CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

Social Security # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

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

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Cell Phone (____) _____ Home Phone (____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (____) _____ Work Phone (____) _____

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

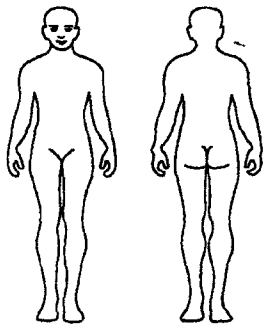
5 PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

6 HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other_____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____

Spinal Exam_____ Chest X-Ray_____ Urine Test _____

Dental X-Ray_____ MRI, CT-Scan, Bone Scan_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No		
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tonsilitis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No	Other _____	
Chicken Pox	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
				Rheumatoid Arthritis	☐ Yes ☐ No		

EXERCISE
☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY
☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS
☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date_____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

7 MEDICATIONS

_____
_____
_____
Pharmacy Name_____
Pharmacy Phone (____) _____

ALLERGIES

_____
_____
_____
_____
_____

VITAMINS/HERBS/MINERALS

_____
_____
_____
_____
_____

Electronic Health Records Intake Form

In Compliance with Requirements for the United Stated Government EHRI Program

First Name_____ Last Name_____

DOB: _____ Gender: Male/Female Preferred Language_____

Email Address:_____

Smoking Status: Every Day Smoker/Occasional Smoker/Former Smoker/Never Smoked

CMS Requires providers to report both race and ethnicity

Race: American Indian or Alaska Native/Asian/Black or African American/White or Caucasion/Hawaiian Native or Pacific Islander/Other/Decline to Answer

Ethnicity: Hispanic/Non-Hispanic/Decline to Answer

Please list any regularly used medication(s) you are currently taking:

Name	Dosage and Frequency (i.e. 5mg once a day, etc.)
_____	_____
_____	_____
_____	_____

Please list any medication allergies:

Type	Reaction	Onset Date	Additional Comments
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I choose to decline a printed clinical summary after each visit. (Due to the nature and frequency of chiropractic care, the clinical summary would be blank. A receipt or itemized statement may be obtained at any time.)

Patient signature:_____ **Date:**_____

For office use only:

Height:_____ **Weight:**_____ **Blood Pressure:**_____/_____

chiropractic & wellness center
AcuHealth

Michael P. McGough, D.C.
Chiropractor

RECORDS RELEASE AUTHORITY

Date: _____

To: _____

Address: _____

City: _____ State: _____ Zip: _____

I hereby authorize the release of my "Protected Health Information" or copies of such and request that they be transferred to the named office/facility below.

- X-rays: Date Range: _____
  - Cervical
  - Thoracic
  - Lumbar
  - Extremity
- MRI/CAT scan studies: Date Range: _____
  - Cervical
  - Thoracic
  - Lumbar
  - Extremity

Lab/Blood Work: Date Range: _____

Treatment/Office Notes: Date Range: _____

Name of Patient: (Please Print) _____ Patient's Date of Birth: _____

Street Address: _____ City, State, Zip: _____

Signature of Patient/Parent/Guardian: _____

Witness: _____ Date Requested: _____

PROHIBITION OF REDISCLOSURE: The information in this facsimile is intended only for the use of the individual or entity named above. This transmission may contain information that is privileged, confidential and/or otherwise exempt from disclosure under applicable law. You are prohibited from making copies and further disclosure of this information except with specific written consent of the person to whom it pertains.

NOTICE TO UNINTENDED RECIPIENT: In the event you have erroneously received this transmittal, please be advised that the accompanying material constitutes confidential information protected by laws. Please contact the sender of the FAX at the number above immediately upon receipt. Your cooperation is appreciated.

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Chiropractor

RELEASE OF INFORMATION

I hereby instruct and authorize my attorney, who is representing me as a result of the motor vehicle accident that occurred on _____ that services provided by Michael P McGough, DC will be paid in full from the proceeds of any settlement or judgment resulting out of the aforementioned accident. Payment of those services should be forwarded within five (5) days of disbursement of funds.

I hereby authorize and instruct my attorney/adjuster named below to release the following information to my healthcare provider, Michael P McGough, DC, AcuHealth Chiropractic & Wellness Center, 5980 Cleveland Avenue, Columbus, Ohio 43231.

