PATIENT INFORMATION FORM

Today's Date: ____________________

Name: ____________________ Birthdate: ____________________

Address: ____________________ City: ____________ State ________ Zip ________

Social Security No. ____________________(Required if filing with insurance)

Home Phone: ____________ Work Phone: ____________ Cell: ____________

Email: ____________________

Marital Status: Single / Married / Divorced Name of Spouse: ____________________

Employment: Full Time / Part Time / Non Place of Employment: ____________________

Student Status: Full time / Part Time / Non

Emergency Contact Name, Relationship, Phone No.: ____________________

____

Patient's Signature: ____________________, I authorize the release of any medical or other information necessary to process an insurance claim.

INSURED INFORMATION (IF NOT THE PATIENT)

Name: ____________________ Birthdate: ____________________

Address: ____________________ City: ____________ State ________ Zip ________

Relationship to Insured ____________________ Insured SSN: ____________________

Home Phone: ____________ Employer & Work No. ____________________

Primary Insurance / Id. No. / Group No.: ____________________

MAIN COMPLAINT

Area of Pain/Injury ____________________

Type of Pain (dull, sharp, achy): ____________ Rate Pain (1-10): ______ Is Pain Worse in AM or PM

Date of Onset & Where: ____________________

What Aggravates It: ____________________

Does the pain seem to travel?: ________ If so, where?: ____________________

Have you had this pain before?: ____________________

What have you done to treat it?: ____________________

DO YOU HAVE DIFFICULT WITH THE FOLLOWING:

__Headaches
__ Loss of Balance
__Anemia
__Diabetes
__Asthma/Allergies
__Grating in Neck
__Nervousness
__Inner Tension
__Face Flushed
__Slipped Disk
__Fatigue
__Head Feels Heavy
__Constipation
__Fainting
__Low Blood Pressure
__Menstrual Irregular
__Hayfever
__Spasms in Neck
__Ulcers
__Swollen Joints
__Arthritis
__Cold Hands
__Twitching of Face
__Depression
__Heart Palpitation
__Swollen Ankles
__High Blood Pressure
__Menstrual Cramps
__Loss of Smell
__Light Bothers Eyes
__Stomach Trouble
__Painful Joints
__Inflamed Throat
__Thyroid Trouble
__Cold Sweats
__Chest Pain
__Shortness of Breath
__Gall Bladder Trouble
__Cold Feet
__Bladder Trouble
__Sinus Trouble
__Dizziness
__Nervous Stomach
__Sleeping Problems
__Tightness of Throat
__Neuritis Shoulder
__Irritability
__Pinched Nerves
__Liver Trouble
__Heart Attacks
__Indigestion
__Pain in Legs/Feet
__Shooting Head Pains
__Ringing in Ears
__Rhuematic Fever
__Cancer
__Lost of Taste
__Tight Shoulder Muscle
__Numbness
__Pins/Needles Feeling
__Loss of Memory
__Heart Pain
__Intestinal Gas
__Kidney Trouble

SYMPTOM SURVEY FORM

(Restricted to Professional Use)

PATIENT ______________________ DOCTOR ______________________ DATE ____________

INSTRUCTIONS: Number the boxes which apply to you. Use (1) for MILD symptoms (occur once or twice a year), (2) for MODERATE symptoms (occur several times a year), and (3) for SEVERE symptoms (you are aware of it almost constantly).

GROUP ONE

No.	Symptom	No.	Symptom	No.	Symptom
1 ☐	Acid foods upset	8 ☐	Gag easily	15 ☐	Appetite reduced
2 ☐	Get chilled, often	9 ☐	Unable to relax; startles easily	16 ☐	Cold sweats often
3 ☐	"Lump" in throat	10 ☐	Extremities cold, clammy	17 ☐	Fever easily raised
4 ☐	Dry mouth-eyes-nose	11 ☐	Strong light irritates	18 ☐	Neuralgia-like pains
5 ☐	Pulse speeds after meal	12 ☐	Urine amount reduced	19 ☐	Staring, blinks little
6 ☐	Keyed up — fail to calm	13 ☐	Heart pounds after retiring	20 ☐	Sour stomach frequent
7 ☐	Cuts heal slowly	14 ☐	"Nervous" stomach		

