Hoff Chiropractic Clinic, P.C.
Innovative Wellness Solutions, LLC
8075 Rt 286 Hwy W.
Indiana PA 15701
724-479-0442

Confidential Patient Case History

Personal Information

Patient's Full Name: _____ Date ____/____/____
Address:_____ City: _____State __ Zip _____
What do you prefer to be called? _____ Number of Children _____
Home Phone _____ Work Phone _____
Cell Phone _____ Cell Phone Provider _____
E-mail Address:_____
Employer's Name: _____ Employer Phone _____
Employer Address: _____Occupation: _____
Birth Date: ____/____/____ Age: _____ Social Security Number _____
Marital Status: (circle one) M S W D Spouse's Name _____
Whom may we thank for referring you to our office? _____
Emergency Contact: Name: _____ Relation _____
Phone Number: Home: _____ Work: _____

Insurance Information:

Insured Person's Name: _____
Insured's Social Security Number: _____ Insured's Birthday ___/___/___
Relationship to Patient: _____
Name of Insurance Carrier: _____ Insured's Employer _____
Do you participate in an Employer Health Reimbursement Plan? (HRA, HSA, Flex Spending Account) Yes _____ No _____

Secondary Insurance Information

Insured Person's Name: _____
Insured's Social Security Number: _____ Insured's Birthday: ___/___/___
Relationship to Patient: _____
Name of Insurance Carrier: _____ Insured's Employer: _____
Do you participate in an Employer Health Reimbursement Plan? (HRA, HSA, Flex Spending Account) Yes _____ No _____

Health Information:

Have you had previous Chiropractic care? Yes ___ No ___ Where? _____
Major Complaint (Why are you here today) _____
How long have you had this condition? _____ Have you had this problem in the past? Yes ____ No ____ How often does this occur? _____
Rate your pain on a scale of 1-10 (10 being the worst) _____
What have you tried to alleviate the condition?(i.e. Ice, Heat, Advil, etc…) _____
Other Complaints: _____
What activities aggravate your condition? _____
Is this condition interfering with Work ____, Sleep____, Daily Routine ____
Other (please specify) _____
How long since you've felt really good _____Surgical Operations and Years: _____
Medications you now take _____
Vitamins/Herbs you now take _____

Confidential Patient Case History (Continued)

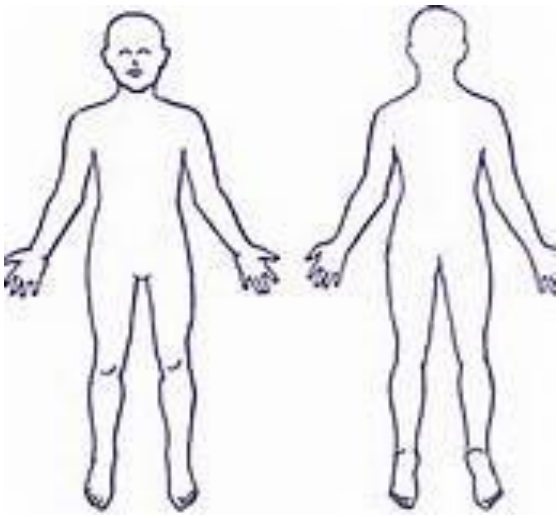
Is your condition due to an auto accident or job related injury? Yes ____No____
Date of Accident ____/____/____

Date of your last physical exam ____/____/____

Have you been in any automobile accidents in the past 2 yrs ___, past 5 yrs ____
over 5 years ____, never _____
If so, please describe the auto accident_____
_____

Have you had any other personal injury accident in the past 2 years ___, past 5 years ___,
over 5 years ____, never _____
If so, please describe the auto accident _____

PLEASE MARK YOUR AREAS OF PAIN ON THE FIGURES BELOW:



HAVE YOU SUFFERED FROM:

Backaches	Yes	No
Neck Pain	Yes	No
Headaches	Yes	No
Sinus Trouble	Yes	No
Nervousness	Yes	No
Digestive Disorder	Yes	No
Asthma	Yes	No
Dizziness	Yes	No
Arthritis	Yes	No
Heart Trouble	Yes	No
Diabetes	Yes	No

AGREEMENT

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, Hoff Chiropractic Clinic, P.C., Innovative Wellness Solutions, LLC, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) _____ DATE _____

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of Hoff Chiropractic Clinic, P.C./Innovative Wellness Solutions, LLC. (Please initial one of the following options and sign below.

