Welcome to Bell Chiropractic & Wellness Center LLC

You must fill out all of the enclosed forms completely prior to your first appointment. Incomplete paperwork will affect your visit with the doctor.

- **Intake form**
- **Consent form for Chiropractic Care**
- **Welcome Letter**
- **Policies form**

This information provides us with a comprehensive picture of your health status and a greater ability to address the health issues which concern you most.

Directions: BCWC is located across from the Dillionville shopping center at the intersection of Plainfield and Galbraith Rd. We are nestled in the heart of Dillionville. Our building is wheelchair accessible.

Parking: one handicap spot is located in the front of the building additional parking to the lot on the left and also across the street in the shopping center. We are accessible to the #4 bus route very convenient options.

Our philosophy: Our goal is to help you solve your health problems and promote a healthy lifestyle. We spend time with each patient treating them as an individual. We listen carefully to your health concerns, review your medical history and answer your questions about how chiropractic care can address your health problems. Together we will discuss a plan of action for you to reach your specified health needs. Please do not hesitate to communicate and ask any questions. We look forward to you trusting us with your health needs.

Chiropractic principles are the basis of our medicine:

- Trust in the body's inherent wisdom to heal itself.
- Look beyond the symptoms to the underlying cause.
- Utilize the most natural, least invasive and least toxic therapies.
- Educate patients in the steps to achieving and maintaining health.
- View the body in all its physical and spiritual dimensions. Prevention: Focus on overall health, wellness, and disease prevention.

Please sign and date below confirming that you have read and understood the content of this letter in its entirety

Signature_____ **Date**_____

BELL
CHIROPRACTIC & WELLNESS CENTER

Patient Intake Forms

Title Mr. /Mrs. / Ms./ Miss./ Dr. Other (circle one)

First_____ Middle_____ Last_____

Please Present ID

Nickname_____ Prefer to be called_____

Date of Birth ____/____/_____ Social Security Number _____-_____-_____

Needed for Insurance Purpose

Address_____ City_____, State_____

Street name Zip code_____

Home Phone (_____) _____-_____ Cell Phone (___) _____-_____ Carrier_____

Work Phone (_____) _____-_____ Email _____@_____.com

Sex: Male /Female (circle one) Marital Status: Single/Married/Divorce/Widow (circle one)

Employment Status: Employed/Unemployed/ Student/Retired (circle one)

Occupation _____ Employer_____

Emergency Contact First_____ Last_____ Relationship_____

Home/Cell Phone (___) _____-_____

How did you hear about our office? TV/Internet/Referral (circle one)

Is this your first visit to a chiropractor? Yes/No (circle one)

If no, when was your last visit? _____ Where_____

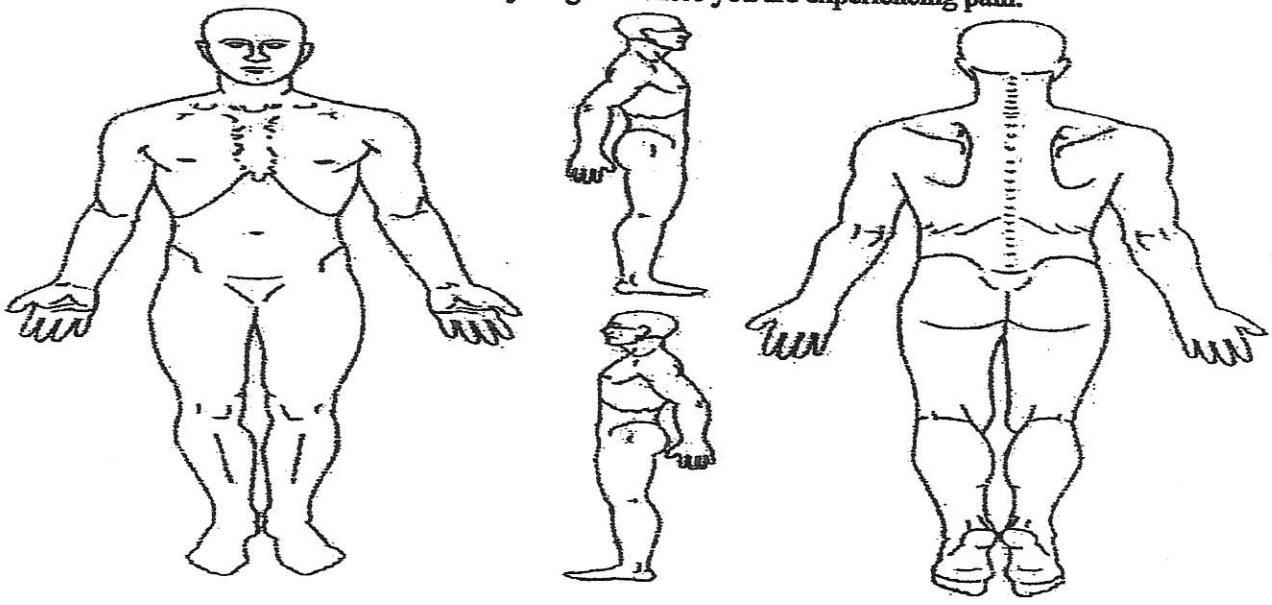
Is this visit: Personal Injury / Auto Injury (circle one)

