PURE HEALTH INC.	Confidential Patient History

NEW PATIENT PROCEDURE OUTLINE:

STEP 1: ALL NEW PATIENTS ARE REQUESTED TO COMPLETE THE PERSONAL HEALTH HISTORY PRIOR TO THEIR APPOINTMENT
STEP 2: YOU WILL MEET WITH OUR PHYSICIAN TO DISCUSS THE CONDITION FOR WHICH YOU SEEK OUR ASSISTANCE
STEP 3: COMPREHENSIVE EXAMINATION TO DETERMINE IF OUR TREATMENT IS APPROPRIATE FOR YOUR CONDITION
STEP 4: YOU WILL BE ADVISED IF ADDITIONAL PROCEDURES (MRI, CT, NCV, BLOOD WORK, ETC…) ARE RECOMMENDED AND PROVIDED WITH THE NECESSARY ORDERS
STEP 5: SHOULD YOUR CASE REQUIRE IMMEDIATE ATTENTION, TREATMENT WILL BE ADMINISTERED
STEP 6: YOU WILL BE SCHEDULED FOR A FOLLOW UP VISIT (REPORT OF FINDINGS- USUALLY THE FOLLOWING DAY) TO REVIEW THE DOCTOR'S EXAMINATION RESULTS AND WHETHER YOUR CASE HAS BEEN ACCEPTED. ADDITIONALLY, YOU WILL BE INFORMED OF SPECIFIC RECOMMENDATIONS REGARDING YOUR PRESENTING CONDITION.
STEP 7: SHOULD THE DOCTOR ACCEPT YOUR CASE, YOUR TREATMENT PLAN WILL BEGIN FOLLOWING YOUR REPORT OF FINDINGS. HOWEVER, IF THE DOCTOR DOES NOT FEEL YOUR CONDITION IS AMENABLE TO HER TREATMENT, THE PROPER REFERRAL WILL BE PROVIDED.

WELCOME TO OUR PRACTICE

THANK YOU FOR CHOOSING OUR OFFICE! IN ORDER TO SERVE YOU PROPERLY, WE REQUIRE THE FOLLOWING INFORMATION. PLEASE PRINT LEGIBLY. IN ACCORDANCE WITH FEDERAL & STATE HIPPA REQUIREMENTS ALL INFORMATION PROVIDED IS CONFIDENTIAL.

Date:_____/_____/_____ Office Use Only:
Patient ID Number:________________________

Patient's Full Name ____

Home Phone: ______________________ Cell Phone: _____________________ E-Mail: ____________________________________

☐ Male ☐ Female Age:____________ Date of Birth:_____/____/______ Social Security # ________ - ________ - ________

Mailing Address:____ City:________________ State:_______ Zip: _____________

☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced Number of Children/Ages ______________________________

Occupation:___________________ Hours/Week_______ Employer:_________________________ Business Phone__________________

Spouse's Name:___________________________ Employer:________________________________ Business Phone_________________

Emergency Contact:____________________________________ Relationship:____________________ Phone: ______________________

Address:____ City:_____________________ State:______________ Zip: _____________

Family Physician: ______________________________ City: ________________________ State:___________ Phone________________

Payment Method: ☐ Cash ☐ Check ☐ MasterCard/Visa ☐ Insurance Do You Have Health Insurance? ______________________

Primary Insurance Company____ Insured's Name_______________________________

Insured's Date of Birth ___/___/___ Insured's Social Security #_______-________-________

ID#_____________________________________ Group#____________________________________

Secondary Insurance Company____ Insured's Name________________________________

ID#_____________________________________ Group#______________________________________

PURE HEALTH INC. **Confidential Patient History**

Referred By:____

Is Today's Visit Due To A Work Related Injury: ☐ Yes ☐ No
Is Today's Visit Due To A Personal Injury or Auto Accident: ☐ Yes ☐ No
(If yes to either questions above, please check with receptionist, additional information is needed)

Date Of Injury:_______________________

YOUR EXPECTATIONS OF US

PATIENTS SEEK CARE FOR A VARIETY OF REASONS. SOME GO FOR SYMPTOMATIC RELIEF OF PAIN OR DISCOMFORT (RELIEF CARE). OTHERS ARE INTERESTED IN HAVING THE CAUSE OF THE PROBLEM, AS WELL AS THE SYMPTOMS CORRECTED AND RELIEVED TO AVOID FUTURE RELAPSES (CORRECTIVE CARE). STILL OTHERS WANT WHATEVER IS "MALFUNCTIONING" IN THEIR BODIES BROUGHT TO THE HIGHEST STATE OF HEALTH POSSIBLE IN ORDER TO OPTIMIZE THEIR PHYSICAL AND EMOTIONAL WELLBEING (COMPREHENSIVE CARE). OUR OFFICE OFFERS SOME OF THE LATEST ADVANCED PROCEDURES FOR OPTIMIZING YOUR NERVOUS SYSTEM FUNCTION.

ADDITIONALLY, OUR OFFICE STRESSES THAT IT IS YOUR HEALTH AND "YOUR CHOICE" TO DECIDE WHICH TYPE OF CARE YOU WISH TO RECEIVE. OUR DOCTORS WILL WEIGH YOUR NEEDS AND DESIRES WHEN RECOMMENDING YOUR TREATMENT PROGRAM. PLEASE CHECK THE TYPE OF CARE YOU WISH TO RECEIVE.

☐ RELIEF CARE ☐ CORRECTIVE CARE ☐ COMPREHENSIVE CARE ☐ WOULD LIKE TO DISCUSS OPTIONS WITH DOCTOR

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release **any information** you deem appropriate concerning my physical or emotional condition and/or health history to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the **direct payment to you** of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services **refuses to make such payment** upon demand by you , I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. However, it is understood that after all reasonable efforts have been made to collect the sums due from the insurance company, or companies, contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what was due, I personally owe you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this state of Ohio.
5. I further agree that this Authorization and Assignment is irrevocable until all moneys owed Pure Health Inc. are paid.

Patient Signature_______________________________________ Date____________________
(Signature of Parent or Guardian if a minor)

AUTHORIZATION & RELEASE: TO THE BEST OF MY KNOWLEDGE, THE QUESTIONS ON THESE FORMS HAVE BEEN ANSWERED ACCURATELY AND COMPLETELY. I UNDERSTAND THAT PROVIDING INCORRECT OR INCOMPLETE 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 PROVIDER AND STAFF TO PERFORM THE NECESSARY SERVICES I MAY NEED.

______________________________________ ________________________

SIGNATURE OF PATIENT (PARENT/GUARDIAN) DATE