Wolf Chiropractic, Inc.
1408 Lexington Ave. Suite C
Mansfield, Ohio 44907
(419) 756-6262

Patient Record Update

PLEASE PRINT

Name: ____ SS# ____ - ____ - ________
Address: ______________________________________ City: _____________________ Zip : ______________
Home Phone # (____) ____ - ________ Cell Phone # (____) ____ - ________
Birthdate: ____ / ____ / ________ Insured's Birthdate: ____ / ____ / ________
Emergency Contact Name: _______________________________________ Phone # (____) ____ - ________
Place of Employment: ______________________________________ Work Phone # (____) ____ - ________
Insurance Company: ______________________________________ Policy # ____________________________
Primary Care Physician: ____

In order to provide you the most appropriate care, we must be appraised regarding your current state of health and that which has transpired since we last saw you. Please fill in the following information so that we may update your records.

PLEASE PRINT

- Reason For This Appointment? ____
- List Present Symptoms: ____
- Date Of Accident Or Appearance Of Symptoms: ____ / ____ / ________
- Accidents, Falls Or Injuries Since Last Seen Here:____
  ____
- Surgeries Undergone And / Or Medications Currently taking:________________________________
  ____
  ____
  ____
- Date Of Last Physical: ____ / ____ / ________
- Doctor(s) Seen Since Last Visit: ____
- Purpose? ____
- List Any Drug Or Other Allergies:____
  ____
- Patients Comments: ____
  ____

Signature:____ Date: ____ / ____ / ________

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Patient Pain Form

Date: ____ / ____ / ________

Name (Print):__________________________________

Signature: ____________________________________

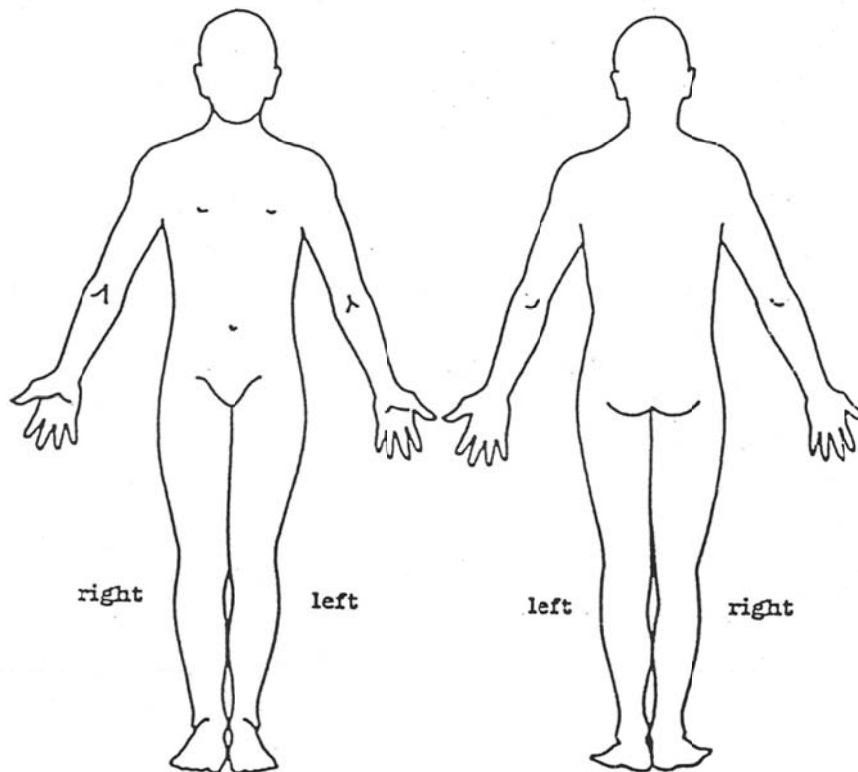
Please Circle The Number Below To Indicate The Level Or Intensity Of Pain You Are Feeling Today.

Absolutely Pain Free **1 2 3 4 5 6 7 8 9 10** *Worse Pain You Could Ever Have*

Using The Symbols Listed Below; Indicate On The Two Drawings Where You Feel The Described Sensations.

Numbness **= = =** *Dull Ache* **o o o** *Hot Burning* **x x x** *Sharp Stabbing* **/ / /** *Pins & Needles* **+ + +**

Other:_____________________________________ *** * * ***



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HIPPA Privacy Notice

The Practice

a) is required by federal law to maintain the privacy of your Personal Health Information (PHI) and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.
b) under the Privacy Rule, which may be required by State Law, to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under Federal law.
c) is required to abide by the terms of this Privacy Notice.
d) reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.
e) will distribute any revised Privacy Notice to you prior to implementation.
f) will not retaliate against you for filing a complaint.

EFFECTIVE DATE

This Notice is in effect as of 04-14-03

Patient Acknowledgement

By subscribing my name below, I acknowledge that I have read and agreed to the terms of this notice.

Name (Print):____

Signature: ____

Date: ____ / ____ / ________

Copy of HIPPA Privacy Rules Requested: Yes ☐ No ☐

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WOLF CHIROPRACTIC FINANCIAL POLICY

Thank you for choosing us as your chiropractic health care provider. We are committed to providing you with the best possible chiropractic care. Please understand payment of your bill is considered as part of your treatment. The following information is provided to avoid any misunderstanding or disagreement concerning payment for services provided by our office.

1. Our office participates with a variety of insurance plans. It is your responsibility to:
   a) Bring your current insurance card to your visit and notify us of changes in coverage.
   b) We will submit a claim to your primary insurance company for you. Balances not paid, per our contract with your primary insurance company, are your responsibility. **We do not submit to your secondary insurance company.**
   c) Be prepared to pay your co-pay at each visit. Payment can be made by cash, check, VISA, MasterCard, Discover, or Care Credit.
   d) I understand that I am assigning benefits from my insurance carrier to Wolf Chiropractic, Inc. and that the payment will be made directly to the doctor.
   e) I understand and certify that I am financially responsible for all health care service charges that are paid to me directly by my insurance carrier, as well as for any applicable co-payment, co-insurance, deductible or charges for non-covered services provided to me or any of my dependents.
2. If you do not have insurance coverage or if you are insured by a company with which we are not contracted, payment *in full* is expected at time of service unless payment arrangements are made and kept.
3. If you have questions about your insurance, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company member services dept (number should be on your insurance card).
4. All balances billed are due by the due date on the statement. A refilling statement fee of $5.00 will be applied if not paid within 30 days. Unpaid balances greater than 30 days are subject to our collection process.
5. There is a $30 fee for all returned checks.
6. There is a fee to copy any or all medical records.
7. There is a fee for FMLA and/or Disability forms. This is a per form fee.
8. Any account that is sent to our collection agency will be assessed an additional 15% of the balance due to cover costs.
9. For anyone who has been sent to collection and wishes to be treated in the future by our office, it will be on a cash-only, up front basis.

Date: ____ / ____ / ________

Name (Print: ____

Signature: ____