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

Patient Information

Date: ____ /____ /_____
Patients Name:_____ Date of Birth:____ /____ /_____
Social Security Number: _____-____-_____
Street Address:_____ City:_____ State: ___ Zip:_____
Home Phone #:(_____) _____-_____ Work#:(_____) _____-_____ Cell#:(_____) _____-_____
Employer:_____ Address: _____
Check One: Single☐ Married☐ Divorced☐
Emergency Contact: _____ Phone #: (____) ____-_____
Relationship:_____

Insurance Information

Insured's Name: _____
Insured's Birthdate:____ / ____ / _____
Insurance Company: _____ Policy # _____
Spouse's Insurance Company:_____ Policy # _____
Who is Responsible for your Bill? Self☐ Spouse☐ Insurance☐ Employer☐
Other☐ (Explain):_____
How will Payment Be Made? Cash☐ Check☐ Charge☐ Health Ins.☐ Employer☐
Other☐ (Explain):_____

Medical History

How Were You Referred to our Office: _____

Primary Care Physician: _____
Date of Last X-rays: ____ /____ /_____
List ALL Drug Allergies: _____
List ALL Other Allergies: _____
Have You Ever Been in an Auto Accident? Never☐ Past Year☐ Past 5 Years☐ Over 5 Years☐
Any Accidents or Falls That Might Have Caused Your Problem? (Explain) _____
_____
What Surgeries Have You Had:_____
_____
Drugs You Now Take: Nerve Pills☐ Pain Medication☐ Muscle Relaxers☐ "Pep" Pills☐
Tranquilizers☐ Insulin☐ Birth Control Pills☐ Other:_____
Have You Consulted Another Chiropractor in the Past? Yes☐ No☐
If "Yes," Name:_____ Last Date Consulted: ___ / ___ / _____
If "Yes," For What Problem? _____
_____

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

Present Physical Complaint

Please Describe Your Major Physical Complaint: _____
_____
_____
When Did Your Pain Start? ____ / ____ / _____
Describe Where Your Pain Is Located: _____
_____
What Caused Your Pain? _____
_____
Which Of The Following Best Describes Your Pain? Dull☐ Sharp☐ Throbbing☐ Shooting☐
My Pain Is: Constant☐ On & Off☐ Worse When Sitting☐ Worse When Standing☐
Is The Pain Localized, Or Does It Travel To Other Areas Of Your Body?
(Explain):_____
_____
_____
Have You Ever Received Any Treatment For This Condition? If Yes, Where And What Were Your Results?
_____
_____
_____
_____
Has This Problem Been Getting: Worse☐ Better☐ Staying The Same☐
What Relieves Your Pain?_____
_____
_____
Is There Anything You Do That Makes Your Condition Worse? _____
_____
_____
Has This Condition Affected Your Sleep? Yes☐ No☐

Please Provide Any Information That You Might Want To Add: _____
_____
_____
_____
_____

Date: ____ / ____ / _____

Name (Print):_____

Signature: _____

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

Patient Pain Form

Date: ____ / ____ / _____

Name (Print):_____

Signature: _____

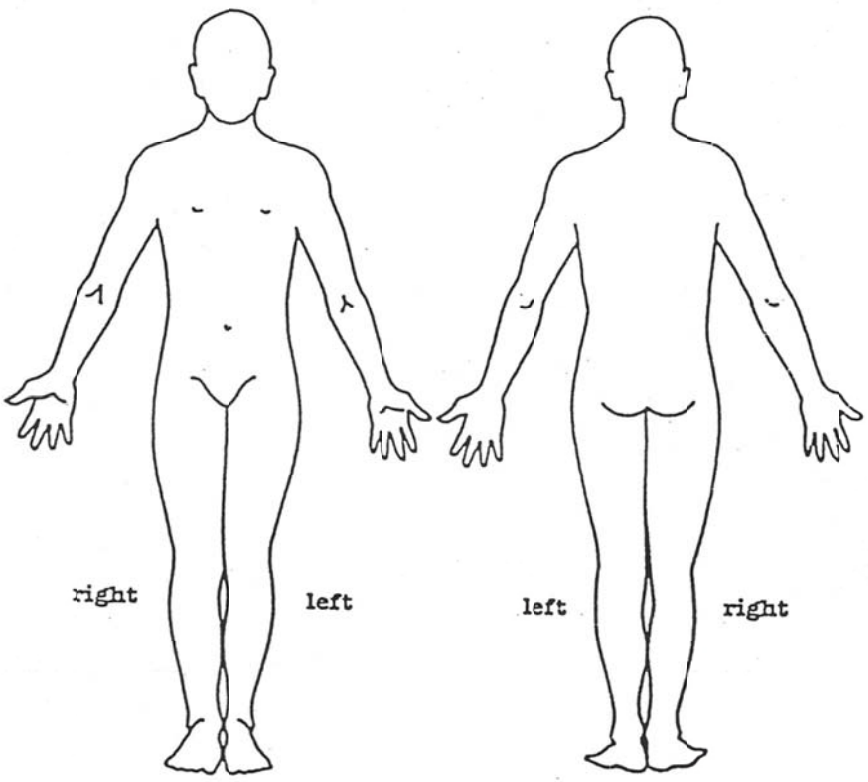
Please Circle The Number Below To Indicate The Level Or Intensity Of Pain You Are Feeling Today.

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:_____ *** * ***



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

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 ☐

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

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: _____