CONFIDENTIAL PATIENT CASE HISTORY

WELCOME TO OUR OFFICE!
Please complete this questionnaire as thoroughly as possible. This confidential history will be part of your permanent records and will help us get a better understanding of your overall health. THANK YOU!

Back to Health
Wellness Center

PERSONAL INFORMATION

Name:_____ Date:_____

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

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

Social Security #:_____-_____-_____ Home Phone:(_____) _____-_____

Cell Phone:(_____)_____-_____ E-mail:_____

Occupation:_____ Employer:_____

Employer Address:_____ Work Phone:(_____)_____-_____

Spouse's Name:_____ Date of Birth:_____ Age:_____

Employer Address:_____ Work Phone:(_____)_____-_____

Social Security #:_____-_____-_____ How Many Children (Ages)?:_____

Emergency Contact:_____ Phone:(_____) _____-_____

Who Referred You To Us?:_____

How Else Did You Hear About Us?:_____

CURRENT PRIMARY HEALTH CONCERN

What is your main symptom?:_____

How long have you had this condition?:_____

Have you had this or similar conditions in the past?:_____

What do you think caused this condition?:_____

What position(s), if any, make it feel worse?:_____

What position(s), if any, make it feel better?:_____

Over time, is this condition: ❑ Improving ❑ Unchanged ❑ Getting Worse?

Is this condition interfering with your: ❑ Work ❑ Sleep ❑ Daily Routine Other:_____

Have you sought advice or treatment from other doctors or therapists for ***this*** condition? ❑ Yes ❑ No

If yes, list all doctors or therapists consulted for this condition (include approximate date of visit and diagnosis).

Name	Date of visit	Diagnosis

Describe any treatment you have had for ***this*** condition (include medication dosage and frequency)?:_____

_____

_____

Family Medical Doctor:_____ Address:_____ Date of Last Physical:_____

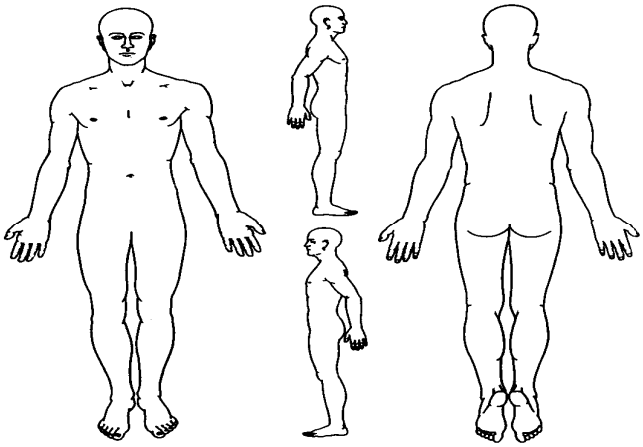
May we communicate our findings on your current health condition to the above provider(s)? ❑ Yes ❑ No

CONFIDENTIAL PATIENT CASE HISTORY

Patient Name:_____ Date:_____

OTHER HEALTH COMPLAINTS

Please list the specific complaints you are experiencing at this time and mark the location on the diagram. Beside each complaint, rate its severity on a scale of 1-10 with 1 being the least discomfort you have experienced and 10 being the most discomfort you have ever experienced.



Primary Complaint:

1) _____ 1 2 3 4 5 6 7 8 9 10

Additional Complaints:

2) _____ 1 2 3 4 5 6 7 8 9 10
3) _____ 1 2 3 4 5 6 7 8 9 10
4) _____ 1 2 3 4 5 6 7 8 9 10
5) _____ 1 2 3 4 5 6 7 8 9 10

PREVIOUS CONDITIONS

Days Lost From Work:_____ Date of Last Physical Examination: _____

Have you sought care for another health condition in the past year? ❑ Yes ❑ No Past 2 years? ❑ Yes ❑ No

