Special Instructions for Filling Out Forms:

1) Please fill out completely. We need this to fulfill documentation requirements and to accurately assess your health and condition.
2) Anything that does not apply, draw a line through it.
3) If you need help, ask the receptionist. Call us if we have faxed or emailed and you need help.
4) Please bring to the front desk when finished. If we faxed or emailed, bring filled-out forms to your appointment.
5) We will need a copy of your insurance card if applicable.

Lash Chiropractic Center/Donald Lash, D.C. Mark Hogue, D.C
100 North Gamble Street Shelby, Ohio 44875
419-342-2931(office) 419-347-7096(fax)

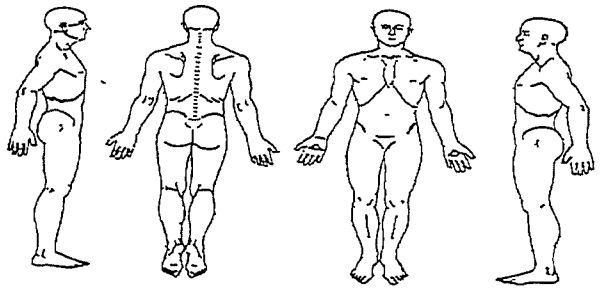
CASE HISTORY

Name: _____

1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain).

Condition / Problem	Severity (Minimal → Severe)	Frequency (% of week) (Occasional → Constant)
a. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
b. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
c. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
d. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
e. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

(Please mark the figures where you experience pain.)



2. Symptoms are worse in the (circle what applies)

-morning -Increase during the day
-afternoon -same all day
-night -decrease during the day

3. Symptom (a.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
4. Symptom (b.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
5. When did your symptoms begin (onset date)? _____
6. How did your symptoms begin? _____
7. Have you experienced these before? _____
8. Do your symptoms radiate? _____
9. Has your condition? ____ Improved ____ Gotten Worse ____ Stayed the same since it began
10. Circle the things that make your problems worse:

Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping

11. Is there anything you can do to relieve the problems? ____No ____Yes Describe: _____

If No, what have you tried that has not helped? _____

12. Have you been treated for this before? ____No ____Yes How long ago? _____
13. What treatment did you receive? _____
14. Results of previous treatment? ____Good ____Poor Comments _____
15. Were you referred to our office by anyone? _____
16. Is this condition interfering with ____ Work ____Sleep ____Daily Routine ____Recreation
17. List any other major injuries you have had, other than those mentioned above: _____

_____

18. Any other Musculoskeletal problems? ____No ____Yes ...Neurological problems? ____No ____Yes

_____Additional information on back side of sheet.

I certify that the above information is accurate to the best of my knowledge.

Patient/Guardian Signature _____ Date: _____

Lash Chiropractic Center: Donald Lash, D.C./Mark Hogue, D.C.
100 North Gamble Street Shelby, Ohio 44875
419-342-2931(phone)~~419-347-7096(fax)

Date: _____

Confidential Patient Information

Patients Name: _____ Chief Complaint: _____
Address: _____ Home Phone: _____
City: _____ Zip: _____ Cell Phone: _____
SS#: _____ Email: _____
Date of Birth: _____ Marital Status: M S W D
Occupation: _____ Employer: _____
Address of Insured (if different than above): _____

Are your present systems or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) ___ Yes ___ No

Ins. Company: _____ Ins. Phone #: _____
ID#: _____ Group #: _____
Name of Policy Holder: _____ Policy Holder DOB: _____
Policy Holders Employer: _____

