McKolosky Chiropractic
401 Theatre Drive
Johnstown, PA 15904
(814) 269-3116

Date: _____

Staff Name:_____

Patient Application Form

Patient Name:_____ Chief Complaint:_____

Address:_____ Date of Injury:_____

_____ Home Phone:_____

Date of Birth:_____Age:_____ Cell Phone:_____

Marital Status: M S W D Work Phone:_____

Referred By?:_____ Employer:_____

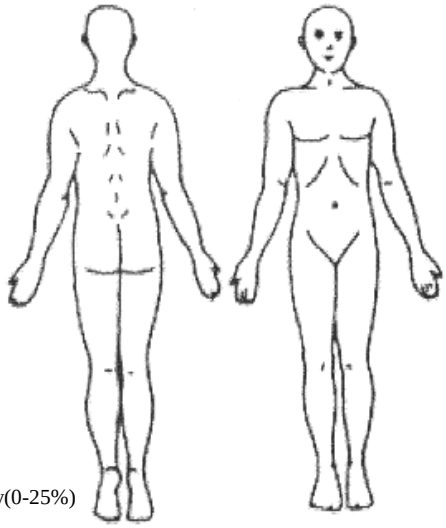
Insurance Company:_____ Occupation:_____

ID#:_____ Name of Insured:_____

Group #:_____ Insured DOB :_____

(Please fill in this section completely)

Mark with an "X" where you feel the pain



When did this Condition BEGIN? _____/_____/_____

Has it ever occurred before? □ Yes □ No. When? _____

Briefly describe your symptoms:_____

_____

How did your symptoms start?_____

_____

Is the Condition: □ Auto Related □ Job Related □ Home Injury

□ Slip or Fall □ Lifting □ Slept Wrong □ Unknown Cause □ Other

Average Pain Intensity:

Rest: No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Activity: No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

How often do you experience symptoms?

__ Constantly(76-100% of the time) __Frequently(51-75%) __Occasionally(26-50%) __Intermittently(0-25%)

How much have your symptoms interfered with your usual daily activities?

__ Not at all __A little bit __Moderately __Quite a bit __Extremely

Emergency Contact (Name, Phone #, and Relationship): _____

What operations have you had? _____When? _____

_____ When? _____

Serious Illness: _____ When? _____

_____ When? _____

Have you seen other doctors for THIS CONDITION? □ Yes □ No

If yes, Who? (Name) _____

Current Medication (s): **List ANY/ALL medications you are CURRENTLY taking. Be Specific.**

Medication	Dosage	For What Condition?	How long have you been taking this?

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 and convey directly to McKolosky Chiropractic 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 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

T e r m s o f A c c e p t a n c e

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 question please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic physician, 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 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 whatever 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 physician 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 Mckolosky Chiropractic, 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.

Women Only:

To the best of my knowledge I am / am NOT pregnant and (give my permission / don't give permission) to x-ray me for diagnostic interpretation.

(Circle one above) *(Circle one above)*

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: _____

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

I, _____, have read and fully understand the above statements.

Acknowledgement

I have received the notice of privacy practices (HIPPA) and have been provided an opportunity to discuss my right to privacy.

Print Name: _____

Signature: _____ Date: _____