If yes, what condition other than your primary complaint?:_____

Was treatment administered? ❑ Yes ❑ No Describe: _____

_____

Do you take medications? ❑ Yes ❑ No List Dosage, Frequency and Reason:_____

_____

_____

Any prior hospitalizations or surgery? ❑ Yes ❑ No Describe with dates:_____

_____

Have you been in an auto accident or had any other personal injury? ❑ Yes ❑ No Describe:_____

_____

CHIROPRACTIC HISTORY

Previous Chiropractic care? ❑ Yes ❑ No If yes, Doctor's name:_____

Date of last chiropractic visit: _____/_____/_____ Date of last chiropractic X-rays:_____/_____/_____

Reason for care:_____ How long were you under care?: _____

Were you satisfied with the previous chiropractic care you received? ❑ Yes ❑ No

Are other family members under chiropractic care? ❑ Yes ❑ No Who?: _____

Are you open to looking at new ideas in health and wellness? ❑ Yes ❑ No

SOCIAL HISTORY

Height:_____ft. _____in. Current Weight:_____ lbs. Have you recently lost or gained more than 10 lbs.? Y N

Mental Work: ❑ Heavy ❑ Moderate ❑ Light Hours per day:_____

Physical Work: ❑ Heavy ❑ Moderate ❑ Light Hours per day:_____

Exercise: ❑ Heavy ❑ Moderate ❑ Light Hours per week:_____ Type:_____

Smoking: ❑ Never ❑ Currently ❑ Previously Packs/day:_____, Pack/week:_____ How long?:_____

Alcohol: Beer/week:_____, Liquor/week:_____, Wine/week:_____ How long?:_____

Caffeine: Cups/day:_____ How long?:_____ Aspirin: No./day:_____ How long?:_____

CONFIDENTIAL PATIENT CASE HISTORY

Patient Name:_____ Date:_____

REVIEW OF SYSTEMS

GENERAL	Now	Past
Weakness	❑	❑
Fatigue	❑	❑
Fever	❑	❑
Chills	❑	❑
Night Sweats	❑	❑
Fainting	❑	❑
SKIN		
Color Changes	❑	❑
Nail Changes	❑	❑
Hair Changes	❑	❑
Moles	❑	❑
Rashes	❑	❑
Sores	❑	❑
Weakness	❑	❑
HEAD & EYES		
Headaches	❑	❑
Injuries	❑	❑
Bumps	❑	❑
Last Eye Exam	❑	❑
Glasses	❑	❑
Contacts	❑	❑
Cataracts	❑	❑
EARS		
Hard of Hearing	❑	❑
Deafness	❑	❑
Ringing	❑	❑
Discharge	❑	❑
Earache	❑	❑
Itching	❑	❑
Dizziness	❑	❑
Room Spins	❑	❑
NOSE		
Decreased Smell	❑	❑
Bleeding	❑	❑
Pain	❑	❑
Discharge	❑	❑
Obstruction	❑	❑
Post Nasal Drip	❑	❑
Deviated Septum	❑	❑
Runny Nose	❑	❑
Sinus Congestion	❑	❑
MOUTH		
Bleeding Gums	❑	❑
Sores	❑	❑
Dental Problems	❑	❑
Bad Breath	❑	❑
Loss of Taste	❑	❑
Dry Mouth	❑	❑
Ulcers	❑	❑
Blisters	❑	❑
THROAT		
Soreness	❑	❑
Bad Tonsils	❑	❑
Hoarseness	❑	❑
Pain	❑	❑
Trouble Swallowing	❑	❑
Recurrent Infections	❑	❑
NECK		
Neck Enlargement	❑	❑
Stiff Neck	❑	❑
Soreness	❑	❑
Lumps	❑	❑
Masses	❑	❑