Patient Name_____ Date_____

Are you pregnant? Yes_____ No _____N/A_____ How Far along are you

Are you aware of any prostate problems? Yes____ No_____

By using the key below, indicate on the body diagram where you are experiencing pain:



On average rating from 0-10, how much pain are you experiencing? 0 = no pain and 10 = the worst pain imaginable?

Please circle: 0 1 2 3 4 5 6 7 8 9 10

Describe your symptoms in order of severity, with worse symptom being #1 _____

_____#2_____

_____#3_____

_____

How are your symptoms changing? Not changing Getting better Getting worse

In your own words give a brief description of the accident: Time _____ Date _____

_____

_____

Were you wearing your seatbelt? Y/N Make /Model/ Year of your car _____, _____,

_____. Make/Model/Year of the car that hit you _____, _____, _____.

Where was the impact? F/R/LS/RS Were you the D/FP/RP/Ped State in which accident occurred OH/KY/IN

Have you been given an estimated amount of damages? Y/N, if so what was the estimate $_____ or was your car totaled out?

Scheduling: When making your initial New patient appointment please be advised that new appointments will not be made 30 minutes prior to close. When scheduling appointments please be advised that any and all copays are due at the time of service and will be applied to your co-pay/co-insurance.

Cancellation Policy: We require 24 hours' notice for cancelled appointment. A $45.00 fee will be applied for Missed appointments and No show appointments. The fee will be charged to your credit card on file for scheduled chiropractic appointments.

Please circle one: Visa MasterCard Discover
Card Number_____ **CVV #**_____
Expiration Date_____/_____
Cardholder_____
Signature_____

Your credit card will not be charged without notification. It is kept on file only to enforce the cancellation policy.

Insurance: We accept most insurances. As a courtesy, our office will bill your insurance company. It is your responsibility to call your insurance company in order to understand and verify your coverage. This information will aid the physician in using the preferred procedure as designated by your insurance company to avoid excess costs. Our office is unable to bill insurance without the proper information, you are responsible for payment at the time of service. You are responsible for any services and labs not covered by your insurance plan. Please call if you have any questions.

We strongly encourage you to mail or drop off the complete forms prior to your appointment.

Payment: Is due at the time of service. We accept Cash, Check, Visa or MasterCard, A $35.00 return check fee will be charged for any return checks

Phone Consultations: Phone calls greater than 10 minutes in length with the doctor will be subject to a $30.00 consultation charge. This fee is non-refundable and is not billable to insurance.

Emails: Emails to **BCWC** are not HIPPA compliant. Discussions concerning medical issues are best addressed in an office visit.

Please sign and date below confirming that you have read and understood the content of this letter in its entirety.