Family Physician: _____ (Note: May we send your health information to this provider Y / N)
Person to contact in case of emergency (Name and Phone): _____
Have you ever been under Chiropractic Care? Y N If so, with whom? _____
Have you had any SPINAL X-Rays / MRI's / CT's taken in the last year? Y N If so, Where? _____
What operations have you had? _____ When? _____
Serious Illness: _____ When? _____
Infectious Diseases: _____ When? _____
Do you have a pace maker? Y / N Have you ever had any Hip or Knee Replacements Y / N
What medications or drugs are you taking? (check those that apply): Pain Killers ____ Insulin _____ Cholesterol Meds _____
Blood Pressure Meds ___ Muscle Relaxers ___ Birth Control ___ Other: _____
What is your goal in our office? _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to **Lash Chiropractic Center: Donald Lash, D.C. or Mark Hogue, D.C.** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____
Signature of Insured / Guardian Date

Confidential Patient Information and Case History Continued Name_____Date___/___/___

Do you have or ever had any of the following diseases or conditions?

Y N Heart attack/stroke	Y N Heart surgery	Y N Heart Murmur	Y N Congenital Heart Defect
Y N Mitral Valve Prolapse	Y N Artificial Valves	Y N Alcohol/Drug Abuse	Y N Venereal Disease
Y N Hepatitis	Y N HIV+/AIDS	Y N Shingles	Y N Cancer
Y N Frequent neck pain	Y N Emphysema	Y N Glaucoma	Y N Anemia
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic fever	Y N Frequent/Severe headaches
Y N Kidney problems	Y N Ulcers/Colitis	Y N Sinus problems	Y N Fainting/Seizures/Epilepsy
Y N Asthma	Y N Diabetes	Y N Tuberculosis	Y N Difficulty breathing
Y N Chemotherapy/Radiation	Y N Lower back problems	Y N Artificial bones/joints	Y N Arthritis

Please list any other serious medical condition(s) you have or ever had:_____

Please list anything that you are allergic to :_____

List any past serious accidents or falls with dates:_____

Family Health History:_____

Do You: Take supplements or Vitamins? ◯Yes ◯No / Exercise? ◯Yes ◯No/ Are you on a special diet? ◯Yes ◯No Since:__/__/__
Do you smoke? ◯No ◯Yes/ How much? _____How long?_____
Are you wearing: ◯Heel lifts ◯Sole lifts ◯Inner soles ◯Arch supports Do you wear your seatbelt? ◯Yes◯No
What is the age of your mattress?_____Is it comfortable? ◯Yes ◯No

For Women: Are you taking birth control? ◯Yes ◯No Are you pregnant? ◯Yes /How long?_____◯No Nursing? ◯Yes◯No

Review of Systems(the doctor will review this with you):

1) Constitutional: Vital signs: 1) sitting or standing blood pressure____, 2) supine blood pressure____, 3) pulse rateand Regularity____4) respiration____, 5) temperature____, 6) height____, 7) weight____

2) Head, Face, neck

3) Eyes, ears, nose, mouth, throat

4) Nervous/psychiatric

5) Endocrine:

6) Cardiovascular:

7) Lymphatic:

8) Respiratory:

9) Gastrointestinal:

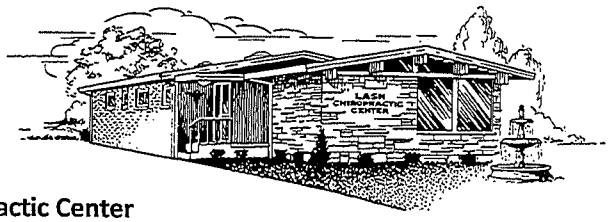
10) Urinary/ Reproductive:

11) Integementary(skin):

12) Musculoskeletal:

Lash Chiropractic Center

DR. DONALD B. LASH • DR. MARK W. HOGUE
100 North Gamble Street • Shelby, Ohio 44875
Phone (419) 342-2931 • Fax (419) 347-7096



Financial Policy for Lash Chiropractic Center

Our fees are payable by you at the time of service. Deductibles and co-pays must be paid at the time of service. We only allow charging IF and ONLY IF insurance has been established and we are certain that they will pay. Not all insurances cover chiropractic. Each insurance company and its deductible and co-pay amounts vary, as well as their reimbursement amount. We will electronically bill your insurance company. In the event that your insurance company reimburses us, we will refund you promptly.

