BOGGS CHIROPRACTIC
Uniontown, OH 44685
(330) 896-2424
www.boggschiropractic.com

File Number: _____
Date: _____

CONFIDENTIAL PATIENT INFORMATION

Name:_____

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

Cell Phone: _____ Home Phone: _____ Work Phone:_____

Personal Email: _____ Birth Date: _____ Age:_____

Gender: Male / Female Marital Status: Married / Single / Other

Race: I Decline to Answer / American Indian / Asian /African American / Caucasian / Native Hawaiian / Other

Ethnicity: I Decline to Answer / Hispanic or Latino / Not Hispanic or Latino

Smoking Status: I Decline to Answer / Every Day / Occasional / Former / Non Smoker

Social Security Number: _____ How did you learn about our office?_____

Occupation: _____Employer:_____

Work Address:_____

Name of Spouse:_____

Spouse's Employer:_____Spouse's Occupation:_____

Emergency Contact Name:_____

Phone Number:_____ Relation to you:_____

PAYMENT INFORMATION

Do you currently have medical coverage: Yes / No

Payment is due at the time of service in the form of: Cash / Check / Credit Card

Insurance Company Name:_____Card Holder Name:_____

Policy Number:_____Group Number:_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that BOGGS CHIROPRACTIC will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to BOGGS CHIROPRACTIC will be credited to my account on receipt. However, I clearly understand and agree that any services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient Signature: _____ Date:_____

Guardian or Spouse Signature: _____ Date:_____

***OFFICE USE ONLY*: *Height:* _____ *Weight:* _____ *BP:* _____/_____ *OA:* _____**

Name: _____ Date: _____

CURRENT COMPLAINTS

What is the purpose for today's visit: _____

Is your visit related to a/an: Automobile Accident / Work Injury / Other: _____
Please describe any injury: _____

Date of injury (if applicable): _____ Date your current symptoms appeared: _____

Have you received treatment for your current symptoms: Yes / No
If yes, explain: _____

Have you been under chiropractic care before Yes / No If yes, when was your last treatment: _____

Do you have any concerns regarding chiropractic treatment: _____

MEDICAL HISTORY

Who is your primary medical doctor: _____
Date of last visit: _____ Date of last physical exam: _____
Is there any chance that you are currently pregnant (Circle One) Yes / No If yes, how many weeks: _____
Have you had x-rays taken in the last 6 months (Circle One) Yes / No If yes, what body part: _____

Are you currently diagnosed with any illnesses and/or other health conditions?

Health Condition	Date diagnosed	What is your doctors name?	Doctor's Practice Name

Please list any medications that you are currently taking (Please include regularly used over the counter medications):

Medication	Dosage	Frequency	Purpose for taking	Has this been beneficial?

Please list any allergies that you have had:

Allergy	Reaction	Onset Date	Additional Comments

Who in your family has experienced pain in their head, neck, back, arms, and/or legs? (Father, Mother, Siblings, Grandparents): _____

_____

Please list any repetitive movements, positions, and/or activities you do on a daily basis: _____

_____

☐ I choose to get a copy of my clinical summary after every visit (*These summaries are often blank as a result of the nature and frequency of chiropractic care*).

Patient Signature: _____ Date: _____

Guardian or Spouse Signature: _____ Date: _____

Boggs Chiropractic
3939 Massillon Rd. Suite 201 Uniontown, OH 44685
330-896-2424(p) ~ 330-896-3294(f)
www.boggschiropractic.com

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.

Informed Consent:

A patient, in coming to the chiropractic 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 physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of 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 **Boggs 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.

Please Circle Below

To the best of my knowledge *I am Pregnant* or *I am NOT pregnant*
***I give my permission* or *don't give permission* for x-rays if necessary for diagnostic interpretation.**

X-Rays

X-rays may be necessary for the diagnosis and treatment of your condition. Those x-rays, if needed, will be taken in this office. It is the policy of this office to send any x-rays taken to Professional Imaging Consultants to be reviewed by a radiologist. *P.I.C. has fees that are separate from Boggs Chiropractic and are not included in any promotional offers for new patients. P.I.C. will bill your insurance carrier, attorney, or the appropriate responsible party. If you do not have insurance or P.I.C. does not accept your insurance, prepayment is expected at your initial visit in the form of cash, check, or credit card. Pricing is as follows $20 for one region or $25 for two or more regions.* Further understand that if Medicare or Medicaid covers you, Medicare and Medicaid do not pay for the interpretation of x-rays taken in a chiropractic office. If you receive a statement from P.I.C. please refer any questions directly to them. A photocopy of this assignment shall be considered valid and as effective as the original.

*****By initialing here [ ] I understand the above statement and Payment is due at my initial visit if applicable.***

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.

Payment of Bills

Boggs Chiropractic is a network provider for Medicare, Medicaid, Workers Compensation, Personal Injury, and most major medical insurances. If you choose not to use insurance, we have many affordable payment options available to you. We are happy to answer any questions you have in the office. We will expect you to honor the financial agreement you make with our office. Please make any payments at the front desk before you go back to see the Doctor. This will decrease the overall time you need to spend in the office. For your convenience the office accepts cash, credit, or check.

Authorization and Assignment

I authorize Boggs Chiropractic to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, and/or adjuster in order to process any claim for reimbursement of charges incurred for services rendered to me by any member of the staff. I also authorize Boggs Chiropractic to communicate with my medical doctor and/or other health care providers about my condition. I also authorize the direct payment of any sum I now or hereafter owe by my attorney, out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to Boggs Chiropractic based in whole or in part upon the charges made for the services I received.
I understand that this office will bill my insurance company for the appropriate fees for services rendered. I will be required to pay my deductible, co-pay, and/or co-insurance payments if mandated by my insurance policy agreement. I hereby promise to pay my bill within ten (10) days from the date my liability claim is settled, or after the passage of three (3) months from the date of my last treatment, whichever comes first.

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:_____ ☐ I wish to opt out of any marketing activity

Signature:_____ Date:_____

Missed Appointment Policy

Boggs Chiropractic
3939 Massillon Rd NW, #201
Uniontown, OH 44685
(330) 896-2424

We will make every effort to accommodate your scheduling needs. In return, we ask that you help us by keeping your scheduled appointments. If you are unable to do so please notify us at least 2 hours in advance; otherwise it is considered a missed appointment. When you give us advance notice we are able to accommodate other patients in need of treatment. Reminder text messages, emails and phone calls are solely a courtesy. Your appointment is considered confirmed at the time you schedule it.

We realize patients get sick, forget appointments, or emergencies arise. As soon as you are aware that you can't make the appointment, please call us. Even if it is late at night, you are able to leave a message on our answering machine.

Please read our policy below:

1. **First Missed Appointment –** The first time you miss an appointment without notifying us will result in a phone call to give you a friendly reminder of our missed appointment policy.
2. **Second Missed Appointment-** The second time an appointment is missed within a **3-month period** will result in a warning by letter. NOTE: Parents bringing two or more family members at the same time will be restricted from scheduling a double or triple appointment after missing two such appointments for multiple family members.
3. **Third Missed Appointment –** The third time an appointment is missed within a **3- month period** may result in dismissal from our office.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have. Our staff appreciates your understanding.

I have read and understand the Missed Appointment Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I, _____ (print name), have received a copy of Boggs Chiropractic Missed Appointment Policy.

Signature of Patient Date