

CONFIDENTIAL PATIENT CASE HISTORY



WELCOME TO OUR OFFICE!

Please complete this questionnaire as thoroughly as possible. This confidential history will be part of your permanent records and will help us get a better understanding of your overall health. THANK YOU!

PERSONAL INFORMATION

Name: _____ Date: _____
Date of Birth: ____/____/____ Age: _____ Sex: Male Female Marital Status: S / M / D / W
Address: _____ City: _____ State: _____ Zip: _____
Social Security #: _____ - _____ - _____ Home Phone: (____) _____ - _____
Cell Phone: (____) _____ - _____ E-mail: _____
Occupation: _____ Employer: _____
Employer Address: _____ Work Phone: (____) _____ - _____
Spouse's Name: _____ Date of Birth: _____ Age: _____
Employer Address: _____ Work Phone: (____) _____ - _____
Social Security #: _____ - _____ - _____ How Many Children (Ages)?: _____
Emergency Contact: _____ Phone: (____) _____ - _____
Who Referred You To Us?: _____
How Else Did You Hear About Us?: _____

CURRENT PRIMARY HEALTH CONCERN

What is your main symptom?: _____
How long have you had this condition?: _____
Have you had this or similar conditions in the past?: _____
What do you think caused this condition?: _____
What position(s), if any, make it feel worse?: _____
What position(s), if any, make it feel better?: _____
Over time, is this condition: Improving Unchanged Getting Worse?
Is this condition interfering with your: Work Sleep Daily Routine Other: _____
Have you sought advice or treatment from other doctors or therapists for **this** condition? Yes No
If yes, list all doctors or therapists consulted for this condition (include approximate date of visit and diagnosis).

_____	_____	_____
Name	Date of visit	Diagnosis
_____	_____	_____
Name	Date of visit	Diagnosis

Describe any treatment you have had for **this** condition (include medication dosage and frequency?): _____

Family Medical Doctor: _____ Address: _____ Date of Last Physical: _____

May we communicate our findings on your current health condition to the above provider(s)? Yes No

CONFIDENTIAL PATIENT CASE HISTORY

Patient Name: _____ Date: _____

OTHER HEALTH COMPLAINTS

Please list the specific complaints you are experiencing at this time and mark the location on the diagram. Beside each complaint, rate its severity on a scale of 1-10 with 1 being the least discomfort you have experienced and 10 being the most discomfort you have ever experienced.

Primary Complaint:

1) _____ 1 2 3 4 5 6 7 8 9 10

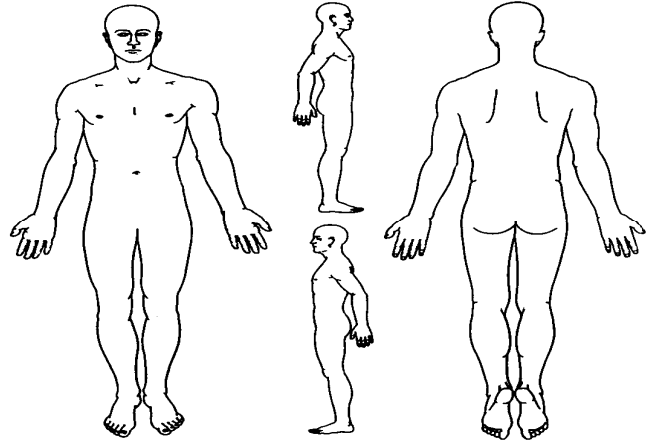
Additional Complaints:

2) _____ 1 2 3 4 5 6 7 8 9 10

3) _____ 1 2 3 4 5 6 7 8 9 10

4) _____ 1 2 3 4 5 6 7 8 9 10

5) _____ 1 2 3 4 5 6 7 8 9 10



PREVIOUS CONDITIONS

Days Lost From Work: _____ Date of Last Physical Examination: _____

Have you sought care for another health condition in the past year? Yes No Past 2 years? Yes No

