SHEPPARD CHIROPRACTIC
Dr. Joseph A. Sheppard
3878 McMann Rd., Cincinnati, OH 45245
(513) 753-7246 (p) ~ (513) 753-7517 (f)

CASE HISTORY

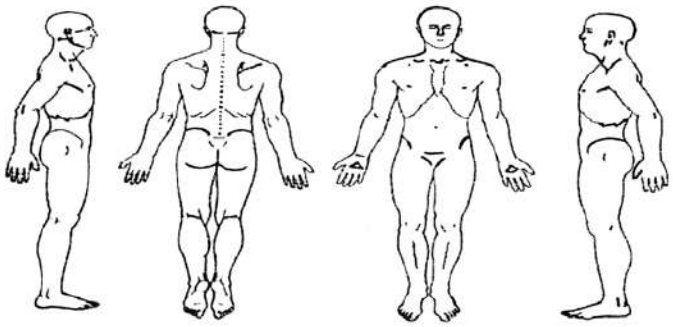
Name: _____ File#: _____

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

Primary Complaints/ Problems — **Severity** (Minimal 0 1 2 3 4 5 6 7 8 9 10 Severe) — **Frequency (% of Day)** (Occasional 0 10 20 30 40 50 60 70 80 90 100 Constant)

1. _____
   Symptom is: Aching / Burning / Dull / Sharp / Stiff /Sore/ Throbbing / Stabbing / Numbness / Tingling / Pins & Needles
2. _____
   Symptom is: Aching / Burning / Dull / Sharp / Stiff /Sore/ Throbbing / Stabbing / Numbness / Tingling / Pins & Needles
3. _____
   Symptom is: Aching / Burning / Dull / Sharp / Stiff /Sore/ Throbbing / Stabbing / Numbness / Tingling / Pins & Needles
4. _____
   Symptom is: Aching / Burning / Dull / Sharp / Stiff / Sore/Throbbing / Stabbing / Numbness / Tingling / Pins & Needles
5. _____
   Symptom is: Aching / Burning / Dull / Sharp / Stiff / Sore/Throbbing / Stabbing / Numbness / Tingling / Pins & Needles
6. _____
   Symptom is: Aching / Burning / Dull / Sharp / Stiff / Sore/Throbbing / Stabbing / Numbness / Tingling / Pins & Needles
7. _____
   Symptom is: Aching / Burning / Dull / Sharp / Stiff / Sore/Throbbing / Stabbing / Numbness / Tingling / Pins & Needles

(Please mark the figures where you experience pain.)



8. Symptoms are worse in the (circle what applies)
   -morning -afternoon -night
   -Increase during the day -same all day
   -decrease during the day
9. When did your symptoms begin (onset date)? _____
10. How did your symptoms begin? _____
11. Have you experienced these before? _____
12. Do your symptoms travel down your Legs / Arms? _____
13. Has your condition? ____ Improved ____ Gotten Worse ____ Stayed the same since it began
14. Circle the things that make your problems worse:
    Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping - Turning - _____
    Limited to _____ _____ _____ _____

Name: _____ File#: _____

15. Is there anything you can do to relieve the problems? ____No ____Yes Describe: _____
    If No, what have you tried that has not helped? _____
16. Have you been treated for this before? ____No ____Yes How long ago? _____
17. What treatment did you receive? _____
18. Results of previous treatment? ____Good ____Poor Comments _____
19. Were you referred to our office by anyone? _____
20. Is this condition interfering with ____ Work ____Sleep ____Daily Routine ____Recreation None
21. List any other major injuries or traumas you have had, other than those mentioned above: None

_____

22. Any other Musculoskeletal problems? ____No ____Yes Neurological problems? ____No ____ Yes
23. Review of Systems: Neg _____
24. Medications: None / See Attached List
    1. _____ 2. _____ 3. _____
    4. _____ 5. _____ 6. _____
25. Allergies: None
    1. _____ 2. _____3. _____ 4. _____
26. Vitals:
    L / R Sitting Blood Pressure _____ Pulse _____ BPM Respiration_____ RPM
    Height ___ ft ____ in Weight _____ Lbs.
27. Surgeries: None
    1. _____2. _____3. _____4. _____
28. Current and Past Health Conditions: None
    1. _____ 2. _____ 3. _____
    4. _____ 5. _____ 6. _____
29. Family History: None Cancer Diabetes HBP Heart Attack/Disease Cholesterol Stroke Arthritis _____
30. Exercise/Diet
    Do you exercise? _____ per week No Eat Healthy Y / N Take Vitamins Y / N
31. Tobacco/Alcohol Use:
    Smoking Yes / No Tobacco Yes / No Drink Alcohol Yes / No Socially

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

Patient/Guardian Signature _____ Date: _____

Joseph A. Sheppard, D.C. _____ Date: _____

Sheppard Chiropractic, Inc.

