SPRANDEL CHIROPRACTIC CLINIC
Patient Consent for use and Disclosure
Of Protected Health Information

I hereby give my consent for SPRANDEL CHIROPRACTIC CLINIC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Sprandel Chiropractic Clinic's Notice of Privacy Practices provides a more complete description of such uses and disclosures).

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Sprandel Chiropractic Clinic reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Sprandel Chiropractic Clinic in care of the Privacy Officer at 1412 Cleveland Ave. NW, Canton, Oh 44703.

With this consent, Sprandel Chiropractic Clinic may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO; such as appointment reminders, insurance items and any calls pertain to my clinical care, including laboratory results among others.

With this consent Sprandel Chiropractic Clinic may mail to my home or other alterative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent Sprandel Chiropractic Clinic may e-mail to my home or any other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Sprandel Chiropractic Clinic restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Sprandel Chiropractic Clinic's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Sprandel Chiropractic Clinic may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Print Patients Name or Legal Guardian

Date_____ Home Phone _____ Cell_____ Work_____ Email_____
Patient Last Name_____ First Name_____ Initial_____
Street Address_____
City_____ State_____ Zip_____
Sex ☐ M ☐ F Age_____ Birth date_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Social Security #_____ Driver's License #_____
Insured Name_____ How and where did you learn about this clinic?_____
Last Name First Name Initial
Relationship To Insured ☐ Self ☐ Spouse ☐ Child ☐ Other
Condition/ Illness Related To ☐ Illness ☐ Employment ☐ Auto ☐ Other

EMPLOYER	Company Name_____ Occupation_____ Address_____ Phone_____ ☐ Full-time ☐ Part-time City_____ State_____ Zip_____ Years Employed_____
SPOUSE (PARENT)	Name_____ Birthdate_____ SSN:_____ Last Name First Name Initial Employer Name_____ Years Employed_____ Address_____ Phone_____ Occupation_____ City_____ State_____ Zip_____ ☐ Full-time ☐ Part-time
PATIENT INSURANCE INFORMATION	Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name_____ Policy/Group #:_____ Effective Date:_____ Name of Insured:_____ ID #:_____
SPOUSE COINSURANCE INFORMATION	Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name_____ Policy/Group #:_____ Effective Date:_____ Name of Insured:_____ ID #:_____
MEDICAL AND LEGAL INFORMATION	**Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? ☐ Yes ☐ No** Your Initials:_____ If you answered yes, please fill out accident specific form, available at the front desk. Pregnant ☐ Yes ☐ No Pacemaker ☐ Yes ☐ No Family Physician_____ Person to contact in emergency (Name and Phone #)_____ Attorney_____ Telephone:_____ Address_____ Do you want us to submit a report to your family physician? ( ) yes ( ) no

Patient Agreement & Authorization For The Release Of Medical And Health Plan Documents For The Claims Processing & Reimbursement As Required by Federal and State Laws

Legal Assignment Of Benefits And Designation Of Authorized Representative: 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 and convey directly to the above named healthcare provider(s), as my designated Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above named provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. 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 provider(s), to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, chose in action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s) under any applicable insurance policies, employee benefits plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from the above named provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. 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**

Sprandel Chiropractic Clinic,
1412 Cleveland Ave. N.W. Canton, Ohio 44703
Tel: (330) 455-4602; Fax: (330) 455-2468

CONFIDENTIAL PATIENT QUESTIONNAIRE

Dear Patient: Today's Date:_____

In order for us to better help you, we need this important confidential questionnaire answered completely by you for your health care. If you need any assistance, please do not hesitate to ask our staff for help. Please write clearly for your health! Thank you.

