about life chiropractic

A B C D

9845 E 116th Street • Suite 300 • Fishers, IN 46037

DEMOGRAPHICS AND ASSIGNMENT OF BENEFITS

Today's Date: ____/____/____
(MM/DD/YYYY)

Whom may we thank for referring you?

Your Last Name

Your Social Security Number *(Only applies to VA Patients)*

Your First Name

Your Middle Name *(Or Initial)*

Gender
□ Male □ Female

Birth Date *(MM/DD/YYYY)*

Address

Marital Status
□ Single □ Married
□ Divorced □ Widowed
□ Separated

Height

City

State

ZIP/Postal Code

Weight

Home Phone

Cell Phone

Spouse's Name

Spouse's Birth Date

E-Mail Address

Child's Name & Age

Emergency Contact

Phone

Child's Name & Age

Your Occupation

Your Employer

Child's Name & Age

Primary Physician

CONFIDENTIAL HEATH INFORMATION

ACKNOWLEDGMENTS

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

_____ INITIALS — I have read and reviewed the Privacy Policy and understand it describes how many personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

_____ INITIALS — I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in the office.

_____ INITIALS — I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

_____ INITIALS — I may request a copy of the Financial Policy at any time.

ASSIGNMENT OF BENEFITS

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered, assigns to the physician or facility named above the following rights, power, and authority.

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney, or insurance adjuster, for the purpose of processing my claim for benefits and payment of service rendered to me.

IRREVOCABLE ASSIGNMENTS OF RIGHTS: You are assigned the exclusive irrevocable right to any cause of action that exists in my favor against any insurance company for benefits to the extent of your bill for total services if such benefits are owed within the terms of policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court costs, or other legally compassable amounts owed by an insurance or state statute. I, as the patient and/or the responsible party, further agree to cooperate and provide information as needed, and appear as needed wherever, to assist in prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above, you are hereby tendered demand for pay in full the bill for services rendered by the physician/facility named above within 60 days following your receipt of such bill for services to the extent such bills are payable under the terms of my/our policy for the benefits, less any amounts which I/we owe personally which are not payable under the terms of your policy. In consideration of the services to be provided to the patient, I/we hereby guarantee payment in full of the patient's account in accordance with the financial arrangements made at the time of discharge or, if no such arrangements are made, then payment shall be made in full within thirty (30) days of discharge. I/we agree that in event of default in payment, reasonable collection agency fees equal to fifty (50%) percent of the delinquent balance and reasonable attorney fees, shall be added to the amount due on the account, plus any applicable court costs.

THIRD PARTY LIABILITY: If patient(s)' treatments for injuries are the result of the negligence of any third party, then patient(s) grant a lien and assignment of cause of action against any right of recovery from such third party(s) to the extent of the bills of treatment, in favor of the physician/facility named above.

INSURANCE AGREEMENT: I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare my necessary reports and forms to assist me in making collection from the insurance company, and that any amount authorized to be paid directly to co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. This demand specifically conforms with this state's insurance code, providing for attorney fees, penalty, court costs, and interest from judgment, upon violation. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

A photocopy of this instrument shall serve as original.

PLEASE SEE OTHER SIDE FOR FURTHER INFORMATION

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PATIENT HISTORY

Today's Date: ____/____/____
(MM/DD/YYYY)

What symptoms prompted you to seek care today? _____

When did these symptoms start? How did they start? _____

PRIOR INTERVENTIONS (What have you done to relieve the symptoms?)

- □ Prescription medication
- □ Over-the-counter drugs
- □ Chiropractic
- □ Ice
- □ Heat
- □ Other _____

What else should About Life know about your current condition? _____

REVIEW OF SYSTEMS (Identify any changes since your most recent evaluation with us)	**Current**	**Past**	**None**
a. **Musculoskeletal System** - osteoporosis, arthritis, neck pain, back problems, poor posture	O	O	O
b. **Neurological System** - anxiety, depression, headache, dizziness, pins & needles, numbness	O	O	O
c. **Cardiovascular System** - high blood pressure, low blood pressure, high cholesterol, chest pain	O	O	O
d. **Integumentary System** - skin cancer, psoriasis, eczema, acne, hair loss, rash	O	O	O
e. **Genitourinary System** - kidney stones, infertility, bedwetting, prostate issues, PMS symptoms	O	O	O
f. **Constitutional System** - fainting, low libido, poor appetite, fatigue, sudden weight, weakness	O	O	O
g. **Lymphatic System** - swelling or pain in lymph nodes of neck, axillae, groin & other areas	O	O	O