REGISTRATION FORM

(Please Print)

Today's Date: _____/_____/_____ Primary Care Physician: _____

PATIENT INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Patient's Last Name	First	Middle	Marital Status (Circle One) Single / Married / Divorced / Separated / Widowed

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name? (Former name)	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address	City	State	Zip Code	Social Security

Occupation	Employer	Employer Phone No.

Cell Phone No.	Home Phone No.	Please circle cell phone carrier for text remiders: Verizon / AT&T / CinciBell / Sprint / Cricket / T-Mobile / Other

E-Mail Address Number of Children

I Found This Office Because of (Please check one box) ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Google

❑ Friend _____ ❑ Family _____ ❑ Close to Home/Work ❑ Other _____

IN CASE OF EMERGENCY

Full Name	Relationship to Patient	Primary Phone No.	Secondary Phone No.

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize Sheppard Chiropractic, Inc. and whomever they may designate as their clinicians to administer care as they so deem necessary to my son/daughter/ward. **I have read and fully understand the terms of acceptance and hereby grant permission for my child to receive chiropractic care**

SIGNATURE: DATE:

HIPPA STATEMENT

1. By subscribing my name and signature below, I acknowledge that I have received a copy of the HIPAA guidelines and am in agreement to, and understanding with, its terms and conditions.
2. In the event that I do not answer my telephone, I hereby give permission/consent to leave relevant medical information on my answering machine or voice mail.

SIGNATURE: DATE:

PATIENT AGREEMENT

I authorize the release of any medical information to my primary care/referring physician, to consultants, if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of benefits to Sheppard Chiropractic.

I understand that I am financially responsible for all services rendered and for the following, but not limited to the following reasons:

If: 1) I do not have the proper referral at the time of service 2) My referral is invalid/expired 3) I have given incorrect/invalid insurance information 4) Expenses are not covered by my insurance company 5) I have not met my deductible 6) The services rendered are deemed medically unnecessary by my insurance company (This applies to present and future visits). **Accounts not paid within 90 days of services are subject to a 6% monthly finance charge.**

Payment is required for all services at the time they are rendered including co-payments and any outstanding balances.

In the event that your account must be turned over to collections, a $25.00 collection fee will be added to your account.

Your signature below signifies your understanding and willingness to comply with the policies of this office and your insurance plan.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician.

I understand that I am financially responsible for any balance. I also authorize Sheppard Chiropractic or my insurance company to release any information required to process my claims.

SIGNATURE: DATE:

SHEPPARD CHIROPRACTIC

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

- **Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.
- **Health:** A state of optimal physical, mental and social well-being, not merely the absence of infirmity.
- **Vertebral Subluxation:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference of the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specialized in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

By signing at the bottom of this page, I certify that I have read and fully understand the above statements.

Pregnancy Release:

By signing the bottom of this page, I certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that an x-ray can be hazardous to an unborn child. Date of last menstrual period _____

Signature_____ Date_____

I AM PREGNANT. I understand the above terms of acceptance and understand that due to radiation, x-ray's cannot be performed while I am pregnant.

Signature_____ Date_____

PATIENT AUTHORIZATION OF RELEASE OF RECORDS

DATE:____ / ____ / ____

PATIENT:_____ ACCT#:_____

DATE OF BIRTH: ____ / ____ / ____ SSN:_____ - _____ - _____

DATE OF RECORDS: _____ _____

These records are needed immediately in order to properly process this patient.

- ❑ Radiology Reports (X-rays, MRI, CT)
  Films in question:_____
- ❑ Actual film copies of X-rays / MRI's / CT's (by mail).
- ❑ Office Notes and Dictations
- ❑ Emergency Room Records / Lab Reports / Diagnostic Studies
- ❑ Ambulance Transporter's Report
- ❑ Special Studies (i.e. NCV, EMG, etc.)
- ❑ Surgical / Post-Surgical Reports
- ❑ Other:_____

I HEREBY AUTHORIZE THE RELEASE OF MY X-RAYS / RECORDS AND REQUEST THAT THEY BE TRANSFERRED TO:

Sheppard Chiropractic
3878 McMann Rd.
Cincinnati, OH 45245
Phone: 513-753-5437 Fax: 513-753-7517

PATIENT SIGNATURE:_____

DATE:____ / ____ / ____

Note of Confidentiality: This is intended for use only by the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone, so that all transmitted materials received may be dealt with appropriately. Thank you.

