



Welcome to Bell Chiropractic & Wellness Center LLC

You must fill out the enclosed forms completely prior to your first appointment if possible. Incomplete paperwork will affect your visit with the physician.

The following documents provide us with a comprehensive picture of your health status and a greater ability to address the health issues which concern you most.

- Intake form
- Consent form for Chiropractic Care
- Welcome Letter
- Policy form

Directions: BCWC is conveniently located across from the Dillonvale shopping center at the intersection of Plainfield and Galbraith Rd. We are nestled in the heart of Deer Park, Ohio. Our building is wheelchair accessible.

Parking: One handicap parking spot is available in the front of the building along with additional parking located on the left of the building. Please do not park in the cleaners parking lot because he will tow you.

Our Philophy: Our goal at BCWC 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 listened 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 specific health needs. Please do not hesitate to communicate and ask questions. We look forward to your 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 the patients in the steps to achieving and maintaining health.
 - * View the body in all its physical and spiritual dimensions.
- Preventions: Focus on overall health, wellness, and disease prevention.

Please sign and date below confirming that you have read and understand the consent of this document in its entirety.

Signature_____ Today's Date:_____

PATIENT INTAKE FORM

Please Present ID

Title: Mr./Mrs./Ms./Miss/Dr. Other (Circle One)

First _____ M. _____ Last _____

Nickname/Name Preferred to be called _____

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

Street Address _____

City _____, State _____ Zip _____

Home Phone () _____ - _____ Cell phone () _____ - _____

Work Phone () _____ - _____

Email Address: _____ @ gmail @ yahoo @.net @.org other

Sex: Male/Female (circle one)

Marital Status: Single/Married/Divorced/Widow (circle one)

Employer Name: _____ City: _____

Occupation: _____

Emergency Contact: First Name: _____ Last Name: _____

Relationship to you: _____

Home/Cell Phone: _____

How did you hear about us: Bus/TV/Internet/Referral (circle one) _____

Patient Name: _____ Date: _____

Is this your first Chiropractic visit: _____

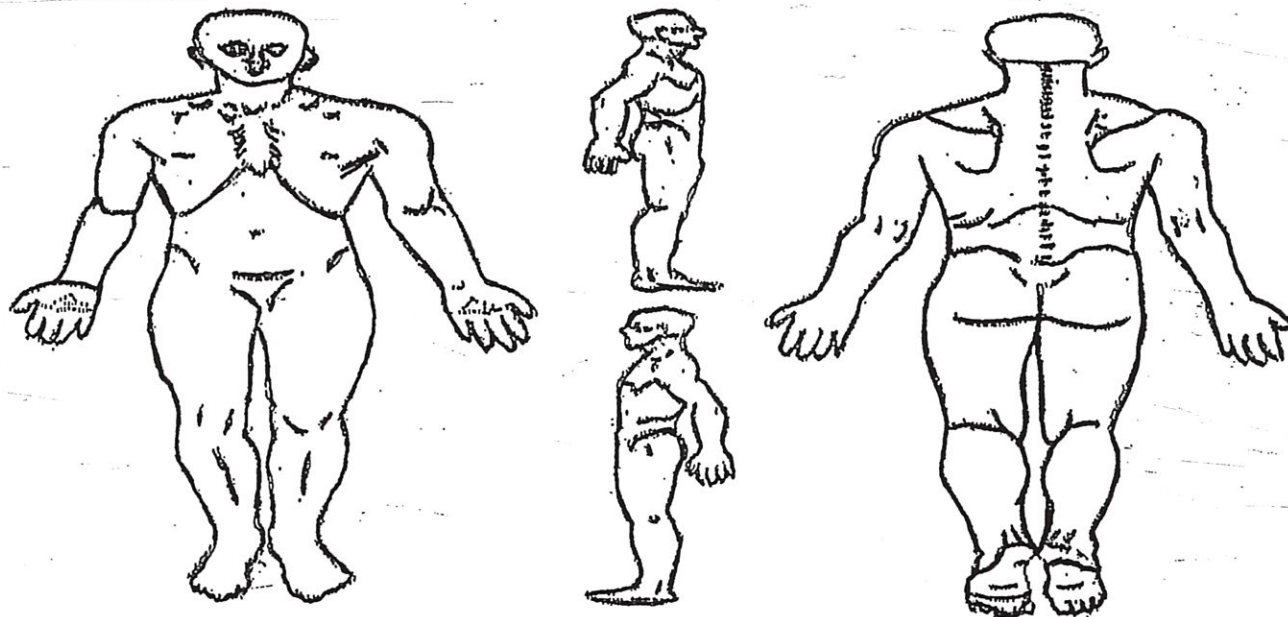
If no, when was your last visit? _____

Where? _____

Are you pregnant? Yes _____ No _____ 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 being the worst pain imaginable

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

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

#1. _____

#2. _____

#3. _____

How are your symptoms changing? Not changing/Getting better/Getting worse (circle one)

Personal injury Auto Cases

Please fill form out completely

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

Date: _____ Time: _____ Were you at fault? Yes/No

Were you wearing your seat belt? Y/N

Make/Model/Year of your car

_____/_____/_____

Where was the impact Front/Rear/Left Side/Right Side?

