Northwest Ohio Orthopedics & Sports Medicine, Inc.

Patient Information (Please print and use in pen)

Last Name:	First Name:	Middle Name:	SSN:
Address:	City:	Sate:	Zip:
Home Telephone:	Cell Phone:	Sex: □ M □ F	Status: □Married □Single □Widowed □Divorced
Date of Birth (mm-dd-yyyy):	Date of Injury/Onset:	Work Related: □ Yes □No	Auto Related: □ Yes □ No

If Medicare, are you currently residing in a Skilled Nursing Facility: □ Yes □ No Name of Facility_____

If you are Medicare, have you received Physical, Occupational, or Speech Therapy services since the beginning of the year? □ Yes □No
If so, do you know if you have exceeded the Medicare cap? □ Yes □ No

If Medicare, are you currently receiving Home Health Services: □ Yes □ No Type of service:
If yes, Name of Agency:_____ Date of Last Service:

Physician Information

Primary Care Physician:	Physician who referred you here:

Employer Information

Employer:	Employer Phone:	Employment Status: □ FT □PT □Self □ Retired □Student □None	
Address:	City:	State:	Zip:

Responsible Party (For Minors and/or Dependents for Insurance Purposes)

If Minor, Does child live with: □ Both Parents □ Mother □ Father □ Other _____

Mother's Name:	Home Phone:	Address (if different):
Date of Birth:	SSN:	Employer:
Father's Name:	Home Phone:	Address (if different):
Date of Birth:	SSN:	Employer:

Emergency Contact

Contact Name:	Phone:	Relationship:

Health Care Primary Insurance

Name of Insurance:	Policy or Claim #:	Group #:	Co-pay:
Policy Holder:	Date of Birth (mm-dd-yyyy):	SSN:	
Employers Name:	Relationship to patient: □ Self □ Spouse □ Dependent □ Other		

Secondary Insurance

Name of Insurance:	Policy or Claim #:	Group #:	Co-pay:
Policy Holder:	Date of Birth (mm-dd-yyyy):	SSN:	
Employers Name:	Relationship to Patient: □ Self □ Spouse □ Dependent □ Other_____		

Authorization: I, with my signature, authorize Northwest Ohio Orthopedics and Sports Medicine, Inc. (NWO) to provide medical care for me, or to this patient for which I am the legal guardian.

I also authorize NWO, to furnish information to the identified insurance carrier(s) for prior authorization, pre-certification, or payment of health care services. This information may include claims, copies of medical information, faxes, and phone calls concerning care provided or proposed. I shall assign all payment for these services to NWO, realizing I am personally responsible for the charges incurred, including items determined to be non-covered.

I also acknowledge that I have been given or have been offered a copy of the "Practice's" privacy policy as required by law. I request the following restrictions be placed on the "Practice's" use and/or disclosure of my health information (leave blank if NO).

_____

_____

Patient/Guardian:_____Date:_____

NWO

MEDICAL QUESTIONNAIRE (PG. 1)

Patient Name (Print) _____ Date _____

Age: _____ ❑F ❑M Dominant Hand: ❑R ❑L Height/Weight _____/_____

Family Doctor: _____ Who requested you visit this office? _____

What is the main reason for this visit? ❑Pain ❑Numbness ❑Weakness ❑Swelling ❑Stiffness ❑Other

What body part is involved? Please mark below.

☐ **Neck**; radiates to: ☐ RT Arm ☐ LT Arm	☐ **Shoulder** ☐ RT ☐ LT	☐ **Elbow** ☐ RT ☐ LT	☐ **Hand** ☐ RT ☐ LT	
☐ **Arm** ☐ RT ☐ LT	☐ **Wrist** ☐ RT ☐ LT	☐ **Back**; radiates to: ☐ RT Leg ☐ LT Leg	☐ **Pelvis** ☐ RT ☐ LT	☐ **Hip** ☐ RT ☐ LT
☐ **Knee** ☐ RT ☐ LT	☐ **Foot** ☐ RT ☐ LT	☐ **Ankle** ☐ RT ☐ LT	☐ **Finger** ☐ RT T 2 3 4 5 ☐ LT	☐ **Toe** ☐ RT B 2 3 4 5 ☐ LT

How long ago did it start? _____ Days _____ Weeks _____ Months _____ Years. Have you had a problem like this before? ❑Y ❑N

In this section, check ONE Box which best describes how your problem started. Please answer the questions below the boxes you check.

❑ **No Injury** (Onset was: ❑ Gradual ❑ Sudden)
Why do you think it started?

