Olson Chiropractic
473 E. Troy Pike, Ste D, Covington, OH 45318
(937) 473-5959 (p) ~ (937) 473-2799 (f)

Date: _____

Confidential Patient Information

Patients Name: _____ Chief Complaint:_____
Address: _____ Home Phone: _____
City: _____ Zip: _____ Cell Phone:_____
SSN#: _____ Email: _____
Date of Birth: _____ Marital Status: M S W D
Occupation: _____ Employer: _____
Address of insured (if different from above):_____
Are your present systems or conditions related to, or the result of an auto collision, work related injury or other personal injury? (Someone else might be responsible for payment?) ____ Yes ____ No

Ins. Company:_____ Ins. Phone #:_____
ID#:_____ Group #:_____
Name of Policy Holder: _____ Policy Holder DOB:_____
Policy Holder's Employer:_____

Family Physician:_____(Note: May we send your health information to this provider **Y / N**)
Person to contact in case of emergency (Name and Phone): _____
Have you ever been under Chiropractic Care? Y N If so, who? _____
Have you had any SPINAL X-Rays/ MRI'S / CT'S taken in the last year? Y N If so, Where?_____
What operations have you had? _____When?_____
Serious Illness: _____ When? _____
Infectious Diseases: _____ When? _____
Do you have a pacemaker? **Y / N** Have you ever had any Hip or Knee Replacements? **Y / N**
What medications or drugs are you currently taking? (check those that apply) Pain Killers _____Insulin_____ Cholesterol Meds_____
Blood Pressure_____ Muscle Relaxers_____ Birth Control _____ Other:_____
What is your goal in our office? _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to **Dr. Brian J. Olson (DBA: Olson Chiropractic)** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue each claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature of Insured / Guardian:_____ Date:_____

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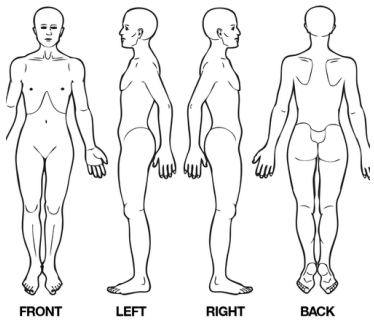
Name:_____ **CASE HISTORY**

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 0 1 2 3 4 5 6 7 8 9 10 Severe)	Frequency (% of week) (Occasional 0 10 20 30 40 50 60 70 80 90 100 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
- Evening - Decrease during 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? _____

9. Has your condition? ____ Improved ____ Gotten Worse ____ Stayed the same since it began

10. Circle the things that make your problem 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. Were you referred to our office by anyone? _____

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 info on back side.

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

Patient/ Guardian Signature:_____ Date: _____

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Patient Name: _____ Date:_____

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent

A patient, in coming to the chiropractor doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Olson Chiropractic, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Missed Appointments

There is a possible fee charged for all appointments that are not canceled prior to the scheduled visit.

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____
Children: _____
Others: _____
No One: _____

May we leave messages regarding your personal healthcare information on any answering device, i.e. home answering machines or voicemails? Yes [ ] No [ ]
May we contact you via email? Yes [ ] No [ ]

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____

Signature: _____ Date: _____

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Patient Financial Responsibility Form

Thank you for choosing Olson Chiropractic as your healthcare provider. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities:

The patient (or patient's guardian, if minor) is ultimately responsible for their payment for treatment, care, and purchases. We will bill your insurance for you; however the patient is required to provide the most correct and updated information regarding their insurance and general contact information. Patients are responsible for payment of copays, deductibles, coinsurance and all other procedures, treatments, or items not covered or approved by their insurance plan. Copays, deductibles (that are not met yet) and non- covered treatment or items are dure at the time of service. Coinsurance is due 30 days from receipt of billing.

Medicare will not cover any procedure except for your adjustment. All insurance companies will not cover massage when performed by our massage therapist and dry needling performed by Dr. Olson. Due to these circumstances we offer low cash fees for those services.

Print Patient Name: _____

Patient Signature: _____ Date: _____

Parent or Guardian (must sign if patient is under 18 years of age)

Signature: _____ Date: _____