Health insurance is in a major state of change due to recent events such as the Federal Affordable Care Act. Therefore, it is our expectation that YOU check your own insurance coverage and know whether it covers chiropractic, what percentage, and the number of visits. Dr. Lash and Dr. Hogue do not make treatment recommendations based on what insurance covers, rather treatment recommendations are based on what we have assessed will best help you regain your health.

It is required that you pay for your initial consultation at the time of service. Once insurance has been established, which takes approximately 4-6 weeks (at most), then your payment will be based on your individual insurance.
Nutritional visits and supplements are not covered by insurance and must be paid by you at the time of service.
Neuroemotional technique (NET) is not covered by any insurance.

First time Chiropractic patient or reactivated former patient examination: (This includes history, appropriate examination, and adjustment)	$70.00
Chiropractic manipulative therapy office visit:	$45.00
First time Nutritional patient (includes nutrition response testing, Bioimpedience analysis (BIA), heart rate variability (HRV), and history)	$100.00
Nutrition office visit:	$45.00

CASH ONLY SERVICES

Job and Sports physical	$45.00
Established patients	$23.00
First-time Neuroemotional Technique (NET) patient (includes history, Examination, and neuroemotional technique)	$70.00
Neuroemotional Technique office visit (30 minutes):	$45.00

Even if you schedule NET and Nutrition on the same day, they are considered two **separate** visits and you will be charged accordingly.

We accept the following forms of payment: Cash, VISA, MC, Discover, AmEx, Debit, Personal Check

By signing below, I understand the above policy, fees, and that I am responsible for payment (full amount) of the first visit and following visits until insurance has been established.

Sign name: _____ Date: _____

Print name: _____

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419-342-2931(phone)~~419-347-7096(fax)

Patient Name: _____ **Date:** _____

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at **Lash Chiropractic Center**, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

No one: ____

May we leave messages regarding your personal healthcare information on any answering device, i.e. home answering machines or voicemails? Yes [ ] No [ ]

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____

Signature: _____ Date: _____

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Protecting Your Health Information

New Regulation Passed

This new regulation is part of the Health Insurance Portability and Accountability Act or HIPAA and does three primary things:

1. It helps standardize and simplify the way healthcare organizations exchange health care data.
2. It provides consumers with additional protections for getting and maintaining health insurance coverage although, it does not guarantee coverage.
3. It creates new security rules to ensure the safety and privacy of individual and medical records.

Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. In addition, we have a policy in effect that makes every attempt to maintain the confidentiality of all patients' information.

Disclosure of Medical Information

In addition to disclosing your medical information for treatment, payment and health care operations, we may disclose medical information for the following purposes: for a court order, subpoena, discovery request or other lawful process. We may disclose medical information to appropriate authorities if we reasonably believe that you are a victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose health information when authorized and necessary to comply with laws relating to worker's compensation, auto accidents, personal injury or other similar issues.

If someone calls or comes by, they will not be given any information about your care and/or appointments unless otherwise specified and noted in your file.

We will also be publicly noting your name in our newsletter and/or picture in our lobby unless otherwise specified. Upon becoming a patient, we will be entering your name and email into our database and you may receive our monthly newsletter. If you do not wish to receive our newsletters, please contact our office and advise the receptionist of such. This list will not be sold to any outside agencies.

Your Rights

You have the right to look at or get copies of your medical records and to receive a list of all the times we shared your medical information for purposes other than treatment, payment and health care operations.

Open Adjusting Concept

Because of the open adjusting concept in this office, it is possible for doctor/patient discussions to be overheard by other patients. Most discussions will involve spinal health, but may also include anything concerning the primary health care of that patient.

Notification by Mail or Phone

Patients may be contacted by mail, email or phone unless written notification is requested that contact be only in person.

Complaints

If you feel that your rights have been violated, contact the Office Manager or the U.S. Department of Health and Human Services.