Name_____ Prefer To Be Called_____
Address_____ Home Phone_____
City_____ State_____ Zip_____ Work Phone_____
Sex ☐M ☐F Marital Status ☐Single ☐Married ☐Widowed ☐Divorced Age_____ Date of Birth_____
Occupation _____ Employer_____ Years Employed_____
Employer's Address_____ City_____ State_____ Phone_____
Spouse's Name_____ Occupation_____ Number of Children_____

Have you ever had ☐Chiropractic ☐Acupuncture care before? ☐Yes ☐No For what problem?_____
What type of care / treatment are you seeking from this clinic? ☐Chiropractic ☐Acupuncture ☐Physical Therapy ☐Whatever Helps
You were referred to this clinic by ☐Newspaper Ads ☐Yellow pages ☐Friend ☐Clinic Sign ☐Other_____

What is your major complaint for which you came to our clinic?_____

Other complaints_____

Please describe in detail how your present illness developed / started from first sign and / or symptom to the present (includes time, place, reasons, courses, mode, results, etc.)

Are your symptoms the result of an auto accident, work- related injury or other personal injury(slip and fall, etc.)? If you answered yes, please fill out accident specific form, available at the front desk. ☐Yes ☐No

Did symptoms/pain begin ☐gradually ☐suddenly?

When was the very last episode of symptoms/discomforts experienced?_____

How long have you had these episodes of symptoms?_____

Please describe in detail how your health problem (s) disturbed / bothered you (including how each of the problems you described).

Are your symptom (s) / pain ☐localized ☐traveling? Please describe where your symptom (s) / pain go to_____

Describe the quality / character of your symptom (s). Some words often used include burning, tingling, aching, tired, numbness, sharp, dull, stabbing, shooting, radiating, pins and needles, etc.

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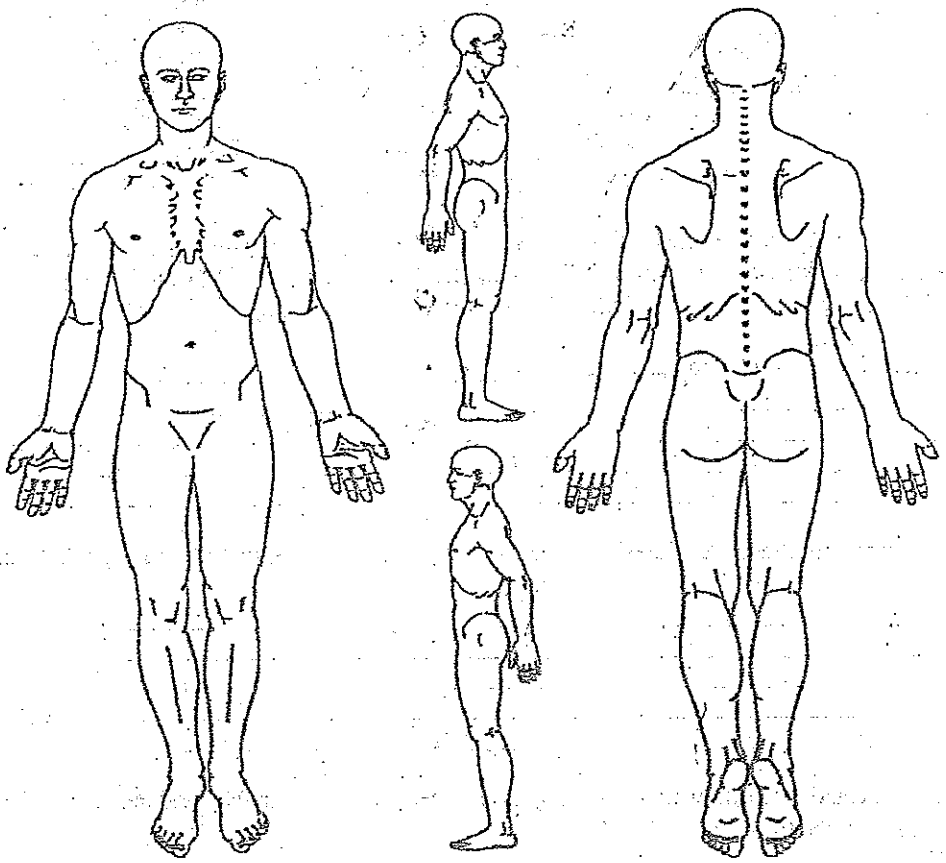
Mark the areas on your body where you feel pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol (s) listed below.

