PATIENT (CHILD'S) NAME

Name: _____ DOB: _____
(FIRST) (MI) (LAST)

PARENT/GUARANTOR/LEGAL GUARDIAN INFORMATION

Name: _____ DOB: _____
(FIRST) (MI) (LAST)

Address: _____

City: _____ State: _____ Zip: _____

SSN: _____-_____-_____ DL#: _____

Marital Status: M S W D Spouse's Name: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Email Address: _____

Emergency Contact: _____ Phone: _____

Signature: _____ Date: _____

CONFIDENTIAL CASE HISTORY

Name: _____Date: _____ Phone: _____

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

Who is responsible for this account: _____ Referred by: _____

Please indicate reason for this office visit: Check- up_____ Specific Complaint: _____

Describe major complaint: _____

_____

Other Doctor's seen: _____

Current Medications: _____

Vitamins: _____

Past Surgeries (include date and doctor): _____

_____

Please check and describe:

____ Broken Bones: _____

____ Sprains: _____

____ Falls: _____

____ Car Accidents: _____

____ Other Trauma: _____

Personal Habits (please circle): Bed Wetting Hyperactivity

Sleep Habits: Number of Hours _____ Awakens Often _____ Nightmares _____

Appetite: Good _____ Fair _____ Poor _____

Have you had previous chiropractic care: Y N If yes, date of last treatment: _____

Do you have health and accident insurance: Y N If yes, with what company: _____

Family History (please check):

PROBLEM:	ALLERGIES	HEART	BLOOD PRESSURE	KIDNEY	LUNG	LIVER	DIABETES	BACK
MOTHER:								
FATHER:								
BROTHER:								
SISTER:								
GRANDPARENT:								

Name: _____ DOB: _____ DATE: _____

CIRCLE THE FOLLOWING CONDITIONS YOU HAVE HAD:

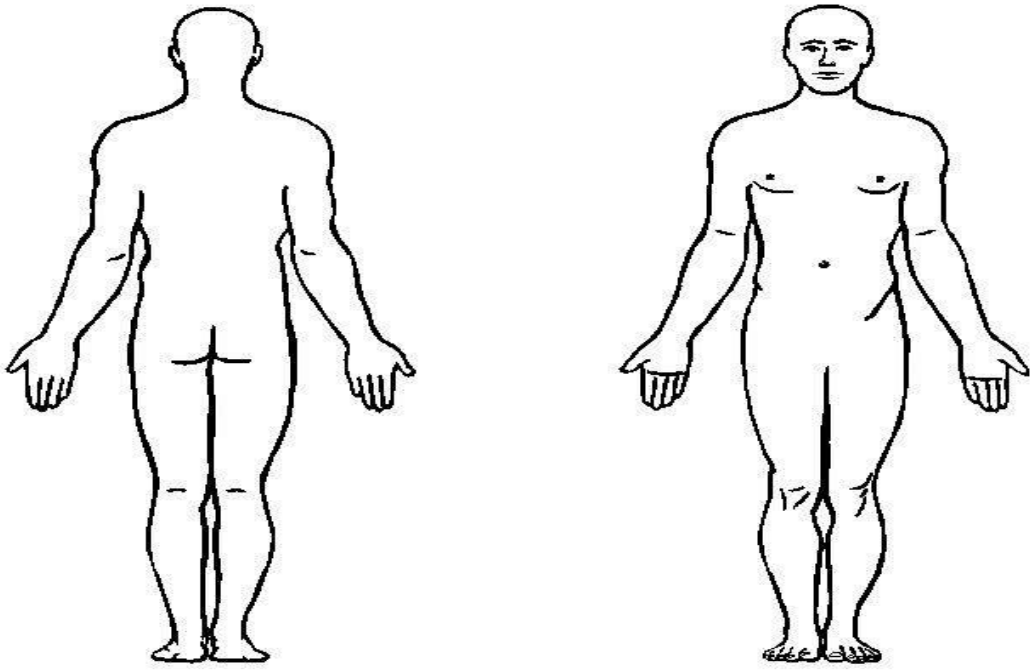
Allergies	Cold Sores	Goiter	Nose Bleeding	Sinus problems
Anemia	Diabetes	Gout	Multiple Sclerosis	Scarlet Fever
Appendicitis	Diphtheria	Heart Disease	Mumps	Tuberculosis
Asthma	Eczema	Influenza	Pleurisy	Typhoid Fever
Bladder Infection	Ear Ache	Lumbago	Pneumonia	Tonsillitis
Cancer	Epilepsy	Malaria	Polio	Venereal Disease
Chorea	Fever Blisters	Measles	Rheumatic Fever	Whooping Cough