Prior Illnesses, operation, Injuries or treatments: _____

Previous xrays? _____ If yes, where? _____

Allergies: _____ Tobacco Use: _____

Medications/Supplements: _____

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

_____
Signature

_____
Date (MM/DD/YYYY)

_____
If the patient is a minor child, print child's full name

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PATIENT EXAM FORM

Incident: PI WC Group Cash MC

Insurance: _____

NP React Re-exam New Injury

_____
Today's Date (MM/DD/YYYY)

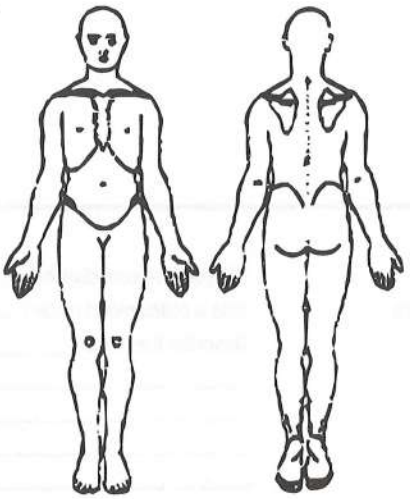
_____ _____ _____
Last Name First Name Middle Name (Initial)

1. **What symptoms prompted you to seek care today?** _____

2. **When did these symptoms start? How did they start?** _____

3. **Quality of Symptoms**
(What does it feel like?)

Please mark the area(s) of complaint(s)



- O Numbness
- O Tingling
- O Tightness
- O Dull
- O Aching
- O Cramps
- O Heavy
- O Sharp
- O Burning
- O Shooting
- O Throbbing
- O Stabbing
- O Other _____
- O Chiropractic: Where _____

4. **Duration & Timing** (How often do you feel it?)
O Constant O Comes and goes

5. **Radiation** (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel?)
_____

Pain Scale:

0	1	2	3	4	5	6	7	8	9	10
None		Mild			Moderate			Severe		Worst

Sleeping:

0	1	2	3	4
Perfect	Mildly Disturbed	Moderately Disturbed	Greatly Disturbed	Totally Disturbed

Self-Care:

0	1	2	3	4
No Pain No Restrictions	Mild Pain	Moderate Slow Moving	Moderate Some Ast.	Severe 100% ast.

Travel:

0	1	2	3	4
No Pain Long Trips	Mild Pain Long Trips	Moderate Long Trips	Moderate Short Trips	Severe Short Trips

Work:

0	1	2	3	4
Usual Duties + extra work	Usual duties no extra	Can do 50% of usual	Can do 25% of usual	Can't work

Recreation:

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do few activities	None

Frequency: (% of day)

0	1	2	3	4
No Pain	25%	50%	75%	100%

Lifting (Weight):

0	1	2	3	4
No pain Heavy	Increased Heavy	Increased Moderate	Increased Light	Increased Any

Walking Distance:

0	1	2	3	4
unlimited	1 mile	1/2 mile	1/4 mile	any

Standing (Hours):

0	1	2	3	4
No pain Several	Increased Several	Increased 1 hour	Increased 1/2 hour	Any Standing

Score: _____ / 40

PEDIATRIC PATIENTS ONLY

Birth History O Vaginal Delivery O C-Section

	Circle One
Forceps or Vacuum Extraction use?	Y or N
Colic?	Y or N
Reflux	Y or N
Frequent Colds/Ear Infections	Y or N
Eczema or other skin conditions?	Y or N
Lip or tongue tie revision?	Y or N

PLEASE SEE OTHER SIDE FOR FURTHER INFORMATION

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INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of procedures, including various modes of physio therapy, chiropractic adjustments, examinations, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) at this location and/or other licensed providers and support staff who now or in the future treat me while employed by, working or associated with or as back-up, including those working at this clinic or office listed below, whether signatories to this form or not.

I have had an opportunity to discuss with this provider and/or with other office or clinic personnel the nature and purpose of the procedures.

I understand and I am informed that, as is with all healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all healthcare treatments, there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms and sprains. I do not expect this provider to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I further understand that treatment is designed to improve health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued.

I further understand that there are treatment options available for my condition, these treatment options include, but limited to self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti inflammatories, muscle relaxants and painkillers; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other options if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient: _____

Signature of Patient: _____

Name Printed of Guardian/Parental and Relationship to Patient: _____

Guardian/Parental Signature: _____

Date: _____