SHEPPARD CHIROPRACTIC

A GENERAL ANNOUNCEMENT TO ALL PATIENTS

As a "Courtesy" Sheppard Chiropractic will verify chiropractic benefits on your insurance policy. We do our best to get accurate information, however, you are ultimately responsible for any balance your insurance does not pay. **It is your responsibility to know if you have Chiropractic Benefits**.

INSURANCE CLAIMS POLICY

Our insurance department will file claims for you or your child's chiropractic treatment for payment to the insurance carrier you supplied. With electronic billing, claims are processed in **4 – 6 weeks**. We will attempt to file claims for up to 90 days following date of treatment for payment. After 90 days, you will be responsible to contact your insurance company and have them pay your benefits to us. If you choose not to do this, we will add the amount of uncollected benefit to your portion of the financial contract, and you will be responsible to pay it.

AUTO ACCIDENT CLAIM POLICY

Claims will be billed to your auto insurance under your Med Pay coverage benefits, or to your personal health insurance. If you do not have either of these types of coverage you will be required to pay at the time of each visit. If you are being represented by and attorney for this injury accident we will work with them, providing them with needed medical and billing documentation. Ohio law states that Med Pay claims will be reimbursed to the policy holder, so you accept financial responsibility for reimbursing Sheppard Chiropractic for all treatment billed to your auto Med Pay insurance.

HIPAA COMPLIANCE STATEMENT

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED,
AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At Sheppard Chiropractic, we are committed to protecting your privacy. We comply with all federal, state, and local laws. This notice describes how we use your health information. It describes some of your rights and some of our responsibilities.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit our offices, we record your symptoms, physical examination, test results, diagnosis, and treatment. This information enables us to: plan for your care, communicate with others who care for you, report to your insurance carrier, bill for our work, and improve the quality of our care.

YOUR RIGHTS

Although your paper chart belongs to our practice, the information contained in the chart is yours. You have the right to: inspect your records, obtain a copy of your chart for a small fee, correct your records, and tell us not to release your information.

OUR RESPONSIBILITIES

We are required to: maintain the privacy of your health information; send needed health information to other medical providers, and release information to insurance companies, certain government agencies, and others. We may be required to release some information, even without your permission.

EXAMPLES OF HOW YOUR INFORMATION IS USED

Your health information will be recorded and used to plan your treatment. Reports may be sent to other doctors to help them plan your treatment. Bills will be sent to your insurance company. The information in the bills will include confidential information such as your name, address, diagnosis, and treatment. In providing your care, we may communicate with other individuals or businesses. Examples include other physicians and/or laboratories. To protect your privacy, we ask our business associates to safeguard your information.

OTHER NOTICES

We may leave a message at your home, at your business, on your answering machine or on your voicemail. We may mail you a postcard or other written notices. We may need to disclose your information to your family members or other people helping with your care. In doing so, we will use our best judgment. We may disclose information to others as required by law or if subpoenaed. If you were injured on the job, we will need to disclose your health information to your workers compensation insurance company. We may, from time to time, update these policies.

FOR MORE INFORMATION OR TO REPORT A PROBLEM: If you have concerns or would like additional information, you may contact the practice's Compliance Officer at (513) 753-7246.

Signature_____ Date_____

You May Be Prescribed Massage as Part of Your Treatment

Massage Benefits: Increased circulation, muscle tension release, relieves referred pain stemming from trigger points, Improvement in range of motion, Flush toxins and relax muscles, increased flexibility and strength, Shortened recovery time.. and much more

OUR MASSAGE POLICY IS

It is our office policy to allow 1 missed massage appointment without notice. From that point on **we require a 3 hour notice for cancellation of a massage appointment**, if you fail to do this you will be charged a **$10 fee** before you may schedule your next appointment. Please know we have other patients who may be able to fill that slot, because of this **we reserve the right** to fill any appointment after 15 minutes of the appointment time.

MASSAGE INSURANCE POLICY

Due to recent changes with insurance companies, massage under the prescription of the doctor is **no longer covered** through a chiropractor. While the therapy is beneficial for your health you will be financially responsible for the **full** cost of massage.

Thank you for being curteous.

Signature:_____ **Date:**_____