❑ **Injury** (❑ Accident-NOT auto or work ❑ Sport)
Date: _____ When/How did it happen?
What sport and school? _____

❑ **Injury at Work** Date: _____
From a ❑ Lift ❑ Twist ❑ Fall ❑ Bend
❑ Pull ❑ Reach

❑ **Work Related, but NO Injury**
Date: _____ How did your job cause this?

❑ **Auto Accident** Date: _____
How was your car hit?

Answer/Comment

*On a scale of 0-10 (10 is the worst), how **severe** is your pain (circle) 0 1 2 3 4 5 6 7 8 9 10

*What is the **quality** of your pain? ❑Sharp ❑Dull ❑Stabbing ❑Throbbing ❑Aching ❑Burning

*Is your pain: ❑Constant ❑Intermittent (Comes & Goes)

Does your pain awake you from sleep? ❑Y ❑N

Do you have: ❑Numbness ❑Weakness ❑Swelling
❑Stiffness ❑Bruising ❑Loss of control of bowel or bladder?

Since your problem started, is it: ❑Getting Better ❑Getting Worse ❑Unchanged

What makes your symptoms **worse**? ❑Standing ❑Walking ❑Lifting ❑Exercise ❑Twisting ❑Bending
❑Lying in Bed ❑Squatting ❑Kneeling ❑Stairs ❑Sitting ❑Coughing ❑Sneezing

What makes your symptoms **better**? ❑Rest ❑Elevation ❑Ice ❑Heat ❑Other

What medications are you taking now or have you taken previously for this problem? _____

Have you had any of these treatments? ❑Injection ❑Brace ❑PT/OT ❑Cane/Crutch ❑Chiropractic ❑Acupuncture ❑None

Were you seen in the Emergency Room for this? ❑Y ❑N If yes, Where? _____

What tests/scans have you had for this problem? ❑X-Rays ❑MRI ❑CAT scan ❑Bone Scan ❑Nerve Test (EMG/NCV)

Have you previously had surgery in this same general area? ❑Y ❑N (If Yes, List Below)

Date: _____ Procedure: _____ Surgeon: _____

Date: _____ Procedure: _____ Surgeon: _____

Current work status? ❑Regular ❑Retired ❑Light duty (How long? _____)
❑Not working due to this problem (Since when? _____) ❑Disabled

Are you currently receiving or plan to apply for: ☐ Disability ☐ Workman's Comp ☐ Unemployment ☐ None

REVIEW OF SYSTEMS (PG 2)

Patient Name (Print) _____ Date _____

1. **M/S** Have you had a **prior problem** with this same Orthopedic condition in the past? ❑Y ❑N

*Please explain: _____

Do you have: ❑Joint pain or swelling ❑Back Pain ❑Gout ❑Rheumatoid Arthritis ❑Osteoporosis

❑Prior Fracture (which bone) _____ ❑None of the above

Have you had a Bone Density Scan for Osteoporosis within the last 2 years? ❑Y ❑N

Have you had any of these symptoms? If not, mark NONE.		**NONE**	**Year**	**Explanation/Comments**
2. **GI**	❑Heartburn/Ulcers ❑Nausea/Vomiting ❑Blood in Stool ❑Hepatitis ❑Liver Disease	☐		
3. **ENDO**	❑Thyroid Disease ❑Heat/Cold Intolerance	☐		
4. **CON**	❑Weight Loss ❑Frequent Fever ❑Loss of Appetite	❑		
5. **EYE**	❑ Blurred Vision ❑Double Vision ❑Loss of Vision	❑		
6. **ENT**	❑Hearing Loss ❑Hoarseness ❑Trouble Swallowing	❑		
7. **CV**	❑Chest Pain ❑Palpitations	❑		
8. **RS**	❑Chronic Cough ❑Shortness of Breath	❑		
9. **GU**	❑Painful Urination ❑Blood in Urine ❑Kidney Problems	❑		
10. **SK**	❑Frequent Rashes ❑Skin Ulcers ❑Lumps ❑Psoriasis	❑		
11. **NEU**	❑Headaches ❑Dizziness ❑Seizures	❑		
12. **PSY**	❑Depression ❑Drug/Alcohol addiction ❑Sleep disorder	❑		
13. **HEM**	❑Easy Bleeding ❑Easy Bruising ❑Anemia	❑		

14. **Are you ALLERGIC to any medications, metals, soaps, dyes, food, environment etc.?** ❑Y ❑N If yes, please list and describe reaction.

