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

5812 Wilmington Pike
Dayton, OH 45459
937-866-7474
937-866-7475

GEM CITY CHIROPRACTIC

Name:_____ DOB:_____ Today's Date:_____

Report of Accident:

Date of Accident:_____ Time of Accident:_____ ❑ A.M. ❑ P.M. City of Accident: _____

Street of Accident that your car was on: Cross Street (intersection):

Road conditions at the time of incident: ❑ Wet ❑ Dry ❑ Icy ❑Other

Were there any witnesses? ❑ Yes ❑ No Were you wearing your seat belt? ❑ Yes ❑ No

Did the police come to the scene of the accident? ❑ Yes ❑ No Was an accident report filed? ❑ Yes ❑ No

If a traffic violation was issued, to whom was it issued?

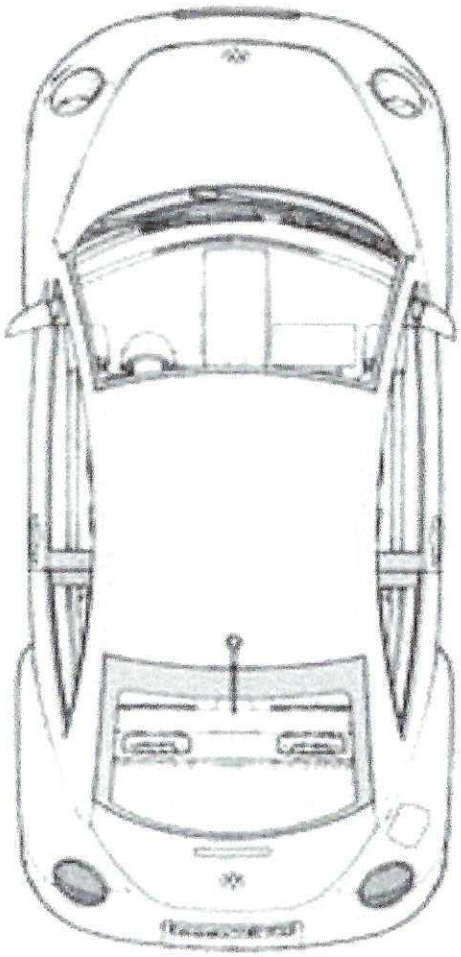
Please explain the details of the accident to the best of your knowledge: _____

_____

_____

_____

Indicate where the initial impact struck your vehicle by marking an "X" on the diagram below:



The following questions pertain to you, the patient, and the vehicle you were in:

Number of people in accident vehicle:

Were you the: ❑ Driver ❑Front Passenger ❑Rear Passenger

Were you ❑ aware of the approaching collision ***or*** ❑surprised by impact?

Were you rendered unconscious? ❑ Yes ❑ No If yes, for how long?

_____

In relation to the base of your skull, where was the headrest?

❑ Above ❑ Below ❑ At base of skull

Was this vehicle equipped with airbags? ❑ Yes ❑ No

If yes, did it/they inflate? ❑ Yes ❑ No

What did your vehicle impact? ❑ Another Vehicle ❑Other

Vehicle Information & Velocity pertaining to the vehicle you were in:

Vehicle Year: Make: Model:

What direction was your vehicle traveling?❑North ❑South ❑East ❑West

Was your car ❑ Moving ***or*** ❑Stopped

If your car was moving:

How fast were you traveling? Approximately MPH

Just before impact, the vehicle you were in was:

❑Slowing down ❑Speeding Up ❑Constant Speed

Did the impact to your vehicle come from the:

❑ Front ❑Rear ❑ Right Side ❑ Left Side ❑ Other:

The following questions pertain to the other vehicle involved in the accident:

Other Vehicle Year: Make: Model:

What direction was the other vehicle traveling?❑North ❑South ❑East ❑West

Was the other car ❑ Moving ***or*** ❑Stopped

If the other car was moving:

How fast was it traveling?_____ Approximately MPH

Just before impact, the other car was:

❑Slowing down ❑Speeding Up ❑Constant Speed

Were there bleeding cuts caused by the accident? ❑ Yes ❑ No Where: _____

Where there any bruises caused by the accident? ❑ Yes ❑ No Where: _____

If any part of your body struck anything during the collision please describe what and where:

_____

What were the cost of damages to the vehicle you were in? $ _____

Which (if any) of the following car parts broke during the accident:

❑Windshield ❑ Steering Wheel ❑ Front Seat ❑ Back Seat ❑Side Window(R/L) ❑Other

Was the trunk of your body pointed straight forward at the time of impact? ❑ Yes ❑ No

If No, which direction was it pointed, and by how much? _____

Was your head pointed straight forward at the time of impact? ❑ Yes ❑ No

If No, which direction was it turned, and by how much? _____

Insurance Information:

Name of Insurance Company: _____ Telephone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Insured's Name: _____ Insured's SS #: _____ DOB: _____

Insured's Employer: _____ Policy #: _____ Claim #: _____

Name of Claim Representative: _____ Telephone #: _____

Attorney Information:

