Back to Health Wellness Center
2504 Monroe Street, LaPorte, IN 46350
PH: (219) 326-5100 FX: (219) 326-0180

Patient History Update

WELCOME BACK TO OUR OFFICE! Since it's been some time since your last visit, please complete this questionnaire in its entirety. This confidential history will be part of your permanent medical records.

PERSONAL INFORMATION

Patient Legal Name: _____ **Date:** _____/_____/_____
Date of Birth: _____/_____/_____ **Age:** _____ **Sex:** ❑ Male ❑ Female **Marital Status:** S / M / D / W
SSN: _____/_____/_____ **Home Phone:** (_____) _____-_____ **Cell Phone:** (_____) _____-_____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Email: _____ **Occupation:** _____
Employer Name/City: _____ **Work Phone:** (_____) _____-_____
Spouse or Guardian's Name: _____ **How Many Children (Ages):** _____
Spouse's Employer: _____ **Spouse's SSN:** _____/_____/_____
Emergency Contact: _____ **Phone:** (_____) _____-_____

If Patient is School Age (15+), I Authorize Treatment in My Absence esp. In Case of Medical Emergency (GUARDIAN SIGN BELOW):

Legal Guardian Signature: _____ Patient Relation: _____ Date: _____

CHIEF COMPLAINT – HPI (HISTORY OF PRESENT ILLNESS)

What is Your MAIN COMPLAINT? _____
WHERE is it located? _____
DESCRIBE this complaint: _____
WHEN did this start? _____
What CAUSED it? _____
How SEVERE is it (rate 1 to 10, with 10 being worst)? _____
How FREQUENT is it? _____
It is Getting better, worse, same over time? _____
What activities RELIEVE it? _____
What activities AGGRAVATE it? _____
Is it RADIATING anywhere? _____

PAST MEDICAL HISTORY

Height: _____ft. _____in. **Current Weight:** _____lbs. **Recently Lost or Gained More Than 10 lbs?** ❑Yes ❑No
Last Physical Exam Date and Results? _____
Have You Seen Other Physicians/Providers for THIS Main Primary Condition? ❑Yes ❑No
List Any Prescription & Non-Prescription Medications, Vitamins You Are Currently Taking: ❑ Not Taking Any Meds

Medication	Dosage	For What Condition?	How Long Been Taking This?

AUTHORIZATION AND RELEASE

I certifty that if I, and/or my dependent(s) have insurance coverage, I assign directly to Back to Health Wellness Center ("BTH") all insurance benefits 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 below on all insurance submissions. I authorize the medical team and staff of both BTH to contact me via mail, email and phone in regards to treatment as well as promotional activities. BTH may use my healthcare information and may disclose such information to my insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurancde benefits ro the benefits payable for related servcies. This consent will end when my current treatment plan is completed or one year from the signed date below.

SIGNATURE of Patient, Parent or Guardian: **X**_____ Date: _____/_____/_____

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Patient Informed Consent to Examination & Treatment

To the Patient:
You understand that consultation, examination and any diagnostic testing will help determine if you are candidate for treatment and what types of treatment, if any, are recommended. You understand that treatment will not begin until all your questions and concerns have been answered to your satisfaction. You have a right as a patient to be informed about your condition, the recommended treatment, and potential risks involved with the recommended treatment. This will allow you to make an informed decision whether to undergo the treatment or not. 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.

Consent for Medical Evaluation and Treatment:
I, with my signature below, authorize Back to Health Wellness Center, it's healthcare providers, and any employee working under the direction of the Doctor/Nurse Practitioner, to provide medical services for me, or to this patient for which I am the parent or legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include, but not limited to, preventative, diagnostic, nutritional, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for coordination of care and treatment. I realize that doctors do not heal or treat any specific condition, but that the goal of holistic health is to strengthen the patient's body in order to heal themselves.

Consent for Chiropractic Evaluation and Treatment:
I have been advised that chiropractic care, like all forms of health care, carries some risk. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which is suggested to occur at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments. Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at Back to Health Wellness Center, have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to examination and treatment by any means, methods, and or techniques the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

Patient Name Printed: _____ Date of Birth: _____/_____/_____

Patient, Parent or Guardian Signature: _____ Date: _____/_____/_____

Witness Initials: _____

FEMALE PATIENTS ONLY:

Regarding X-Rays/Imaging Studies and Procedures: *Please read carefully, check the boxes, include the appropriate date, then sign below if you understand and have no further questions. Otherwise, see your case manager for further explanation.*

❑ I am aware of when I am most likely to become pregnant, and to the best of my knowledge, I AM NOT PREGNANT, nor is pregnancy suspected or confirmed at this time. I consent to X-rays if the doctor/nurse practitioner deems them necessary for evaluation of my condition.