GROUP TWO

No.	Symptom	No.	Symptom	No.	Symptom
21 ☐	Joint stiffness after arising	29 ☐	Digestion rapid	37 ☐	"Slow starter"
22 ☐	Muscle-leg-toe cramps at night	30 ☐	Vomiting frequent	38 ☐	Get "chilled" infrequently
23 ☐	"Butterfly" stomach, cramps	31 ☐	Hoarseness frequent	39 ☐	Perspire easily
24 ☐	Eyes or nose watery	32 ☐	Breathing irregular	40 ☐	Circulation poor, sensitive to cold
25 ☐	Eyes blink often	33 ☐	Pulse slow; feels "irregular"	41 ☐	Subject to colds, asthma, bronchitis
26 ☐	Eyelids swollen, puffy	34 ☐	Gagging reflex slow		
27 ☐	Indigestion soon after meals	35 ☐	Difficulty swallowing		
28 ☐	Always seems hungry; feels "lightheaded" often	36 ☐	Constipation, diarrhea alternating		

GROUP THREE

No.	Symptom	No.	Symptom	No.	Symptom
42 ☐	Eat when nervous	49 ☐	Heart palpitates if meals missed or delayed	53 ☐	Crave candy or coffee in afternoons
43 ☐	Excessive appetite	50 ☐	Afternoon headaches	54 ☐	Moods of depression — "blues" or melancholy
44 ☐	Hungry between meals	51 ☐	Overeating sweets upsets	55 ☐	Abnormal craving for sweets or snacks
45 ☐	Irritable before meals	52 ☐	Awaken after few hours sleep — hard to get back to sleep		
46 ☐	Get "shaky" if hungry				
47 ☐	Fatigue, eating relieves				
48 ☐	"Lightheaded" if meals delayed				

GROUP FOUR

No.	Symptom	No.	Symptom	No.	Symptom
56 ☐	Hands and feet go to sleep easily, numbness	63 ☐	Get "drowsy" often	68 ☐	Bruise easily, "black and blue" spots
57 ☐	Sigh frequently, "air hunger"	64 ☐	Swollen ankles worse at night	69 ☐	Tendency to anemia
58 ☐	Aware of "breathing heavily"	65 ☐	Muscle cramps, worse during exercise; get "charley horses"	70 ☐	"Nose bleeds" frequent
59 ☐	High altitude discomfort	66 ☐	Shortness of breath on exertion	71 ☐	Noises in head, or "ringing in ears"
60 ☐	Opens windows in closed room	67 ☐	Dull pain in chest or radiating into left arm, worse on exertion	72 ☐	Tension under the breastbone, or feeling of "tightness", worse on exertion
61 ☐	Susceptible to colds and fevers				
62 ☐	Afternoon "yawner"				

SYMPTOM SURVEY FORM - Page 2

GROUP FIVE

- 73 [ ] Dizziness
- 74 [ ] Dry skin
- 75 [ ] Burning feet
- 76 [ ] Blurred vision
- 77 [ ] Itching skin and feet
- 78 [ ] Excessive falling hair
- 79 [ ] Frequent skin rashes
- 80 [ ] Bitter, metallic taste in mouth in mornings
- 81 [ ] Bowel movements painful or difficult
- 82 [ ] Worrier, feels insecure
- 83 [ ] Feeling queasy; headache over eyes
- 84 [ ] Greasy foods upset
- 85 [ ] Stools light-colored
- 86 [ ] Skin peels on foot soles
- 87 [ ] Pain between shoulder blades
- 88 [ ] Use laxatives
- 89 [ ] Stools alternate from soft to watery
- 90 [ ] History of gallbladder attacks or gallstones
- 91 [ ] Sneezing attacks
- 92 [ ] Dreaming, nightmare type bad dreams
- 93 [ ] Bad breath (halitosis)
- 94 [ ] Milk products cause distress
- 95 [ ] Sensitive to hot weather
- 96 [ ] Burning or itching anus
- 97 [ ] Crave sweets

GROUP SIX

- 98 [ ] Loss of taste for meat
- 99 [ ] Lower bowel gas several hours after eating
- 100 [ ] Burning stomach sensations, eating relieves
- 101 [ ] Coated tongue
- 102 [ ] Pass large amounts of foul-smelling gas
- 103 [ ] Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
- 104 [ ] Mucous colitis or "irritable bowel"
- 105 [ ] Gas shortly after eating
- 106 [ ] Stomach "bloating" after eating