If yes, what condition other than your primary complaint?: _____

Was treatment administered? Yes No Describe: _____

Do you take medications? Yes No List Dosage, Frequency and Reason: _____

Any prior hospitalizations or surgery? Yes No Describe with dates: _____

Have you been in an auto accident or had any other personal injury? Yes No Describe: _____

CHIROPRACTIC HISTORY

Previous Chiropractic care? Yes No If yes, Doctor's name: _____

Date of last chiropractic visit: ____/____/____ Date of last chiropractic X-rays: ____/____/____

Reason for care: _____ How long were you under care?: _____

Were you satisfied with the previous chiropractic care you received? Yes No

Are other family members under chiropractic care? Yes No Who?: _____

Are you open to looking at new ideas in health and wellness? Yes No

SOCIAL HISTORY

Height: ____ft. ____in. Current Weight: _____ lbs. Have you recently lost or gained more than 10 lbs.? Y N

Mental Work: Heavy Moderate Light Hours per day: _____

Physical Work: Heavy Moderate Light Hours per day: _____

Exercise: Heavy Moderate Light Hours per week: _____ Type: _____

Smoking: Never Currently Previously Packs/day: _____, Pack/week: _____ How long?: _____

Alcohol: Beer/week: _____, Liquor/week: _____, Wine/week: _____ How long?: _____

Caffeine: Cups/day: _____ How long?: _____ Aspirin: No./day: _____ How long?: _____

CONFIDENTIAL PATIENT CASE HISTORY

Patient Name: _____

Date: _____

REVIEW OF SYSTEMS

GENERAL

	Now	Past
Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>

SKIN

Color Changes	<input type="checkbox"/>	<input type="checkbox"/>
Nail Changes	<input type="checkbox"/>	<input type="checkbox"/>
Hair Changes	<input type="checkbox"/>	<input type="checkbox"/>
Moles	<input type="checkbox"/>	<input type="checkbox"/>
Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Sores	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>

HEAD & EYES

Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Injuries	<input type="checkbox"/>	<input type="checkbox"/>
Bumps	<input type="checkbox"/>	<input type="checkbox"/>
Last Eye Exam	<input type="checkbox"/>	<input type="checkbox"/>
Glasses	<input type="checkbox"/>	<input type="checkbox"/>
Contacts	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>

EARS

Hard of Hearing	<input type="checkbox"/>	<input type="checkbox"/>
Deafness	<input type="checkbox"/>	<input type="checkbox"/>
ringing	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Earache	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Room Spins	<input type="checkbox"/>	<input type="checkbox"/>

NOSE

Decreased Smell	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Obstruction	<input type="checkbox"/>	<input type="checkbox"/>
Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>
Deviated Septum	<input type="checkbox"/>	<input type="checkbox"/>
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>

MOUTH

Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>
Sores	<input type="checkbox"/>	<input type="checkbox"/>
Dental Problems	<input type="checkbox"/>	<input type="checkbox"/>
Bad Breath	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Taste	<input type="checkbox"/>	<input type="checkbox"/>
Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Blisters	<input type="checkbox"/>	<input type="checkbox"/>

THROAT

Soreness	<input type="checkbox"/>	<input type="checkbox"/>
Bad Tonsils	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>
Trouble Swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent Infections	<input type="checkbox"/>	<input type="checkbox"/>

NECK

Neck Enlargement	<input type="checkbox"/>	<input type="checkbox"/>
Stiff Neck	<input type="checkbox"/>	<input type="checkbox"/>
Soreness	<input type="checkbox"/>	<input type="checkbox"/>
Lumps	<input type="checkbox"/>	<input type="checkbox"/>
Masses	<input type="checkbox"/>	<input type="checkbox"/>

BREASTS

	Now	Past
Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Lumps	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Nipple Changes	<input type="checkbox"/>	<input type="checkbox"/>
Skin Changes	<input type="checkbox"/>	<input type="checkbox"/>
Bloated	<input type="checkbox"/>	<input type="checkbox"/>

RESPIRATORY

Cough	<input type="checkbox"/>	<input type="checkbox"/>
Phlegm	<input type="checkbox"/>	<input type="checkbox"/>
Blood	<input type="checkbox"/>	<input type="checkbox"/>
Short of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>
Congestion	<input type="checkbox"/>	<input type="checkbox"/>
Inhalant exposure	<input type="checkbox"/>	<input type="checkbox"/>

