405 Firemans Ave, LaVale, MD 21502 Phone: 301-777-3710 Fax: 301-777-0436

In order to provide you the best possible Chiropractic Care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

YOUR PERSONAL INFORMATION

Today's Date: ____/____/____

Name:________________________________Birth Date:____/___/____ Age:_____SSN: _______-_____-_____ Sex __M __F

Address:____City, State, Zip:___________________________

Home Phone:_______-_______-_______Work Phone:________-_______-_______Cell Phone:________-_______-______

Driver's License #:____ Are You: ☐Married ☐Single ☐Divorced ☐Widowed

E-Mail:_________________________________Would you like to receive our practice wellness newsletter via email ☐Yes ☐No

Employer:___________________________Occupation: __________________

Do You Have Children? ☐No ☐Yes, How Many? ___Ages:________________ Could You Be Pregnant Now? ☐Yes ☐No

Spouse Name:_________________________Spouse Employer:_____________________Spouse SSN: ______-_____-_____

Spouse Date of Birth: ____/____/______*Required if using your spouse's insurance for care

Emergency Contact Name, Phone, and Relationship: ____

How were you referred to this office? ____

CURRENT HEALTH CONDITION

Purpose of this appointment: ____

Is this condition: ☐Job Related ☐Auto Accident ☐Sports Injury ☐Chronic ☐Other:__________________________________

When and How did it begin?____

Has this Condition occurred before? ☐No ☐Yes If Yes, when?____

What treatments or activities make it better? ____

What treatments or activities make it worse? ____

Family Doctor Name:______________________________May we provide your family doctor your treatment info? ☐Yes ☐No

Medications or Supplements taken? ____

Major Surgeries or Hospitalizations: ____

Previous Chiropractic Care: ☐None ☐Doctor's name and last visit ____

Have you had X-ray, MRI or CT Scan in the last 6 months? ☐Yes ☐No If so where? ________________________________

WHY CHIROPRACTIC?

People go to chiropractors for a variety of reasons and there are different levels of care.
Please check the type of care desired so that Dr. Bohn may be guided by your wishes whenever possible.

☐**Stage 1: Pain relief**: *Just get rid of the pain, Doc! Relief is short-term.*

☐**Stage 2: Rehabilitation**: *Get rid of the pain, Doc, but then fix this problem so that it doesn't come back!*

☐**Stage 3: Optimal Health**: *Get rid of the pain, fix the problem, and then put me on a preventive maintenance plan that includes diet, exercise and chiropractic so that I stay as healthy as possible.*

HAVE YOU EVER:	NO	YES	BRIEFLY EXPLAIN:
Broken any Bones?	☐	☐	______________________________
Been hospitalized?:	☐	☐	______________________________
Been in an auto accident?	☐	☐	______________________________
Had sprains or strains?	☐	☐	______________________________
Been struck unconscious?	☐	☐	______________________________
Had surgery?	☐	☐	______________________________

FAMILY HISTORY

Family Member	Present and Past health conditions: (example: heart disease, cancer, diabetes, arthritis, etc.)
________________	____
________________	____
________________	____
________________	____

PLEASE CHECK ALL THAT APPLY

GENERAL
1) o Fever
2) o Chills
3) o Night Sweats
4) o Loss of Sleep
5) o Fatigue
6) o Nervousness
7) o Weight Loss or Gain
8) o Allergies
9) o Bleeding Problem
10) o Anemia
11) o Diabetes
12) o Cancer
13) o Thyroid Disease/Goiter
14) o Alcoholism
15) o Drug Abuse

EYE EAR NOSE THROAT
16) o Poor Vision
17) o Pain in Eye(s)
18) o Deafness/Difficulty Hearing
19) o Nosebleeds
20) o Nose Problems
21) o Sinus Trouble
22) o Dental Problems
23) o Hoarseness
24) o Tonsillectomy

GASTROINTESTINAL
25) o Poor Appetite
26) o Poor Digestion
27) o Difficulty Swallowing
28) o Belching or Gas
29) o Frequent Nausea
30) o Vomiting
31) o Vomiting Blood
32) o Pain over Abdomen
33) o Ulcer
34) o Black or Bloody Stools
35) o Liver Problems
36) o Gall Bladder Problems
37) o Jaundice
38) o Hernia
39) o Diarrhea
40) o Constipation
41) o Hemorrhoids
42) o Appendicitis

MEN ONLY
43) o Testicular Swelling/Pain
44) o Prostate Problems

RESPIRATORY
45) o Difficulty Breathing
46) o Chronic Cough
47) o Spitting Phlegm
48) o Spitting Blood
49) o Wheezing/Asthma
50) o Pneumonia
51) o Tuberculosis

CARDIOVASCULAR
52) o Irregular Heartbeat
53) o High Blood Pressure
54) o Pain over Heart
55) o Previous Heart Trouble
56) o Ankle Swelling
57) o Varicose Veins
58) o Rheumatic Fever
59) o Stroke

