Dr. J. Scott Gillis, *Chiropractic Physician*
Meritra Clinics LLC.
103 Commerce Park Dr. Suite A
Westerville, OH 43082
Phone: 614-818-0000 Fax: 614-818-0011

New Patient Form

Please present valid identification and your insurance card to the receptionist. All questions contained in this questionnaire are strictly confidential and will become a part of your medical record.

Patient Demographics

Today's Date: ____

Patient Name: ____ ☐ Male ☐ Female

What you prefer to be called: ____

DOB: __________________________ Age: _________ SSN: ________________________________

Home Address: ____

Street

____

City *State* *Zip Code*

Phone Number: __________________________ Work Number: ______________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse's Name: ____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Occupation: ____

Place of Employment: ____

How did you hear about us? ☐ Referred by (Name): ____

☐ Other: ____

Insurance Information

Insurance Company: ____

Insurance Phone Number: ____

Insurance Billing Address: ____

Street *City* *State* *Zip Code*

☐ Check if Patient is Subscriber. If not, Subscriber Name: ____________________________________

Subscriber DOB: __________________________ Relation to Patient: ___________________________

Policy Number: ____________________________ Group Number: ____________________________

Reason for Visit

Have you ever been treated by a chiropractor before? ☐ Yes ☐ No

If so, please explain when and why: ____

The reason for this visit is a result of: ☐ Work ☐ Sports ☐ Auto ☐ Trauma ☐ Chronic

Explain what happened:

____

____

Describe the pain and the location: ____

When did the condition begin? ____

Is the condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and Goes

Is the condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine

Have you had this or similar conditions in the past? ☐ Yes ☐ No

If yes, please explain: ____

Have you been treated by a Medical Physician for this condition? ☐ Yes ☐ No

Indicate your degree of comfort while performing the following activities:

Activity	Comfortable	Uncomfortable	Painful (even if only sometimes)
Lying on Back	☐	☐	☐
Lying on Side	☐	☐	☐
Lying on Stomach	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Stretching	☐	☐	☐
Walking	☐	☐	☐
Running	☐	☐	☐
Sports	☐	☐	☐
Working	☐	☐	☐
Lifting	☐	☐	☐
Bending	☐	☐	☐
Kneeling	☐	☐	☐
Pulling	☐	☐	☐
Reaching	☐	☐	☐

How many hours are in your normal workday? ____

Please indicate any physical activity you are required to perform:

☐ Standing	☐ Twisting	☐ Lifting
☐ Sitting	☐ Typing	☐ Working w/ arms above head
☐ Crawling	☐ Stooping	Others:
☐ Bending	☐ Operating Equipment	☐
☐ Driving	☐ Walking	☐

