SMERGLIA CHIROPRACTIC
1821 Portage Trail
Cuyahoga Falls, OH 44223
(330) 928-2000

Patient ID #_____

Date _____

CONFIDENTIAL PATIENT INFORMATION

Social Security # _____

Name _____ **Home/Cell Phone** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Age _____ **Birth Date** _____ **Marital Status**: ☐ Married ☐ Single ☐ Widowed ☐ Divorced # of Children _____

☐ **Male** ☐ **Female** **Height** _____ **Weight** _____ Email _____

Race/Ethnicity: ☐ Caucasian ☐ African American ☐ Asian American ☐ Hispanic/Latino ☐ Other _____

Occupation _____ Employer _____

Address _____ Office Phone _____

Name of Wife/Husband _____ Occupation _____

Employer _____ Office Phone _____

Patient's Nearest Relative _____ Address _____

Home Phone _____ Work Phone _____

Referred by _____

Who should we contact in case of emergency? _____ Phone _____

Date of Last Physical Examination _____ Family Physician _____

Medications _____ ☐ None

Allergies _____ ☐ None

Tobacco Use ☐ Yes ☐ No Frequency _____

Have you ever suffered from:

	Yes	No		Yes	No
1. Dizziness	☐	☐	8. Asthma	☐	☐
2. Backaches	☐	☐	9. Neuritis	☐	☐
3. Heart Trouble	☐	☐	10. Digestive Disorders	☐	☐
4. Diabetes	☐	☐	11. Nervousness	☐	☐
5. Tuberculosis	☐	☐	12. Sinus Trouble	☐	☐
6. Arthritis	☐	☐	13. Anemia	☐	☐
7. Headaches	☐	☐	14. Cancer	☐	☐

Reason for Appointment _____

Other Doctors seen for this Condition _____

Have you been treated for any health condition by a Physician in the last year? ☐ Yes ☐ No

Describe _____

PAYMENT IS EXPECTED AT THE TIME OF VISIT. Will you be paying today by: ☐ Cash ☐ Check ☐ Credit Card

*By signing below, you are not binding yourself to a chiropractic care plan. You are acknowledging any out-of-pocket expenses that may be charged to your account.

CHARGED CANCELLATION POLICY:

Due to limited office capacity and high demand, Smerglia Chiropractic may, on occasion, have to turn away patients for care on a given day. This is an unfortunate truth and something we do not enjoy doing. Therefore, when scheduled patients do not inform our facility of the potential for a missed appointment prior to the time of service, it prevents our team from scheduling another patient during that time that needs the care. AS A DETERRENT, we enforce a $20.00 fee for any visit that is cancelled with less than a FIVE HOUR prior notice to our office. This would include visits where a patient fails to notify our office of any cancellation and misses their visit completely. If your chiropractic care plan is through a personal injury claim and incur the $20.00 fee, the patient will be held responsible for this fee separate from the personal injury claim.

Name of Person Responsible for Payment _____

Patient's Signature _____ Date _____

Guardian or Spouse's Signature _____ Date _____

PATIENT-DOCTOR AGREEMENT

The purpose of this agreement is to allow us to more completely serve you and for you to get the best results in the shortest amount of time. It is our experience that those patients who follow through with these agreements get the best results.

-Signing in: When you arrive, sign in on the clipboard at the reception counter. You will be called and assigned a room in the order you signed in for the Doctor. If you are a new patient you may have a longer wait, this is to assure the Doctor is able to spend as much time with you as necessary. Rest and relax, the Doctor will be in as soon as possible.

-Missing/Changing Appointments: The Doctor will set up a specific course of treatment for you. A certain number of treatments in a set amount of time are required to get the results we both desire. Thus, if you need to change the time of your appointment, plan to come another time the same day to avoid our charged cancellation policy. If the same day is not possible, it is important that you make up a missed appointment within one week.

-Appointment Times: We will set a specific time for your treatment. Please be prompt, as the Doctor has set time aside just to detect and correct any spinal misalignments you may have. If you come at another time, you may have to wait a few minutes, as the Doctor also sets aside specific times to see new patients and conduct extended consultations. We value your time and do not want you to wait needlessly.

-Progress evaluations and re-examinations: During your treatment, re-examinations and progress reports will be done on a regular bases. These are to ensure that you are progressive as scheduled or if changes in your treatment plan are necessary.

-Communication: Please communicate directly to the Doctor any upsetting matter such as long wait times, rudeness by any staff member, failure to understanding the treatment plan, need for extended consultations, etc. We are here to serve you. Your criticism will help us to help you as well as others.

-**Payment of bills**: We will expect you to honor your financial agreement you make with our office. In order to serve you better, please plan to make any payments as the front desk during each visit with us. You may pay for your treatments at the beginning of the week or during each treatment. For your convenience the office accepts cash, credit, or check, and payment plans are also offered.

-Insurance: As a service to you, please presents your insurance card and photo identification in the office at your first visit so we can verify your insurance benefits for you. If you chose 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.

-Authorization and assignment: In consideration of us undertaking you as a patient, you agree to the following:

1. We are authorized to release any information deemed appropriate concerning your physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charged incurred for services rendered to you by any staff member of our office.

2. You authorize the direct payment to us of any sum you now or hereafter owe us by your attorney, our of the proceeds of any settlement of your case, and/or by any insurance company obligated to make to you based in whole or in part upon the charges made for your services.

3. You understand that this office will bill your insurance company for the appropriate fees for services rendered, You will be required to pay deductible and/or co-insurance payments if mandated by your insurance policy agreement. You hereby promise to pay your bill within ten (10) days from the date your liability claim is settles, or after the passage of three (3) months from the date of your last treatment, whichever comes first.

4. By signing this form you confirm that you have read the Notice of Privacy Practices form and understand your rights as it regards to HIPPA.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that SMERGLIA 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 SMERGLIA CHIROPRACTIC will be credited to my account on receipt. However, I clearly understand and agree that any services rendered 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 me will be immediately due and payable.

1, _____, have read and understand the above policies and agree to abide by them.

Signature: _____ Date: _____