GENITOURINARY
60) o Frequent Urination
61) o Painful Urination
62) o Blood in Urine
63) o Kidney Disease
64) o Urinary Infection
65) o Inability to Control Urination
66) o Difficulty Starting Urine Flow
67) o Get Up at Night to Urinate
68) o Breast Lump or Pain
69) o Venereal Infection
70) o Sexual Difficulties

SKIN
71) o Itching
72) o Bruising Easily
73) o Change in Mole(s)
74) o Skin Cancer

WOMEN ONLY
75) o Painful Periods
76) o Excessive Flow
77) o Irregular Cycles
78) o Vaginal Burning/Itching
79) o Hot Flashes
80) o_____Date Last Period Began
81) _____Date of Last PAP Test

NEUROLOGIC
82) o Weakness
83) o Twitching
84) o Tremors
85) o Headache
86) o Fainting
87) o Dizziness
88) o Convulsions
89) o Epilepsy
90) o Numbness/Tingling
91) o Arm/Leg Pain (125)
92) o Mental Disorder

MUSCULOSKELETAL
93) o Neck Stiffness/Pain
94) o Pain Between Shoulders
95) o Low Back Pain
96) o Swollen Joints
97) o Painful Joints (CC)
98) o Muscle Aches/Soreness
99) o Spinal Curvature
100) o Arthritis

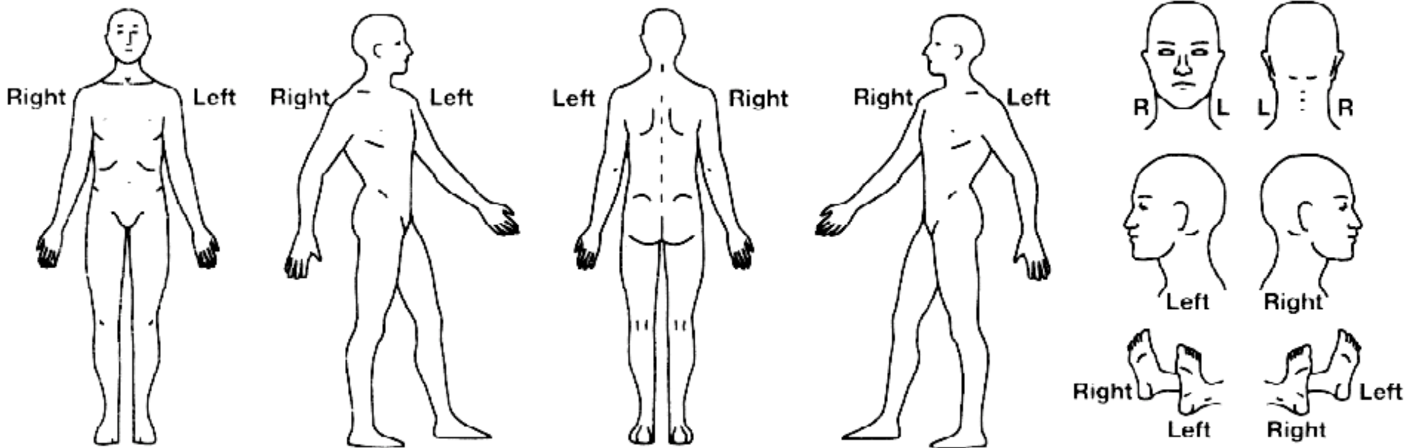
HABITS
101) o Smoking o Packs/Day
102) o Drinking
103) o Recreational Drug Use

EXERCISE
104) o None
105) o 1-2 Times/Week
106) o 3-5 Times/Week
107) o 6-7 Times/Week

FAMILY HISTORY
Include information on brothers, sisters, parents and grandparents. DO NOT INCLUDE YOURSELF.
108) o Diabetes
109) o Thyroid Disease/Goiter
110) o Tuberculosis
111) o Kidney Disease
112) o High Blood Pressure
113) o Heart Disease
114) o Cancer
115) o Muscle, Bone or Nerve Disease

BODY PAIN CHART

Please label where your pain is located on the drawing below. Use these following letters to indicate the type of pain and symptoms you are currently experiencing: **A** = Ache **B** = Burning **N** = Numbness **P** = Pins/Needles **S** = Stabbing **O** = Other



FINANCIAL POLICY AND PATIENT SERVICE AGREEMENT

Who is responsible for paying your bill? You and: ☐Worker's Comp ☐Auto Ins. ☐Medicare ☐Health Insurance

In order to receive the best care possible within your maximum benefits, it is important that you comply with our financial policy:

1. **Payment is expected at the time of service** in the form of a deductible, co-payment, or coinsurance payment.

It is illegal to waive these fees.

