Allied Pain Relief Clinics

NEW PATIENT REGISTRATION FORM

Date:
File#

Welcome to Allied Pain Relief Clinics. We ask that you complete this paperwork. It will help us to help you. We understand it can be difficult to complete paperwork, especially when you are in pain. If you need help, or have any questions, please ask. Thank you!

PATIENT INFORMATION				Home #
Name:				Work #
Address:				Cell#
City:	State:		Zip:	Email:
Gender: M F	Date of birth:		Age:	How did you hear about APRC?
SS#:	Drivers Lic#			**IS THE PATIENT A MINOR?**
Primary Phsician Name:				Mother's Name: Ph:
Employer:				Father's Name: Ph:
Work Address:				Whom does minor reside with:
City:	State:		Zip:	School Attended:

Marital Status **Single** **Married** **Div** **Wid**	**EMERGENCY CONTACT INFORMATION**
Spouse Name:	Name:
Date of birth: SS#	Phone:
Spouse Employer: Occupation:	Relationship:

CONSENT TO TREATMENT OF A MINOR CHILD

I hearby authorize Dr. John J. Clendenin, D.C. and whomever he may designate as assistants to administer treatment as deemed necessary to my (son, daughter, etc).

_____
Name of Minor

Signed: _____
Parent or Guardian Date

Witnessed: _____

INSURANCE DISCLAIMER

"A quote of benefits and/or authorizatin does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at the time of service."

INSURANCE LIABILITY FOR PAYMENT:

Your health insurance company will only pay for services that it determines to be "reasonable and necessary." Every effort will be made by APRC to have all services and procedures pre-verified by your health insurance company. If your insurance company determines that a particular service is not reasonable and necessary, or is not covered by your plan, your insurer will deny payment.

BENEFICIARY AGREEMENT:

I understand that my health insurance company may deny payment for services identified above, for the reasons stated. If my insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my insurance company does make payment for services, I will be responsible for any co-payment, deductible, or co-insurance that applies.

Print Name: _____ Date: _____

Signature: _____

HIPAA COMPLIANCE

ATTENTION PATIENTS

This form is to inform you that we are under HIPAA compliance to protect your patient confidentiality with our office. Upon signing this form, you understand that we have HIPAA standards to protect your privacy upon treatment in this office.

_____
Patient Signature: Date

AUTHORIZATION TO RELEASE MEDICAL INFORMATION/FINANCIAL AGREEMENT

I hereby authorize this office to release any information requested by my insurance company to document my claim for benefits.
I understand that I am personally responsible for full payment of all charges for my treatment. Services are payable at the time rendered

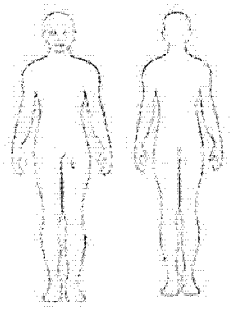
_____
Patient or Guardian Signature Date

HISTORY OF PRESENT ILLNESS

Please indicate regions of complaint and the severity of symptoms.

Region	Mild Moderate Severe
Headache Pain	1 2 3 4 5 6 7 8 9 10
Neck Pain	1 2 3 4 5 6 7 8 9 10
Upper/Mid Back Pain	1 2 3 4 5 6 7 8 9 10
Low Back Pain	1 2 3 4 5 6 7 8 9 10
Shoulder/Elbow/Wrist/hand Pain	1 2 3 4 5 6 7 8 9 10
Other	1 2 3 4 5 6 7 8 9 10

R R R R L L R



Please use the letters below to indicate the *type* and *location* of your pain and sensations.

A= Acute
B= Burning
S= Stabbing
N= Numbness
P=Pins/Needles

Mark an **X** on the picture where you are continuing to have pain.

PATIENT PAST MEDICAL, FAMILY, SOCIAL HISTORY

Condition/Disease	Patient History (Y/N)	Family History Of (M=mother/F=father)		Condition/Disease	Patient History (Y/N)	Family History Of (M=mother/F=father)	
Arthritic Condition		M	F	Smoker		M	F
Cancer		M	F	Alcohol		M	F
Diabetes		M	F	Headaches/Migraines		M	F
Heart Problems		M	F	Other		M	F
High Blood Pressure		M	F	Birth Control Medications			
Vascular Condition		M	F	Currently Pregnant			
Lung Problems		M	F	Exercise Regularly			
Usual Childhood Diseases		M	F				
Unusual Childhood Diseases		M	F				

List of Medications	Surgery/Hospitalization Date
	Environmental/Medicinal Allergies

INJURY/CONDITION BACKGROUND

When did injury/cond start?

What makes this condition worse?

What makes this condition better?

Have you received previous treatment?

Radiology Reports Performed?

MRI *CT SCAN* *XRAY*

Who have you seen for this condition?

