Patient Data

Date: _____

Title: ☐Mr. ☐Mrs. ☐Ms ☐Miss (check one)

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Address Line 1: _____

Address Line 2: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: (_____)_____-_____ **Work Phone:** (_____)_____-_____

Cell Phone: (_____)_____-_____

Date of Birth: _____/_____/_____ **Sex:** ☐Male ☐Female **Email:** _____

Social Security Number: _____-_____-_____ **Marital Status:** ☐Single ☐Married ☐Other

Employment Status: ☐Employed ☐Full Time Student ☐Part Time Student ☐Other (check one)

Spouse Data

Is your spouse a patient in the clinic? ☐Yes ☐ No **Date of Birth:** _____/_____/_____

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Home Phone: (_____)_____-_____ **Work Phone:** (_____)_____-_____

Employer Data

Name: _____

Address Line 1: _____

Address Line 2: _____

City: _____ **State:** _____ **Zip Code:** _____

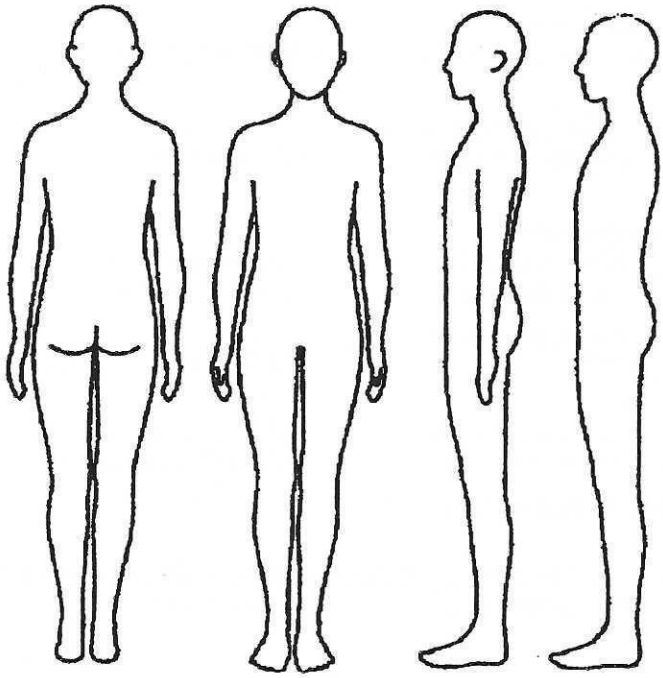
Emergency Contact

Contact Name: _____

Contact Phone: (_____) _____-_____

By using the key below, indicate on the body diagram where you are experiencing the following symptoms:

 # = Numbness **X = Burning** **/ = Stabbing** **0 = Pins & Needles** **+ = Dull Ache**



Describe your symptoms:_____

_____

When did your symptoms start? **Month**_____ **Day**_____ **Year**_____

How did your symptoms begin?_____

_____

How often do you experience your symptoms?

- ❑ Constantly (76-100% of the day)
- ❑ Frequently (51-75% of the day)
- ❑ Occasionally (26-50% of the day)
- ❑ Intermittently (0-25% of the day)

What describes the nature of your symptoms?

- ❑ Sharp
- ❑ Burning
- ❑ Dull ache
- ❑ Tingling
- ❑ Numb
- ❑ Stabbing
- ❑ Shooting

How are your symptoms changing?

- ❑ Getting better
- ❑ Not changing
- ❑ Getting worse

During the past 4 weeks, indicate the average intensity of your symptoms: (0 = None to 10 = Unbearable)

- ❑ 0 None
- ❑ 1
- ❑ 2
- ❑ 3
- ❑ 4
- ❑ 5
- ❑ 6
- ❑ 7
- ❑ 8
- ❑ 9
- ❑ 10 Unbearable

During the past 4 weeks, how much has pain interfered with your normal work (including both work outside the home and housework):

- ❑ Not at all
- ❑ A little bit
- ❑ Moderately
- ❑ Quite a bit
- ❑ Extremely

During the past 4 weeks, how much of the time has your condition interfered with your social activities?

- ❑ All of the time
- ❑ Most of the time
- ❑ Some of the time
- ❑ A little of the time
- ❑ None of the time

_____

Name & Date

Created 07/31/2007
Revised 10/24/2023

In general, would you say your overall health right now is....

❑ Excellent ❑ Very good ❑ Good ❑ Fair
❑ Poor

Who have you seen for your symptoms:

❑ No one ❑ Other Chiropractor ❑ Medical Doctor ❑ Physical Therapist
❑ Other

What treatment did you receive for your symptoms?