GROUP SEVEN

(A)

- 107 [ ] Insomnia
- 108 [ ] Nervousness
- 109 [ ] Can't gain weight
- 110 [ ] Intolerance to heat
- 111 [ ] Highly emotional
- 112 [ ] Flush easily
- 113 [ ] Night sweats
- 114 [ ] Thin, moist skin
- 115 [ ] Inward trembling
- 116 [ ] Heart palpitates
- 117 [ ] Increased appetite without weight gain
- 118 [ ] Pulse fast at rest
- 119 [ ] Eyelids and face twitch
- 120 [ ] Irritable and restless
- 121 [ ] Can't work under pressure

(B)

- 122 [ ] Increase in weight
- 123 [ ] Decrease in appetite
- 124 [ ] Fatigue easily
- 125 [ ] Ringing in ears
- 126 [ ] Sleepy during day
- 127 [ ] Sensitive to cold
- 128 [ ] Dry or scaly skin
- 129 [ ] Constipation
- 130 [ ] Mental sluggishness
- 131 [ ] Hair coarse, falls out
- 132 [ ] Headaches upon arising wear off during day
- 133 [ ] Slow pulse, below 65
- 134 [ ] Frequency of urination
- 135 [ ] Impaired hearing
- 136 [ ] Reduced initiative

(C)

- 137 [ ] Failing memory
- 138 [ ] Low blood pressure
- 139 [ ] Increased sex drive
- 140 [ ] Headaches, "splitting or rending" type
- 141 [ ] Decreased sugar tolerance

(D)

- 142 [ ] Abnormal thirst
- 143 [ ] Bloating of abdomen
- 144 [ ] Weight gain around hips or waist
- 145 [ ] Sex drive reduced or lacking
- 146 [ ] Tendency to ulcers, colitis
- 147 [ ] Increased sugar tolerance
- 148 [ ] Women: menstrual disorders
- 149 [ ] Young girls: lack of menstrual function

(E)

- 150 [ ] Dizziness
- 151 [ ] Headaches
- 152 [ ] Hot flashes
- 153 [ ] Increased blood pressure
- 154 [ ] Hair growth on face or body (female)
- 155 [ ] Sugar in urine (not diabetes)
- 156 [ ] Masculine tendencies (female)

(F)

- 157 [ ] Weakness, dizziness
- 158 [ ] Chronic fatigue
- 159 [ ] Low blood pressure
- 160 [ ] Nails weak, ridged
- 161 [ ] Tendency to hives
- 162 [ ] Arthritic tendencies
- 163 [ ] Perspiration increase
- 164 [ ] Bowel disorders
- 165 [ ] Poor circulation
- 166 [ ] Swollen ankles
- 167 [ ] Crave salt
- 168 [ ] Brown spots or bronzing of skin
- 169 [ ] Allergies - tendency to asthma
- 170 [ ] Weakness after colds, influenza
- 171 [ ] Exhaustion - muscular and nervous
- 172 [ ] Respiratory disorders

SYMPTOM SURVEY FORM - Page 3

FEMALE ONLY

173 ☐ Very easily fatigued
174 ☐ Premenstrual tension
175 ☐ Painful menses
176 ☐ Depressed feelings before menstruation
177 ☐ Menstruation excessive and prolonged
178 ☐ Painful breasts
179 ☐ Menstruate too frequently
180 ☐ Vaginal discharge
181 ☐ Hysterectomy/ovaries removed
182 ☐ Menopausal hot flashes
183 ☐ Menses scanty or missed
184 ☐ Acne, worse at menses
185 ☐ Depression of long standing

IMPORTANT

TO THE PATIENT: Please list below the five main physical complaints you have in order of their importance:

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

MALE ONLY

186 ☐ Prostate trouble
187 ☐ Urination difficult or dribbling
188 ☐ Night urination frequent
189 ☐ Depression
190 ☐ Pain on inside of legs or heels
191 ☐ Feeling of incomplete bowel evacuation
192 ☐ Lack of energy
193 ☐ Migrating aches and pains
194 ☐ Tire too easily
195 ☐ Avoids activity
196 ☐ Leg nervousness at night
197 ☐ Diminished sex drive

(TO BE COMPLETED BY DOCTOR)

Postural Blood Pressure: Recumbent __________ Standing __________ Pulse __________

