

**Randall R. Shaffer, DC**  
1038 Kauffman Ave. Fairborn, OH 45324  
(p) (937) 878-8080 ~ (f) (937) 878-7072

Date: \_\_\_\_\_

**Confidential Patient Information**

Patients Name: \_\_\_\_\_ Chief Complaint: \_\_\_\_\_  
Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
City: \_\_\_\_\_ Zip: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
SS#: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Email: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Marital Status: M S W D  
Employer: \_\_\_\_\_ Gender M F (circle one)

Are your present systems or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) \_\_\_ Yes \_\_\_ No

**Front desk will take a copy of your insurance card**

*CMS requires providers to report both race and ethnicity*

Race (circle one) : American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)  
Native Hawaiian or Pacific Islander / I decline to specify

Ethnicity (circle one) : Hispanic or Latino / NOT Hispanic or Latino / I decline to specify

Preferred Language(circle one) : English Other \_\_\_\_\_

Smoking Status: Every Day Smoker/ Occasional/ Former / Never Smoked

I choose to decline receipt of my clinical summary after every visit (initial) \_\_\_\_\_  
(These summaries are often blank as a result of the nature and frequency of chiropractic care)

How were you referred to our office? \_\_\_\_\_

Have you ever been under chiropractic care? Y N If so, Who? \_\_\_\_\_

Have you had any SPINAL X-Rays / MRI's / CT's taken in the last year? Y N If so, where? \_\_\_\_\_

What operations have you had? \_\_\_\_\_ When? \_\_\_\_\_

Illnesses or Infectious Diseases: \_\_\_\_\_ When? \_\_\_\_\_

Do you have a pace maker? Y / N Have you ever had any Hip or Knee Replacements Y / N

What medications or drugs are you taking? (check those that apply): Pain Killers \_\_\_\_\_ Insulin \_\_\_\_\_  
Cholesterol Meds \_\_\_ Blood Pressure Meds \_\_\_ Muscle Relaxers \_\_\_ Birth Control \_\_\_ Other: \_\_\_\_\_

What is your goal in our office? \_\_\_\_\_

Family Physician: \_\_\_\_\_ (Note: May we send your health information to this provider Y / N)

Person to contact in case of emergency (Name and Phone): \_\_\_\_\_

**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 at clinic's request, and convey directly to Randall R. Shaffer, D.C., Inc. 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 hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. 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

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## Protecting Your Health Information

This regulation is part of the Health Insurance Portability and Accountability Act or HIPAA and does three primary things:

1. It helps standardize and simplify the way healthcare organizations exchange health care data.
2. It provides consumers with additional protections for getting and maintaining health insurance coverage although, it does not guarantee coverage.
3. It creates new security rules to ensure the safety and privacy of individual and medical records.

### Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. In addition, we have a policy in effect that makes every attempt to maintain the confidentiality of all patients' information.

### Disclosure of Medical Information

In addition to disclosing your medical information for treatment, payment and health care operations, we may disclose medical information for the following purposes: for a court order, subpoena, discovery request or other lawful process. We may disclose medical information to appropriate authorities if we reasonably believe that you are a victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose health information when authorized and necessary to comply with laws relating to worker's compensation, auto accidents, personal injury or other similar issues.

If someone calls or comes by, they will not be given any information about your care and/or appointments unless otherwise specified and noted in your file.

We will also be publicly noting your name in our newsletter and/or picture in our lobby unless otherwise specified. Upon becoming a patient, we will be entering your name and email into our database and you may receive our monthly newsletter. If you do not wish to receive our newsletters, please contact our office and advise the receptionist of such. This list will not be sold to any outside agencies.

### Your Rights

You have the right to look at or get copies of your medical records and to receive a list of all the times we shared your medical information for purposes other than treatment, payment and health care operations.

### Open Therapy Concept

Because of the open therapy concept in this office, it is possible for doctor/patient discussions to be overheard by other patients. Most discussions will involve spinal health, but may also include anything concerning the primary health care of that patient. Please inform doctor or staff if you wish to speak privately.

### Notification by Mail or Phone

Patients may be contacted by mail, email or phone unless written notification is requested that contact be only in person.

### Complaints

If you feel that your rights have been violated, contact the Office Manager or the U.S. Department of Health and Human Services.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**Terms of Acceptance**

In order to provide for the most effective healing environment, most effective application of chiropractic procedures, and the strongest possible doctor-patient relationship, it is our wish to provide each patient with a set of parameters and declarations that will facilitate the goal of optimum health through chiropractic.

To that end, we ask that you acknowledge the following points regarding chiropractic care and the services that are offered through this clinic:

- A. Chiropractic is a very specific science, authorized by law to address spinal health concerns and needs. Chiropractic is a separate and distinct science, art, and practice. It is not the practice of medicine.
- B. Chiropractic seeks to maximize the inherent healing power of the human body by restoring normal nerve functions through the adjustment of subluxation(s). Subluxations are deviations from the normal spinal structures and configurations that interfere with the normal nerve process.
- C. The chiropractic adjustment process, as defined in the law of this "jurisdiction" involves the application of a specific directional thrust to a region or regions of the spine with the specific intent of re-positioning misaligned spinal segments. This is a safe, effective procedure applied over one-million times each day by doctors of chiropractic in the United States alone.
- D. A thorough chiropractic examination and evaluation is part of the standard chiropractic procedure. The goal of this process is to identify any spinal health problems and chiropractic needs. If, during this process, any condition or question outside the scope of chiropractic is identified, you will receive a prompt referral to an appropriate provider or specialist, according to the initial indications of the need.
- E. Chiropractic does not seek to replace or compete with your medical, dental or other type(s) of health professionals. They retain responsibility for the care and management of medical conditions. We do not offer advice regarding treatment prescribed by others.
- F. Your compliance with care plans, home and self-care, etc. is essential to maximum healing and optimal health through chiropractic.
- G. We invite you to speak frankly to the doctor on any matter related to your care at this facility, its nature, duration or cost, in what we work to maintain as a supporting, open environment.

I, \_\_\_\_\_ have read and fully understand the above statements.  
(Print name)

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

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

# **Shaffer Chiropractic Clinic**

## **Cancelation/ No Show Policy**

We understand that you may need to cancel or reschedule an appointment and that emergencies happen. We do ask that if you are unable to make your appointment you give the office at minimum a 1 hour notice. If you no show or call with less than an hour notice more than 1 time you will be charged a \$20 fee. You have the option to call the office or if you receive our appointment reminders you may reply to the text message.

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Patient Signature/ Date