

**Confidential Patient Information**

Patient's Name: \_\_\_\_\_ Work Status: Part Time Full Time Not employed

Address: \_\_\_\_\_ Occupation: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip: \_\_\_\_\_ Employer: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Are you limited in work capacity? \_\_\_\_\_

Text Reminders: Y \_\_\_ N \_\_\_ Cell Carrier: \_\_\_\_\_ Driver's License Number: \_\_\_\_\_

Email Address: \_\_\_\_\_ Chief Complaint: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F Relationship of Insured: Self Spouse Child Other

Marital Status: Married Single Widowed Divorced

SS#: \_\_\_\_\_

Referred by: Family Friend Doctor Internet Event Phone Book \_\_\_\_\_

Are your present systems or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) Yes \_\_\_ No \_\_\_

Ins. Company: \_\_\_\_\_ Ins. Phone #: \_\_\_\_\_

ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Name and Address of Insured (if different): \_\_\_\_\_

Policy Holder DOB: \_\_\_\_\_ Policy Holders Employer: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_ #: \_\_\_\_\_

**CHECK  
HERE IF NO  
CHANGE**

Family Physician: \_\_\_\_\_ (Note: May we send your health information to this provider (Y / N)

Person to contact in case of emergency (Name and Phone): \_\_\_\_\_

What is your goal in our office? \_\_\_\_\_

I have read and understand THE NOTICE OF PRIVACY PRACTICES, PATIENT RIGHT AND RESPONSIBILITES POLICY, PATIENT RESPONSIBILITIES AND GRIEVANCE POLICY AND PROCEDURES FOR PATIENT. I understand the necessity of these policies and all my questions have been answered in regard to these policies. By signing this form, you give Dr. Dianne Elizabeth Starkey, Dr. Patrick Starkey, Dr. Anthony Berardino, Dr. Kellee Leonard, and staff permission to contact you by either phone, mail, or email.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

**LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS**

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to **Dr. Dianne Elizabeth Starkey, and Dr. Patrick Starkey** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature of Insured / Guardian \_\_\_\_\_

Date \_\_\_\_\_

**Dr. Dianne Elizabeth Starkey, Dr. Patrick Starkey, Dr. Anthony Berardino, Dr. Kellee Leonard**  
 237 Leatherman Rd Wadsworth Ohio  
 Phone: (330) 336-2120 ~ Fax: (330) 334-8305

**Chiropractic Health Questionnaire**

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Do you take  Muscle relaxers  Pain Killers  Insulin  Birth Control  Over the counter meds  
 Name and dosages of medications or supplements \_\_\_\_\_

Allergies: \_\_\_\_\_

Accidents or injuries: (Include Date) \_\_\_\_\_

Surgeries or Hospitalizations: (Include Date) \_\_\_\_\_

Have you been diagnosed with COVID-19? \_\_\_\_\_ If so when? \_\_\_\_\_

Date of last: Physical Exam \_\_\_\_\_ Spinal X-ray \_\_\_\_\_ Blood test \_\_\_\_\_  
 Spinal exam \_\_\_\_\_ Chest X-ray \_\_\_\_\_ Urine test \_\_\_\_\_  
 Dental x-ray \_\_\_\_\_ MRI, CT, bone scan \_\_\_\_\_

Sleep \_\_\_\_\_ hrs./night Do you sleep on your  Back  Side  Stomach Hours of exercise \_\_\_\_\_ hrs./wk

Do you smoke:  Yes \_\_\_\_\_ years  No \_\_\_\_\_  Quit \_\_\_\_\_ years

Do you drink:  No  Yes, daily \_\_\_\_\_, weekly \_\_\_\_\_, monthly \_\_\_\_\_, occasionally \_\_\_\_\_

Age of mattress \_\_\_\_\_ Is your bed comfortable?  Yes  No

What kind of pillow do you use?  Thick  Medium  Thin  None  Memory

Do you wear  Heel lifts  Shoe Lifts  Arch support  Orthotics, describe:

Stress level (circle): No stress -1 2 3 4 5 6 7 8 9 10- Extremely Stressed

<b>Conditions: Please check any that apply to you:</b>			
<input type="checkbox"/> AIDS	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Measles	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Migraine	<input type="checkbox"/> Scarlet fever
<input type="checkbox"/> Anemia	<input type="checkbox"/> Epilepsy	headaches	<input type="checkbox"/> Stroke
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Suicide attempt
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Fractures	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Goiter	<input type="checkbox"/> Mumps	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Tumors, growths
<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Gout	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Typhoid fever
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Bulimia	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Polio	<input type="checkbox"/> Vaginal Infections
<input type="checkbox"/> Cancer	<input type="checkbox"/> Herpes	<input type="checkbox"/> Prostate problem	<input type="checkbox"/> Venereal disease
<input type="checkbox"/> Cataracts	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Prosthesis	<input type="checkbox"/> Whooping cough
<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> HIV positive	<input type="checkbox"/> Psychiatric care	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Rheumatoid arthritis	_____
	<input type="checkbox"/> Liver disease		_____