❑ Adjustments ❑ Physical Therapy ❑ Medication ❑ Surgery
❑ Other

When did you receive this treatment?

❑ In the last month ❑ 2 – 3 months ago ❑ 3 – 6 months ago ❑ 6 months to 1 year ago
❑ 1 – 2 years ago ❑ 2 – 5 years ago ❑ 5 – 10 years ago

What tests have you had for your symptoms?

❑ X-rays ❑ MRI ❑ CT Scan ❑ Other

When were these tests done?

❑ In the last month ❑ 2 – 3 months ago ❑ 3 – 6 months ago ❑ 6 months to 1 year ago
❑ 1 - 2 years ago ❑ 2 – 5 years ago ❑ 5 – 10 years ago

Have you had similar symptoms in the past?

❑ Yes ❑ No

If you have seen treatment in the past for the same or similar symptoms, who did you see?

❑ This Office ❑ Other Chiropractor ❑ Medical Doctor ❑ Physical Therapist
❑ Other

What is your occupation?

❑ Professional/Executive ❑ White Collar/Secretarial ❑ Tradesperson ❑ Laborer
❑ Homemaker ❑ Full-time Student ❑ Retired ❑ Other

If you are not retired, a homemaker or a student, what is your work status?

❑ Full-time ❑ Part-time ❑ Self-employed ❑ Unemployed
❑ Off work ❑ Other

Thank you. Please return to the front desk.

Is it okay to call you at work?

❑ Yes ❑ No

How did you hear about our clinic? Or who referred you?

❑ Family member	❑ Attorney	❑ Internet web site	❑ Health class
❑ Friend	❑ Yellow Pages	❑ Billboard	❑ Brochure
❑ Physician	❑ Newspaper ad	❑ TV Commercial	❑ Direct mail ad
❑ Employer	❑ Sign on building	❑ Radio	❑ Other

If you selected 'Yellow Pages' please indicate which Yellow Pages:

_____ _____ _____ _____

If you selected 'family member', 'friend', or 'physician' please enter their name below:

_____

If you selected 'other' please describe

_____

Medical Conditions:

❑ Arthritis	❑ Cancer	❑ Diabetes	❑ Heart Disease
❑ Hypertension	❑ Psychiatric Illness	❑ Skin Disorder	❑ Stroke

Surgeries:

❑ Appendectomy	❑ Cardiovascular procedure	❑ Cervical disc procedure	❑ Hysterectomy
❑ Joint replacement	❑ Laminectomies	❑ Radical prostatectomy	❑ Transuretheral prostate surgery

Allergies:

❑ Eggs	❑ Fish and Shellfish	❑ Milk or Lactose	❑ Peanut
❑ Soy	❑ Sulfites	❑ Wheat/Gluten	

Social History:

❑ Caffeine used occasionally	❑ Caffeine used often	❑ Chew tobacco occasionally	❑ Chew tobacco often
❑ Drink alcohol occasionally	❑ Drink alcohol often	❑ Exercise not at all	❑ Exercise occasionally
❑ Exercise often	❑ Experience stress occasionall	❑ Experience stress often	❑ Smoke 1 pack or less per day
❑ Smoke more than 1 pack a day	❑ Wear seat belts always	❑ Wear seat belts never	❑ Wear seatbelts usually

Family History:

❑ Arthritis (parent)	❑ Arthritis (sibling)	❑ Cancer (parent)	❑ Cancer (sibling)
❑ Cholesterol (parent)	❑ Cholesterol (sibling)	❑ Diabetes (parent)	❑ Diabetes (sibling)
❑ Heart problems (parent)	❑ Heart problems (sibling)	❑ High blood pressure (parent)	❑ High blood pressure (sibling)
❑ Psychiatric (parent)	❑ Psychiatric (sibling)	❑ Stroke (parent)	❑ Stroke (sibling)
❑ Thyroid (parent)	❑ Thyroid (sibling)		

Substance Use:

❑ Alcohol (past)	❑ Alcohol (present)	❑ Amphetamines (past)	❑ Amphetamines (present)
❑ Barbiturates (past)	❑ Barbiturates (present)	❑ Cocaine (past)	❑ Cocaine (present)
❑ Crystal Meth (past)	❑ Crystal Meth (present)	❑ Heroine (past)	❑ Heroine (Present)
❑ Marijuana (past)	❑ Marijuana (present)		

Male Children:

❑ Under 6 years	❑ Under 10 years	❑ Under 19 years

Female Children:

❑ Under 6 years	❑ Under 10 years	❑ Under 19 years

Occupational Activities:

❑ Administration	❑ Business owner	❑ Clerical/secretarial	❑ Computer user
❑ Construction	❑ Daycare/childcare	❑ Executive/legal	❑ Food service industry
❑ Health care	❑ Heavy equipment operator	❑ Heavy manual labor	❑ Home services
❑ Household	❑ Light manual labor	❑ Manufacturing	❑ Medium manual labor

Review of Systems:

Have you had trouble with any of the following:

Cardiovascular: No ____

	Present	Past	No
Poor Circulation			
High Blood Pressure			
Aortic Aneurism			
Heart Disease			
Heart Attack			
Chest Pain			
High Cholesterol			
Pace Maker			
Jaw Pain			
Irregular Heartbeat			
Swelling of Legs			

Genitourinary: No ____

	Present	Past	No
Kidney Disease			
Lower Side Pain			
Burning Urination			
Frequent Urination			
Blood in urine			
Kidney Stone			

Hematologic/lymphatic: No ____

	Present	Past	No
Hepatitis			
Blood Clots			
Cancer			
Easy Bruising			
Easy Bleeding			
Fevers/Chills/Sweats			

Neurologic: No ____

	Present	Past	No
Stroke			
Seizures			
Head Injury			
Brain Aneurysm			
Numbness			
Severe Headaches			
Pinched Nerves			
Parkinson's Disease			
Carpal Tunnel			
Spinning/Balance			

Respiratory: No ____

	Present	Past	No
Asthma			
Tuberculosis			
Shortness of Breath			
Emphysema			
Cold/Flu			
Cough/Wheezing			

Ears/Nose/Throat: No ____

	Present	Past	No
Dizziness			
Hearing Loss			
Sinus Infection			
Nosebleed			
Sore Throat			
Difficulty Swallowing			
Bleeding Gums			

Eyes: No ____

	Present	Past	No
Glaucoma			
Double Vision			
Blurred Vision			

Integumentary: No ____

	Present	Past	No
Skin Ulcers			
Skin Disease			
Eczema			
Psoriasis			
Rashes			

Psychiatric: No ____

	Present	Past	No
Depression			
Anxiety Disorder			
Unusual Stress			

Constitutional: No ____

	Present	Past	No
Weight Loss/Gain			
Energy Level Problem			
Difficulty Sleeping			

Allergic/Immunologic: No ____

	Present	Past	No
Hives			
Immune Disorder			
HIV/AIDS			
Allergy Shots			
Cortisone Use			

Gastrointestinal: No ____

	Present	Past	No
Gallbladder Problems			
Bowel Problems			
Constipation			
Liver Problems			
Ulcers			
Diarrhea			
Nausea/Vomiting			
Bloody Stools			
Poor Appetite			

Musculoskeletal: No ____

	Present	Past	No
Gout			
Arthritis			
Joint Stiffness			
Muscle Weakness			
Osteoporosis			
Broken Bones			
Joints Replaced			

Endocrine: No ____

	Present	Past	No
Thyroid Disease			
Diabetes			
Hair Loss			
Menopausal			
Menstrual Problems			

Indy Spine and Rehab
Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy, which we require you to read and sign. This will remain in effect for all services rendered during your time as a patient at Indy Spine and Rehab.

All patients must complete a patient registration form and provide a copy of their insurance card(s).

WE ACCEPT CASH, CHECKS, AND VISA/MASTERCARD

Regarding Insurance:
If we are a participating provider in your insurance plan, we will file claims with your insurance company. As part of our insurance contract, we do require co-pays to be paid at the time of service. Should we receive notification from your insurance company showing that your payment was in excess of the contracted amount, we will refund you accordingly. Any deductibles or percentages not covered by your insurance company will be billed to you upon receipt of explanation of benefits from said insurance. Charges billed are due upon receipt. We cannot bill your insurance company unless you give us your information. Your insurance policy is a contract between you and your insurance company. We are not part of that contract. Please be aware that some, perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your medical insurance plan. You may be asked to sign a date/procedure waiver if we believe that your insurance may deny payment for that service. Like most rehabilitation and physical therapy clinics, we bill for everything we do whether that is manipulation, soft tissue work, Active Release Technique, exercises and so on. Being in your insurance network we have agreed to their set fee schedule. You will see an itemized listing on what was performed and the price adjustment by your insurance company. We don't set the prices, your insurance company has. We simply accept the prices they set for reimbursement.

Usual and Customary Rates:
Our practice is committed to providing the best treatment of our patients, and we charge what is usual and customary for this area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult Patients:
Adult patients are responsible for full payment at the time of service.