The first day of my last menstrual cycle (period) was on: (date) _____/_____/_____

By my signature below, I am acknowledging that the doctor, nurse practitioner, and/or staff member discussed with me the potentially hazardous effects of certain in office procedures, such as X-rays, that may cause ionization to an unborn child. I have conveyed my understanding of these risks and documented above my non-pregnancy condition as it relates to X-ray examination the doctor/nurse practitioner may have deemed necessary in my case.

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Patient/Guardian Signature: _____ Date: _____/_____/_____

Witness Initials: _____

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Acknowledgments, Agreements and Authorizations

Patient Acknowledgment of Receipt of HIPAA Notice of Privacy Practices and Consent for Use of PHI, Disclosure of Ownership Interest, and Statement of Patient Rights & Responsibilities

I acknowledge receipt of a copy of Back to Health Wellness Center Privacy Notice, last updated 3/1/2019, as well as a Disclosure of Ownership Interest and Statement of Patient Rights & Responsibilities.

_____ initials

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 healthcare providers. 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, technicians, assistants and other health care personnel who are in training may also participate in the Patient's care as part of their education.

_____ initials

Payment Guarantee / Assignment of Benefits

In consideration of the services provided by Back to Health Wellness Center (hereafter, "the Clinic"), Provider to Patient, you agree to; 1) guarantee payment of all charges incurred by Patient in connection with such services ("Patient Charges"); 2) irrevocably assign and transfer to the Clinic, all right, title and interest to medical insurance reimbursement benefits to which Patient is entitled for the purpose of payment of Patient Charges; and 3) authorize payment of such benefits directly to the Clinic. 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.

_____ initials

Notice of Non-Coverage

If you have insurance, insurance companies will only pay what is covered in each individual's insurance policy. Your insurance likely does not pay for all of your healthcare costs. Your insurance policy will only cover services that it deems "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 chiropractic care ($65 per visit), nutritional supplements, therapeutic modalities used for maintenance ($30), rehabilitation therapy ($50 per unit), and any service beyond your benefit plan visit limitations or services that are excluded from the benefit plan.

_____ initials

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

For any service in which you pay for 100% out-of-pocket, you have the 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.

_____ initials

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. Back to Health Wellness Center is not responsible for lost or stolen items.

Patient Name Printed: _____ Date of Birth: _____/_____/_____

Signature of Patient, Parent or Guardian: _____ Date: _____/_____/_____

Witness Initials: _____

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Consent to Call, Email or Text Message for Appointment Reminders and Other Communication

We have the ability to call, email or text you, reminding you of your scheduled appointments in our office. Patients in our practice may be contacted via phone, text message or email to be reminded of an appointment, to obtain feedback on an experience within our office, to view and obtain your personal health information in a secure way, test results, and to provide general health reminders and office information. **YOUR INFORMATION WILL NEVER BE SOLD AND WILL ONLY BE USED FOR DIRECT COMMUNICATION BETWEEN OUR OFFICE AND YOU.**

1) I consent to receiving appointment reminders and other healthcare communications and information via phone from Back to Health Wellness Center. By completing and providing the phone number information below, you consent to this phone call communication.

   Preferred Phone Number for VOICE COMMUNICATION: (_____) _____ - _____

2) I consent to receive text messages from Back to Health Wellness Center and temporarily from Back to Health Wellness Center on my cell phone and any number you have set forwarding/transferring to that number. The cell phone number that I authorize to receive text messages for appointment reminders, feedback and general health reminders/information is. By completing and providing the phone number information below, you consent to this text communication.

   Preferred Phone Number for TEXT COMMUNICATION: (_____) _____ - _____

3) I consent to receive email messages from Back to Health Wellness Center and temporarily from Back to Health Wellness Center for the reasons stated above. The email that I authorize to receive email messages for general health reminders, feedback, and office information is provided below. By providing the email information below, you consent to this email communication.

   Preferred email for EMAIL COMMUNICATION: _____

I understand that this request to receive phone calls, emails and/or text messages from our office to you will apply to all future appointment reminders, feedback, health information unless I request a change in writing. By signing below, you consent to the above approved communication methods.

Patient/Guardian Signature: _____ Date: _____/_____/_____

Authorized Representatives

Your privacy is of utmost importance to us. If you are over age 18, you are the only one our office is authorized to communicate with regarding any aspect of your care, including appointments, finances and billing. Please list anyone you are authorizing to obtain verbal medical information about you, including your spouse or anyone else you authorize. If you do not list anyone below, then you will remain the only one authorized for office to communicate.

Name of Authorized Representative	Initiated Date	Phone Number	Relationship to You	Discontinue Date
1.				
2.				
3.				
4.				