2. Your policy is a contract between you and the insurance company and you are responsible for any unpaid or denied claim, and for any collection fees, court costs, and attorney's fees if your account is turned over for collection.
3. If your insurance company sends you checks, it is your responsibility to deliver them to our office within 5 (five) days.
4. Affordable payment plans or hardship forms are available in special cases.
5. All account balances outstanding more than 90 days from the last date of treatment will incur a late fee at 1 1/2% per month or 18% per year. In the event that Accent on Health Chiropractic and Massage refers my account to any attorney for collection, the undersigned agrees to pay any court costs, private process fees, investigative fees, collection costs of attorney's fees of 33 1/3% of all sums due, which attorney's fees the undersigned expressly agrees is reasonable, in addition to the balance of the account."
6. This Agreement, along with any exhibits, appendices, addendums, schedules, and amendments hereto, encompasses the entire agreement of the parties, and supersedes all previous understandings and agreements between the Parties, whether oral or written. The parties hereby acknowledge and represent, by affixing their hands and seals hereto, that said parties have not relied on any representation, assertion, guarantee, warranty, collateral contract or other assurance, except those set out in this Agreement, made by or on behalf of any other party or any other person or entity whatsoever, prior to the execution of this Agreement.

Signed____**Date**____________________

Patient or responsible party

☐ Financial Responsibilities

For and in consideration of treatment rendered to the patient(s) hereinbefore set forth, the undersigned guarantees the payment of all sums due Accent on Health for such treatment. The undersigned acknowledges that all services must be paid for at the time are rendered. It is expressly agreed the undersigned shall remain liable for any sums or deductible not paid or for any delay in payment from any insurer and that Accent on Health is not obligated to await payment from any other party and may in its discretion demand payment for services at any time.

The undersigned further assigns any insurance benefit to which the undersigned is entitled for the payment of any services rendered hereunder. I authorize Accent on Health and/or its agents to release any information pertinent to my treatment to any insurance company or other third party in order to effectuate collection. I further appoint Accent on Health and/or Dr. David A. Bohn, DC and/or his agents my attorney-in-fact to endorse my name upon any checks or drafts made payable to me in satisfaction of any sum now or hereinafter due Accent on Health or Dr. David A. Bohn, DC.

All account balances outstanding more than 90 days from the last date of treatment will bear interest at 1.5% per month or 18% per year. In the event that Accent on Health refers my account to any attorney for collection, the undersigned agrees to pay any court costs, private process fees, investigative fees, collection costs plus attorney's fees of 33 1/3% of all sums due, which attorney's fees the undersigned expressly agrees are reasonable, in addition to the balance of the account.

PATIENT'S SIGNATURE: ____________________________(Seal) DATE: _____/____/______
(Parent's signature if a minor)

WITNESS: ____
Accent on Health 405 Firemans Ave, LaVale, MD 21502

☐ Authorization and Assignment of Benefits

I irrevocably assign and authorize full and complete payment of any and all sums due this facility from any insurance settlement, judgment or verdict. I understand that I am providing full authorization and assignment directing any liable entity (attorneys, and insurance company, etc) for the purpose of full and complete payment of any and all sums due at this facility and/or his agents prior to disbursement of any funds.

I authorize Accent on Health Chiropractic and Massage and/or Dr. David A. Bohn, DC to receive priority of payment of any funds to be distributed.

I direct any liable entity (attorneys, any insurance company, etc.) to contact this facility, immediately prior to disbursement of funds to obtain an accurate amount of all sums due this facility.

I authorize Accent on Health Chiropractic and Massage and/or Dr. David A. Bohn, DC to withhold from releasing my medical records, billing, etc. to any non-medical entity (i.e. attorney, insurance company, etc.) until such parties provide a signed guarantee of direct payment to this facility for all sums due this facility prior to disbursement of any funds.

I agree never to rescind this document and that a rescission will not be honored by any liable entity (attorneys, any insurance company, etc.)

I hereby instruct that in the event another attorney is substituted in this matter, the new attorney to honor this lien as inherent to the settlement and enforceable upon the case as if it was executed by him.

PATIENT'S SIGNATURE: ____________________________(Seal) DATE: _____/____/______
(Parent's signature if a minor)

WITNESS: ____
Accent on Health 405 Firemans Ave, LaVale, MD 21502

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

Notice of Privacy Practices for Accent on Health Chiropractic and Massage

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal law that requires us to protect the privacy of individually identifiable health information about you ("Your Protected Health Information") that we create or receive. Your Protected Health Information may be oral, written, electronic, or in any other form. We are required by law to provide you with this Notice of our duties and privacy practices with respect to Your Protected Health Information. When we use or disclose Your Protected Health Information, we are required to abide by the terms of this Notice.

I have been offered the opportunity to read a digital or printed copy of "The Health Insurance Portability and Accountability Act of 1996" as it pertains to treatment in this office.

Patient Signature: ___________________________________ **Date:** __________

☐ **INFORMED CONSENT FOR CHIROPRACTIC CARE**

A patient, in coming to Accent on Health Chiropractic and Massage to see a chiropractor, gives the doctors permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments 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 health care if he 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 health care procedures whatever he or she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractor. The chiropractor 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 regime.

I understand that if I am accepted as a patient by a physician at Accent on Health Chiropractic and Massage, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Patient Signature: ___________________________________ **Date:** __________

☐ CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize Dr. David Bohn or whomever he may designate as his assistant to administer treatment, as he so deems necessary to my son/daughter ____.

Signed: ____Date: _____/_____/_____

Witnessed: ____