Ache >>>>>>	Numbness ======	Pins and Needles ↓↓↓↓↓↓	Burning ××××××
Stabbing ▽▽▽▽▽	Throbbing ~~~~~~	Tingling +++++	Sharp ↔↔↔↔
Dull 0 0 0 0 0	Soreness ∩∩∩∩∩	Shooting ⊕ ⊕⊕ ⊕	Other



On a pain analog scale of 0 to 10, with 0 being the absence of pain and 10 being significant enough to seek emergency care, which number would describe your pain/discomfort, please circle.

What is your pain/discomfort like today? -0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
What is your least pain/discomfort? -0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
What is your worst pain/discomfort? -0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

How much time during an average day are you in pain/discomfort?

- ☐ Less than 1 hour per day
- ☐ Between 1 and 4 hours per day
- ☐ Between 4 and 8 hours per day
- ☐ Almost anytime that you are not lying down
- ☐ Almost 24 hours per day
- ☐ Other_____

Since your symptoms began, have they ☐ improved ☐ worsened ☐ stayed the same?

What made your current symptoms worse?_____

What made your current symptoms better?_____

Is your sleep disturbed by these symptoms? ☐ YES ☐ NO

If you are restricted/limited or have difficulties in any activities or performance of your work because of your discomfort/pain, please describe in detail ☐ YES ☐ NO

If you are restricted/limited or have difficulties in any activities or performance at your home/activities of daily living or recreational activities because of your discomfort/pain, please describe in detail(such as bathing, grooming, dressing, eating, walking, stooping, bending, grasping, driving, etc.) ☐ YES ☐ NO

Have you done anything to try to help or relieve your complaint, such as rest, heat,cold,aspirin, medication, sit, lie down. Or other?
☐ YES ☐ NO Describe in detail

Are you doing any corrective exercises for your present symptoms? ☐ YES ☐ NO
If yes, who recommended them? Briefly describe the exercises/stretches you are doing

Do you participate in other exercises (aerobics, walking, jogging, etc.)? ☐ YES ☐ NO
If yes, what type and how many times per week/month

Have you seen a physician or chiropractor outside this clinic for the problem(s) for which you came to this clinic?
☐ YES ☐ NO If yes, please list each doctor individually

A. If yes, whom did you see? Doctor's Name: Specialty:
Address: City State Phone
When were you seen? From to Are you still under this doctor's care? ☐ Yes ☐ No
Were ☐ X-ray ☐ MRI ☐ CAT Scan ☐ EMG ☐ Bone scan or others taken?
What was diagnosis?
What type of treatment(s) were received? Please list in detail all the treatments you received from this doctor (includes medications, injections, surgeries, physical therapy and others)
How much were your symptoms/discomforts helped? Please circle.
No improvement -0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Full improvement

B. If yes, whom did you see? Doctor's Name: Specialty:
Address: City State Phone
When were you seen? From to Are you still under this doctor's care? ☐ Yes ☐ No
Were ☐ X-ray ☐ MRI ☐ CAT Scan ☐ EMG ☐ Bone scan or others taken?
What was diagnosis?
What type of treatment(s) were received? Please list in detail all the treatments you received from this doctor (includes medications, injections, surgeries, physical therapy and others)
How much were your symptoms/discomforts helped? Please circle.
No improvement -0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Full improvement

C. If yes, whom did you see? Doctor's Name: Specialty:
Address: City State Phone
When were you seen? From to Are you still under this doctor's care? ☐ Yes ☐ No
Were ☐ X-ray ☐ MRI ☐ CAT Scan ☐ EMG ☐ Bone scan or others taken?
What was diagnosis?
What type of treatment(s) were received? Please list in detail all the treatments you received from this doctor (includes medications, injections, surgeries, physical therapy and others)
How much were your symptoms/discomforts helped? Please circle.
No improvement -0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Full improvement

Have you seen a physical therapist for this problem? ☐ YES ☐ NO
If yes, whom did you see? Name: Address:

What type of therapies were received? _____

How much were your symptoms/discomforts helped? please circle.