Do you work with others that can help with heavy lifting? ☐ Yes ☐ No ☐ N/A

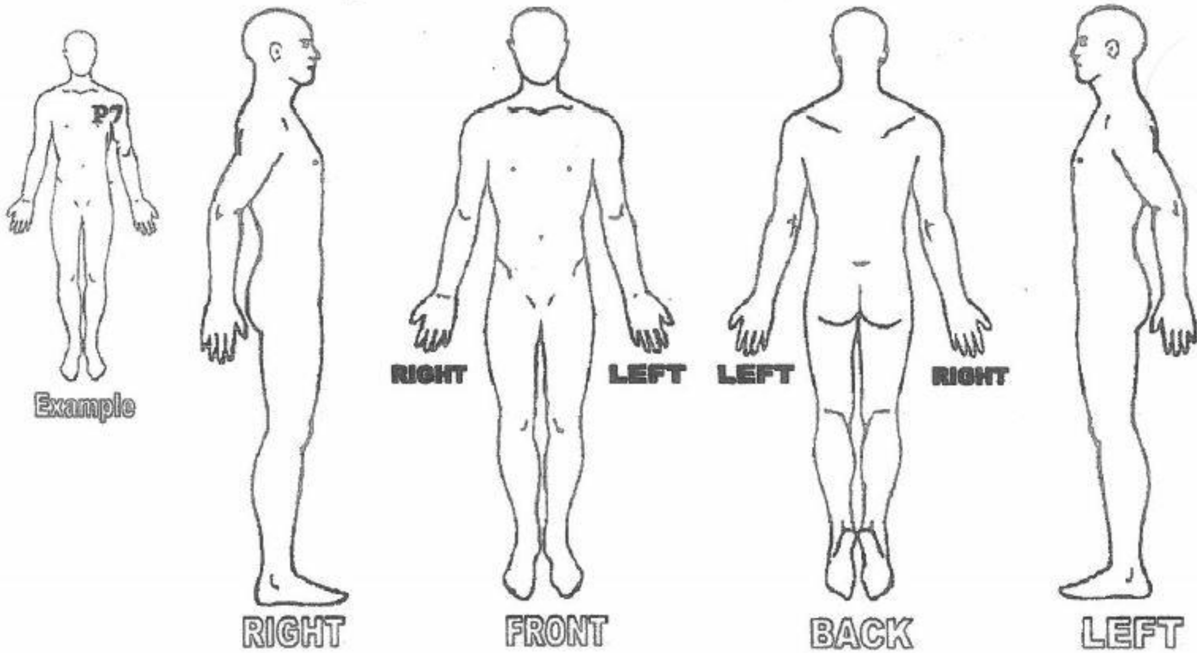
Is there any light duty work you could request? ☐ Yes ☐ No ☐ N/A

SHOW US WHERE IT HURTS

Please mark area(s) of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

Description →	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol →	(N)	(P)	(B)	(A)	(S)

(X) Circle any area of pain not represented by a symbol.



Patient Remarks:

____

____

Doctor's Remarks:

____

____

____

____

____

Patient Health History

Patient Height: ________________________________ Weight: ___________________________________

Are you taking any of the following medications? ☐ Nerve Pills ☐ Pain Killers (Including Aspirin) ☐ Muscle Relaxers ☐ Stimulants ☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Other: __________________________

Have you ever had any of the following diseases/medical condition(s)?

☐ Heart Attack/Stroke	☐ Pacemaker	☐ Heart Murmur
☐ Congenital Heart Disease	☐ Mitral Valve Prolapse	☐ Artificial Valves
☐ Alcohol/Drug Abuse	☐ STD	☐ Hepatitis
☐ HIV+/AIDS	☐ Shingles	☐ Cancer
☐ Frequent Neck Pain	☐ Emphysema/Glaucoma	☐ Anemia
☐ High/Low Blood Pressure	☐ Psychiatric Problems	☐ Rheumatic Fever
☐ Severe/Frequent Headaches	☐ Kidney Problems	☐ Ulcers/Colitis
☐ Fainting/Seizures/Epilepsy	☐ Sinus Problems	☐ Asthma
☐ Diabetes/Tuberculosis	☐ Difficulty Breathing	☐ Chemotherapy
☐ Lower Back Problems	☐ Artificial Bones/Joints	☐ Arthritis

Please list any other serious medical condition(s) you have or ever had:

____

____

Please list anything you may be allergic to:

____

____

Please list any previous surgeries/treatments with dates:

____

____

Please list any past serious accidents with dates:

____

____

Do you smoke: ☐ Yes ☐ No How Much? ____________________ How Long? ____________________

Are you wearing any of the following? ☐ Heels ☐ Lifts ☐ Sole lifts ☐ Inner Soles ☐ Arch Supports

For Women: Are you taking Birth Control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No How Long? ________________________

Worker's Compensation Case Patients

Claim Number: ______________________________ Employer Name: ________________________________

Employer Address: ____

Street *City* *State* *Zip Code*

MCO Name: ____

MCO Address: ____

Street *City* *State* *Zip Code*

MCO Phone: ____________________________________ Fax: _______________________________________

MCO Case Manager Name: ____

Date of Accident: _________________________ Time of Accident: _________________________________

Was your accident directly related to your work? ☐ Yes ☐ No

Briefly describe the events that occurred just before and during your accident:

____

____

Give the address where the accident occurred (if different from Employer Address):

____

____

Was anyone else present during your accident? ☐ Yes ☐ No

Did you report the accident to your employer? ☐ Yes ☐ No

What recommendations did your employer make just after your accident?