_____

Medical History

What medications do you take? ❑NONE Please list with dosage: _____

_____

Have you had cortisone within the past year? ☐Y ☐N

Are you a diabetic? ❑Y ❑N Treatment: ❑Insulin ❑Oral Meds ❑ Diet ❑NONE

Are you taking, or have you ever taken, blood thinners? ❑Y ❑N If yes, which one? _____

Past Surgical History: What operations have you had and when? ❑NONE _____

Have you ever had a reaction to anesthesia? ❑Y ❑N

Previous hospitalizations, other than for surgery? ❑NONE _____

Past/Current health problems or diagnosis _____

Have you ever had: ❑Heart Attack (year) _____ ❑High Blood Pressure ❑Blood Clots (year) _____ ❑Stroke

❑Heart Failure ❑Ankle Swelling ❑Kidney Failure ❑Asthma ❑Sulfa Allergy

❑Aspirin Sensitivity ☐ Stomach Ulcers ❑Bleeding Ulcers ❑Stomach-ache/taking Anti-Inflammatory

(including Advil/Aleve) Name of the Anti-Inflammatory have you had a problem with: _____

❑Cancer (Type) _____ ❑MS ❑Polio ❑ **NONE** of the above

Family History

Have any **direct** relatives had any of the following disorders? If so, which relative?

❑ Diabetes_____ ❑ High Blood Pressure_____ ❑ Heart Disease_____

❑ Rheumatoid Arthritis_____ ❑ **NONE** of the above

Social History

Do you use Tobacco? ❑Y ❑N Packs/ day _____ Alcohol? ❑Y ❑N How often? ❑Daily ❑ _____/week

Do you use Drugs? ☐Y ☐N Marital History: M S D W How many people live with you? _____ ☐ Student

Occupation: _____ Employer: _____ Do you like your job? ☐ Y ☐ N

Do you plan to be working 6 months from now? ☐Y ☐N

****Please Sign:** The information contained on these forms is accurate to the best of my knowledge. **Patient Signature:** _____

SYMPTOM CHECKLIST

Patient Name:_____ Date of Birth:_____

Patient Signature:_____ Today's Date:_____

Please indicate which of the following symptoms you experience:

Office Use Only

Symptom	Side of the Body				Clinical Assessment
Back and Leg Pain	**Right**	**Left**	**Both**	**None**	**Confirmed: ☐ Yes ☐ No**
Pain in your buttocks	☐	☐	☐	☐	**Exam Notes:**
Pain or burning in your legs	☐	☐	☐	☐	
Numbness or tingling in your legs	☐	☐	☐	☐	
Weakness in your legs	☐	☐	☐	☐	
Loss of strength in your legs	☐	☐	☐	☐	
Foot Pain	**Right**	**Left**	**Both**	**None**	**Confirmed: ☐ Yes ☐ No**
Pain or burning in your feet	☐	☐	☐	☐	**Exam Notes:**
Numbness or tingling in your feet	☐	☐	☐	☐	
Feels like pins and needles in your feet	☐	☐	☐	☐	
Increased sensitivity to touch on your feet (for example, it hurts when bed covers touch them)	☐	☐	☐	☐	
Trouble feeling your feet when you walk	☐	☐	☐	☐	
Discomfort or pain at right in your feet	☐	☐	☐	☐	
Hand, Finger or Wrist Pain	**Right**	**Left**	**Both**	**None**	**Confirmed: ☐ Yes ☐ No**
Pain or burning in your fingers	☐	☐	☐	☐	**Exam Notes:**
Numbness or tingling in your fingers	☐	☐	☐	☐	
Difficulty gripping things with your hands	☐	☐	☐	☐	
Difficulty forming things with your hands	☐	☐	☐	☐	
Discomfort in hands wakes you up at night	☐	☐	☐	☐	
Diabetes Mellitus					**Eye Exam Documentation:** ☐ Yes ☐ No
Do you have diabetes? ☐ Type 1 ☐Type 2 ☐ No					**Exam Notes:**
If yes, are you receiving care from an Ophthalmologist? ☐ Yes ☐ No					
If yes, date of your last Dilated Eye Exam? _____ ☐ Don't Know					

Physician Use Only

Physician Review:_____

Schedule NCS Date:_____

Schedule RIS Date:_____

Northwest Ohio Orthopedics & Sports Medicine, Inc.