Were you the Driver/Front Passenger/Right Passenger/Pedestrian

State in which the accident occurred OH/KY/IN

Have you been given an estimate amount for damages? Yes/No

If so, what was the estimate \$ _____

If no, was your car totaled out? Yes/No

Bell Chiropractic & Wellness Center
Dr. Henry J. Bell Jr. D.C.
Clinic Director

Scheduling Appointments: When making your appointment(s) please be advised that new appointments will not be made 45 minutes prior to close. When scheduling appointments please be advised that all copays are due at the time of service and will be applied to your co-pay/co-insurance.

Cancellation Policy: Our office does require 24 hours notice for cancellation of any appointment. A \$ 35.00 will be applied for any 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 Code (Back of Card) _____

Expiration Date: _____ / _____

Cardholder's Name: _____

Your credit card will not be charged without notification. It is kept on file only if you would like us to bill your card for your visit. Or for a cancellation fee.

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

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

Payments: Payment is due at the time of service. We accept Cash, Check, Visa, Mastercard, Discover, and American Express.

Phone Consultations: Phone consultations greater than 10 minutes in length with the physician will be subject for a \$60.00 consultation charge.

Emails: Emails to BCWC are not HIPAA compliant. Discussing concerning medical issues are best addressed during an office visit.

Please sign and date confirming that you have read and understand the content of this document in its entirety.

Signature: _____ Date: _____

Insurance Information

Responsible Party for Bill: Self/Spouse/Health Insurance/Auto Insurance/Medicaid/Medicare (circle one)

Insurance Carrier: _____ Insurance ID# _____

Policy Holder Information

Policy Holder First Name: _____ Last Name: _____

Policy Holder Date of Birth: _____ Primary Care Physician: _____

Policy Holder Social Security # _____ - _____ - _____

Auto Injury Case

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

Date: _____ Time: _____ am/pm of Accident

Insurance Company: _____

Claim Filed with Insurance Company: _____

Claim # _____

Are you using Med Pay? Yes/No

Claim Adjuster Name: _____ Adjuster Phone #: _____

Claim Adjuster Fax #: _____

Police Report Filed: Yes/No (circle one)

Were you wearing a seat belt? Yes/No (circle one)

Have you treated with another Chiropractor in the last 6 months? Yes/No (circle one)

Have you been seen anywhere else for this accident? Yes/No (circle one)

Limited Power of Attorney (Only for Accident Cases)

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

This is a legal consent and assignment of benefits form. Please read it carefully. A photo static copy of this consent form will be valid and may be used and relied upon with the same effects 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 and 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: _____

Patient DOB: ____/____/____

Patient or Guardian Signature: _____

Date: _____

Date: _____



INFORMED CONSENT FORM

Patient's First Name: _____ Last Name: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Should you have any questions or if anything is unclear, please do not hesitate to ask.

The nature of 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/Examination/Treatment

As part of the analysis examination and treatment, you are consenting to 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 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 relaxers, and pain killers
- ▶ Hospitalization
- ▶ Surgery

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

The risks and dangers of non treatment can result in further progression. Additional scar tissue that can limit range of motion. Increase pain cycle and can lead to dysfunction to where invasive procedures may need to be performed. Which can consist of injections, opioids, and or surgeries.

Date: ____/____/____

Patient's Name: _____ Physician's Name: Dr. Henry J. Bell Jr. D.C.

Patient's Signature: _____ Physician's Signature _____

Signature of Parent of Guardian: _____
(if patient is a minor)

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Injury Claim Notification

If you are being seen today due to an injury that was within the last 2 years this form must be read, signed and completed before seeing the physician. **Even if you are not being seen today for any type of injury claim this form must be read, signed and completed.** If this injury took place at work, we are not in network with Workman's Compensation. This office does not do any type of Workman's Compensation claims. Our office does provide injury evaluations should you need one. An injury appointment request form must be completed prior to seeing the physician. Please ask the staff for a form. The fee structure varies depending on the complexity of the injury.

Please initial below that you understand what you have read.

☐ I understand that Bell Chiropractic & Wellness Center is not a provider for Workman's Compensation.

☐ I understand that Bell Chiropractic & Wellness Center cannot submit any paperwork to Workman's Compensation on my behalf.

☐ I understand that I am stating that I have not had any work related injuries in the last **2 years reported or not reported.**

☐ I understand that if I need an injury evaluation that I must call the office and request a separate appointment **specifically for an injury evaluation. Once my appointment is scheduled I must pay the fee for my appointment prior to being seen.**

☐ I understand that I must request an injury evaluation prior to seeing the treating physician.

☐ I understand that injury evaluations by the treating physician are not provided on the same day as a scheduled treatment day. A separate date will be provided to me when I make my appointment.

Today's Date: _____

Patient's Printed Name: _____

Patient's Signature: _____

Witness: _____

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Clinic Director**

This form must be signed by the patient prior to treatment

This office does provide Disability Evaluations. This is done after the patient has been under the treating physician at Bell Chiropractic & Wellness Center for a minimum of 9 months. Any disability evaluation that requires an evaluation report and or research there is an **upfront fee of \$795.00**. The fee must be paid before any paperwork has been initiated by the physician or reports released to the patient and or requesting party. **Payment of this fee does not guarantee a Disability diagnosis.**

Patient's Name: _____

Patient's Signature: _____

Today's Date: _____

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Welcome Packet

A Welcome Packet will be given to you at the end of your visit. This packet will include an ice pack with icing instructions and a sample of Stop Pain. Stop Pain is a topical cooling pain relieving gel that can be applied to the skin to temporarily ease minor aches and pains.

Signature: _____

Date: _____

Bell Chiropractic & Wellness Center
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