Birth: _____

Address: _____
City State Zip

Home Phone: _____ Cell Phone: _____

E-Mail: _____ Marital Status: M S W D

IN CASE OF EMERGENCY

Name: _____
Relationship:_____ Phone number:_____

Accident/ Injury Information

Is your condition due to an Auto Accident? ____ No ____ Yes Date: _____

Is your condition due to an injury sustained at work? _____ No _____ Yes Date: _____

Is your condition due to another form of accident? _____ No _____ Yes Date:_____

If YES, please explain: _____

Employment

Occupation: _____ Employer: _____

Full Time Student Part Time Student School: _____

Disabled Military N/A

HIPAA NOTICE OF PRIVACY PRACTICES
SUMMARY AND DISCLOSURE

Gem City Chiropractic
Effective Date: 03/13/2017

Our HIPAA Notice of Privacy Practices describes the privacy practices of Gem City Chiropractic. We respect our legal obligation to keep health information that identifies you private, and by law, we are obligated to provide you a notice of our privacy practices.

We are required by law to maintain the privacy of your health information, to follow the terms of our Notice that are currently in effect, and if you request, to provide you a copy of our Notice regarding our privacy practices and legal duties in respect of you and the information we collect and maintain regarding your health information. Our Notice also describes your rights regarding your health information and certain obligations that mandate how we use and disclose your health information.

Your Rights – You may…

- Request to inspect any copy of your records
- Request to amend incomplete or inaccurate information in your records
- Receive an accounting of certain disclosures of your health information
- Ask for additional privacy protections (although your request may be declined)
- Ask for confidential communications in a particular manner
- Receive a paper copy of this Notice
- File a complaint without penalty

Use and Disclosure – We will not use or disclose your information unless you tell us to do so or unless the law allows or requires us to do so . We use and disclose your information:

- For treatment, payment, and health care operations
- Through patient scheduling; to notify family or a close friend you have entrusted with your care; or for notification after benefits and services.
- As permitted or required by the law
- For certain activities when the law requires it, such as: public health, reporting of abuse, neglect, or domestic violence; health oversight; lawsuits and disputes; law enforcement activities; coroner; medical examiner, or funeral director purposes; organ donation; avoidance of a serious threat to health or safety; workers' compensation; national security
- With your authorization

Changes to this Notice – We reserve the right to change this Notice at any time as allowed by law. Updated Notice will be in our office and paper copies will be available upon request.

Complaints - If you believe that we have not properly respected the privacy of your health information, you may file a complaint with our clinic by contacting an Office Manager by calling (937) 886-7474, sending a letter to our office address, or by e-mailing drnathanbaxter@gmail.com

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Please Indicate below if we may discuss your health information, appointment scheduling and/or billing with someone you trust:

Spouse: _____ Yes, Health info ____ Yes, Billing Info ____ Yes, Scheduling ____

Parent/s or Guardian: _____ Yes, Health Info ____ Yes, Billing Info ____ Yes, scheduling ____

Relative/Friend/ Other: _____ Yes, Health Info ___ Yes, Billing Ingo ___ Yes, scheduling ____

Acknowledgement of Receipt of this Notice As a patient of Gem City Chiropractic, I acknowledge that I have received and seen this notice and understand that I may request a copy of the full HIPAA Notice Privacy Practice for additional information. I understand that Gem City Chiropractic respects their legal obligation to keep health information private unless require by law. My signature below indicates that I agree to these conditions.

Printed Patient Name: _____

Signature of Patient: _____ Date: _____

Gem City Chiropractic Financial Policy

If you have insurance that we are in network with, we will make a copy of your card and collect any co-pay or coinsurance that is due. Once we receive an EOB (Explanation of Benefits) from your insurance company, we will send you a statement if there is a balance remaining for us to collect.

If you have insurance that we are *not* in network with, you may contact your insurance company to see if they will reimburse you for visiting an out of network provider. You will be responsible for providing payment at the time of service. We will assist you by providing receipt of your treatment in our office, or that you may seek reimbursement form your insurance company.

Common Insurance Terms:

Allowed amount: For the insurance companies that we are in-network with, there is an amount that we have agreed to receive as payment for our services. This contracted amount is sometimes less than our standard fee schedule. This "allowed amount" will be made by a combination of the patient and the insurance company, sometimes wholly by one party or the other. How much of this amount the insurance will pay is determined by the patient's deductible, co-pay, coinsurance, and out of pocket limit amounts with their insurance company.

Deductible: Most insurance policies are written with a deductible. The deductible is amount that the patient must pay before the insurance company is responsible. Sometimes the deductible is figured on a per-person basis with a maximum amount per year for the family. The deductible may apply to all charges, or it may apply only to office visit charges and exclude x-rays, exams, and diagnostic procedures. The services that are subject to the deductible are decided by the insurance contract or policy. The amount of the deductible will differ from one company and one contract to another.