_____ I wish to receive a paper copy of the Privacy Notice

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time.

Please initial below:

_____ I acknowledge that it is the policy of Hoff Chiropractic Clinic, P.C./Innovative Wellness Solutions, LLC to leave a reminder message on my answsering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

_____ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Office, Donna McGinnis, about my concerns.

Patient/Guardian Signature _____ Date _____

Witness (Office Staff) _____ Date _____

Please initial below

_____ I acknowledge that I have been given Patient Bill of Rights.

_____ I acknowledge that I have been given Office Hours of the Operation.

HOFF CHIROPRACTIC CLINIC, P.C.
INNOVATIVE WELLNESS SOLUTIONS, LLC
8075 Rt 286 Hwy W.
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CONSENT TO CARE

I hereby authorize the Doctor's to treat my case as they deem appropriate through the use of physiotherapeutic modalities, rehabilitation, manual therapy, chiropractic manipulation of the spine, nutritional support, trigger point injection and diagnostic testing. I realize the goal of holistic healthcare is to strengthen the patient's body in order to heal themselves.

A patient coming to the doctor provides him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor will not provide specific healthcare services, if known or to learn through health care procedures or diagnostics, that the symptoms from whatever he/she is suffering from are related to latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

It is understood and agreed the amount paid the clinic for x-rays is for interpretation and only the x-ray negatives will remain the property of this office, being on file. The patient also agrees that he/she is responsible for all bills incurred at this office.

I have read and understand the foregoing.

Patients Signature: _____ Date: _____

X-RAY QUESTIONNAIRE: FOR WOMEN ONLY

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you're not pregnant at this time.

Name: _____

- o There is a possibility that I may be pregnant at this time
- o Yes, I am definitely pregnant
- o No, I am definitely not pregnant at this time

Date of last menstrual period: _____

Patients Signature _____ Date _____

CONSENT TO CONTACT

I give Hoff Chiropractic Clinic, P.C., Innovative Wellness Solutions, LLC consent to contact me at:

Home # _____ Yes ____ No ____

Work # _____ Yes ____ No ____

Cell # _____ Yes ____ No ____

E-Mail _____ Yes ____ No ____

_____
Please Print Name

_____ _____
Signature Date

Financial Office Policies

1. All Patients are on a cash basis until our staff can verify all insurance coverage(s).
2. Your insurance will be verified promptly and will be reviewed with you if applicable.
3. After coverage and deductible are verified, this office may accept assignment on most policies provided the insured/patient signs an appropriate statement of benefits and/or a lien authorizing payment to be sent to the doctor.
4. Waiting for the insurance payment is a courtesy and it may be withdrawn under certain circumstances.
5. As a patient, it is your responsibility to take care of the co-payment (usually a percent or a fixed dollar amount) and any non-covered services at the time of service. Other financial arrangements will be discussed during your report of findings.
6. This office does not warrant or guarantee that your insurance company will pay the fees charged. Insurance policies are an arrangement between the insurance carrier and the patient/insured.
7. Any service not covered or coverage reductions by your insurance carrier will be the patient's responsibility.
8. The office will submit an insurance claim for you. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly with your insurance adjuster or agent. Any denied or disputed claims will be treated as uncovered.
9. If your account should go to collections for any reason, it will be the patient's responsibility for any court costs, attorney fees, and or collection costs incurred in collecting the account balance.
10. I authorize the release of any medical or other records or information from my health record. I authorize release of records or information necessary to process any claims.
11. All insurance payments, regardless of which company issues the check first, are applied to your account as long as any balance is due. This means refunds are made only after your balance is completed and cleared with this office.
12. If you receive correspondence of checks from your insurance company, you agree to bring these into our office so that we may determine if any action needs to be taken or if the check is on assignment to this office.
13. If you change insurance companies or employers, you agree to provide this office with the current information immediately.
14. If this office gives you any professional or accounting discount for treatment and you decide to drop out of care then the standard fees will apply.
15. This office accepts MasterCard, Visa, Care Credit, personal checks and cash.
16. If you have any questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the doctor.
17. If you stop care and have a financial agreement signed with our office, you will be responsible for any/all charges that you have incurred at our office.
18. No returns on any equipment, vitamins, or other products once distributed.
19. Refund policy: refunds will be provided and paid within 30 days of the receipt of written request.

Thank You for your cooperation in this matter.

I have read and fully understand the financial office policy and agree to abide by these terms.

_____

Patients Signature or Responsible Party Date

_____

Staff Signature Date