



Freedman Clinic of CHIROPRACTIC

PATIENT APPLICATION FORM

WELCOME TO OUR CLINIC. We specialize in assisting our patients to achieve their highest level of health through our spinal and postural corrective programs. Our approach is very unique and advanced from other rehabilitative programs. This allows our patients to achieve far superior results compared to most other systems.

Please fill out the following information thoroughly so the doctor can let you know if you are a case we can accept. Please feel free to ask any questions if you need assistance. We look forward to serving you.

Patient Signature:

Today's Date:

File #:

APPLICATION FOR CARE AT FREEDMAN CLINIC OF CHIROPRACTIC, INC.

Today's Date: _____

HRN: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____ Age: _____ Male Female
 Address: _____ City: _____ State: _____ Zip: _____
 Email Address: _____ Home Phone: _____ Fax: _____
 Mobile Phone: _____ Work Phone: _____ Fax: _____
 Social Security #: _____ Insurance Policy Holders Date of Birth: _____
 Employer: _____ Occupation: _____
 Name of Spouse: _____ Spouse's Employer: _____
 Occupation: _____ Names and Ages of your children: _____
 Name & Number of Emergency Contact: _____ Relationship: _____

HISTORY of COMPLAINT

Please list in order of importance all complaints and the symptoms you are currently experiencing that brought you to this office

Primary problem	2nd	3rd	4th
When did each problem/symptom begin: Primary complaint _____	2nd _____	3rd _____	4th _____
Number of times you have experienced: Primary complaint _____	2nd _____	3rd _____	4th _____
When was the last episode? Primary complaint _____	2nd _____	3rd _____	4th _____
What relieves your symptom(s)? Primary complaint _____	2nd _____	3rd _____	4th _____
What makes them feel worse? Primary complaint _____	2nd _____	3rd _____	4th _____

Please mark the box with a "C" if you feel your pain constantly or an "I" if you experience it intermittently for each complaint:
 Primary problem 2nd 3rd 4th

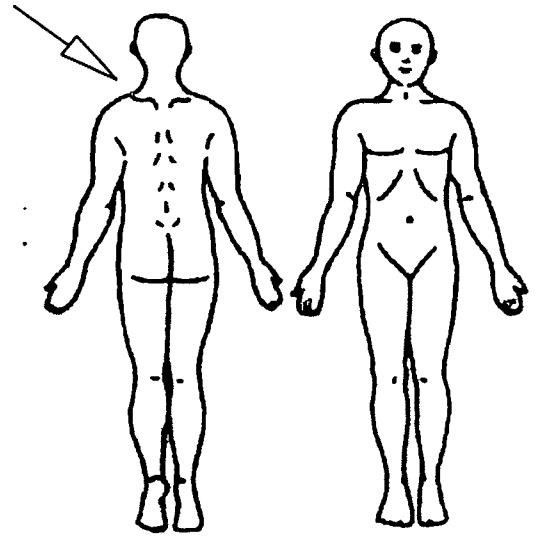
On a scale of 1 to 10 with 10 being the worst pain and 0 being no pain, rate how you feel today (Circle the number).
 Primary or chief complaint 0 1 2 3 4 5 6 7 8 9 10
 Second complaints 0 1 2 3 4 5 6 7 8 9 10
 Third complaint: 0 1 2 3 4 5 6 7 8 9 10
 Fourth complaint: 0 1 2 3 4 5 6 7 8 9 10

PLEASE MARK the areas on the Diagram with the following letters to describe your symptoms: R = Radiating B = Burning D = Dull
 A = Aching N = Numbness S = Sharp/ Stabbing T = Tingling

Do your symptoms cause you to feel worse in the AM PM mid-day late PM
 Have these Problems ever been treated by anyone in the past? No Yes If yes

Who provided: _____
 How long ago? _____ What type of treatment did you receive? _____
 What were the results? Favorable Unfavorable → please explain. _____

List any medications taken to treat these conditions: _____
 Did they help? No Yes If you still take them how often? _____
 Have you ever been under chiropractic care? No Yes If yes how long ago: _____
 Name of Previous Chiropractor: _____
 Are any of your problem(s) the result of ANY type of accident. No Yes If yes
 How long ago? _____ Please explain what type of accident: _____