PAIN DRAWING: TELL US WHERE YOU HURT

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

ACHE > > > > > NUMBNESS = = = = PINS & NEEDLES O O O O

BURNING X X X X STABBING / / / / / THROBBING ~ ~ ~ ~ ~



Below is a list of diseases and disorders that may seem unrelated to the purpose of your appointment. However, the following information may affect your response to our care as well as our approach to handing your case. Please complete the following as thoroughly as possible.

CHECK ANY OF THE FOLLOWING THAT APPLIES TO YOU:

Allergies	Kidney Problems	Gout	Addictions past/present
Diabetes	Osteo-Arthritis	Chronic Fatigue	Intake or Use:
Cancer	Epilepsy	Lupus	Alcohol
Heart Problems	AIDS or ARC	ALS/MS	Tobacco (chew or smoke)
Stroke	Frequent Illnesses	Parkinson's	Caffeine
Pacemaker	Fibromyalgia	Rheumatoid Arth	Drugs of Abuse

Do you exercise regularly? YES NO Are you dieting? YES NO Since:_____

CHECK ANY PROBLEM AREAS THAT YOU HAVE HAD IN THE PAST YEAR:

MUSCLES/SKELETON
Low Back
Middle Back
Neck
Arm(s)
Leg(s)
Shoulder(s)
Knee(s)
Jaw-TMJ
General Stiffness

NERVE SYSTEM
Headaches
Nervousness
Depression
Numbness/Tingling
Muscular Weakness
Dizziness
Fainting
Convulsions/Seizures
Stress
Shaking/Tremors

CIRCULATION/BREATHING
Chest
Breathing
Blood Pressure
Heart
Lungs
Poor Circulation

DIGESTION/ELIMATION
Poor Appetite
Excessive Thirst
Nausea
Diarrhea
Constipation
Hemorrhoids
Weight Loss/Gain
Gas/Bloating
Heartburn

MALES ONLY
Prostate Problems
Testicular Problems
Erectile Dysfunction

EYE-EAR-NOSE-THROAT
Eyes
Dental
Throat
Ear(s)
Nose
Sinus

URINARY/GENITALS
Pain Upon Urination
Infrequent Urination
Frequent Urination
Weak Urine Stream
Bladder Control

FEMALES ONLY
Menstrual Problems
Low Back Pain w/ Periods
Breast Lump(s)/Problems
Hot Flashes
Postmenopausal

ARE YOU PREGNANT?
YES NO NOT SURE

FAMILY HISTORY: (I.E. heart, cancer, stroke, diabetes, blood pressure, etc.)
Mother's Side:_____

Father's Side: _____

Any Other Problems Not Listed Above:_____

Patient Name: _____ DOB: _____

SIGNATURE: DATE:

ASSIGNMENT OF BENEFITS

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

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

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

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named below, you are hereby tendered demand for pay in full the bill for services rendered by the physician/facility named below within 60 days following your receipt of such bill which I/we owe personally which are not payable under the terms of your policy. This demand specifically conforms to this state's insurance code, providing for attorney fees, penalty, court costs, collection costs, and interest from judgement, upon violation.

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

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

A photocopy of this instrument shall serve as original.

X_____ _____

Signature of patient and/or responsible party Date

HEALTH CARE CENTER
3525 Mitchell Road, Bedford, IN 47421
Informed Consent

Name: _____ Date of Birth: _____

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign it if there is anything that is unclear.

