Synergy Medical
16705 Square Drive Marysville, Ohio 43040

Patient Name_____ **DOB:**_____ ▢ **Male** ▢ **Female**

Check appropriate box: ▢ Minor ▢ Single ▢ Married ▢ Divorced ▢ Widowed ▢ Separated

SS#/ SIN_____

Email_____ Home Phone_____ Cell Phone_____

Patient's Address_____ City_____ State_____ Zip_____

Employer Name_____

Spouse or Patients' Guardian Name_____ Spouse's Employer_____

How did you hear about us?_____

Emergency Contact_____ Phone_____

Responsible Party

Name of the person responsible for this account_____ Relationship to patient_____

Is the person currently a patient at our office? ▢ Yes ▢ No

Email_____ Home Phone_____ Cell Phone_____

Address_____ City_____ State_____ Zip_____

Driver's License # _____ Date of Birth_____

Do you have Medical Insurance? ▢ Yes ▢ No if yes, complete the following:

Name of the insured_____ Relationship to patient_____

Birthdate_____ SS#/SIN_____ Work Phone_____

Name of Employer_____

Employer Address_____ City_____ State_____ Zip_____

Insurance Company_____ ID #_____ Group #_____

Ins. Co. Address_____ City_____ State_____ Zip_____

In case of a medical emergency, if the patient is of school age 15+, it is ok to treat in my absence.

_____ _____

Parent or Guardian Date

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS Y PERSONAL REPRESENTATIVE
AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Synergy Medical, Doctor Charita Cooper, Doctor Patrick Cooper, Mackenzie MacKenzie CNP, and Lindsay West, CNP** as well as all employees, employers, representatives, and agents thereof (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that **have been or will be** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health Insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with the same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that the Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment and designation will remain in effect unless revoked by me in writing. It is my intent that the effective date of this document shall relate back to include all services, supplies, tests, treatments, or medications that have been previously provided by Healthcare Providers. A photocopy or scan or this document is to be considered as valid as the original.

Signed this_____ day of _____, 20_____.

X_____
(Patient signature)

X_____
(Signature of Guardian if applicable)

X_____
(Please print patient name)

Health History

Chief Complaint:_____

History of Present Illness:

Location:_____
(Where is the Pain/ Problem?)

Quality:_____
(Example: Normal vs abnormal color, activity, etc..)

Severity:_____
(How severe is the pain/problem on a scale of 1-10 severe?)

Duration:_____
(How long have you had this pain/ problem? being the most When did it start?)

Timing:_____
(Does the pain/problem occur at a specific time?)

Context:_____
(Where were you at the onset of this pain/problem?)

Associated Signs/Symptoms:_____
_____
_____
(What other associated problems have you been having?)

Modifying Factors:_____
(What makes the pain/problem worse or better? Have you had previous episodes?)

Past Medical History

Have you ever had the following: (Please check all that apply)

▢ Anemia	▢ Back Trouble	▢ Hepatitis
▢ Bladder Infection	▢ High Blood Pressure	▢ Ulcer
▢ Epilepsy	▢ Low Blood Pressure	▢ Kidney Disease
▢ Whooping Cough	▢ Migraine Headaches	▢ Hemorrhoids
▢ Scarlet Fever	▢ Tuberculosis	▢ Bleeding Tendency
▢ Diphtheria	▢ Diabetes	▢ Asthma
▢ Smallpox	▢ Cancer	▢ Hives or Eczema
▢ Pneumonia	▢ Polio	Date of Last Chest X-Ray_____
▢ Rheumatic Fever	▢ Glaucoma	*Any Other Disease, (Please List):*
▢ Arthritis	▢ Hernia	_____
▢ Venereal Disease	▢ Mitral Valve Prolepses	_____
▢Stroke Chronic Bronchitis		
▢ Infectious Mono AIDS & HIV		

Previous Hospitalizations/ Surgeries/Serious Illnesses	When?	Hospital, City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication: *(include non prescription)*

_____
_____

Drug Allergies:

_____
_____

Sleep:

Average length of sleep (hours):_____
How many pillows do you sleep with? 1 2 3 4
How has your mood been lately? _____

Does pain affect sleep? ▢ NO ▢ YES
Energy level: ▢ Low ▢ Moderate ▢ Adequate

Patient Social History:

Use of Alcohol: ▢ Never ▢ Rarely ▢ Moderate ▢ Daily
Use of Tobacco: ▢ Never ▢ Rarely ▢ Moderate ▢ Daily
Use of Drugs: ▢ Never Type/Frequency:_____
Excessive Exposure At home or at work to: ▢ Fumes ▢ Dust ▢ Solvents ▢ Airborne Particles ▢ Noise

Family Medical History:

	Age	Disease	If Deceased, Cause Of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Sibling's	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Indicate which of the below you have experienced in the last 1-2 months
1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes/Ears/Nose/Throat/Respiratory