Minor Patients:
The adult accompanying a minor or the parent(s) or guardian(s) of the minor are responsible for full payment. For unaccompanied minors, treatment will be denied unless payment is collected prior to services rendered by cash, check, or credit card.

Worker's Compensation:
Worker's compensation will be filed if the patient notifies Indy Spine and Rehab upon scheduling appointment and supplies billing information upon check-in. Details of the accident will be required and a worker's compensation form will be completed.

Missed Appointments:
Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $45.00. If you are greater than 15 minutes late for your appointment, you will have the option to wait until an opening is available or you may reschedule for another date and time.

Returned Check Fee:
For any check that is returned due to non-sufficient funds, it is our policy to charge a fee of $25.00.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read the financial policy of Indy Spine and Rehab. I understand and agree to this financial policy.

Patient Name (print): _____

X _____ **Date:** _____
(Signature of patient or responsible party)

CONSENT TO TREAT: I request and give consent to the doctors and therapists of Indy Spine & Rehab to provide and perform such chiropractic or physical therapy tests, procedures, and other services and supplies as are considered necessary or beneficial for my health and well being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or are relied upon by me.

INITIAL_____

RELEASE OF MEDICAL INFORMATION AND AUTHORIZATION TO PAY INSURANCE BENEFITS: I authorize Indy Spine & Rehab to release information from my medical records to my insurance carrier(s) or government agency for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to Indy Spine & Rehab.

INITIAL_____

MEDICARE CERTIFICATION: I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize Indy Spine & Rehab to release information from my medical record to the Social Security Administration and/or to the Health Care Financing Administration and its agents. Any information needed to determine these benefits or the benefits payable related services and/or to the Professional Standards Review Organizations for processing of claims for medical benefits. I request that payment of authorized benefits be made directly to Indy Spine & Rehab, on my behalf.

INITIAL_____

FINANCIAL AGREEMENT: For, and in consideration of, the services rendered and to be rendered by Indy Spine & Rehab, P.C., the undersigned hereby jointly and severally guarantee the payment of all charges incurred for the account of the patient and further agree that should it become necessary to refer the account to an attorney for collection, the undersigned shall pay all court costs, interest, and reasonable attorney's fees.

INITIAL_____

PATIENT'S
SIGNATURE_____DATE_____

PARENT/GUARDIAN
SIGNATURE_____DATE_____

HIPAA Notice of Privacy Practices

Indy Spine and Rehab, P.C.

718 Adams St., Ste D
Carmel, IN 46032
(317) 817-9900

1173 N. Commercial Dr.
Delphi, IN 46923
(765) 564-1900

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature_____Date_____

Indy Spine and Rehab, P.C.

Carmel, IN 46032 317-817-9900
Delphi, IN 46923 765-564-1900

Patient Authorization

Standard Authorization of Use and Disclosure of Protected Health Information

Carmel 317-817-9900 Delphi 765-564-1900

Information to Be Used or Disclosed

The information covered by this authorization includes:

Billing or Scheduling Questions

Persons Authorized to Use or Disclose Information

Information listed above will be used or disclosed by:

X

Name or Person or Persons that we have permission to talk to, if None, write None

Expiration Date of Authorization

This authorization is effective through No Expiration unless revoked or terminated by the patient or patient's personal representative.

Patient Rights

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to this office and contact the Privacy Officer.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

If you understand and agree with all of the above policies, please sign your name below.

Patient or Legally Authorized Individual Signature

Date

Print Patient's Full Name

Time

Witness Signature

Date

To our clients,

Due to the ever changing regulations that insurance companies are requiring our providers to adhere to, we must ask you to sign an acknowledgment of responsibility form. Any services denied by your insurance company are your responsibility. We will write down your costs to the lowest dollar amount possible.

In addition, this form will also serve as a reminder that your insurance policy is a contract between you and your insurance company. Indy Spine and Rehab P.C. and their employees are not a part of that contract.

Thank you for your understanding and we appreciate your business.

Sincerely,

Indy Spine and Rehab

Print Name	Signature	Date

Office Name: Indy Spine & Rehab P.C.

Office Address: 718 Adams St. Suite D Carmel, IN 46032

Patient Messaging Consent

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or other communications via an automated outreach and messaging system. I also authorize my healthcare provider to disclose to third parties who may intercept these messages (individuals you have provided with access to your digital devices or email accounts) limited protected health information (PHI) regarding my healthcare events. I consent to receiving multiple messages per day from the automated outreach and messaging system, when necessary.

Patient Name

Date

Patient Signature