Southeastern Indiana Spine & Rehab Center

Confidential Patient Information

1214 State Road 229, Suite A, Batesville, IN 47006 Phone: (812) 932-2399 Fax: (812) 932-2398 www.spinerehabindiana.com

Date: _____ /_____ /_____

Patient's Full Name:_____ Social Security #_____

Address:_____ City:_____ State:_____ Zip:_____

E-mail address:_____ Home Phone:_____ Cell Phone:_____

Age:_____ Date of Birth:_____/_____/_____ Gender: Male / Female Marital Status: M S W D

Status: Employed Full-Time Student Part-Time Student Retired Unemployed

Occupation:_____ Employer:_____

Employer's Address:_____ Business Phone:_____

Spouse:_____ Occupation:_____ Employer:_____

Primary Insurance Company:_____ID#_____Group#_____

Insured's Name:_____Date of Birth:___/___/___Employer:_____Relation to Insured:_____

Secondary Insurance Company:_____ID#_____Group#_____

Insured's Name:_____Date of Birth:___/___/___Employer:_____Relation to Insured:_____

Is Today's Visit Due To A Work Related Injury? Yes / No Is Today's Visit Due To An Auto Accident? Yes / No

If you answered yes to either question above, please see the receptionist for additional paperwork.

Emergency Contact:_____ Relationship:_____ Phone:_____

Family Physician:_____ City:_____ State:_____ Phone:_____

Previous Chiropractic Care? Yes / No If yes, for what problem?_____

Doctor's Name:_____ City:_____ State:_____ Phone:_____

Previous Physical Therapy Care? Yes / No If yes, for what problem?_____

Please describe your long-term goal from treatment?_____

Where did you hear about us? Referred by (Friend, Relative, Physician, Ad or Other):_____

AUTHORIZATION AND RELEASE

I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I authorize my attorney to make direct payments to the chiropractor of settlement proceeds. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be **immediately due and payable**.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. 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 this consent. The following person(s) have my permission to receive my personal health information:

_____

_____

Patient's Signature:_____ Date:_____ /_____ /_____

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HISTORY OF PRESENT AND PAST ILLNESS:

Chief Complaint: Purpose of this appointment:_____

Date symptoms appeared or accident happened:_____ /_____ /_____

Secondary or related complaint(s) if any:_____

Is this due to: Auto_____ Work_____ Other_____

Have you ever had the same or a similar condition? Yes / No If yes, when and describe:_____

_____

Days lost from work:_____ Date of last physical examination:_____ /_____ /_____

Describe what caused the pain:_____

What have you done that has made the pain better?_____

PLEASE ANSWER THE FOLLOWING QUESTIONS TO DESCRIBE YOUR **CHIEF COMPLAINT**:

Does your pain radiate?
- ___ Single Spot (Local)
- ___ Radiates (e.g. Down Leg)
- ___ Other:_____

How often are you aware of the pain?
- ___ Intermittent (less than 25% of time when awake)
- ___ Occasional (25-50% of time when awake)
- ___ Frequent (50-75% of time when awake)
- ___ Constant (75-100% of time when awake)

Does any of the following make the pain worse?
- ___ Lifting/bending/pushing/pulling
- ___ Cough/sneeze/bowel movement
- ___ Driving/riding/sitting
- ___ Walking/running/standing

Does any of the following make it better?
- ___ Rest/laying down
- ___ Sitting
- ___ Walking/Exercise

Has your current complaint lead to or been associated with any of the following? (Please Circle)

Muscle Weakness Bowel/Bladder problems Digestion Cardiac/Respiratory

Have you **ever** had a stroke or issue with hypertension? Yes / No If yes, when: _____

Have you recently experienced **dizziness**, unexplained **fatigue, weight loss,** or **blood loss**? Yes / No

If yes, explain: _____

Have you **ever** had any major illnesses, injuries, falls, broken bones, auto accidents or surgeries? Women, please include information about childbirth (include dates): _____

_____

Have you been treated for any health condition by a physician in the last year? Yes / No

If yes, describe:_____

What medications or drugs are you taking?_____

_____

What supplements/vitamins are you taking?_____

Are you currently pregnant? Yes / No

Do you wear orthotics or arch supports? Yes / No

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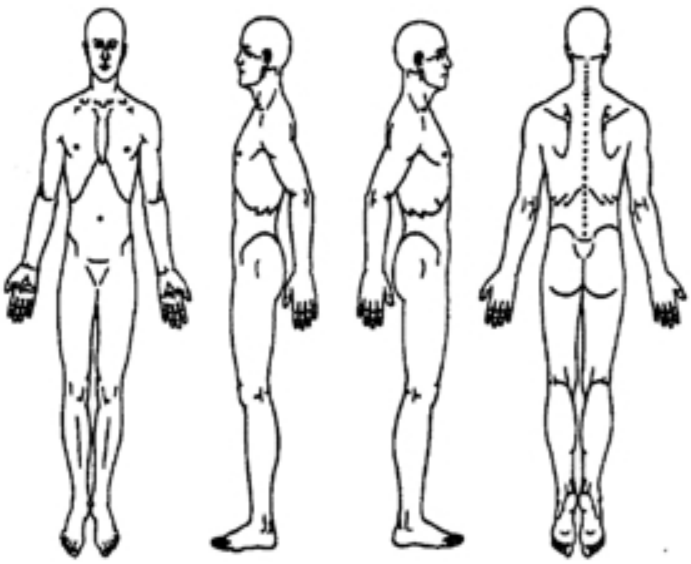
PAIN CHART (For your chief complaint)