Does/Did any of your family members have the above conditions? Which conditions?  
 \_\_\_\_\_  
 \_\_\_\_\_

**General Symptoms: Check any symptom you currently have or had in the past.**

General	Gastro-intestinal	Eye, ears, nose throat	Men Only
<input type="radio"/> Bruise easily	<input type="radio"/> Poor appetite	<input type="radio"/> Bleeding gums	<input type="radio"/> Breast lump
<input type="radio"/> Chills	<input type="radio"/> Bloating	<input type="radio"/> Blurred vision	<input type="radio"/> Erection difficulties
<input type="radio"/> Dental Problems	<input type="radio"/> Bowel changes	<input type="radio"/> Crossed eyes	<input type="radio"/> Lump in testicles
<input type="radio"/> Depression	<input type="radio"/> Constipation	<input type="radio"/> Difficulty swallowing	<input type="radio"/> Penile discharge
<input type="radio"/> Difficulty sleeping	<input type="radio"/> Diarrhea	<input type="radio"/> Double vision	<input type="radio"/> Sore on penis
<input type="radio"/> Dizziness	<input type="radio"/> Excessive hunger	<input type="radio"/> Earache	<input type="radio"/> Other _____
<input type="radio"/> Fainting	<input type="radio"/> Excessive thirst	<input type="radio"/> Ear discharge	<b>Women only</b>
<input type="radio"/> Fever	<input type="radio"/> Gas	<input type="radio"/> Hay fever	<input type="radio"/> Abnormal pap smear
<input type="radio"/> Forgetfulness	<input type="radio"/> Hemorrhoids	<input type="radio"/> Hoarseness	<input type="radio"/> Bleeding between periods
<input type="radio"/> Headache	<input type="radio"/> Indigestion	<input type="radio"/> Loss of hearing	<input type="radio"/> Breast lump
<input type="radio"/> Loss of sleep	<input type="radio"/> Nausea	<input type="radio"/> Nosebleeds	<input type="radio"/> Extreme menstrual pain
<input type="radio"/> Loss of weight	<input type="radio"/> Rectal bleeding	<input type="radio"/> Persistent cough	<input type="radio"/> Hot flashes
<input type="radio"/> Nervousness	<input type="radio"/> Stomach pain	<input type="radio"/> Ringing in ears	<input type="radio"/> Nipple discharge
<input type="radio"/> Numbness	<input type="radio"/> Vomiting	<input type="radio"/> Sinus problems	<input type="radio"/> Painful intercourse
<input type="radio"/> Sweats Day/Night	<input type="radio"/> Vomiting blood	<input type="radio"/> Vision-flashes	<input type="radio"/> Vaginal discharge
<input type="radio"/> Tiredness	<b>Cardiovascular</b>	<input type="radio"/> Vision-halos	<input type="radio"/> Other _____
<input type="radio"/> Weight gain	<input type="radio"/> Chest pain	<b>Skin</b>	Date of last menstrual
<b>Genito-Urinary</b>	<input type="radio"/> High blood pressure	<input type="radio"/> Bruise easily	period _____
<input type="radio"/> Blood in urine	<input type="radio"/> Irregular heart beat	<input type="radio"/> Hives	Date of last pap
<input type="radio"/> Frequent Urination	<input type="radio"/> Low blood pressure	<input type="radio"/> Itching	smear _____
<input type="radio"/> Lack of bladder control	<input type="radio"/> Poor circulation	<input type="radio"/> Change in moles	Have you had a mammogram,
<input type="radio"/> Painful Urination	<input type="radio"/> Rapid heart beat	<input type="radio"/> Rash	when? _____
<input type="radio"/> Sensation loss around	<input type="radio"/> Swelling of ankles	<input type="radio"/> Scars	Are you pregnant? _____ mths
buttock/perineum/groin	<input type="radio"/> Varicose veins	<input type="radio"/> Sores that won't heal	Number of children _____