____

____

Has this type of accident happened to you before? ☐ Yes ☐ No

To the best of your knowledge, has this accident occurred in your workplace before? ☐ Yes ☐ No

In general: ☐ Yes ☐ No

Is your job physically stressful? ☐ Yes ☐ No

Is your job mentally stressful? ☐ Yes ☐ No

Is your workplace noisy? ☐ Yes ☐ No

Have you changed jobs in the last year? ☐ Yes ☐ No

Personal Injury Case Patients

Patient Claim Number: ____________________________ Auto Insurance: __________________________
Auto Policy Number: ____
Insurance Address: ____
Street *City* *State* *Zip Code*
Insurance Phone: _______________________________ Fax: _____________________________________
Agent's Name: ____
Attorney's Name: ____
Attorney Phone: ________________________________ Fax: _____________________________________

Liable Party Auto Insurance: ____
Auto Policy Number: ____
Insurance Address: ____
Street *City* *State* *Zip Code*
Insurance Phone: _______________________________ Fax: _____________________________________
Agent's Name: ____

Date of Accident: _________________________ Time of Accident: _________________________________
Location of Accident: ____
Were you the: ☐ Driver ☐ Pedestrian ☐Front Passenger ☐ Rear Passenger
Make & Model of the vehicle you were occupying? ____
What did your vehicle impact? ☐ Another vehicle ☐ Other: _____________________________________
If another vehicle, what was its make and model? ____
Did the police come to the accident site? ☐ Yes ☐ No
Were there any witnesses? ☐ Yes ☐ No
Were you wearing a seatbelt? ☐ Yes ☐ No
Was the vehicle equipped with airbags? ☐ Yes ☐ No
If yes, did it/they inflate? ☐ Yes ☐ No
In relation to the base of your skull, where was the headrest? ☐ Above ☐ Below ☐ At the Base of Skull
Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No
If yes, please describe: ____
In which direction were you headed? ☐ N ☐ S ☐ E ☐ W
What was the approx. speed of your vehicle? ____
In which direction was the other vehicle headed? ☐ N ☐ S ☐ E ☐ W
What was the approx. speed of the other vehicle? ____
Did the impact to your vehicle come from the: ☐ Left Side ☐ Right Side ☐ Front ☐ Rear ☐ Other
During impact, were you facing: ☐ Right ☐ Left ☐ Forward
Were you aware or surprised by the impact? ☐ Aware ☐ Surprised
In your words, please describe the accident?
____
____
Did the accident render you unconscious? ☐ Yes ☐ No
If so, for how long? ____

Please describe how you felt immediately after the accident:

____

____

Have you gone to a Hospital or seen any doctor? ☐ Yes ☐ No

When did you go? ☐ Just after the Accident ☐ the next day ☐ 2 days plus

How did you get there? ☐ Ambulance ☐ Private Transportation

Name of Hospital and/or attending doctor: ____

Describe any treatment you received: ____

Were X-Rays taken? ☐ Yes ☐ No

Was medication prescribed? ☐ Yes ☐ No

Have you been able to work since this injury? ☐ Yes ☐ No

Are your work activities restricted since this injury? ☐ Yes ☐ No

Indicate the symptoms that are a result of this accident:

☐ Dizziness	☐ Upset Stomach	☐ Numb Hands
☐ Nausea	☐ Difficulty Sleeping	☐ Blurred Vision
☐ Arm Pain	☐ Memory Loss	☐ Back Stiffness
☐ Numb Fingers	☐ Shoulder Pain	☐ Neck Stiffness
☐ Neck Pain	☐ Fatigue	Other:
☐ Tension	☐ Chest Pain	☐
☐ Severe/Frequent Headaches	☐ Numb Feet/Toes	☐
☐ Buzzing/Ringing in Ears	☐ Jaw problems	☐
☐ Leg Pain	☐ Difficulty Breathing	☐
☐ Lower Back Pain	☐ Irritability	☐

Is your condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and Goes

Medicare Patients

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** ____________ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** ____________ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Chiropractic Exam **X-Rays** **Modalities** **Supports**	**Non-Covered Services**	**$25 / $50** **$40 to $150** **$15 to $30** **$10 to $95**

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** ____________ listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** ____________ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** ____________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.** ____________ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

I. Patient Consent Form

I authorize Meritra Clinics LLC to release any medical or other information that may be necessary to process medical claims on my behalf to related physicians, rehabilitation counselors, social workers, insurance carriers, or attorneys.