The information to be supplied includes:

1) Case status as requested
2) The amount of the total settlement
3) Case settlement date
4) Settlement disbursement breakdown of all expenses
5) Copies of settlement checks

Attorney

_____

_____

_____

Patient's Printed Name_____

Patient's Signature_____Date_____

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Michael P. McGough, D.C.
Chiropractor

DOCTOR'S LIEN

To Adjuster/Attorney:

I do hereby authorize Michael P McGough, DC, to furnish you, my attorney/adjuster, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney/adjuster, to pay directly to said doctor such sums as may be due and owing him for medical services rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to protect said doctor. And, I hereby further give lien on my case to said doctor against any and all proceeds of any settlement, judgment, or verdict which may be paid to my attorney or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And, I further understand that such payment is not contingent on any settlement, judgment, or verdict that I may eventually recover said fee.

Date: _____ Patient's Signature _____

Patient's Printed Name _____

The undersigned being the attorney/adjustor of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect Dr Michael P McGough, DC.

Date: _____ Attorney _____

Attorney's Printed Name _____

www.acuhealthchiro.com

5980 Cleveland Avenue ▮ Columbus, Ohio 43231 ▮ 614.475.2992 ▮ 614.475.2993 fax ▮ drmikemcgough@yahoo.com

PATIENT HIPAA ACKNOWLEDGEMENT

AcuHealth Chiropractic has made me aware of HIPAA Privacy Practices and I acknowledge reading a copy of these Privacy Practices. I may request a written copy of these Privacy Practices by notifying any staff member at any time.

_____

Print Patient Name

_____

Patient Signature Date

FOR PRACTICE USE ONLY

_____Patient Refused to Sign HIPAA Acknowledgement

_____

Staff Signature Date

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CASH AND INSURANCE PATIENTS

Insurance

It is the responsibility of each patient to contact his/her insurance company to obtain details of their coverage and to be informed of insurance account balances. Our office can assist in acquiring this information and in clarifying benefits. Changes in insurance coverage should be reported immediately to our staff.

Cash

Cash patients are expected to pay for services rendered at each visit. Pre-paid discount packages are an option for those paying cash.

Missed Appointments

Our office accommodates urgent appointment requests and schedules patients in consideration of their needs whenever possible. When patients cancel without notice or fail to appear for an appointment, this affects all our patients by limiting their schedule options.

For cancellations made less than 24 hours in advance of an appointment, AcuHealth Chiropractic reserves the right to charge patients the following fees:

Adjustments	$45
Ultrasound	$30
Decompression	$45
Acupuncture	$55

_____

Signature Date

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CONSENT TO TREATMENT

I hereby request and authorize Michael P McGough, DC to perform diagnostic tests and render chiropractic adjustments, physical therapy and other treatments. This authorization also extends to all other doctors and office staff employed at AcuHealth Chiropractic and is intended to include radiographic examinations completed at the doctor's discretion.

_____

Signature Date

_____

Relationship to Patient If Not Self

www.acuhealthchiro.com

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Pregnancy Release Form

It is recognized that ionizing radiation can be harmful to a fetus or that the effects of a magnetic field on a fetus has been undetermined as of yet. It is the policy of AcuHealth Chiropractic & Wellness Center that women who are pregnant or suspect they are pregnant should not have an exam that utilizes ionizing radiation or magnetic fields unless the referring physician believes that the patient's life would be compromised without the exam. AcuHealth Chiropractic & Wellness Center requires confirmation of pregnancy/non-pregnancy for women of child bearing age (10-55 years of age) prior to performing a radiological exam.

Patient: Please check and initial your pregnancy status:

☐ I am not pregnant _____ (patient initials)

☐ I am _____ weeks pregnant _____ (patient initials)

☐ I am unsure of my pregnancy status _____ (patient initials)

By signing below, I agree that the above statements are true and hereby release AcuHealth Chiropractic & Wellness Center and its subsidiaries from any complications that may occur from exposure to ionizing radiation or a magnetic field and assume responsibility for my decision to undergo the procedure/exam.

_____ _____
Patient/Legal Representative Signature Date/Time

_____ _____
AcuHealth Chiropractic & Wellness Center Date/Time