Signature_____ **Date**_____

Sincerely,

Bell Chiropractic & Wellness Center

Insurance Form

Insurance Information

Responsible for bill: Self/Spouse Health/Auto Insur. Medicaid/Medicare (circle one)

Insurance Carrier _____ Insurance ID#_____

Policy Holder First_____ Last_____ Group#_____

Policy Holder Date of Birth ____/____/___ Primary Care Physician _____

Policy Holder Social Security# ____-____-_____

Auto Injury

Have you filed a report with your insurance company? Yes/No

Date: ___/___/____ Time: ___ : ____ am/pm of Accident

Claim#_____ Are you using Med Pay? Yes/No

Adjuster Name _____ Adjuster Phone# (___) _____-_____

Adjuster Fax# (___) _____-_____

Was a report file with the police? Yes/No Where you wearing your seatbelt? Yes/No
Have you been seen anywhere else for this injury? Yes/no

Attorney Name _____ Frim Name_____

Attorney Phone# (___) _____-_____ Attorney Fax# (___) _____-_____

LIMITED POWER OF ATTORNEY (Only for Accident Cases)

I hereby grant Bell Chiropractic &Wellness Center, power to endorse my name upon payments received from my insurance company, who present payment for services rendered by Bell Chiropractic & Wellness Center. _____ initial

LIEN ASSIGNMENT (Only for Accident Cases)

If you're in need of treatment as a result of an accident, our office will work with you and your insurance and/or attorney to collect fees from the responsible party and/or the responsible party's insurance company. As the injured party you agree to be responsible for all charges with Bell Chiropractic & Wellness Center. You agree to assign the portion of any settlement or

judgment owed to our office for services obtained from the responsible party to Bell Chiropractic & Wellness Center. _____ initial

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This is a legal consent and assignment of benefits form. Please read it carefully. A photo static copy of this consent form shall be valid and may be used and relied upon with the same effect as the signed original.

Print Patient Name: _____ **DOB:** ____/____/_____

Patient or Guardian Signature: _____ **Date:** __/____/____

Witness: _____

I understand and agree that health & accident insurance policies are an arrangement between an insurance company & myself. Furthermore, I understand that Bell Chiropractic & Wellness Center will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Bell Chiropractic & Wellness Center will be credited to my account upon receipt. However, I clearly understand and agree that I am personally responsible for payment of all services rendered to me. I also understand that if I suspend or terminate care at this office, any outstanding charges for professional services rendered to me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this account. I authorize Bell Chiropractic & Wellness Center to obtain a credit report if deemed necessary.

Print Patient Name: _____ **DOB:** ___/___/____

Patient Signature _____ **Date**_____

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INFORMED CONSENT FORM

PATIENT NAME: First_____ Last_____ DATE:_____/____/_____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. In anything is unclear, please ask questions before you sign.

The nature of the chiropractic adjustment

One treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis I Examination I Treatment

As a part of the analysis examination and treatment, you are consenting to the chiropractic procedures.

The material risks inherent in chiropractic treatment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: muscle strain, cervical myelopathy, costovertebral strains and separations and burns. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Symptoms may increase and over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me[ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Bell and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Date: ____/____/____

_____	_____
Patient's Name	Doctor's Name
_____	_____
Signature	Signature
_____	
Signature of Parent or Guardian (if a minor)	

Bell Chiropractic & Wellness Center
Dr. Henry J. Bell Jr., DC

This information is confidential. If we do not believe your problem will respond favorably with chiropractic care, we will not accept your case and refer you to the proper medical professionals we believe will help you most. Please fill the form out completely, neatly, and accurately. Thank you!

BELL

CHIROPRACTIC & WELLNESS CENTER

4069 E. Galbraith Road, Cincinnati, Ohio 45236

513-841-1050 Phone 513-841-1052 Fax

I have received my Welcome Packet which contains a welcome letter, clinic policies, one (1) ice packet and two (2) sample packs of Bio-Freeze.

Signature_____ Date_____