Please Mark Your Areas of Pain Using an **X Accompanied by the Proper Codes on the Pictures Provided

A = Ache N = Numbness
B = Burning P = Pins & Needles
ST = Stabbing T = Throbbing
SP = Spasm



SEVERITY OF PAIN
Please circle the number which represents the intensity of your pain.

0 1 2 3 4 5 6 7 8 9 10
no pain unbearable

SYSTEMS REVIEW QUESTIONS:

Do you or have you ever had any problems with the following areas? (Mark a **Y** for yes or **N** for no)

1. ____Eyes
2. ____Ears, Nose, Mouth, Throat
3. ____Heart
4. ____Lungs/Breathing
5. ____Urinary
6. ____Intestinal/Bowels
7. ____Muscles
8. ____Nerves
9. ____Joints/Bones
10. ____Skin
11. ____Internal Organs
12. ____Blood
13. ____Allergies
14. ____Psychological/Emotional

Females Only:

15. ____Gynecological/Menstrual/Breast

Males Only

16. ____Prostate/Testicular

Please explain all **Yes** answers:

_____
_____
_____
_____

SOCIAL HISTORY:

Do you exercise?	Yes / No	How often?_____
Do you smoke?	Yes / No	How many packs?_____
Do you use other forms of tobacco?	Yes / No	How often?_____
Do you consume alcohol?	Yes / No	How much?_____
Do you consume caffeine?	Yes / No	How much?_____
Do you use recreational drugs?	Yes / No	If yes, explain:_____
Do you get enough sleep?	Yes / No	If no, explain:_____
Is your work stressful to you?	Yes / No	If yes, explain:_____
Is your family life stressful to you?	Yes / No	If yes, explain:_____
Do you have other mental stresses?	Yes / No	If yes, explain:_____

FAMILY HISTORY (List any diseases, disorders or major illnesses. If deceased, from what?)

1. Mother: _____
2. Father: _____
3. Sisters: _____
4. Brothers: _____
5. Grandparents: _____
6. Other: _____

Southeastern Indiana Spine & Rehab Center
Financial Policy and Disclaimer

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 you 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 Southeastern Indiana Spine & Rehab Center.

Regarding Insurance:
If we are a participating provider in your insurance plan, we will file claims with your insurance company. As a 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 contract is 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 therapy, Active Release Technique, exercises, etc. 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.

Worker's Compensation:
Worker's compensation will be filed if the patient notifies Southeastern Indiana Spine & Rehab Center upon scheduling appointment and provides the billing information upon arrival for appointment. Details of the accident will be required and a worker's compensation form will be completed.

Appointments:
If unable to keep an appointment, as courtesy to our staff and other patients please give 24-hour notice. If it is a continual problem there will be a **$20.00 charge** added towards your account each visit that is missed. The patient is responsible for payment.

Returned Checks:
It is our policy to collect **$25.00 for checks that are returned** to us. This covers any fees that apply from the transaction.

Financial Policy Questions:
We will be happy to address any questions that you may have regarding your account. Please direct questions to our billing administrator.

I have read, understand and agree to the financial policy of Southeastern Indiana Spine & Rehab Center.

Patient's Name (Please Print): _____

Patient's Signature: _____ Date: _____ /_____ /_____

INFORMED CONSENT

I _____, do hereby give my consent to the performance of conservative non-invasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulation/adjustments involving movement of the joints and soft tissues, physical therapy, exercise, and acupuncture.

Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, there are certain complications that can occur as a result of spinal manipulation/adjustments. These complications include, but are not limited to: soreness or bruising, dizziness, fractures or joint injury and muscle strain. Very rare complications include, but are not limited, a stroke. The most common complication or complaint following spinal manipulation is ache or soreness, much like after when you exercise.

I understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

I also understand there are reasonable alternative treatments available to me including rest, home applications of therapy, medications, exercises and possible surgery.

I have read or had read to me the above explanation of chiropractic treatment. Any and all questions I have regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Patient's Name (Printed): _____

Signature of Patient: _____ Date: _____ / _____ / _____

Signature of Parent/Guardian: _____ Date: _____ / _____ / _____
(if minor)

Signature of Witness: _____ Date: _____ / _____ / _____