**Neck, Back and Extremities Check symptoms you are currently having or have had in the past year.**

<b>Neck</b>	<input type="radio"/> Pain from front to back	<input type="radio"/> Pinched nerve in back
<input type="radio"/> Pain in neck	<input type="radio"/> Muscle spasms in mid-back	<input type="radio"/> Low back feels out of place
<input type="radio"/> Neck Stiffness	<b>Arms and hands</b>	<input type="radio"/> Muscle spasms in back
<input type="radio"/> Pinched nerve	<input type="radio"/> Pain in upper arm O Right O Left	<input type="radio"/> Sciatic pain
<input type="radio"/> Neck feels out of place	<input type="radio"/> Pain in elbow O Right O Left	<b>Hips, legs and feet</b>
<input type="radio"/> Muscles spasms in neck	<input type="radio"/> Pain in forearm O Right O Left	<input type="radio"/> Pain in buttocks O Right O Left
<input type="radio"/> Grinding/popping sounds in neck	<input type="radio"/> Pain in hand O Right O Left	<input type="radio"/> Pain in hip joint O Right O Left
<b>Shoulders</b>	<input type="radio"/> Pain in fingers	<input type="radio"/> Pain down leg O Right O Left
<input type="radio"/> Pain in Shoulder joint O Right O Left	<input type="radio"/> Pins and needles in arm O Right O Left	<input type="radio"/> Pain in knee O Right O Left
<input type="radio"/> Pain across Shoulders	<input type="radio"/> Pins and needles in fingers O Right O Left	<input type="radio"/> Pain in ankle O Right O Left
<input type="radio"/> Can't raise arm O Right O Left	<input type="radio"/> Weakness in arms O Right O Left	<input type="radio"/> Pain in foot O Right O Left
<input type="radio"/> Tension in shoulders	<input type="radio"/> Weakness in hands O Right O Left	<input type="radio"/> Weakness in leg O Right O Left
<input type="radio"/> Pinched nerve in shoulder O Right O Left	<input type="radio"/> Hands are cold O Right O Left	<input type="radio"/> Weakness in knees O Right O Left
<b>Mid-back</b>	<b>Low back</b>	<input type="radio"/> Leg cramps O Right O Left
<input type="radio"/> Mid-back pain	<input type="radio"/> Low back pain	<input type="radio"/> Pins and needles O Right O Left
<input type="radio"/> Mid- back stiffness	<input type="radio"/> Low back stiffness	<input type="radio"/> Other
<input type="radio"/> Pain between shoulder blades	<input type="radio"/> Low back weakness	Symptoms _____
		_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of her staff responsible for any errors or omission that I may have made in the completion of this form.

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
**Reviewed by Doctor** \_\_\_\_\_ **Date** \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

## Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions please feel free to ask one of our staff members.

### Informed Consent:

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

#### ***The nature of the chiropractic adjustment:***

The primary 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. This 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 the following procedures:

- spinal manipulative therapy
- palpation
- vital signs
- range of motion testing
- orthopedic testing
- basic neurological testing
- muscle strength testing
- postural analysis
- EMS
- ultrasound
- hot/cold therapy
- radiographic studies
- Other (please explain): \_\_\_\_\_

#### ***The material risks inherent in chiropractic adjustment.***

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: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke, however, this is a rare occurrence. Some patients will feel some stiffness and soreness following the first few days of treatments. 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 probability of those risks occurring.***

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

#### ***The availability and nature of other treatment options.***

Other treatment options for your condition may include → 1: Self-administered, over-the-counter analgesics and rest 2: Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain killers 3: Hospitalization 4: 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 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. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

**CONSENT TO EVALUATE AND TREAT A MINOR:** I, \_\_\_\_\_ being the parent or legal guardian of \_\_\_\_\_, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

**Women Only:**

To the best of my knowledge I **am** / **am NOT** pregnant and (**give my permission / don't give permission**) to x-ray me for diagnostic interpretation.  
(Circle one above) (Circle one above)

**Missed Appointments:**

There is a possible fee charged for all appointments that are not canceled prior to scheduled visit.  
Any appointment that is not canceled 24 hours prior to scheduled appointment will be charged \$35 - \$70.  
The fee will be based on the type of appointment that was scheduled.

**Communications:**

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: \_\_\_\_\_

Children: \_\_\_\_\_

Others: \_\_\_\_\_

No one: \_\_\_\_\_

May we leave messages regarding your personal healthcare information on any answering device,  
i.e. home answering machines, voicemails, emails, text message? Yes [ ] No [ ]

**Acknowledgement**

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Dr. Dianne Elizabeth Starkey, Dr. Patrick Starkey, Dr. Anthony Berardino, Dr. Kellee Leonard**

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## **PATIENT FINANCIAL POLICY**

Our primary responsibility is to help you experience good health and we wish to spend our time and energy toward that end. In the interest of good health care practice, it is best to establish a financial policy to avoid misunderstanding.

1. All accounts are due and payable at the time of your visit unless you make satisfactory arrangements with the office manager.
2. It is our policy that if we are filing a claim with your insurance company, we will expect you to pay any unpaid deductible as well as the copayment/coinsurance required by your insurance company at the time of your visit.
3. Even though you may have an insurance claim pending, you will receive a statement each month for the outstanding balance of your account. We cannot accept responsibility for collecting an insurance claim or negotiating a disputed claim.
4. Remember, insurance reimbursement is a contract between you and your insurance carrier. If after 45 days your insurance has not been paid, we will turn to you for payment. You are responsible for your bills regardless of what your insurance pays.
5. If for any reason you have an unpaid balance at 60 days past due, we will automatically charge you \$5.00 per month on your unpaid balance.
6. To better serve all of our patients, we request that you inform us at least twenty-four hours in advance if you need to cancel your appointment. If for any reason you fail to do this, we will bill you (not your insurance company) for an office visit.
7. There will be a \$25.00 charge on all returned checks, per submission.
8. We do not wish to cause you any undue hard ship, however, we must be able to continue our service to the community.

I have read this financial policy and understand that, regardless of any insurance coverage I may have, I am responsible for payment of my account within the usual limits of this credit policy. I agree that in the event costs and/or fees are incurred in connection with the collection of my account, I will pay all such costs and fees, including collection costs, Attorney's fees and all court costs.

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**PARTY RESPONSIBLE FOR ACCOUNT**