CARDIOVASCULAR

Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Rapid Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Extremities	<input type="checkbox"/>	<input type="checkbox"/>
Cold Extremities	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain, Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>
Blue Extremities	<input type="checkbox"/>	<input type="checkbox"/>

BLOOD

Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Iron	<input type="checkbox"/>	<input type="checkbox"/>
Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>
Easy Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Nodes	<input type="checkbox"/>	<input type="checkbox"/>
Painful Nodes	<input type="checkbox"/>	<input type="checkbox"/>
Sugar in Blood	<input type="checkbox"/>	<input type="checkbox"/>
Red Spots	<input type="checkbox"/>	<input type="checkbox"/>

GASTROINTESTINAL

Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Bloated	<input type="checkbox"/>	<input type="checkbox"/>
Belching	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Indigestion	<input type="checkbox"/>	<input type="checkbox"/>
Irreg. Bowel Habits	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Gas	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>
Food Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Bloody Stools	<input type="checkbox"/>	<input type="checkbox"/>
Black Stools	<input type="checkbox"/>	<input type="checkbox"/>

GENITOURINARY

Urgency	<input type="checkbox"/>	<input type="checkbox"/>
Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Straining	<input type="checkbox"/>	<input type="checkbox"/>
Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Voiding	<input type="checkbox"/>	<input type="checkbox"/>
Stones	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>
Bed Wetting	<input type="checkbox"/>	<input type="checkbox"/>
Small Stream	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Impotence	<input type="checkbox"/>	<input type="checkbox"/>

GENITOURINARY

	Now	Past
Dribbling	<input type="checkbox"/>	<input type="checkbox"/>
Cloudy Urine	<input type="checkbox"/>	<input type="checkbox"/>
Spotting	<input type="checkbox"/>	<input type="checkbox"/>
Menstrual Cramps	<input type="checkbox"/>	<input type="checkbox"/>
Painful Menses	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>
Painful Intercourse	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Periods	<input type="checkbox"/>	<input type="checkbox"/>
Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>

NEUROLOGICAL

Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Vertigo	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Hand Trembling	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Sensation	<input type="checkbox"/>	<input type="checkbox"/>
Incoordination	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Facial	<input type="checkbox"/>	<input type="checkbox"/>
Weak Grip	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Speech	<input type="checkbox"/>	<input type="checkbox"/>
Tingling	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Memory	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>

ENDOCRINE

Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>
Extremely Thin	<input type="checkbox"/>	<input type="checkbox"/>
Heat Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Cold Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Hair Changes	<input type="checkbox"/>	<input type="checkbox"/>
Breast Changes	<input type="checkbox"/>	<input type="checkbox"/>

IMMUNIZATION/VACCINATION

DPT	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>
Smallpox	<input type="checkbox"/>	<input type="checkbox"/>
Typhoid	<input type="checkbox"/>	<input type="checkbox"/>
Tetanus	<input type="checkbox"/>	<input type="checkbox"/>
Measles	<input type="checkbox"/>	<input type="checkbox"/>
Pneumococcal	<input type="checkbox"/>	<input type="checkbox"/>
Influenza	<input type="checkbox"/>	<input type="checkbox"/>
Polio	<input type="checkbox"/>	<input type="checkbox"/>
MMR	<input type="checkbox"/>	<input type="checkbox"/>

PSYCHIATRIC

Hyperventilation	<input type="checkbox"/>	<input type="checkbox"/>
Insecurity	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Troubles Sleep	<input type="checkbox"/>	<input type="checkbox"/>
Irritable	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Memory	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>
Drug Dependent	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal Thoughts	<input type="checkbox"/>	<input type="checkbox"/>
Extreme Worry	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Problems	<input type="checkbox"/>	<input type="checkbox"/>

MUSCULOSKELETAL

Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Cramps	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Joint Stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>

PAST MEDICAL HISTORY

Check only the ones you have had in the past.

