All Health
Chiropractic • Rehabilitation • Massage

24932 Aurora Rd. Suite C
Bedford Heights, Ohio 44146
(440) 439-9440 • Fax (440) 439-9447

27801 Euclid Ave. Suite 100
Euclid, Ohio 44132
(216) 289-2632 • Fax (216) 289-2654

PATIENT INFORMATION – *Please fill out all information* (If Worker's Compensation) Claim # ____________

Today's Date: ____________

Name: ____________ (First MI Last) Email: ____________ Age: ______ Birth Date: ______

Address: ____________ City: ____________ State: ______ Zip: ______

Telephone (H): ____________ Phone (Cell): ____________ Phone (W): ____________

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed Number of Children: ______

Employer: ____________ Occupation: ____________ How Long? ______

Employer Address: ____________ City: ____________ State: ______ Zip: ______

Spouse's Name: ____________ Spouse's Employer: ____________

IN CASE OF EMERGENCY CONTACT: Name: ____________

Telephone (H): ____________ Phone (Cell): ____________ Phone (W): ____________ Relationship: ______

INSURANCE DATA

Do you have Health Insurance? ☐ Yes ☐ No - If Yes, Subscriber Health Ins. Company: ____________
Patient Social Security # ____________ Subscriber Name: ____________ & Birth Date: ______
Is your problem related to a Work Injury? ☐ Yes ☐ No Car or Motorcycle Accident? ☐ Yes ☐ No Wellness Care? ☐ Yes ☐ No
Date Injury: ______ MCO: ______ Have an Attorney? ☐ No ☐ Yes - Name: ____________

TODAY'S VISIT

1. Symptoms you are having: ____________
2. Have you had these problems before this injury? ☐ Yes ☐ No - If so, explain: ____________
3. Medications currently taking: ____________
4. Habits: List daily amounts: ☐ Coffee ______, ☐ Soft Drinks ______, ☐ Alcohol ______, ☐ Tobacco ______
5. Do you have cancer, diabetes, high blood pressure, heart or lung disease or other symptoms or diseases? (*Use other side if needed*) ______
____
6. Who is your primary doctor for these pre-existing medical conditions? ____________

I certify all information is true and correct. I authorize the Clinic to treat me as the Clinic deems appropriate. I understand the Clinic will not be held responsible for pre-existing medical conditions, and will only be treating my current complaints. I understand I am ultimately responsible for bills incurred at this office and I can use my health insurance if necessary. I give the clinic permission to contact me by email or phone regarding my appointments and to send my information to providers for the purpose of treatment and coordination of care.

Signature: ____________ Date: ______

Dr. Elias Arnitsis, DC___ Dr. Arkady Peterman, MD _____Dr. Patrick Brennan, DC _____Dr. Moumita Majee, DC ____

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INFORMED CONSENT DOCUMENT

Patient 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. 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 adjusting instrument upon your body in such a way as to mobilize the 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 the following procedures:

- Spinal manipulative therapy
- Range of motion testing
- Muscle strength testing
- Ultrasound
- Palpation
- Orthopedic testing
- Postural analysis
- Hot/cold therapy
- Vital signs
- Basic neurological
- Testing
- EMS
- Radiographic studies
- Physical therapy
- 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, 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. Some patients will 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 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 and X-ray. 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 for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization and/or Surgery

If you chose 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 physicians.

The risks and dangers of remaining untreated: Remaining untreated may allow the formations 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.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read, or I have had read to me, the above explanation of the chiropractic adjustment and related treatment. I have discussed it and have had my questions answered to my satisfaction. By signing below I stated that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

______________________________ ______________________________
Date Patient's Signature *(or Parent if minor)*

______________________________ ______________________________
Print Patient's Name Doctor's Signature

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect immediately, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

How WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care

decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information

requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (ores otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request roust be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (email).

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official: Dr. Elias Arnitsis

Notice of Privacy Practices

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We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

I, ______________________________ have received a copy of the Notice of Privacy Practices.

Signature: ______________________________ Date: ________________

Doctor/ Witness Signature: ______________________ Date: ________________

AUTHORIZATION FOR USE AND DISCLOSURE OF RECORDS (PHI)

Name______________________________________Soc Sec__________________________Date of Birth_____________
Address____

I Authorize:

____

____

____

To Release to:

All Health Chiropractic and Rehabilitation Center,inc.
24932 Aurora Rd
Bedford Hts, OH 44146 • Fax (440) 439-9447

SPECIFIC DESCRIPTION OF INFORMATION (PHI)
TO BE USED AND DISCLOSED
(specify dates for each, unless "entire medical record" is selected)

- ☐ Treatment from (date)to (date)________________ to ______________________
- ☐ Entire Medical Record for all dates
- ☐ Hospital Admission Summary
- ☐ Hospital Discharge Summary
- ☐ Operative Reports
- ☐ Pathology Reports
- ☐ Psychiatric Reports
- Other (please specify) ____
- ☐ Lab Reports
- ☐ Radiology (X-ray/MRUCT) Reports
- ☐ Radiology (X-ray/MRI/CT) Films
- ☐ EMG Reports
- ☐ Progress/Clinic Notes
- ☐ Immunization Records

☐ Verbal Discussion Only- No written records to be released.