Name of Attorney/Law Office: _____ Telephone #: _____

Address of Attorney: _____ City: _____ State: _____ Zip: _____

Work:

To evaluate the effect that continuing work will have on your recovery please complete the following:

Have you been able to work since the injury? ❑ Yes ❑ No

Are your work activities restricted as a result of your injuries sustained? ❑ Yes ❑ No

How many hours are in your normal work day? _____

What can you do for work with minimum physical effort and for how long? _____ ❑ N/A

Prior to the injury were you capable of working on an equal basis with others your age? ❑ Yes ❑ No ❑ N/A

While in recovery, is there any light duty work you could request? ❑ Yes ❑ No ❑ N/A

Please indicate your daily job duties and any activities in which you are occasionally asked to perform:

❑ Standing ❑ Sitting ❑ Walking ❑ Lifting

❑ Driving ❑ Twisting ❑ Crawling ❑ Bending

❑ Operating equipment ❑ Working with arms above head

❑ Typing ❑ Stooping

❑ Other: _____

Complaint(s)/Pain Location(s): ❑ Dizziness ❑ Memory Loss ❑ Blurred vision ❑ Ringing/Buzzing in ear

❑ Left ❑Right ❑ Bi-lat; ❑ Difficulty sleeping ❑ Fatigue ❑ Irritability ❑ Stomach Upset ❑ Nausea ❑ Migraine(s)

❑ Headache(s) ❑ Neck ❑ pain ❑ stiffness ❑ Jaw problems ❑ Arm pain ❑ Left ❑ Right ❑ Bi-lat ❑ Shoulder pain

❑ Left ❑ Right ❑ Bi-lat ❑ Numb Hands/Fingers ❑ Left ❑ Right ❑ Bi-lat ❑ Chest pain ❑ Shortness of breath

❑ Tension ❑ Upper back ❑ pain ❑ stiffness ❑ Mid back ❑ pain ❑ stiffness ❑ Lower pain ❑ pain ❑ stiffness

❑ Leg pain

CASE HISTORY

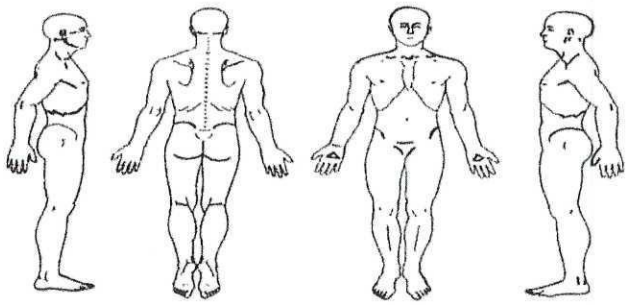
GEM CITY CHIROPRACTIC

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: _____

I understand that my automobile insurer, or an insurer representing someone I believe to be at fault for causing my injuries, or that persons' attorney, or an attorney representing me in a claim for injuries, may request reports, copies of records, may require a physician from this Clinic to provide deposition testimony or testimony in court, or other information. I understand and agree that I am financially responsible to this Clinic to pay the Clinic's costs for these items, and that the Clinic may request payment in advance for some, or all of these items, even if this Clinic's Assignment states otherwise.

I understand and agree that all my records, including x-rays, are permanent records of this Clinic. I authorize the release of any information relevant to my treatment, including information regarding treatment fees, to insurers and attorneys who are involved with my claim and their respective representatives. I understand that the Clinic may require any recipient of such information to comply with applicable federal, state, and/or local law prior to and during receipt of such information.

I HAVE READ THIS DOCUMENT AND I FULLY UNDERSTAND IT.

THIS DOCUMENT IS MADE A PART OF THE ASSIGNMENT.

I HAVE SIGNED IN FAVOR OF THE CLINIC.

I HAVE RECEIVED A COPY OF THIS DOCUMENT.

_____ _____

(Signature of Patient) (Date)

_____

(Print or Type Patient Name)

_____

(Signature of Parent or Legal Guardian)

ASSIGNMENT

I was involved in an accident on or around _____[date] in which I was injured for which I have or may have a claim against another person(s) for causing my injuries (including _____) (referenced as "My Claim"), who is insured by: _____.

In consideration of the agreement of Gem City Chiropractic. (referenced as the "Clinic") to delay billing me personally for medical services rendered until resolution of My Claim:

1. I now assign, without any right to later revoke, a part of any proceeds from My Claim equal to the fees incurred by me to this Clinic. I am not assigning any legal cause of action in My Claim above, but only prospective proceeds. **The Clinic is not a subrogee for its charges. This Assignment does not assign My Claim itself. This Assignment assigns an interest in prospective proceeds from My Claim. Any Obligor (defined below) will be bound at the moment proceeds from My Claim exist.** Separate and apart from my own pursuit of My Claim, I will submit a claim for the Clinic's fees for medical payments coverage in my automobile liability policy, or the policy of the driver of the car in which I rode.
2. **This Assignment and related documents which I have signed in connection with its states the entire agreement and my complete understanding regarding the Clinic's fees. I have not relied on any statements by the Clinic or the Doctor or other information before making this Assignment. I understand that I remain responsible for any Clinic fees not paid out of My Claim. If I subsequently die or become totally disabled, this Assignment is binding on my estate and my personal representative(s).**
3. **I understand that it is my responsibility during treatment to remain aware of my cumulative account balance for services rendered. I have received a schedule of treatment fees for this Clinic, or if I have not, will request this Clinic for one in writing.**
4. I understand that this is an express contract to pay for the services rendered by this Clinic. I agree to pay my account balance in full regardless of whether any other person or entity attempts to or fails to fully reimburse me for it. I f I dispute my account balance or treatment rendered, I agree that my remedy will be to resolve it with a separate action from My Claim or to escrow my proceeds in the amount of my account balance.
5. **NOTICE: I DIRECT ANY INSURANCE COMPANY, ATTORNEY, OR OTHER PERSON WHO NOW HOLDS OR LATER HOLDS ANY PROCEEDS FROM MY CLAIM ("OBLIGOR") TO APPLY ANY PROCEEDS FROM MY CLAIM TO MY TOTAL ACCOUNT BALANCE OUT OF THE TOTAL PROCEEDS FOR MY CLAIM TO COMPLY, ANY OBLIGOR MAY SIMPLY INCLUDE THE CLINIC AS A JOINT PAYEE ON ALL SETTLEMENT DRAFTS ISSUED TO ME. "TOTAL PROCEEDS" HELD BY AN ATTORNEY FOR MY CLAIM SHALL MEAN PROCEEDS AFTER DEDUCTION OF ATTORNEY FEES, BUT MED PAY PROCEEDS RECEIVED OR HELD BY MY ATTORNEY SHALL NOT BE SUBJECT TO PRIOR DEDUCTION OF ATTORNEY FEES.**
6. This Assignment is governed by Ohio law. Jurisdiction shall be in Ohio, and venue shall lie in any Ohio county permitted by law.
7. **I REALIZE THAT I HAVE NOW GIVEN AWAY A PART OF THE PROCEEDS FROM MY CLAIM. IF I RECEIVE ANY PROCEEDS FROM MY CLAIM, I AGREE TO IMMEDIATELY DETERMINE IF THIS CLINIC HAS BEEN SEPARATELY PAID IN FULL. UNLESS THE CLINIC CONFIRMS FULL PAYMENT IN WRITING, I REALIZE THAT ANY USE BY ME OF THESE ASSIGNED PROCEEDS IS TAKING AND CONVERTING MONEY THAT IS THE PROPERTY OF THIS CLINIC.**
8. I HAVE READ THIS DOCUMENT AND I FULLY UNDERSTAND IT. I RECEIVED A COPY.

_____ _____

(Signature of patient) *(Date)*

_____

(Print or type patient name)

This Assignment Has Been Signed On the Clinic Premises

_____ _____

(Signature of Parent or Legal Guardian) *(Staff Witness)*

PATIENT VERIFICATION

I have been advised by this Clinic that the preferred method for payment of treatment fees is for the fees to be paid directly by me as I receive treatment. **Check every box that is true:**

- ☐ I do not choose to pay for treatment fees as received, for financial reasons.

- ☐ I do not have health insurance that will cover my treatment for my injuries

- ☐ This Clinic is not under contract as a provider for my health insurance. I do not want my health insurance to be billed for treatment of my injuries, except in the case that my own liability insurer requires it as condition to qualifying for medical payments coverage. **I have chosen to <u>not</u> seek and <u>not</u> authorize health insurance reimbursement for this Clinic's treatment fees knowingly, and after considering my alternatives. I do <u>not</u> want to pay health insurance co-payments and/or do not want the potential obligation to have to currently pay this Clinic for treatment which is not covered by my health insurance.**

- ☐ The Clinic is under contract as a provider for my private health insurance, or I am covered by Medicare, or Medicaid, or other government sponsored health insurance. I authorize this Clinic to bill my health insurance for all covered services. I understand that I may be required to pay co-payments at the time of service. **I understand and agree that all services and charges of this Clinic <u>not covered by my health insurance</u> will be paid pursuant to the Assignment and related documents I have signed.**

I authorize this Clinic to bill my own liability (auto) insurer for treatment fees I incur, (unless required to bill my health insurer, as checked above). I authorize this Clinic to send notice of the Assignment to my own liability (auto) insurer, to the liability (auto) insurer of the person I claim caused my injuries, and to the attorney representing me for My Claim. This document is made a part of the Assignment I have signed in favor of the Clinic.

_____ _____

Name of Liability Insurer for Person at Fault | Name of My Liability Insurer

_____

Name of My Attorney

I have received a copy of an Assignment which I have signed in favor of this Clinic and Schedule of Treatment Fees.

_____ _____

(Signature of Patient, Parent, or Legal Guardian) | (Date)

_____ _____

(Print or Type Above Name) | (Staff Witness)

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: _____