Hay Fever	<input type="checkbox"/>
Mumps	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>
Allergies	<input type="checkbox"/>
Angina	<input type="checkbox"/>
Cancer	<input type="checkbox"/>
Tumor	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>
Stroke	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>
Skin Trouble	<input type="checkbox"/>
Gallstones	<input type="checkbox"/>
Liver Trouble	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>
Parasites	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>
Polio	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>
Depression	<input type="checkbox"/>
Nervous Breakdown	<input type="checkbox"/>
Migraine	<input type="checkbox"/>
Gout	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>
Prostate Problems	<input type="checkbox"/>
Sexual Problems	<input type="checkbox"/>
Gonorrhea	<input type="checkbox"/>
Syphilis	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>
Bladder Trouble	<input type="checkbox"/>
Kidney Stones	<input type="checkbox"/>
Kidney Infections	<input type="checkbox"/>
Dysentery	<input type="checkbox"/>

ALLERGIES

List known allergies below

**If Female,
Are You Pregnant?**

Yes
 No

CONFIDENTIAL PATIENT CASE HISTORY

Patient Name: _____ Date: _____

FAMILY HISTORY - List any of the diseases listed previously which run in your family

Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses (if any)
Father:	_____	_____	_____	_____	_____
Mother:	_____	_____	_____	_____	_____
Brother(s):	_____	_____	_____	_____	_____
Sister(s):	_____	_____	_____	_____	_____
Grandfather (Mat):	_____	_____	_____	_____	_____
Grandmother (Mat):	_____	_____	_____	_____	_____
Grandfather (Pat):	_____	_____	_____	_____	_____
Grandmother (Pat):	_____	_____	_____	_____	_____

Spouses Health Status: Poor Fair Good Excellent

Children's ages and health status: _____

INSURANCE INFORMATION

Who is responsible for this account?: _____

Relationship to Patient?: _____

Insurance Co.: _____ Patient ID#: _____ Group #: _____

Is patient covered by additional or secondary insurance? Yes No

Subscriber's Name: _____

Relationship to Patient?: _____ Birth Date: _____

Insurance Co.: _____ Patient ID#: _____ Group #: _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage and assign directly to Back to Health Wellness Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I understand that interest is charged on overdue accounts at the annual rate of 18%. I authorize the doctor or chiropractic office to contact me via mail, email and phone in regards to treatment as well as promotional activities. The above-named clinic may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

I have also received a copy of this office's Financial Policy and Appointment Policy and agree to its terms.

SIGNATURE of Patient, Parent or Guardian: _____

PRINTED Name of Patient, Parent or Guardian: _____

Date: _____ Relationship to Patient: _____

Witness Signature: _____ Date: _____

INFORMED CONSENT for EXAMINATION & TREATMENT

Name: _____ Dr.

Case #: _____ DOB: _____

Date: _____ Age: _____

Back to Health Wellness Center, 2504 Monroe St., LaPorte, IN 46350

TO THE PATIENT: You have a right as a patient to be informed about your condition, the recommended chiropractic treatment, and potential risks involved with the recommended treatment. This will allow you to make an informed decision whether or not to undergo the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedures and/or treatment.

I request and consent to the performance of examination and treatment (chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, rehabilitative exercises and diagnostic X-rays). The chiropractic treatment may be performed by the Doctor(s) of Chiropractic working at Back to Health Wellness Center. Chiropractic treatment and other therapies and procedures may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below as well as those working at the clinic or office who now or in the future treat me while being employed by, working or associated with Back to Health Wellness Center.

I have had adequate opportunity to discuss with the Doctor of Chiropractic, or other clinic personnel, the nature and purpose of my chiropractic treatment (adjustments) and different physical therapy procedures (therapies and active rehabilitation). I have also discussed with Doctor of Chiropractic the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment which includes no treatment at all.

