ProWellness Chiropractic
11876 Olio Rd, Suite 500
Fishers, IN 46038
317-595-9620

Welcome to ProWellness Chiropractic

Please Print Clearly and Fill In Completely

Personal Information

Name Age Birthdate SS#

Address City State ZIP

Cell Work Home

E-mail

Occupation Employer Work Duties

Spouses Name Children Names/Ages

Circle what's applicable | Male Female | Right Handed Left Handed | Married Single Divorced Widowed

Who May We Thank For Referring You To Our Office?

Health History

Reason for seeking chiropractic care:

Describe any health problems, including how long you've had them:

Are you under the care of any other doctor? Yes ◯ No ◯

If Yes, the conditions being treated for:

List any current Medications:

List any past surgeries & dates:

List any past accidents & dates:

List any x-rays you've had in the past 2 years:

Spouse's health status:

Children's health status:

Below, please fill in any other health information you feel we might need for your care:

Chiropractic History

Have you ever been to a Chiropractor before? Yes ◯ No ◯ If yes, Doctor's Name

Date of last chiropractic visit: How long were you under care?

Reason for care:

Are other family members under chiropractic care? Yes ◯ No ◯ Who?

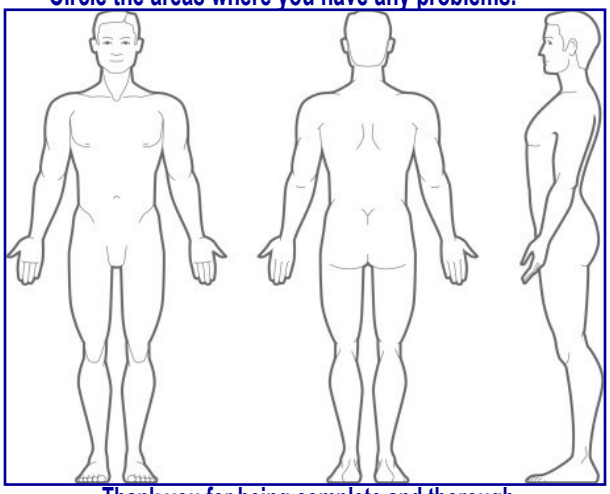
Females

Please Check One. Is there a possibility of you being pregnant? Yes ◡ No ◡ Due Date:

Please check all symptoms you have ever had, even if they do not seem related to your current problem.

Condition, Symptom or Problem	Constantly or Frequently	Sometimes or Occasionally
Headache	○	○
Migraines	○	○
Neck Pain	○	○
Shoulder Pain	○	○
Arm/Hand Pain	○	○
Mid Back Pain	○	○
Low Back Pain	○	○
Hip Pain	○	○
Leg/Foot Pain	○	○
Disc Problems	○	○
Arthritis	○	○
Other Joint Pain	○	○
Numbness	○	○
Joint Swelling	○	○
Dizziness	○	○
Nausea	○	○
Weakness	○	○
Fatigue	○	○
Nervousness	○	○
Insomnia	○	○
Heart Problems	○	○
Frequent Colds	○	○
Nose Bleeds	○	○
Ringing in Ears	○	○
Earaches	○	○
Hearing Loss	○	○
Cough	○	○
Chest Pains	○	○
Menstruation Problems	○	○
Allergies	○	○
Asthma	○	○
Cancer	○	○
Osteoporosis	○	○
Diabetes	○	○
Hypoglycemia	○	○
Digestive Problems	○	○
Urinary Problems	○	○
Skin Conditions	○	○
Other_____	○	○

Circle the areas where you have any problems.



Thank you for being complete and thorough.

Date: _____

For Office Use Only Below

Dr Notes

Are there any injured areas or conditions, such as bruises, cuts, sores, abnormal blood pressure, blood clots or cancer that may be aggravated by massage? [No] [Yes] – What?

Do you like aromatherapy (i.e. scented oils)? [No] [Yes]

Do you have any allergies to fragrances of flowers? [No] [Yes]
What?_____

In undertaking a massage at ProWellness, I (print name)_____
Agree that: The purpose of the massage is to provide stress relief, pain control and relax.

The therapist will not treat, prescribe or diagnose an illness, disease or any other physical or mental disorder. Nothing said in the course of a massage session should be misconstrued to be such. I understand that a massage involves having my body touched. I hereby authorize the therapist to perform massage. I understand that any relief of physical or emotional symptoms is the product of processes, which reside within me. The power to heal comes from within. I understand that I am responsible for my emotions, feelings, body and belongings and the therapist is responsible only for giving a massage. Control of the session is always mine and I can stop it at any time. In the spirit of this understanding, I agree to hold ProWellness and its employees blameless from any problem which may arise as a result of my massage.

I have read, understand, and agree to the above.

Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

Protected health information may be disclosed or used for treatment, payment, or health care operations.
The Practice has Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
The practice reserves the right to change the Notice of Privacy Practices.
The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
The Practice may condition receipt of treatment upon the execution of this Consent.