Hema-Combistix Urine readings: pH __________ Albumin per cent __________ Glucose per cent __________

Occult Blood __________ pH of Saliva __________ pH of Stool specimen __________ Weight __________

Hemoglobin __________ Blood Clotting Time __________

RECOMMENDATIONS AND SUMMARY:

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________
7. ____________________
8. ____________________

CASE RECORD

Name ______ Date ______ Telephone ( )

Address ______ City ______ State ______ Zip ______

Age ______ Weight ______ Height ______ Sex ______

Occupation: ______ Married ______

History of Illness and Treatment ______

Operations, Accidents or Injuries: ______

Present Illness or Complaints: ______

Diagnostic Summary: ______

Treatment, Recommendations, and Progress: ______

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Form No. SP-113(R 11/89)

NOTICE OF OUR PRIVACY PRACTICES

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your individually identifiable health information.

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and your treatment and the services we provide for you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at this time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may us and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Dr. James B. Gerni
449 E. Main Street
Hagerstown, IN 47346
765-530-8117

and/or

Dr. James B. Gerni
249 S. Franklin Street
Bloomfield, IN 47424
765-541-9450

C. WE MAY USE AND DISCLOSURE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. Any of the people who work for our practice – including, but not limited to, our doctors and nurses, or indirectly with any provider we refer you to – may use or disclose your IIHI in order to treat you, or to assist others in your treatment. Additionally, we may need to disclose your IIHI to others who may assist in your care, such as your spouse, children, or parents.
2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may

contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment and health status to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members or insurance companies. Also, we may use your IIHI to bill you directly for services and items.

3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you receive from us, or to conduct cost-management and business planning activities for our practice.
4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you or a family member who answers the phone (or to leave a recorded message) to remind you of an upcoming appointment.
5. **Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.
6. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.
7. **Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to our office for care. In this example, the babysitter may have access to this child's medical information.
8. **Disclosures Required by Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. In general, we will require that the party that requests your records provide a records-release form, signed by you within the last 3 months.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct

- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identify or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organs and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation in you are an organ donor.

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a research that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being used only for the research and (iii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the research only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research, and if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your IIHI for worker's compensation and similar programs.

PRIVACY PRACTICES - PATIENT RECEPTION FORM

I have received or reviewed the privacy practice notice (4 pages) for Dr. James B. Gerni and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office (my New patient Form Application For Care) on my first visit, whenever that may have occurred.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

Patient Signature ______________________________ Date ________________

Print the Patient Name ______________________________

Dr. James B. Gerni
Clean Living Health Clinic

449 East Main Street, Suite 201
Hagerstown, Indiana 47346
765-530-8117

249 South Franklin Street
Bloomfield, Indiana 47424
765-541-9450

OFFICE AND PAYMENT POLICY

Dr. James B. Gerni's business is a cash practice. This means that payment in full is due after each visit.

Our office will file your insurance claim for you. Dr. Gerni is not in any networks except Medicare. Your insurance will cover whatever it covers for out of network providers. Dr. Gerni may or may not be on your provider list, if your insurance has a provider list. After your deductible is met, your insurance will repay you directly for any payment due you for your visit. If we happen to receive payment, you will get a credit on your account to use toward services or supplements; or you can request a check for the amount of the credit. You can check with your insurance company to see what your insurance covers for chiropractic services.

Medicare only covers the chiropractic adjustment. Medicare does not cover an office visit fee, or any other services or supplements. After a patient meets the deductible, Medicare reimburses the patient with a check for 80 percent of the adjustment part of the visit. The other 20 percent is covered by the patient's supplemental insurance. Medicare keeps a nominal fee. Medicare usually sends a check to the patient within three or four weeks of claim submission. Medicare automatically bills the patient's supplemental (secondary) insurance. This refers to traditional Medicare. If you have Medicare Advantage or the like as your primary insurance, the visit may not be covered or require precertification by the patient. Dr. Gerni is not a registered Medicaid provider and cannot participate in Medicaid. Dr. Gerni does not participate in workman's compensation or personal injury cases.

We accept credit and debit cards, HSA cards, cash and checks.

Your signature documents that you understand and agree to the above; and consent to examination and treatment by Dr. James B. Gerni. Thank you for allowing us to share in your health.

Patient's Signature____________________________________
Date____________________________________