I understand that neither chiropractic, nor any medical treatment for that matter, is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand, and I am informed, that there are some risks to chiropractic examination and treatment (adjustments and physical therapy) including, but not limited to: fractures, spinal or disc injuries, strokes, strain/sprains, dislocations, increased or unchanged symptoms and pain; and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of treatment as to which risks and complications are significant. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about my examination and treatment, and all my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

FEMALE PATIENTS: By my initials here _____, I do hereby state that to the best of my knowledge, I AM NOT PREGNANT, nor is pregnancy suspected or confirmed at this particular time and. I consent to X-rays if the doctor deems them necessary for the evaluation of my condition. First Day of Last Menstrual Period: ____/____/____.

CONSENT TO EXAMINATION AND TREATMENT OF MINOR: I hereby agree to the above statements and authorize the doctor(s) of this clinic, and whomever they may designate as their assistants, to administer examination and treatment as they so deem necessary to my:

son daughter Minor's Name: _____

Patient:

Print Name: _____ Signature: _____ Date Signed: _____

Patient's Representative:

Print Name of Patient's Representative: _____ Relationship to Patient: _____

Signature of Patient's Representative: _____ Date Signed: _____

Doctor or Staff:

Witness of Patient's Signature: _____ Date Signed: _____

Translated by: _____ Date Signed: _____

(A scanned copy of this document shall serve as the original.)

AGREEMENTS and AUTHORIZATION

Consent To Health Care Services/Release of Health Care Information

You, (the undersigned Patient, or undersigned person responsible for consenting on Patient's behalf), hereby request and consent to Patient health care services from Back to Health Wellness Center. The Patient health care services will be provided by and overseen by licensed, treating physicians. Health care services will also be provided by non-physician health care professionals and assistants employed or otherwise retained by Back to Health Wellness Center. Medical, nursing, and other health care personnel who are in training may also participate in the Patient's care as part of their education.

_____ initial

Payment Guarantee

In consideration of the services provided by Back to Health Wellness Center, Provider to Patient, you agree to; I) guarantee payment of all charges incurred by Patient in connection with such services ("Patient Charges"); II) irrevocably assign and transfer to Back to Health Wellness Center, all right, title and interest to medical reimbursement benefits to which Patient is entitled for the purpose of payment of Patient Charges; and III) authorize payment of such benefits directly to Back to Health Wellness Center. You also agree to be fully responsible for the payment of any and all Patient Charges to the extent that these charges are not satisfied by the assigned benefits.

_____ initial

Notice of Non-Coverage

If you have insurance, insurance companies will only pay what is covered in each individual's insurance policy. Your insurance does not pay for all of your healthcare costs, specifically as it relates to treatment in a chiropractic office. Your insurance policy will only cover services that it deems are "Medically Necessary" according to their specific guidelines. When you receive a service or item that your insurance policy does not cover, then you are personally responsible for the non-covered services at the time they were rendered (unless prior arrangements have been made). Specifically, your insurance policy will not allow payment for the following non-covered services and you will have to pay out-of-pocket the normal fee as listed below because they are routinely deemed not-medically necessary according to insurance guidelines: maintenance/wellness/preventative care (\$45 per visit), nutritional supplements (\$25-40), therapeutic modalities used for maintenance (\$25), massage (\$35-95) and any service beyond your benefit plan visit limitations or services that are excluded from the benefit plan.

_____ initial

Patient Right To Restrict Disclosure of Protected Health Information (PHI)

For any service in which you pay for 100% out-of-pocket, you have a right to restrict the disclosure of that healthcare information for that particular service to any health insurance entity. This is according to your HIPAA privacy rights established under the American Recovery and Reinvestment Act (ARRA) of 2009. For services that are non-covered under your insurance plan and that you pay for in-full out-of-pocket, you understand and request that Back to Health Wellness Center do not bill for any of these non-covered services or items on my behalf and that you wish to restrict the disclosure of PHI of these services from your insurance company.

_____ initial

Responsibility For Personal Property

You accept sole responsibility for all Patient property, except for property expressly accepted by Back to Health Wellness Center for safekeeping under its sole care and custody.