Pediatric Health History

Please Print

Child's Full Name_____ **Date** _____

Parent #1 Name _____ **Parent #2 Name** _____

Child's Home Address _____ **City**_____ **State** _____ **Zip** _____

Home Telephone _____ **Parent(s) Phone Work and/or Cell** _____

Adoption Information

Child's Age When Adopted _____ **Date of Adoption** _____

Known Health History of Child_____

_____

Birth Information

Birth Date_____ **Sex**: ☐F ☐M **Birth Weight** _____ **Birth Length** _____ **Current Age of Child** _____

Type of Birth (check one): Vaginal ☐ Forceps ☐ Breech ☐ Cesarean ☐ Home ☐ Birth Center ☐ Hospital ☐

Any problems during pregnancy and/or labor?_____

_____

_____

Apgar Scores_____ **Jaundice (yellow) at Birth**? ☐ Y ☐N **Cyanosis (blue)?** ☐ Y ☐N

Congenital Anomalies/Defect ☐ Y ☐N Please explain_____

_____

Infant Feeding (please check one) Breast ☐ Bottle☐ Formula☐

Other Food or Drink Information _____

No. of Hours Child Sleeps Daily_____ **Quality of Sleep (please check one):** Good ☐ Fair ☐ Poor☐

Explain (if needed)_____

Number of Siblings_____ **Siblings Name, Age & Sex**_____

_____

Health & Medical Information

Obstetrician &/or Midwife Name_____ **Location**_____

Pediatrician &/or Family MD Name_____ **Location**_____

May we contact them? ☐ Y ☐ N **Date of Last Visit to Dr**_____ **Purpose of that visit**_____

_____

Immunization History_____

_____

Has your child ever been treated on an emergency basis? ☐Y☐ N **Please describe**: _____

_____

Purpose of the appointment today with the chiropractor/nutritional consultation:_____

_____

_____

Pregnancy History _____

_____

Delivery/Birth History _____

_____

_____

Developmental History----At What Age Did the Child		**Childhood Diseases—Age of the Child When Occurred**	
Respond to Sound _____	☐ N/A	Chicken Pox _____	☐ N/A
Crawl_____	☐ N/A	Rubella _____	☐ N/A
Follow an Object with their Eyes _____	☐ N/A	Rubeola _____	☐ N/A
Hold Head Up _____	☐ N/A	Whooping Cough _____	☐ N/A
Stand_____	☐ N/A	Mumps _____	☐ N/A
Sit Alone _____	☐ N/A	Measles _____	☐ N/A
Walk Alone_____	☐ N/A	Other _____	

Has this child ever suffered from (please check any that apply):

☐ Diabetes	☐ Bed Wetting	☐ Convulsions	☐Neck Problems
☐ Fainting	☐ Tuberculosis	☐ Backaches	☐ Heart Trouble
☐ Dizziness	☐ Stomach Aches	☐ Allergies	☐ Orthopedic Problems
☐ Asthma	☐ Walking Problems	☐ Rheumatic Fever	☐ Hypertension
☐ Sugar Concentration	☐ Headaches	☐ Blood Disorders	☐ Broken Bones
☐ Sleeping Problems	☐ Digestive Disorders	☐ Sinus Trouble	☐ Leg Problems
☐ Diarrhea	☐ Constipation	☐ Paralysis	☐ Joint Problems
☐ Arm Problems	☐ Hyperactivity	☐ Chronic Earaches	☐ Colds/Flu
☐ Arthritis	☐ Neuritis	☐ Anemia	☐ Poor Appetite
☐ Behavioral Problem	☐ Muscle Jerking	☐ Ruptures/Hernias	☐ "Growing Pains"

☐ Any Other Problems _____

Present Health History or Additional Information_____

_____

Surgery Information_____

Medications/Vitamins/Supplementation_____

_____

Accidents_____

FAMILY HISTORY

Have the immediate family members had any of the following:

☐ High Blood Pressure	☐ HIV Positive	☐ Back Problems	☐ Headaches
☐ Heart Disease	☐ Asthma	☐ Ulcer or Stomach Problems	☐ Thyroid Disease
☐ Emphysema	☐ Diabetes	☐ Stroke	☐ Circulation Problems
☐ Seizures-Convulsions	☐ Kidney Diseased	☐ Arthritis-Rheumatism	☐ Cancer
☐ Mental Illness	☐ Osteoporosis		

Parent/Guardian Signature _____ **Date** _____

Northwest Ohio Orthopedics & Sports Medicine, Inc.

EXPLANATION OF CONDITION

Patient Name: _____
First MI Last

CONDITION/ACCIDENT/INJURY DETAILS

Symptoms first begin on: _____/_____/_____ or have been experiencing for _____days _____ weeks _____months _____ years.