I AUTHORIZE RELEASE OF ALL ALCOHOL AND/OR DRUG ABUSE RECORDS THAT ARE PART OF THE RECORDS I SPECIFIED ABOVE, UNLESS OTHERWISE INDICATED HERE:
Do not release records from alcohol or drug abuse treatment programs that are protected under federal law.

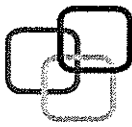
PURPOSE OF THE USE AND DISCLOSURE

- ☐ Insurance Application
- ☐ Disability Determination
- ☐ Vocational Rehabilitation Evaluation
- ☐ By request
- ☐ Personal Records
- ☐ Education
- ☐ Payment of Insurance

I authorize the use and disclosure of my individual identifiable protected health information as described above. This allows my records to be verbally discussed, mailed, emailed and faxed. I understand that this authorization is voluntary. i understand that if the person or organization I authorize to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and could be re-disclosed. I understand that my health care and payment for my health care will not be affected if I do not sign this form.
I understand that I may revoke this authorization in writing at any time except to the extent action has already been taken in reliance on it. I understand this authorization will expire on (12 months from the date of signing if no date or event is specified.)
A photocopy, fax or email of this authorization will be treated in the same manner as the original.

Signature of patient or representative: ____Date:______________________

Office Representative:____ Date:______________________



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Authorization for Use and/or Disclosure of Information

I authorize the employees of Chiropractic & Rehabilitation for Injuries & Wellness Center, Inc., to share and disclose my protected health information with the following (e.g., radiographs, progress notes, prescriptions, impressions, study models, photographs, images, etc.):
I further authorize this information to be shared and discussed by, including but not limited to, telephone, facsimile, unencrypted and/or encrypted e-mail, encrypted and/or unencrypted portable storage media (e.g., CD, thumb drive, portable hard-drive, etc.) and/or by conventional mail, and I hereby authorize the aforementioned parties to discuss my protected health information with employees of Chiropractic & Rehabilitation for Injuries & Wellness Center, Inc., in the same manner. I understand that some of these listed forms of communication are not secure and may be intercepted by unintended parties. If I have any objection to sending of my PHI through unsecure channels and/or specifically desire that my PHI not be shared through unencrypted email, then I would not sign this Authorization. I also authorize the use of my protected health information, including but not limited to, photographs and medical histories, and radiographs, by the aforementioned entities for research, educational, and publication purposes without restriction and further consent to the use of any text used in conjunction therewith. I hereby waive any right that I may have to inspect or approve the finished product or products and the text, copy, or other matter which may be used in conjunction therewith, or to the use to which it may be applied. I agree that this release validates use of my photographs, videos, audio, and/or medical records in any means, including but not limited to live and/or recorded instructional programs, instructional exercises, and promotional materials or advertising. I hereby agree to release, discharge and agree to save harmless Chiropractic & Rehabilitation for Injuries & Wellness Center, Inc., its heirs, legal representatives and assigns, and all persons acting under its permission or authority, or those for whom it is acting, from any liability by virtue of blurring, distortion, alteration, optical illusion, electronic manipulation, or use in composite form, whether intentional or otherwise, that may occur during publication or in any subsequent processing thereof, including without limitation any claims for libel or invasion of privacy. This authorization for release of information from Chiropractic & Rehabilitation for Injuries & Wellness Center, Inc., covers all past, present, and future periods of time until January 1, 2050, or when I choose to revoke said authorization in writing.

- I understand that I have the right to revoke this authorization from any or all the aforementioned entities in writing, at any time, by submitting my written request about each aforementioned entity independently.
- I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned by any employee of Chiropractic & Rehabilitation for Injuries & Wellness Center, Inc., on whether or not I sign this authorization.
- I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

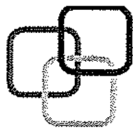
____
Signature of patient or personal representative

____
Relationship to patient, if personal representative or guardian

____
Printed name of patient

____
Date

Dr.Elias Arnitsis, DC___ Dr.Arkady Peterman, MD___ Dr.Patrick Brennan,DC___Dr.Moumita Majee,DC___



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Massage Therapy Informed Consent

I understand that the massage given to me by a licensed massage therapist is for the purpose of (stress reduction, pain reduction, relief from muscle tension and increasing circulation).

I understand that the massage therapist does not diagnose illness or disease and does not prescribe medical treatment or pharmaceuticals, nor are spinal manipulations part of massage therapy.

I understand that massage therapy is not a substitute for medical care and that it is recommended that I work with my primary caregiver for any condition I may have.

I understand that the massage therapist will use his or her discretion to evaluate and treat surrounding muscle groups to help the affected/allowed conditions to achieve maximum benefit.

I have stated all my known physical conditions and medications, and I will keep the massage therapist updated on any changes.

____
Signature of patient or personal representative

____
Relationship to patient, if personal representative or guardian

____
Printed name of patient

____
Date

Dr. Elias Arnitsis, DC___ Dr. Arkady Peterman, MD _____Dr. Patrick Brennan, DC _____Dr. Moumita Majee, DC ____