SIGNATURE of Patient, Parent or Guardian: _____

PRINTED Name of Patient, Parent or Guardian: _____

Date: _____ Relationship to Patient: _____

Witness Signature: _____ Date: _____

AUTHORIZATION and HIPAA PRIVACY NOTICE

Consent To Release Information

Here at Back to Health Wellness Center, we do not sell or release your information to third parties. There will be cases along the course of your care where information will need to be released in certain circumstances. You authorize Back to Health Wellness Center to release to employer groups, government agencies (Medicare, Medicaid, Champus, State or Federal government, etc.), insurance companies, or other third-party payers and their agents, and its collection representatives and attorneys, the following "Patient Information": medical history, diagnosis and procedures performed, course of treatment, plan of care, prognosis, supplies and/or such other information that may be requested for the purpose of determining eligibility and availability of Patient's benefits, obtaining authorization/payment for Patient's health care services, or billing and collection of amounts due to Back to Health Wellness Center for services rendered. In the case of Patient Information released for purposes of payment of Patient Charges, this authorization shall be valid only for the period of time necessary to process payment claims. You agree to pay any Patient Charges that are denied or are ineligible for medical reimbursement benefits as a result of your refusal or revocation of consent to disclose Patient Information.

You further authorize any individual health care professional, including treating physician(s), to provide Back to Health Wellness Center or its designee with Patient Information for quality assurance and, or risk management purposes. Finally, in the event that the Patient's employer, or an insurance company representing such employer, requests Patient Information relating to healthcare services provided for worker's compensation injuries, it is understood and agreed that Back to Health Wellness Center is required, under state law, to release copies of such information to such employer or insurance company without the authorization of Patient or Patient's representative. Again, here at Back to Health Wellness Center, we strive to provide you with the best care possible and in order to do that this consent is necessary.

_____ initial

HIPAA Privacy Notice Patient Acknowledgment

For use and/or disclosure of Protected Health information (PHI) to carry out Treatment, Payment and Healthcare Operations

I hereby state that by signing this Consent I acknowledge and agree as follows:

- 1) The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice would be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
- 2) The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
- 3) The Practice's "Notice of Privacy Practices" is also provided in the reception area display table and on the Practice's web site at www.LaPorteWellness.com. I may also request a copy from this office at any time via US Mail.

This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.

_____ initial

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

SIGNATURE of Patient, Parent or Guardian: _____

PRINTED Name of Patient, Parent or Guardian: _____

Date: _____ Relationship to Patient: _____

Witness Signature: _____ Date: _____

(A scanned copy of this document shall serve as the original.)

OFFICE FINANCIAL POLICY



Your understanding of our financial policy is an essential part of your care and treatment. If you have any questions, please don't hesitate to discuss them with our office staff.

- No Insurance/Self Pay
- Group Health Insurance
- Managed Care
- HSA/HRA/Flex
- Medicaid
- Medicare
- Secondary Insurance
- Workers' Compensation
- Auto Accident
- Personal Injury
- Maintenance/Wellness Care (Not covered by insurance)

- As a courtesy we will contact your insurance carrier to verify your coverage, but this is only an estimate of what the insurance company will pay until we receive an actual payment. It is not a guarantee of payment.
- Your insurance policy is a contract between you and your insurance company. Also as a courtesy, we will file your insurance claims for you if you assign benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly.
- We are glad to assist you in billing your insurance, but you are ultimately responsible for full payment. Patients are encouraged to contact their carrier for clarification of benefits prior to services being rendered. You are considered a cash-based patient until we verify and determine the extent of benefits under your policy.
- Due to frequent erroneous information given to us from insurance carriers and the frequent difficulty in collecting payments from the carrier, we may ask for active assistance from you in rectifying the situation.
- All payments are due at the time of service. No personal balance is to exceed \$150. We accept cash, checks, and most major credit cards.
- All deductibles and co-payments are due at the time of service or by an authorized payment plan. Most insurance does not cover 100% of services rendered. Because of this and the delay in payment common with insurance carriers, you will be asked to pay your deductible and your portion of your charges the day the service is rendered.
- After 60 days, any outstanding balances will be due in full by you. Balances over 60 days past due will be automatically debited from your checking account or credit card on file or through a third-party vendor. All balances past due 60 days or greater will be charged at a 1.5% monthly (18% annual) interest rate.
- You must inform this office of all insurance changes and referral requirements. In the event the office is not informed or the proper referral was not obtained by you in advance, you will be responsible for any charges denied as a result of not informing us or not obtaining the authorized referral.
- A 50% minimum down payment is required to place an order for products, supplies, orthotics, etc. with the remainder becoming due upon receiving such supplies or products. Full payment is required before receiving any products or supplies.
- Insurance is designed for sick care and only reimburses for services it deems "medically necessary" according to their guidelines. Unfortunately, prevention and health maintenance care is not reimbursable. When your schedule of visits exceeds 3 weeks or if the doctor releases you from active treatment, you will not be eligible for insurance benefits since maintenance/wellness care is a non-covered service.
- Non-compliance with a prescribed treatment plan may jeopardize insurance reimbursement. If you discontinue care or suspend care for any reason other than discharge by the doctor, any fees for professional services will become immediately due and payable in full by you, regardless of any claim submitted.
- There is a service fee of \$35 for all returned checks. Your insurance company does not cover this fee.
- Past due accounts (those over 120 days) are subject to collection proceedings, which may affect your credit. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office.