PAST HISTORY

- If you have ever been diagnosed with any of the following conditions please indicate with a P for in the Past, C for Currently have and N for Never have had:
 - ___ Broken Bone ___ Dislocations ___ Tumors ___ Disability ___ Fracture
 - ___ Rheumatoid Arthritis ___ Cancer
 - ___ Heart Attack ___ Osteo Arthritis ___ Diabetes ___ Stroke ___ Seizure ___ Concussion ___ Other serious conditions

2. PLEASE identify ALL PAST and any unrelated current conditions you feel may be contributing your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
PREVIOUS ACCIDENTS →			
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES →			
ADULT DISEASES →			

Reserved for doctor's use only → Systems reviewed with patient:

- Musculoskeletal
 Neurological

-

SOCIAL HISTORY

- 1 Smoking: cigars pipe cigarettes → How often? Daily Weekends Occasionally Never
 2 Alcoholic Beverage: consumption occurs → Daily Weekends Occasionally Never
 3 Recreational Drug use: Daily Weekends Occasionally Never
 4 How many years of school did you complete? 1-8 8-12 12-14 14-16 16 +
 5. Hobbies -Recreational Activities- Exercise Regime: How does your present problem affect the following:

IDENTIFY TYPE:

EFFECT:

- No Effect Painful (can do) Painful (limits) Unable to Perform
 No Effect Painful (can do) Painful (limits) Unable to Perform
 No Effect Painful (can do) Painful (limits) Unable to Perform
 No Effect Painful (can do) Painful (limits) Unable to Perform

6. Work Activities: Please complete all questions!

Hours worked per day: _____ Days per week: _____

Does your job require lifting? No Yes If yes, what is the maximum required? < 5 lbs 5-20 lbs 20-50lbs > 50 lbs

Lifting Frequency: Constant (66-100% of day) Frequent (33-66% of day) Occasional (0-33% of day)

Lifting Postures: Knee Torso Arm Shoulder Off Posture

Standing: _____ Hrs per day Sitting: _____ Hrs per day Pushing: _____ Hrs per day
 Twisting: _____ Hrs per day Climbing: _____ Hrs per day Pulling: _____ Hrs per day
 Kneeling: _____ Hrs per day Reaching: _____ Hrs per day Walking: _____ Hrs per day

7. Repetitive Activities:

Computer: _____ Hrs per day Grasping: _____ Hours per day Hand Tools: _____ Hrs per day
 Machinery: _____ Hrs per day Assembly: _____ Hrs per day Phone: _____ Hrs per day
 Other: _____ Hrs per day

8. What Impact does your present problem have on your ability to work :

9. How does your problem affect your ability to carry out activities of daily life? No Effect Painful Limits Unable
 No Effect Painful Limits Unable

FAMILY HISTORY:

- 1 Does anyone in your family suffer with the same condition(s)? No Yes
 If yes whom: grandmother grandfather mother father sister's brother's son(s) daughter(s)
 2. Have they ever been treated for their condition? No Yes I don't know
 3. Any other hereditary conditions the doctor should be aware of No Yes: _____



I hereby authorize payment to be made directly to Freedman Clinic of Chiropractic, Inc. for all benefits which may be payable under A healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to [PRACTICE NAME] for any and all services I receive at this office.

 Patient or Authorized Person's Signature

 Date Completed

FREEDMAN CLINIC OF CHIROPRACTIC, INC. ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Sit to Stand	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climbing Stairs	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Pet Care	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Extended Computer Use	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Household Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lifting Children	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Reading/Concentration	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Bathing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Shaving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sexual Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleep	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Static Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Yard work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Washing/Bathing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sweeping/Vacuuuming	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Dishes	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Laundry	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Garbage	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lifting Groceries	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Other: _____	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

Patient signature

INFORMED CONSENT TO TREAT

Chiropractic care, like all forms of health care, while offering considerable benefit, may also provide some level of risk. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures. One of the rarest complications associated with Chiropractic cares occurring at a rate between one instance per one million to one per two million is a cervical spine (neck) adjustment causing injury to a vertebral artery which could lead to a stroke.