Copay and Coinsurance amounts: a ***copay*** is a **set dollar amount** that the patient is responsible for. With **coinsurance**, the patient is responsible for **a percentage of the allowed amount** on a service. Some insurance contracts will have the patient responsible for a combination of a copay and coinsurance on charges, or may utilize a copay for certain services and a co-insurance for others.

To help you understand your payment responsibility, our staff will be happy to check your benefits**. However, a quote of benefits by our staff does not guarantee payment by your insurance company or verify eligibility**. Should your health insurance company deny payment, you are personally and fully responsible for your charges. It is for this reason that **we highly** recommend that you contact your insurance company to discuss your benefit coverage for chiropractic services when provided by our practitioners.

Gem City Chiropractic is pleased to offer **EVERYONE** a **time of service (TOS) discount**.

A **Time of Service Discount** is a discount off our standard fee schedule. This discount is available when making payment at the time that service is rendered. Payment can be made via cash, check, or credit card.

By signing below, I agree to the following: " I have read, understand and agree with the described financial policies on this page. By signing, I agree that I also understand that as the patient, or legal guardian of the patient, I am ultimately personally responsible for any and all costs associated with the course of my treatment and care at Gem City Chiropractic. Failure to pay all costs associated with my care as agreed may result in collection activity on my account as well as reporting of my payment history to credit reporting bureaus."

_____ _____

Patient Name (please print) Date

_____

Signature of Patient or Authorized representative

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of the nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I, _____ have read and fully understand the above statements.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____

Signature Date

GEM CITY
CHIROPRACTIC

Gem City Chiropractic

5812 Wilmington Pike

Centerville, OH 45459

937-886-7474

Informed Consent for Chiropractic Treatment

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy, and if necessary diagnostic x-rays on me (or on patient named below, for whom I am legally responsible: _____ by W. Nathan Baxter, D.C. And/or working in this office authorized by above referenced doctor of chiropractic.

I further understand that such chiropractic services may be performed by Gem City Chiropractic office and/or other licensed Doctors of Chiropractic who may treat me now, or in the future at this office. I have had an opportunity to discuss with W. Nathan Baxter, D.C., and/or his staff the nature and purpose of chiropractic adjustments and other procedures. I understand that the results are not guaranteed.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic carries some risks to treatments: including, but not limited to: sprains, fractures, disc injury, burns, dislocations, and strokes. I do not expect the doctor to be able to anticipate and explain all the risks and complications. Further, I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels are in my best interest at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask question about its contents, and by signing below, I agree to the treatment recommended by my doctor. I intend this consent for to cover the entire course of treatment for my present condition(s) for which I seek treatment at this facility.

Printed Name of Patient

Signature of Patient

Signature of Patient's representative if patient is a minor

DATE: _____

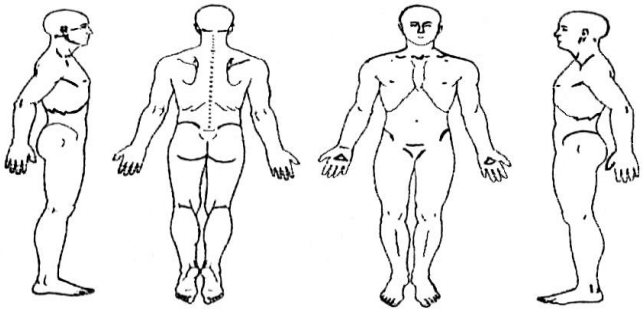
CASE HISTORY

Name: _____

1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain).

Condition / Problem	Severity (Minimal → Severe)	Frequency (% of week) (Occasional → Constant)
a. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
b. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
c. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
d. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
e. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

(Please mark the figures where you experience pain.)



2. Symptoms are worse in the (circle what applies)

-morning -Increase during the day

-afternoon -same all day

-night -decrease during the day

3. Symptom (a.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
4. Symptom (b.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
5. When did your symptoms begin (onset date)? _____
6. How did your symptoms begin? _____
7. Have you experienced these before? _____
8. Do your symptoms radiate? (Please describe where they radiate)

   _____
9. Since your condition began, has it? ____ Improved ____ Gotten Worse ____ Stayed the same since it began
10. Circle the things that make your problems worse:

    Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping
11. Is there anything you can do to relieve the problems? ____No ____Yes Describe: _____

    If No, what have you tried that has not helped? _____
12. Have you been treated for this before? ____No ____Yes How long ago? _____
13. What treatment did you receive? _____
14. Results of previous treatment? ____Good ____Poor Comments _____
15. Who referred you to our office? _____
16. Is this condition interfering with ____ Work ____Sleep ____Daily Routine ____Recreation
17. List any other major injuries you have had, other than those mentioned above: _____

    _____
18. Any other Musculoskeletal problems? ____No ____Yes …Neurological problems? ____No ____ Yes

_____Additional information on back side of sheet.

I certify that the above information is accurate to the best of my knowledge.

Patient/Guardian Signature _____ Date: _____