This consent was signed by: _____

Printed Name-Patient or Responsible Party

_____

Patient Signature or Responsible Party Date

_____

Relationship to patient (if other than patient)

Witness: _____

Printed Name-Practice Representative

_____

Signature Date

Authorization For Use of Health Care Information

Your personal health information, including your clinical records and billing information, may be disclosed to another health care provider, insurance carrier for further diagnosis, assessment, or for payment of services.

(More information on how, when and why we will use your health care information can be found on the HIPAA patient consent form in this packet.)

I authorize my healthcare provider, and/or any entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging and/or other electronic communication to contact me for any reason by using any telephone number, email address and/or mailing address associated with my account.

Social Media Photo/Video Release:

We use social media to spread the word about chiropractic care and market to potential new patients. We ask your permission to use, re-use, publish and republish photographic portraits or pictures, videos or any other social media content with you in it. You are authorizing that all media or reproduction hereof in color or otherwise may be used to promote or advertise ProWellness or any of its employees.

Because of our Federal Tax ID and business registration your Explanation of Benefits may show visits from our office as services being performed by Freedom Chiropractic doing business as Prowellness Chiropractic.

Patient Authorization for Referral Thank You Cards and Testimonials:

If you respond favorably to chiropractic care, you may be asked to fill out a "patient testimonial," you may decline if you wish. This will help others to read the success of chiropractic. If you choose not to authorize this information your decision will not have an adverse effect on your care from our office or on your relationship with our staff.

Open Adjusting Environment:

Our office is an open adjusting environment. Your examinations, X-rays and report of findings are performed in the privacy of a closed room. Conversations between you, your doctor and our staff during normal treatments may be overheard by others in the building. Our goal is to maintain as much privacy as possible. If you are uncomfortable discussing your case, you may request a private consultation for your next visit.

Cancellation Policy for Chiropractic:

- Please arrive on time to your scheduled appointment in order to ensure a complete treatment/session.
- If you arrive late to your appointment we will do our best to fit you into the schedule. Please understand that you may have an extended wait until there is an opening in our schedule.
- You may cancel/reschedule your appointment without charge anytime before the time of your appointment.
- If you do not call to cancel/ reschedule your appointment, you will be considered a no-show, and will be charged our cash rate of $49.00 for that scheduled service, no matter your original rate.
- **No-show charges are not covered by your insurance.**
- **All charges must be paid in full by your next appointment.**

Cancellation Policy for Massage and Acupuncture:

- You may cancel your appointment without charge anytime before the close of business on the business day preceding your appointment.
- Same day cancellations will be charged 50% of the scheduled service price.
- If you do not call to cancel your appointment or do not show up for your scheduled appointment, you will be considered a no-show and will be charged the full price for the scheduled service.
- If you are sick or not feeling well please notify us as soon as possible so we can reschedule your massage. Chiropractic adjustments can be beneficial to your immune system but we prefer to not risk the health of our massage therapist. If you arrive to your scheduled massage and are unwell you may be asked to reschedule for a later date. We thank you for your understanding in this matter.

Your signature indicates you have read, understand and authorize the above activities.

Printed Name Signature Date

If you are under the age of 18 you must be represented by a parent or guardian.

Printed name of Parent or guardian Signature Date

*This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable time for the change in our system to be complete.

Prepaid Agreement: If at any time you decide to stop care, the unused portion of the money will be returned to you (pro-rated for services rendered.)

Discontinuation:

1. In the event you (the patient) decide to discontinue care for any reason, or ProWellness Chiropractic regretfully finds it necessary to discontinue your care for any reason, any outstanding fees become immediately due and payable.
2. Retail fees will be calculated and pro-rated on a per visit basis.
   E.g. retail fees equal $49 per visit.
   (E.g. If you have received 10 visits when care is discontinued you will owe $490 respectively.)
3. All discounts become null and void if care plans are discontinued prematurely.

Insurance and your corrective care plan:

1. Cost of your care plan may change based on the actual insurance coverage for services rendered. Your insurance company may only cover charges based on medical necessity.
2. This agreement will become null and void if your insurance company does not find your care medically necessary. A new care plan with the appropriate financial revisions will be presented to you in this situation.
3. You are responsible for reporting any insurance coverage changes to this office. Care plan cost may be revised upon a change of insurance coverage.

Our Recommended Care: Based on cases similar to yours and current scientific literature, we have estimated the following time period for your care plan. This is only an estimate and is dependent upon factors such as: physiological properties, arthritis, age, gender, patient compliance, etc. Because of the variables involved, there can be no guarantee to the results you will experience.

INFORMATION CONSENT TO RECEIVE CHIROPRACTIC CARE: I, the undersigned, give the doctor permission and authority to provide care in accordance with standard chiropractic tests, analysis, diagnosis, and treatment. Chiropractic care seldom causes any complications, but in rare cases, due to underlying physical defects, deformities or pathologies may render a patient susceptible to injury. The doctor will not provide care if they are aware of any contraindication that may be present. It is the responsibility of the patient to make it known to the doctor or health care provider if they are aware of any underlying deformities or defects that may not otherwise come to the attention of the doctor.

Patient's Name: _____D.O.B.:_____/_____/_____

Patient's Signature: _____ Date: _____/_____/_____

Doctor's Signature: _____Date:_____/_____/_____