I understand the risks associated with chiropractic adjustments and therapy. All my questions regarding treatment have been answered to my complete satisfaction, and I have conveyed my understanding of all risks to the doctor. After careful consideration I do hereby consent to Treatment Objectives as well as the risks associated with chiropractic adjustments therapy have been explained to me and I have conveyed my understanding of these risks to the doctor. After careful consideration I do hereby consent to

Treatment by any means, method and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

Allow my minor child to be treated by any means, method, and or techniques, the doctor deems necessary to treat my child's condition at any time throughout the entire clinical course of their care.

Patient or Authorized persons Signature

Date

FREEDMAN CLINIC OF CHIROPRACTIC, INC
3624 W. MARKET ST. SUITE 101
FAIRLAWN, OHIO 44333

PATIENT CONSENT

To Performance of Imaging Studies

Today's Date: _____

Patients Name: _____ DOB: ___/___/___ HR
#: _____

PREGNANCY VERIFICATION

- The first day of my last menstrual cycle was on ____-____-____ (date)
- I have been given a full explanation of when I am mostly likely to become pregnant, and to the best of my knowledge, I am not pregnant,

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of all risks involved in being exposed to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

Patients' Signature: _____

Date: _____

HEALTH CARE PRIVACY NOTICE – INFORMED CONSENT – ASSIGNMENT OF BENEFITS – AUTHORIZATION & LIEN

This office is committed to providing patients with quality health care services delivered with dignity and concern. Fulfilling this commitment requires the efforts of the doctors, therapists, staff and patient working together as a team to obtain the maximum results. Patient satisfaction is a vital interest to our staff.

This Facility is required by law to abide by the terms of this Health Care Privacy Notice as well as other applicable federal and state laws governing privacy practices in health care. Our Facility may change and/or modify the terms of this Notice at anytime without additional notice to you except to publicly post in our Facility and/or make available to patients any updated notices. Photocopy of this Notice is available to you upon request. The term Facility refers to this office or clinic. The term Provider refers to doctors and/or licensed professionals of this Facility.

Our Facility & staff are committed to maintaining the privacy of your protected health information (PHI). PHI is information about you, including demographic information that may identify you and that may be related to your present, future and past physical or mental health or condition and the care and treatment you receive from our practice. This Notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read this Notice and direct questions, misunderstandings or concern to the Compliance Officer of this Facility.

Our Facility may use & disclose your PHI for health care delivery purposes. Your PHI may be used and/or disclosed without your written authorization by the doctors and staff of this Facility for the purposes of your care and treatment; paying your health care bills; and to support the operations of this practice. Your doctor and the staff will take all reasonable measures to maintain the confidentiality of your PHI.

The Privacy Rule allows you the right to review and receive copies of your health care records as it relates to your health care. The request must in writing, allowing your provider 30 days to respond. Your provider may deny your request if it will cause harm to you or to another person. Your provider may charge a copy fee, which will be in compliance with State law. Your provider will comply with any reasonable request to have confidential communication by alternative means or at an alternative location if not doing so endangers you.

You may request to have an amendment placed in your record if you disagree with anything in your record. This does not mean that anything will be removed or changed and the provider has the right to respond with a rebuttal statement if he/she feels it is necessary. You may revoke authorization, in writing, at any time, except in the event that the provider has acted as indicated in the doctor's Authorization Notice.

You have the right to file a written complaint with our Compliance Officer if you believe that any of your privacy rights have been violated. You can obtain a complaint form from the Compliance Officer and/or the Office of the Civil Rights. All complaints must be filed within 180 days of when you knew or should have known that the violation occurred. The Privacy Law prohibits our Facility from taking any retaliatory actions against anyone who files a complaint. A more detailed, updated & comprehensive Health Care Privacy Notice is available for your review in this Facility.

I understand that this Facility, its doctors & staff are accepting my case based on examination findings & believe the outlined treatment should produce change and/or improvement. However as with any diagnostic test, procedure, examination or doctors care a guarantee of improvement or complete recovery cannot be made and it is even possible that no change will occur.

I further understand that in the practice of medicine, chiropractic, psychological counseling, massage therapy & physical therapy there are some risks including but not limited to fractures, disk injuries, strokes, dislocations, sprains-strains, drug interactions & reactions and/or other injuries or side effects which cannot be pre-determined.