The nature of chiropractic treatment: The primary treatment I use as a Doctor of Chiropractic is spinal manipulation therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joins. That may cause an audible "pop" or "click", much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment: As a part of the analysis, examinations, and treatment, you are consenting to the following procedures if indicated in your treatment, spinal manipulation therapy, ultrasound/laser therapy, hot/cold therapy, electrical stimulation, exercise, massage therapy, graston technique, spinal decompression, radiographic studies, range of motion testing, muscle strength testing, palpation, orthopedic testing, postural analysis, vital signs, basic neurological testing, EMS.

The material risks inherent in chiropractic treatment: As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring: Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check during the taking of your history and during the examination and x-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one if five million cervical adjustments. The other complications are generally described as rare.

The availability and nature of other treatment options: Other treatment options for your condition may include, self-administered, over the counter analgesics, and rest, medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers, hospitalizations, and surgery. If you choose one of the above noted "other treatment" options, you should be aware that there are risks and benefits to such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated: Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

Please check appropriate block and sign below.

I have read ( ) or have had read to me ( ) the above explanation of the chiropractic adjustment and related treatment. I have discussed it with the doctor and have had my questions answered to my satisfaction. By signing below I State that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Date:_____ Date: _____

Patient's Name: _____ Doctor's Name: _____

Signature: _____ Signature: _____

Signature of Parent or Guardian if a minor: _____

HEALTH CARE CENTER

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby request and authorize _____ to furnish to

Health Care Center
3525 Mitchell Road
PO Box 608
Bedford, IN 47421
Phone: 812-275-4419 Fax: 812-275-8044

Access to or copies of the medical records (specified below) for the following person:

Patient's Name : _____
(Last) (First) (Middle/Maiden)

Address: _____

Date of Birth:_____ Social Sec. No: _____

Phone Number: _____

__ Admission History and Physical	__Discharge Summary	__Progress Notes
__Consultations	__Lab Reports	__Pathology Reports
__ Xray Reports	__ Xray Films	__ Therapy Notes
__ Diagnostic Test Results	__Clinic Notes	__ Specify other below
		_____

For the purpose of: _____

I understand that this authorization is subject to written revocation at any time except to the extent that action has been taken based upon it.

Date: _____ Signature: _____
(patient)

Signature: _____
(parent/guardian) (relationship)

Witness: _____
(if patient is unable to sign) (reason)

Information used or disclosed because of this authorization may be further disclosed by the recipient and would therefore be no longer protected.

Acknowledgement of HIPAA Privacy Notice and Designation of Disclosure

Acknowledgement of Health Care Center's Notice of HIPAA Privacy
I have received or read a copay of the notice of HIPAA Privacy for the Physician's Practice

_____ _____ _____ _____

(Patient Name) (Date of Birth) (Signature of Patient/Guardian) (Date)

Designation of certain relative, close friends, and other caregivers

I agree that the practice may disclose my health information to a family member, close personal friend, or other caregiver, since such person is involved with my health care or payment relating to my health care. In that case, the Health Care Center will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care. I wish to be contacted in the following manner.
Check all that apply

____Home Telephone/Answering Machine

____Work Telephone/Voice Mail

____OK to leave message with detailed information

____OK to leave message with Doctor's name

____Leave message with call back numbers only

____Home Address

____Work Address

____OK to mail my home address

____OK to mail my work/office address

____Other

I designate the following persons listed below as persons involved with my health care or payment relating to my health care for the purpose of the practice making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.

Print Name: _____ Relationship to Patient: _____

Print Name: _____ Relationship to Patient: _____

Print Name: _____ Relationship to Patient: _____

The following person(s) are NOT allowed to receive my Patient Health Information:

Print Name: _____ Print Name: _____

Please note that if the above sections are NOT completed, we will assume that we have your approval to contact you using any of these methods.

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and request for, Patient Health Information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the patient/parent/guardian. Uses and disclosures for treatment, payment, and health care operations may be permitted without prior consent.