BREASTS	Now	Past
Discharge	❑	❑
Lumps	❑	❑
Pain	❑	❑
Bleeding	❑	❑
Nipple Changes	❑	❑
Skin Changes	❑	❑
Bloated	❑	❑
RESPIRATORY		
Cough	❑	❑
Phlegm	❑	❑
Blood	❑	❑
Short of Breath	❑	❑
Wheezing	❑	❑
Pain	❑	❑
Congestion	❑	❑
Inhalant exposure	❑	❑
CARDIOVASCULAR		
Murmur	❑	❑
Palpitations	❑	❑
Rapid Heartbeat	❑	❑
Swollen Extremities	❑	❑
Cold Extremities	❑	❑
Chest Pain,Pressure	❑	❑
Varicose Veins	❑	❑
Blood Clots	❑	❑
Blue Extremities	❑	❑
BLOOD		
Anemia	❑	❑
Low Blood Iron	❑	❑
Easy Bruising	❑	❑
Easy Bleeding	❑	❑
Swollen Nodes	❑	❑
Painful Nodes	❑	❑
Sugar in Blood	❑	❑
Red Spots	❑	❑
GASTROINTESTINAL		
Abdominal Pain	❑	❑
Nausea	❑	❑
Bloated	❑	❑
Belching	❑	❑
Heartburn	❑	❑
Indigestion	❑	❑
Irreg. Bowel Habits	❑	❑
Constipation	❑	❑
Diarrhea	❑	❑
Gas	❑	❑
Hemorrhoids	❑	❑
Poor Appetite	❑	❑
Food Intolerance	❑	❑
Bloody Stools	❑	❑
Black Stools	❑	❑
GENITOURINARY		
Urgency	❑	❑
Incontinence	❑	❑
Straining	❑	❑
Back Pain	❑	❑
Frequent Voiding	❑	❑
Stones	❑	❑
Burning	❑	❑
Bed Wetting	❑	❑
Small Stream	❑	❑
Discharge	❑	❑
Impotence	❑	❑

GENITOURINARY	Now	Past
Dribbling	❑	❑
Cloudy Urine	❑	❑
Spotting	❑	❑
Menstrual Cramps	❑	❑
Painful Menses	❑	❑
Itching	❑	❑
Painful Intercourse	❑	❑
Irregular Periods	❑	❑
Hot Flashes	❑	❑
NEUROLOGICAL		
Seizures	❑	❑
Vertigo	❑	❑
Dizziness	❑	❑
Hand Trembling	❑	❑
Loss of Sensation	❑	❑
Incoordination	❑	❑
Loss of Facial	❑	❑
Weak Grip	❑	❑
Paralysis	❑	❑
Difficulty Speech	❑	❑
Tingling	❑	❑
Loss of Memory	❑	❑
Numbness	❑	❑
ENDOCRINE		
Weight Loss	❑	❑
Weight Gain	❑	❑
Extremely Thin	❑	❑
Heat Intolerance	❑	❑
Cold Intolerance	❑	❑
Hair Changes	❑	❑
Breast Changes	❑	❑
IMMUNIZATION/VACCINATION		
DPT	❑	❑
Mumps	❑	❑
Smallpox	❑	❑
Typhoid	❑	❑
Tetanus	❑	❑
Measles	❑	❑
Pneumococcal	❑	❑
Influenza	❑	❑
Polio	❑	❑
MMR	❑	❑
PSYCHIATRIC		
Hyperventilation	❑	❑
Insecurity	❑	❑
Depression	❑	❑
Troubles Sleep	❑	❑
Irritable	❑	❑
Hallucinations	❑	❑
Loss of Memory	❑	❑
Alcoholism	❑	❑
Drug Addiction	❑	❑
Drug Dependent	❑	❑
Suicidal Thoughts	❑	❑
Extreme Worry	❑	❑
Sexual Problems	❑	❑
MUSCULOSKELETAL		
Muscle Pain	❑	❑
Muscle Weakness	❑	❑
Muscle Cramps	❑	❑
Muscle Stiffness	❑	❑
Joint Stiffness	❑	❑
Joint Pain	❑	❑

PAST MEDICAL HISTORY

Check only the ones you have had in the past.