Keep this copy for your information.

APPOINTMENT POLICY



We want to thank you for choosing us as your chiropractic healthcare provider. We understand that your time is as valuable as ours. Because of this, it is our goal to provide to you with our highest quality care in the most cost effective and efficient manner. An understanding of our appointment guidelines is essential for a healthy relationship.

Advanced Multiple Appointments: As you know, healing takes time. Your care will likely require repeated visits as your body progresses through the healing process. As a means of reducing your costs and improving efficiency, advanced multiple appointments are established in order to limit your time in our office by reducing the need to schedule visit-by-visit with the front desk staff. Any deviation from the prescribed treatment schedule may potentially jeopardize insurance reimbursement.

Rescheduling Appointments: Please remember that we have reserved appointment times especially for you and that your appointments are “written in pencil”, meaning that it is okay to reschedule if something unexpected arises. Please let us know at least 24 hours in advance of the need to reschedule an appointment. Giving us advance notice will allow time to fill in that appointment with someone else who needs it.

Cancelling Appointments: Please let us know at least 24 hours in advance of the need to cancel an appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. Canceled appointments will be recorded in your medical record.

Missed Appointments “No-Show”: An appointment that is missed without at least a 12-hour advance notice to cancel or reschedule is considered a missed appointment. It is the policy of this office to assess a **\$10** missed appointment fee. One missed visit will not result in the assessment of a fee, but you will be charged for any additional missed visits. This clinic provides care for many individuals and missed visits result in time lost that could have been used to provide care for others. This fee is not reimbursable by any insurance plan. Missed appointments will be recorded in your medical record.

Extra Visits: Adhering to your prescribed schedule of care is vitally important to your health recovery process. If you reschedule, cancel or miss any appointment, it is your obligation to complete an extra visit within 7 days in order to not delay your progress.

Arriving Early: You are more than welcome to arrive early for any appointment; however, you will be seen by the doctor at your reserved appointment time.

Arriving Late: If you arrive more than 10 minutes after your scheduled appointment time you will be worked into the schedule at the next available time slot in order to honor the appointment times of others.

Open Door Promise: We understand that life can get busy. So if at any time you get “side-tracked” and decide to put your healthcare on hold, please know that you are always welcome back at any time. Our door is always open to you whenever you decide to start again. Even though it is our duty to educate and encourage you to make the best decisions for your optimal health, we promise to never scold, lecture or yell at you for any decision you make in regards to your own healthcare.

Keep this copy for your information.

HIPAA PRIVACY NOTICE



Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. You understand and agree to allow this office to use your Patient Health Information for the purpose of treatment, payment, healthcare operations and coordination of care. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of a request to do so and a cost-based fee for photocopying, postage and preparation may apply.

You may request changes to your records which our practice has the right to accept or deny.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our office is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager, Dr. Kirkham or Kay Engle at 326-5100.

If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing the consent on the Confidential Patient Case History form.

Thank You.

Keep this copy for your information.