I do not expect the doctor/provider to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor/provider to exercise judgment during the course of the procedure(s) which the doctor/provider feels at the time is in my best interest.

In addition, because psycho-social, spiritual, and cultural values affect a patient's response to care, patients are allowed to express and follow spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of treatment.

Patients have the right to refuse treatment, but must be aware of the probable consequences of refusing treatment and/or failing to cooperate with the prescribed treatment. Should you refuse and/or fail to comply with prescribed treatment your provider will discuss specific consequences with you.

Therefore I give my full consent to the doctor/provider to render treatment on me or the minor for whom I am legally responsible by a health care provider of this Facility.

I, the assignee, being the patient or legal guardian for said minor listed below, do hereby irrevocably authorize, direct, assign and give a full lien to the office named above and listed below, hereinafter referred to as the "Facility" against any & all insurance benefits, proceeds of any settlement, judgment or verdict which may be paid to the undersigned as a result of the injuries or illness for which I have been treated by the Facility.

I, the assignee further authorizes any and all insurance company, attorney and any & all third party payer to pay directly to the Facility all sums of money due them for any & all services rendered to me or minor by whom I am responsible for by reason of accident, illness and by any & all reason of any other bills that are due or may become due, and to withhold such sums from any health & accident, workers compensation and or including all insurance or third party benefits.

Assignee agrees that this Facility & staff may deliver medical records, consultations, depositions and/or court appearances which must be paid in full in advance and authorizes this Facility to release any information pertinent to said health care to any insurance company, adjuster, attorney or legal service bureau to facilitate collections under the terms of this document. Assignee grants the Facility a full power of attorney to endorse &/or sign my name on any & all checks for payment of any indebtedness owed this office & assignee.

INSURANCE BENEFITS – CREDIT POLICIES – PAYMENT TERMS & CONDITIONS

As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us but some third party payers misquote benefits, coverage and liability. Our Facility & staff are not responsible for what a third party payer and/or representative may tell us. Any contractual, written, verbal or other obligations or arrangements between you and an attorney, insurance company, liable or third party payer are between you and said person.

1. Our Facility will file initial insurance claims for you. Secondary claim submission and/or additional reports or documents sent for your benefit may result in an additional filing or medical report charges, which you are responsible to pay.
2. Co-pays, deductibles and all non-covered service charges are due the day the service is rendered.
3. Patients are responsible for charges on all service(s) and/or product(s) which may exceed the maximum allowable and/or when a third party and/or insurance carrier does not reimburse this Facility enough to meet our cost of service.
4. All account balances, including automobile and work injury claims must be paid in full within 90 days of treatment. Patients are fully responsible for all money owed this office and such payment is not contingent on any settlement, claim, judgment, or verdict by which they may eventually recover said fee and it is also regardless of any attorney liens or pending settlement(s). If a third party payer fails to pay said balance in full within the 90-day period, the patient must pay the balance in full. Assignee is fully responsible for all money owed this Facility for any and all treatment, products & services rendered to the patient or minor shown below.
5. A non-discriminatory "Time of Service Discount" is offered to anyone who pays for services the day they are rendered. The "TOS" is only offered on the day the service is rendered. This discount does not apply to orthopedic supports, orthotics, physical therapy equipment rentals or purchases, vitamins, supplements, ointments, acupuncture treatments, weight loss programs, psychological counseling services and massage therapy.
6. A service charge is computed by a 'periodic rate' of 1 1/2 % per month – 18% per annum & is added to all balances owed 60+ days. Any balance past due 90 days or more may be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all monthly service charges, interest, costs related to but not limited to all collection related expenses, attorney fees, court & filing fee's. Returned checks, debit & credit charges made payable to this Facility for insufficient funds, stop payments or other reasons of non-payment will be assessed a \$30.00 charge.
7. Patients are eligible for a maximum \$250 personal credit limit when approved. For your convenience we accept most major credit & debit cards.

PATIENT CONSENT & SIGNATURE

By my signature below I acknowledge that I have read or have had read to me and have received a photocopy upon my request of this document including the Health Care Privacy Notice, Facility terms & conditions, credit policies and Informed Consent and fully understand and have had all of my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valid as an original.

Print Name of Patient _____

Ψ

Signature (if minor, parent must sign) _____

_____ Date