I authorize Meritra Clinics LLC to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

II. Financial Responsibility / Assignment of Benefits

I understand that I am responsible for paying my co-payments and deductibles at the time of service. I also understand that I am responsible for any balance due after payment by my insurance company.

I, the undersigned, understand that Meritra Clinics LLC will bill my insurance company for services rendered upon verification of coverage by my insurance company. If my insurance company fails to render payment for services rendered, I hereby personally guarantee payment for medical care and services rendered. If your insurance company does not remit payment within 60 days, the balance will be due in full from you.

I hereby request that my insurance carrier make payment directly to Meritra Clinics LLC for all services rendered by this facility. If my current policy prohibits direct payment to Meritra Clinics LLC, I hereby instruct and direct my insurance company to make the check out in my name but send the check to the listed address of Meritra Clinics LLC.

If my insurance carrier makes a payment to me I agree to immediately pay over these funds to Meritra Clinics LLC. I also authorize Meritra Clinics LLC to deposit checks received on my account when made out to me.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

Charges related to Worker’s Compensation injury shall be forwarded to the Worker’s Compensation Insurance carrier. However, be advised if you claim Worker’s Compensation benefits and are subsequently denied such benefits, you will be held responsible for the total amount of charges for services rendered to you.

Charges related to Personal Injury shall be forwarded to my attorney, or my car insurance carrier for payment. However, be advised that if your Personal Injury Claim is denied you will be held responsible. I direct all payments from my insurance carrier/attorney to pay directly to Meritra Clinics LLC for services rendered. Upon settlement of my personal injury claim, Meritra Clinics LLC will be paid or I assume all responsibilities on my account.

I, the undersigned, acknowledge that by signing this form authorize Meritra Clinics to submit my charges via mail or internet to my insurance carrier. This is a “Signature on File” authorization.

Patient recognizes that Policy quotes are not a guarantee of payment by carrier and the patient is responsible for obtaining actual Policy benefits, limits from the carrier and if needed any referrals from primary care physicians or pre-authorization for chiropractic treatment. Patients are responsible to confirm referrals/pre-authorization with insurance. All referrals or recommendations from our office have no confirmation of payment or benefits to referring provides.

I authorize my healthcare provider and/or entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging or other electronic communication to contact me for any reason by any telephone number, email address and/or mailing address provided. I authorize all my numbers that I have provided to the office in my file able to accept phone and/or text messages. I authorize stating a detailed message to all phone numbers I have given Meritra Clinics LLC.

List of prices (subject to change):

Chiropractic Adjustment: $55.00	Therapy: $35.00/each
Examinations: $55.00/$130.00	X-Rays: $35.00-$100.00 each

Please see receptionist for a complete list of office charges. The above only references the most commonly used treatment.

The patient, legal guardian or parent (if patient is under 18 years old) will be responsible for the co-payment and the deductible that the time of service.

III. Acknowledgment of Receipt of Notice of Privacy Practices

I certify that I was offered a copy of Meritra Clinics LLC's Notice of Privacy Practices. The Notice of Privacy Practices describes the types and uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Meritra Clinics LLC's health care operations. The Notice of Privacy Practices also describes my rights and Meritra Clinics LLC's duties with respect to my protected health information. The Notice of Privacy Practices is also posted in the reception area.

Meritra Clinics LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I, the undersigned, state that I have read Sections I, II, and III, and agree to the terms and conditions set forth.

____	____
Patient Signature	*Date*
____	____
(Or) Guardian Signature	*Date*
____	____
Physician Signature	*Date*