Hay Fever	❑
Mumps	❑
Rheumatic Fever	❑
Allergies	❑
Angina	❑
Cancer	❑
Tumor	❑
Blood Disease	❑
Leukemia	❑
Heart Trouble	❑
Varicose Veins	❑
Phlebitis	❑
Hypertension	❑
Stroke	❑
Ulcers	❑
Jaundice	❑
Skin Trouble	❑
Gallstones	❑
Liver Trouble	❑
Hepatitis	❑
Parasites	❑
Epilepsy	❑
Paralysis	❑
Polio	❑
Mental Illness	❑
Alcoholism	❑
Depression	❑
Nervous Breakdown	❑
Migraine	❑
Gout	❑
Hemorrhoids	❑
Prostate Problems	❑
Sexual Problems	❑
Gonorrhea	❑
Syphilis	❑
Diabetes	❑
Bladder Trouble	❑
Kidney Stones	❑
Kidney Infections	❑
Dysentery	❑

ALLERGIES

List known allergies below

_____
_____
_____
_____
_____
_____
_____

If Female,
Are You Pregnant?

❑ **Yes**
❑ **No**

CONFIDENTIAL PATIENT CASE HISTORY

Patient Name:_____ Date:_____

FAMILY HISTORY - List any of the diseases listed previously which run in your family

Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses (if any)
Father:	_____	_____	_____	_____	_____
Mother:	_____	_____	_____	_____	_____
Brother(s):	_____	_____	_____	_____	_____
Sister(s):	_____	_____	_____	_____	_____
Grandfather (Mat):	_____	_____	_____	_____	_____
Grandmother (Mat):	_____	_____	_____	_____	_____
Grandfather (Pat):	_____	_____	_____	_____	_____
Grandmother (Pat):	_____	_____	_____	_____	_____

Spouses Health Status: ❑ Poor ❑ Fair ❑ Good ❑ Excellent

Children's ages and health status:_____

_____

INSURANCE INFORMATION

Who is responsible for this account?: _____

Relationship to Patient?: _____

Insurance Co.: _____ Patient ID#: _____ Group #: _____

Is patient covered by additional or secondary insurance? ❑ Yes ❑ No

Subscriber's Name: _____

Relationship to Patient?: _____ Birth Date: _____

Insurance Co.: _____ Patient ID#: _____ Group #: _____

ASSIGNMENT AND RELEASE

I certify that if I, and/or my dependent(s) have insurance coverage, I will assign directly to Back to Health Wellness Center all insurance benefits, if any, 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 on all insurance submissions. I understand that interest is charged on overdue accounts at the annual rate of 18%. I authorize the doctor or chiropractic office to contact me via mail, email and phone in regards to treatment as well as promotional activities. The above-named clinic may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

I have also received a copy of this office's Financial Policy and Appointment Policy and agree to its terms.

SIGNATURE of Patient, Parent or Guardian: _____

PRINTED Name of Patient, Parent or Guardian: _____

Date: _____ Relationship to Patient: _____

Witness Signature: _____ Date: _____

(A scanned copy of this document shall serve as the original.)

WORKER'S COMPENSATION QUESTIONNAIRE

Employee's Name: _____ Date: _____

Occupation: _____

Employer's Name: _____

Employer's Address: _____

Employer's Phone Number: _____ Type of Business: _____

HR Contact Person: _____

When did the injury occur? Date: _____ Time: _____ AM / PM

What address were you at when you were injured?: _____

Did you notify your employer of this injury? ❑ Yes ❑ No

Did you receive authorization from your workplace to have treatment in this facility? ❑ Yes ❑ No

Have you retained an attorney? ❑ Yes ❑ No

If yes, attorney name, address, phone: _____

Are you currently in litigation for this injury? ❑ Yes ❑ No ❑ Maybe

Explain how the injury or illness occurred: _____

_____

_____

What injuries did you suffer? _____

_____

Have you missed work due to this injury or illness? ❑ Yes ❑ No ; If yes, how many days? _____