No improvement -0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Full improvement

Have you seen a physician, chiropractor or physical therapist for any other problems? ☐ YES ☐ NO

If yes, please describe_____

_____

Are you aware of any blood relatives with **similar** discomforts/problems?

☐ No ☐ YES, please describe_____

Any family history of diseases or death of parents, siblings and children (e.g. heart problems, diabetes, asthma, herediary disease etc.)

☐ No ☐ YES_____

_____

Please list all major past diseases and accidental injuries (include concussions, head injuries, broken bones, high blood pressure, etc.) you may have had which did not require hospitalization (please include dates and any recurring problems)

Illness/injury	Date	Recurring

Have you ever been involved in injuries from following:

☐ Automobile accident ☐ Worker's compensation ☐ Personal injuries (slip and fall, etc.)

☐ Yes ☐ No If yes, please list all of them with date, type, and legal status

Injury	Date	Settled	Not settled	Attorney's name

Please list all surgeries/operations you have ever had. Please also list when these were done, where they were done, who the surgeon was, and if you have had any remaining problems associated with these procedures. (Attach separate sheet if necessary.)

Date	Type of surgery	Where	Surgeon's name	Complications	Remaining problems

Please list all hospitalizations you have had in the past which did not involve surgery. Also list any remaining problems you attribute to these illnesses.

Date	Cause of hospitalizations	Remaining problems

Please list all medications (including birth control pills, aspirin, cortisone or vitamins), even if only occasionally, include how often you take the medication, how much you take,and/how long you have taken it.

Medication	How often	How much	For how long

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Are you allergic to anything (medications, lotion, etc.)? ☐ YES ☐ NO

If yes, to what?_____

Do you smoke or use any tobacco products? If yes, how much & often?_____
Do you drink alcoholic beverages? If yes, how Much & often?_____
Do you drink caffeinated beverages? If yes, how much & often?_____
Please circle your level of formal education group:

- ☐ Less than High School
- ☐ High School Diploma or GED
- ☐ Some College
- ☐ College Degree
- ☐ Advanced Degree
- ☐ Vocational Training in_____

Have you missed any work as a result of this illness/pain? ☐ YES ☐ NO
If yes, how many days/weeks?_____ Dates of absence_____to_____

What type of physical activities or postures does your job involve (prolonged sitting, standing, bending, etc.)
_____

Please list all and any other health problems you have had in the past or have now (such as headache, dizziness, blurred vision, vertigo, heart attack, high blood pressure, stomachache, vomiting, bloody stool, kidney infection, pneumonia, asthma, etc.).
Illness/discomforts Date
_____
_____
_____
_____
_____
_____

Women only

a. Are you pregnant or think you may be pregnant?_____
b. Date of last menstrual period_____
c. Do you or have you suffered from any menstrual disorders? ☐ YES ☐ NO
If yes, please describe_____

Who is filling out this questionnaire? ☐ Self ☐ Spouse ☐ Other_____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient's Signature_____ Date_____

Physician's Signature (upon review)_____ Date_____
Judson Sprandel II DC

PHYSICIAN'S NOTES:

HISTORY IS TAKEN FROM ☐ PATIENT ☐ SPOUSE ☐ OTHER_____
INFORMATION IS ☐ RELIABLE ☐ NOT RELIABLE ☐ SATISFACTORY ☐ NOT SATISFACTORY.
ADDITIONAL COMMENT ☐ NO ☐ YES_____
_____
_____