What symptoms are you experiencing? _____

_____

What body parts are affected? _____

_____

Have any of these body parts been injured before? YES NO If yes, please describe: _____

_____

What medications are you currently taking? _____

_____

Give a brief description of the accident. Please include location of the accident (home, work, school, auto, etc.) and a brief description (fall, bump against, collision, cut, struck by, etc.). _____

_____

_____

Will you seek payment from another party? YES NO If yes, who? BWC MVA Other

If an attorney is involved, please provide name, address, and phone number: _____

_____

Was this injury sustained in an automobile accident? YES NO If yes, please complete the following:

MOTOR VEHICLE ACCIDENT INFORMATION

Date of Accident: _____/_____/_____ State Accident Occurred: _____ Time: _____

Auto Insurance Name: _____ Adjuster's Name: _____

Adjuster's Phone Number: _____ Name of Insured: _____

Claim Number: _____ Policy Number: _____ MVA Work Related? Y N

We will bill your motor vehicle insurance; however, you are ultimately responsible for your account balance. We do require your health insurance information since most auto coverage is limited. We will bill your health insurance for any remaining balance after your Auto Insurance has paid. **Please note that should your motor vehicle accident require litigation proceedings, you will be required to speak with our financial counselor to arrange monthly payments in order to keep your account current during your hearings.** Once your claim has been settled, any overpayments you have made on the account will be refunded to you at that time.

AUTHORIZATION

I, with my signature, authorize **Northwest Ohio Orthopedics And Sports Medicine, Inc**., and any employee working under the direction of the care provider, to provide medical care for me, or to this patient for which I am the legal guardian. I also authorize **Northwest Ohio Orthopedics And Sports Medicine, Inc**., to furnish information to the identified insurance carrier(s) for prior authorization, pre-certification, or payment of health care services. This information may include claims, copies of medical information, faxes, and phone calls concerning care provided or proposed. I shall assign all payments for these services to this practice. I understand that I am responsible for all co-payments, deductible, and other amounts that may be deemed my responsibility by the insurance plan, as required by my contract with my insurance plan and state regulation.

Patient/Legal Representative: _____ Date: _____

Northwest Ohio Orthopedics & Sports Medicine, Inc.

FINANCIAL POLICY

Regarding Your Insurance:
Our office participates in a variety of insurance plans, and we will submit all claims to those carriers. We make every effort to get claims paid; however, please remember that your insurance policy is a contract between you, your employer, and your insurance company. Any balance remaining after the insurance has paid, is the **patient/guarantor's responsibility** (i.e. co-pay, co-insurance, non-covered benefits, exclusions, etc.). If NWO is not in your insurance plan, the patient/guarantor is responsible for all charges. If you do not have insurance, a payment plan must be arranged, prior to treatment, with our Financial Counselor. Partial payment for self-pay patients is required at the time of the initial visit.

In an effort to minimize insurance errors and maximize insurance payment, please bring your most recent insurance card(s) with you to every visit. **Co-payments are to be paid at the time of your visit**. In the event we receive payment from your insurance company for services you have paid for, a refund will be made to you in a timely manner.

Payment Information:
We accept cash, check, and credit/debit card payments. If you are unable to pay your balance in full, a payment plan arrangement can be made or you can sign up for CareCredit with the option of no interest financing. Contact our Financial Counselor at 419-427-3116 for more information. These options will lessen the possibility of your account being sent to a collection agency because of non-payment.

Past Due Accounts:
If your balance is not paid in a timely manner, we reserve the right to forward your account to an outside collection agency or attorney. A 10-day notice prior to sending your account to a collection agency will be mailed to you.

Orthopedic, Family Medicine, Chiropractic & Podiatry No-Show Fee:
Missed or non-cancelled appointments will result in a $25.00 no-show fee.

Imaging No-Show Fee:
Cancellation within 24 hours prior to a scheduled MRI or a scheduled CT will be subject to a $50.00 no-show fee.

Durable Medical Equipment:
If you need to return a product, and you are the original purchaser, you need to do so **within 10 days of receiving**. All products must be returned in its original packaging with all instructions and parts. The product must be in new condition. We reserve the right to refuse any product not in new condition for health safety reasons. There is a 30% restocking fee on all returns. Upon notification that the product has been returned in new condition, a credit will be issued to your account less the restocking fee. For product exchanges, upon receipt of the returned product we will credit your account minus the 30% restocking fee if a product needs to be exchanged. This charge will be waived if NWO made the mistake in providing you with the wrong product.

