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

Please Circle | Sex : Male Female | Dominant Hand: Left Right | Marital Status: 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:

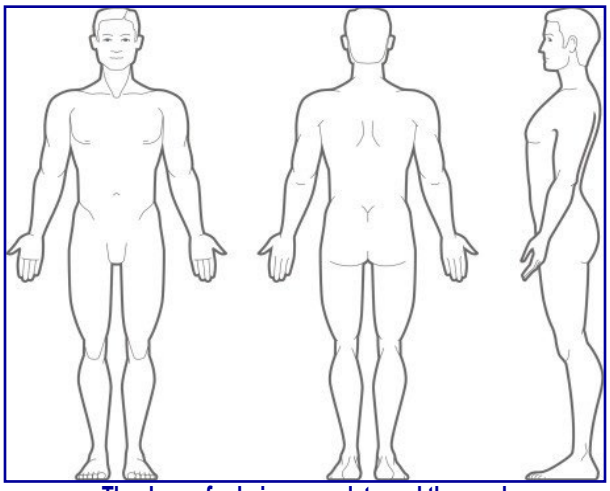
Are other family members under chiropractic care? Yes ◯ No ◯ Who?

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. Skip symptoms you don't experience

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	○	○
Ringing in Ears	○	○
Earaches	○	○
Nose Bleeds	○	○
Hearing Loss	○	
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.

For Office Use Only Below
Dr Notes

Date:

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?

Have you received a professional massage before? [No] [Yes]

If yes, when was your last massage? _____

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

Do you have any allergies to fragrances, flowers, oils, or topical creams? [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.

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.

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

Witness at ProWellness Chiropractic Signature Date

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.

FINANCIALS You are financially responsible for anything insurance does not cover. The amount your insurance will allow and pay for and your financial responsibility is determined by your insurance company and the policy you have chosen. Your claim will be processed according to the benefits of your insurance plan. The deductible, co-insurance, and co-pay are your financial responsibility. It is your responsibility to understand your insurance plan. If you are a cash or out-of-pocket patient without insurance, all charges are due at the time of the visit. We do not send bills to cash patients.

The following services are not covered by insurance at this office. We will not be billing insurance and you are responsible for payment at the time of service:

Laser therapy $25 per unit, Decompression $35, Dry Needling $40, Nasal Specific Technique $40, Shockwave $50, Massage Therapy $49 for 30 min, or $79 for 60 min., Custom-Made Foot Orthotics $299 for one pair, or $499 for two pairs

CANCELLATION POLICY $49, $55, or $79 No Show Fee for any Missed Appointment that was not cancelled or rescheduled prior to the appointment. Please be considerate and call before your appointment if you cannot come in. Chiropractic appointment we need 2 hours notice and the fee is $55. Massage appointment we need 24 hours notice ($49 30 min, $79 60 min)

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.

AUTHORIZATION FOR USE OF HEALTH INFORMATION 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.

OPEN ADJUSTING ENVIORNMENT 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.

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.

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.