

# Dr. Danielle R. Rice

-----Worthington Family Chiropractic-----

## CONFIDENTIAL PATIENT INFORMATION

Please complete this questionnaire and the following forms. Your answers will help us determine if our care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. This information will also help us to get to know you as a person and will help us determine how we can best meet your needs.

Name \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

How do you wish to be addressed in our office?  First name  Dr.  Mr.  Mrs.  Miss.  Ms.

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

E-Mail Address \_\_\_\_\_ Age \_\_\_\_\_ Birthday \_\_\_\_\_ Marital Status: M S D W

Employer \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Employer \_\_\_\_\_

Number of Children \_\_\_\_\_ How did you learn about our office? \_\_\_\_\_

Name of nearest relative not living with you \_\_\_\_\_

Name: \_\_\_\_\_ Phone \_\_\_\_\_

Health Information: Family Physician \_\_\_\_\_ Dentist \_\_\_\_\_

Other (massage therapist, etc.) \_\_\_\_\_

### YOUR PRESENT COMPLAINT(S):

List other Doctors seen for this condition:

Personal Medical history (if any of the following are relevant to your medical history, please check box)

- |  |   |  |  |                                      |
|--|---|--|--|--------------------------------------|
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Polio       |
| <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Scarlet Fever      | <input type="checkbox"/> Sinus Trouble   | <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Nervousness         | <input type="checkbox"/> Backaches          | <input type="checkbox"/> Arthritis       | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Asthma      |
| <input type="checkbox"/> Numbness            | <input type="checkbox"/> Heart Trouble      | <input type="checkbox"/> Concussion      | <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Diabetes    |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> German Measles  | <input type="checkbox"/> Venereal Disease    |                                      |

Describe any operations you've had and the dates:

Have you been treated for any health condition in the last year?  Yes  No.

Describe Condition \_\_\_\_\_ Date of last physical \_\_\_\_\_

List medications you are taking \_\_\_\_\_

Are you allergic to any medication?  Yes  No. What kind? \_\_\_\_\_

Are you pregnant?  Yes  No. Date of last menstrual period: \_\_\_\_\_

Do you have insurance?  Yes  No. Company \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

I hereby authorize Worthington Family Chiropractic and whomever they may designate as their assistants to administer treatment as they so deem necessary and I also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above information is true and correct.

SIGNATURE AUTHORIZING CARE \_\_\_\_\_ DATE \_\_\_\_\_

# Dr. Danielle R. Rice

Worthington Family Chiropractic

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*Pain Relief and Wellness Care using the gentle & safe  
N.U.C.C.A. Chiropractic Technique*

## **INSURANCE AND FINANCIAL POLICY**

At times, dealing with insurance can be somewhat confusing and frustrating. It is very important to remember that your insurance company is *your* insurer. Your policy is a contract between yourself or the company you work for and your insurance company. It is the responsibility of your insurance company to *reimburse* you for the fees you have paid in this office to the extent of your "healthcare" policy. You are responsible for contacting your insurance company to determine your benefits. It is your responsibility to file claims with your insurance company. *We will assist you in filing your claim by printing any insurance claim for you upon your request.* We have found that patients are reimbursed much quicker when they send in their own insurance claim forms. This form merely needs to be mailed or faxed to your insurance company for reimbursement. According to Ohio's Prompt Pay Law (ORC Sec. 3901.38B), your insurance company has to pay completed claims within 24 days. If we are not "providers" for your insurance company, we have no contract with your insurance company and therefore can not accept "co-pays" or contracted percentages. There is a \$10.00 fee for the doctor to fill out extra insurance forms or papers requested by your insurance company.

Payment is expected at the time of service. We collect fees so that we may continue to provide service. We do not provide service so that we may collect fees. Any outstanding balances over 60 days are assessed interest at 20% ARP.

I have read and understand the above statement concerning my insurance coverage.

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(Please Print Name)

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(Date)

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(Signature)

# NOTICE OF PRIVACY PRACTICES

Dr. Danielle R. Rice  
57 E. Wilson Bridge Road, Suite 200  
Worthington, Ohio 43085  
Phone: (614) 785-9999  
Fax (614) 785-9995  
Website: [www.drdaniellerice.com](http://www.drdaniellerice.com)  
Email: [drdaniellerice@yahoo.com](mailto:drdaniellerice@yahoo.com)

## Authorization for the Use and Disclosure of Protected Health Information

This authorization has been requested by Dr. Danielle R. Rice, Worthington Family Chiropractic

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW.

### USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

This is how we use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

#### FOR TREATMENT

We may use medical information about you with medical treatment or services. We may disclose medical information about you to law enforcement, victims of abuse, neglect, or domestic violence, as well as other health care providers to assist them in treating you.

#### FOR PAYMENT

We may use and disclose your medical information for payment purposes including health insurances, workers compensation, Medicare and Medicaid.

#### FOR HEALTH CARE OPERATIONS

We may use your address to send thank you cards, birthday cards, newsletters, holiday cards and frequent mailings. We may use your initials on testimonials which are received from the patients on a volunteer basis. These testimonials may be placed in the reception area, newsletters and website. With the patient's permission, a picture may be taken for the sole purpose of accompanying a testimonial.

Once agreed to, you have the right to revoke this authorization as you deem necessary. If you wish to revoke this authorization please do so in writing.

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(Please Print Name)

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(Date)

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(Signature)

# Dr. Danielle R. Rice

Worthington Family Chiropractic

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## Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

The goal of chiropractic care in our office is to correct spinal misalignments, to reduce nerve system stress, and to promote normal healing and body function. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine utilizing the NUCCA system of spinal correction.

**Health:** A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

**Vertebral Subluxation:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential. We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual finding, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others.

**Our only practice objective** is to eliminate a major interference to the expression of the body's innate ability to function properly. Our only method is specific adjustments to correct vertebral subluxations.

I, \_\_\_\_\_, have read and fully understand the above statements.  
(Please Print Name)

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)