FMLA, Disability, and Drug Company Assistance Forms:
Any patient needing forms filled out by our office will incur a one time $15.00 fee per form. Payment for this service is due at the time of drop-off or pick-up.

Medical Records Copying Fees:
Charges for copying medical records vary depending on whether the individual/organization requesting the information is the patient/personal representative or a non-personal representative. In compliance with the Ohio Revised Code Section 3701.742, if the person requesting records is the patient/personal representative, fees are: $2.92/page for pages 1-10, $.61/page for pages 11-50, and $.25/page for pages 51+. Fees for a non-personal representative are: $17.97 retrieval fee, $1.18/page for pages 1-10, $.61/page for pages 11-50, and $.25/page for pages 51+. Film prices for patient/representative and non-representative are: $2.00/sheet or $2.00/disc. Postage paid to send records will also be paid by the requestor.

_____ _____

Patient/Guarantor Signature **Date**

Northwest Ohio Orthopedics & Sports Medicine, Inc.

Patient Medication List

Patient Name: _____ Date of Birth: _____

What medications do you currently take? (Including over the counter, vitamins/supplements)

☐ None

Name of Medication	Dosage	Doctor That Prescribed

Patient/Guardian Signature: _____ Date: _____

N W O Northwest Ohio Orthopedics & Sports Medicine, Inc.

Heather A. Heck, D.C.

Mission Statement

We will make every effort to remain current in the areas of chiropractic healthcare and nutritional research and to provide you with the best care possible. As a result, we will attempt to the best of our ability to relieve pain, restore function and regain health in those patients who request our care. Since it is our **GOAL** to engage you in being an active participant in **YOUR CARE**, you must understand your condition, our interventions and most importantly, the expected outcome. We want you to be an educated healthcare consumer and to take an active role in the future of your health. To accomplish our therapeutic alliance and strengthen our relationship, we ask you to consider the following:

- The educational process will involve consent documents, educational pamphlets as well as models in the exam rooms and posters. There will also be discussion about your condition, treatment, your potential outcome and possible adverse events.

- Informed consent documents are not just legal documents, but are an important educational instrument. The purpose of the informed consent is to inform and teach you about your condition, the expected outcome as well as the risks that could affect your decision both to undergo a given treatment procedure and the expected outcome. More importantly we feel it is **YOUR OPPORTUNITY TO ASK ANY ADDITIONAL QUESTIONS YOU MAY HAVE REGARDING THE TREATMENT OR PROCEDURE THAT WERE NOT DISCUSSED OR YOU MAY HAVE QUESTIONS ABOUT**.

Please understand that you will be seen, heard and understood at every step by both the physicians and the staff in the office as well throughout our facility. We emphasize education so that we can deliver information to you that makes sense and enhances your ability to become a partner in **YOUR CARE**. We request that you notify us of any concerns or constructive criticism so that you can make your care and the care for our community better. By enlisting your help we expect you to be an active participant in the decision making with the understanding that in the end **YOU** control much of what can and will happen in your healthcare treatment plan. Your involvement in this process can play a major role not only in improving your outcome and overall function, but the safety and outcome of other patients as well. Thank you and we look forward to our partnership.

Sincerely,

Heather A. Heck D.C. MSACN, MPH
Entire Staff of NWO

Northwest Ohio Orthopedics & Sports Medicine, Inc.

Consent for Minor to Receive Treatment

I, the parent/guardian of _____, give consent for my child to receive the following types of medical services at the Northwest Ohio Orthopedics & Sports Medicine, Inc. ("NWO"):.

_____

_____

_____.

I understand that this consent form will be good until _____.

Except to the extent that the law requires my child's signed consent prior to disclosure, I understand that I will be entitled access to medical information concerning services provided to my child pursuant to this consent. I understand that nothing in this consent affects the ability of the NWO to provide medical services to my child without my consent to the extent expressly permitted under Ohio law.

I understand that I will be responsible for payment for any charges relating to services provided to my child pursuant to this consent, to the extent that such services are not covered in full by insurance or other third-party payor covering my child. NWO may release information regarding treatment to third party payers for billing purposes.

_____ _____

Signature of Parent / Legal Guardian Date

NOTARY PUBLIC SIGNATURE / STAMP / SEAL REQUIRED

State of Ohio
County of _____

Subscribed and sworn to me this _____ day of _____ 20 _____

Signature: _____

My commission expires: _____