DO NOT WRITE BELOW THIS LINE. FOR CLINICAL STAFF ONLY

REVIEW OF SYSTEMS

CONSTITUT'L	EYES	EAR, NOSE, THROAT		RESPITORY	Cardio	MUSCULO		GASTRO	SKIN/BREAST	URINARY	NEURO
Hygiene	Pain	Nose bleed	Ringing in	cough	chest pain	muscle pain		diarrhea	lesions	incontinence	headaches
Fatigue	Redness	Stuffiness	ears	wheezing	palpations	joint pain		constipation	open sores	burning during	dizziness
Fever/chills	Flashing	Discharge	Ear pain	phlegm	faintness	neck pain		heartburn	wounds	urination	head injury
Weakness	Floaters	Dry mouth	Swollen	blood cough	tightness	neck injury		difficulty	rash	fruequent	
Weight loss	Blurry	Sore throat	Glands	shortness of		stiffness		swallowing	bruising	urgency	
Loss of appet	cataracts			breath				hernia	lumps	blood in urine	
nausea	Vision Loss							abdominal	breast		
								pain	pain		
NEG	NEG	NEG	NEG	NEG	NEG	NEG	NEG	NEG	NEG	NEG	NEG

PHYSICAL EXAM

HT:	TEMP:	PULSE:	Eyes	Respiratory	Skin	GI	Muscoloskeletal	Psychological
WT:	BP:		ENT	Cardiovasc		GU	Neurological	Hem/Lymph

John Clendenin, DC

Patient Signature

A. Notifier:Allied Pain Relief Clinic

B. Patient Name: _____ C. Identification Number: _____

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare and /or Medicaid doesn't pay for D. _____ below, you may have to pay. Medicare/Medicaid does not pay for everything, even some care that you or your health care provider may have good reason to think you need. We expect Medicare may not pay for the D. _____ below.

D.	E. Reason Medicare/Medicaid May Not Pay:	F. Estimated Cost
1. Exam: 99203-99204, 99211-99214	Statutorily Non-covered services	$25-$50
2. Spinal Adjustment: 98940-98942	Exceeds plan benefit/Statutorily NC	$30-$40
3. 97012-Manual Traction	Statutorily Non-covered services	$5
4. 97014-Electrical Stimulation	Statutorily Non-covered services	$5
5. Therapuetic Procedure: 97110, 97112	Statutorily Non-covered services	$26.00
6. Lumbar Belt	Statutorily Non-covered services	$20
7. SI Belt (s, m, l)	Statutorily Non-covered services	$14-$18
8. Deep Tissue Massage Therapy	Statutorily Non-covered services	$50-$60

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. _____ listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the D. _____ listed above. You may ask to be paid now, but I also want Medicare/Medicaid billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare/Medicaid doesn't pay, I am responsible for payment, but **I can appeal to Medicare/Medicaid** by following the directions on the MSN. If Medicare/Medicaid does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the D. _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare/Medicaid is not billed.**

☐ **OPTION 3.** I don't want the D. _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare/Mediciaid would pay.**

H. Additional Information: This ABN form is only for services never paid for by Medicare or Medicaid for Chiropractic physicians. The only reason for using Option 1 above is when you have secondary that *might* reimburse you.

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

2400 Niles Courtland Road, Warren, Ohio 44484 · Phone (330) 652 4222 Fax (330) 652-0574

Patient Name: _____

Patient Address: _____

Date of Birth: _____

HIPPA Release of Information Authorization Form

I hereby authorize the following person(s) with access to any and all Health Information contained in my medical records pertaining to patient relationship with Allied Pain Relief Clinic (APRC Inc.) or any affiliate referral, or transitioning care.

I authorize the release of information via phone or in person.

Authorized person(s):

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Patient signature: _____ Date: _____

Or Signature of patient's Representative: _____

Relationship: _____ Date: _____

Allied Pain Relief Clinics
2400 Niles-Cortland Rd S.E.; Warren, OH 44484 Ph: (330) 652-4222 Fax:(330) 652-0574

NOTICE OF PRIVACY PRACTICE--EFFECTIVE 02/01/2017
Security Officer: Todd MacGregor
Email: aprcrelief1@yahoo.com

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. If you have any questions, concerns or complaints you can contact the security office above.

Please review the following information carefully.

Your Rights. You have the right to the following: Get a copy of your paper or electronic medical record;Correct your paper or electronic medical record; Request confidential communication; Ask us to limit the information we share; Get a list of those with whom we've shared your information; Get a copy of this privacy notice; Choose someone to act for you; File a complaint if you believe your privacy rights have been violated.

Your Choices. You have some choices in the way that we use and share information as we: Tell family and friends about your condition; Provide disaster relief; Include you in a hospital directory; Provide mental health care; Market our services and sell your information; Raise funds.

Our Uses and Disclosures. We may use and share your information as we: Treat you; Run our organization; Bill for your services; Help with public health and safety issues; Do research; Comply with the law; Respond to organ and tissue donation requests; Work with a medical examiner or funeral director; Address workers' compensation, law enforcement, and other government requests; and Respond to lawsuits and legal actions

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Your Rights. When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

You can complain if you feel we have violated your rights by contacting us using the information on page 1. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775or at www.hhs.gov/ocr/privacy/hipaa/complaints/.

We will not retaliate against you for filing a complaint.

Your Choices. For certain health information, you can tell us your choices about what we share.
If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

Share information with your family, close friends, or others involved in your care; Share information in a disaster relief situation; Include your information in a hospital directory; If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

We never market or sell personal information. APRC periodically mails reminders and updates by way of postcard. You may tell us in writing if you prefer to receive this information in a sealed envelope.

Our Uses and Disclosures: How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.
For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as: Preventing disease; Helping with product recalls; Reporting adverse reactions to medications; Reporting suspected abuse, neglect, or domestic violence; Preventing or reducing a serious threat to anyone's health or safety.

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you: For workers' compensation claims; For law enforcement purposes or with a law enforcement official; With health oversight agencies for activities authorized by law; For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

- **We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.**