Asthma	1 2 3 4 5
Stuffy Nose	1 2 3 4 5
Hay Fever	1 2 3 4 5
Itching	1 2 3 4 5
Chronic Cough	1 2 3 4 5
Chest Congestion	1 2 3 4 5
Shortness of Breath	1 2 3 4 5
Wheezing	1 2 3 4 5
Shoulder Pain	1 2 3 4 5
Hip Pain	1 2 3 4 5
Knee Pain	1 2 3 4 5
Ankle/Foot Pain	1 2 3 4 5
Pain b/t shoulder blades	1 2 3 4 5
Muscle Spasm	1 2 3 4 5

Muscular/Skeletal

Muscle Aches	1 2 3 4 5
Fibromyalgia	1 2 3 4 5
Arthritis	1 2 3 4 5
Joint Pain	1 2 3 4 5
Low Back Pain	1 2 3 4 5
Neck Pain	1 2 3 4 5
Wrist/Hand Pain	1 2 3 4 5
Elbow Pain	1 2 3 4 5

Neurological

Headaches	1 2 3 4 5
Migraines	1 2 3 4 5
Dizziness	1 2 3 4 5
Numbness	1 2 3 4 5
Tingling	1 2 3 4 5
Pins/needles in hands/feet	1 2 3 4 5
Recent Vision Changes	1 2 3 4 5
Loss of Consciousness	1 2 3 4 5
Forgetfulness	1 2 3 4 5
Insomnia/difficult sleeping	1 2 3 4 5

General

Fatigue	1 2 3 4 5
Malaise	1 2 3 4 5
Weakness, tiredness	1 2 3 4 5
Lightheadedness	1 2 3 4 5
Irritability	1 2 3 4 5
Constipation	1 2 3 4 5
Diarrhea	1 2 3 4 5
Feeling foggy	1 2 3 4 5

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of the Patient, Parent or Guardian *Date*

Provider's Review

_____ _____

Signature of Provider *Date*

CONSENT TO TREAT

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 below and if you have any questions, please feel free to ask.

AUTHORIZATION TO GIVE MEDICAL CARE-CONSENT TO TREATMENT:

I hereby voluntarily consent to outpatient care from Synergy Medical encompassing routine diagnostic procedures, physical examination, and medical treatment including (but not limited to) routine laboratory work and administration of medications prescribed by the providers (joint injections, PRP, trigger point injections, regenerative cell medicine). I further consent to the performance of those diagnostic procedures, examinations, and rendering of medical treatment by Synergy Medical's medical providers and staff, as is necessary in the medical staff's judgement. I understand that during the course of treatment, health care workers may be exposed to the patient's blood and/or body fluids increasing the risk of contracting Hepatitis B, Hepatitis C and/or HIV. In the event that exposure occurs, I understand the need for testing for these diseases and I agree to such testing of myself to promote the health and welfare of the healthcare worker. I understand that this consent will be valid and will remain in effect as long as I attend the clinic. Please see below for potential risks and side effects.

- Injection: increased pain or discomfort, infection, allergic reactions, numbness, trauma to nerves, fainting, soft tissue swelling, bruising, hematoma formation, collapsed lung, seizures, even remote risk of death or serious disability that exist with any surgical procedure.
- Blood Draw: increased pain or discomfort, infection, numbness, trauma to nerves, fainting, soft tissue swelling, bruising, or hematoma formation.
- Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations, and sprains.
- Therapeutic Modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.
- Radiographs: ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

Consent to Evaluate and Treat a Minor:

I, _____being the parent or legal guardian of _____, have read and fully understand the above terms and hereby grant permission for my child to receive treatment with Synergy Medical.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

[ ] No One [ ] Name/Relationship: _____ Phone: _____

May we leave messages regarding your personal healthcare information on an answering device, i.e. home answering machines or voicemails? Yes [ ] No [ ]

Acknowledgment

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Patient Print Name: _____Signature: _____ Date: _____

Witness Name Print: _____ Signature:_____ Date:_____

Women Only:

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

Synergy Medical
16705 Square Dr. Marysville, OH 43040
(937)642-4400 (p) ~ (937)642-4443 (f)

Protecting Your Health Information

New Regulation Passed

This new regulation is part of the Health Insurance Portability and Accountability Act or HIPPA 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 individuals 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 the 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 the 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 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 Adjusting Concept

Because of the open adjusting 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 include anything concerning the primary health care of that patient.

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.

Patient/Guardian Signature:_____Date:_____

Mackenzie MacKenzie, CNP ● Lindsay West, CNP ● Charita N.Cooper, DC CACCP ● Patrick S. Cooper, DC CCEP

When it comes to your health, chiropractors and medical doctors should be working together for your benefit!

I agree! I give you permission to inform my primary care physician of my condition, treatment and expected/actual response to care at this office.

Patient/Guardian Signature:_____

Name (Please Print):_____

Primary Care Physician:_____

Physician's Address/Phone:_____

_____