When was the last day you worked? _____

Have you been examined by another physician? ❑ Yes ❑ No

If yes, who examined you? _____

What was the doctor's diagnosis? _____

Have you received any treatment prior to visiting this office? ❑ Yes ❑ No

What treatment did you receive? _____

Have you ever injured this area before? ❑ Yes ❑ No

If yes, when did this previous injury occur? _____

Did you lose time from work from this previous injury? ❑ Yes ❑ No

Do you have other injuries or illness that affect your employment? ❑ Yes ❑ No

If yes, please explain: _____

Do you have a history of absenteeism caused from accidents on the job? ❑ Yes ❑ No

Have you ever had a Worker's Compensation claim before? ❑ Yes ❑ No

Before the injury were you capable of working on an equal basis with others your age? ❑ Yes ❑ No

Are your work activities restricted or limited as a result of this accident? ❑ Yes ❑ No

Since the injury, are your symptoms: ❑ improving ❑ getting worse ❑ remaining the same

Assignment of Payment

My insurance carrier and/or attorney are hereby requested and authorized to pay direct to Back to Health Wellness Center, PC any monies due on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay Back to Health Wellness Center, PC the difference, if any, between the total amount of charges on my account and the amount paid by the insurance carrier and/or attorney It is further understood that I, the undersigned, agree to pay Back to Health Wellness Center, PC the full amount of charges on my account should my condition be such that it is not covered by my policy or if for any reason the insurance carrier and/or attorney refuses to pay my claim.

Patient's signature: _____ Date: _____

Printed name: _____

Witness: _____

Name: Dr.

Case #: DOB:

Date: Age:

Back to Health Wellness Center, 2504 Monroe St., LaPorte, IN 46350

INFORMED CONSENT for EXAMINATION & TREATMENT

TO THE PATIENT: *You have a right as a patient to be informed about your condition, the recommended chiropractic treatment, and potential risks involved with the recommended treatment. This will allow you to make an informed decision whether or not to undergo the treatment. 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.*

I request and consent to the performance of examination and treatment (chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, rehabilitative exercises and diagnostic X-rays). The chiropractic treatment may be performed by the Doctor(s) of Chiropractic working at Back to Health Wellness Center. Chiropractic treatment and other therapies and procedures may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below as well as those working at the clinic or office who now or in the future treat me while being employed by, working or associated with Back to Health Wellness Center.

I have had adequate opportunity to discuss with the Doctor of Chiropractic, or other clinic personnel, the nature and purpose of my chiropractic treatment (adjustments) and different physical therapy procedures (therapies and active rehabilitation). I have also discussed with Doctor of Chiropractic the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment which includes no treatment at all.

I understand that neither chiropractic, nor any medical treatment for that matter, is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand, and I am informed, that there are some risks to chiropractic examination and treatment (adjustments and physical therapy) including, but not limited to: fractures, spinal or disc injuries, strokes, strain/sprains, dislocations, increased or unchanged symptoms and pain; and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of treatment as to which risks and complications are significant. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about my examination and treatment, and all my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

❑ **FEMALE PATIENTS:** By my initials here _____, I do hereby state that to the best of my knowledge, I AM NOT PREGNANT, nor is pregnancy suspected or confirmed at this particular time and. I consent to X-rays if the doctor deems them necessary for the evaluation of my condition. First Day of Last Menstrual Period: ____/____/_____.

❑ **CONSENT TO EXAMINATION AND TREATMENT OF MINOR:** I hereby agree to the above statements and authorize the doctor(s) of this clinic, and whomever they may designate as their assistants, to administer examination and treatment as they so deem necessary to my:

❑ son ❑ daughter Minor's Name:_____

Patient:

Print Name:_____ Signature:_____ Date Signed: _____

Patient's Representative:

Print Name of Patient's Representative: _____ Relationship to Patient: _____

Signature of Patient's Representative: _____ Date Signed: _____

Doctor or Staff:

Witness of Patient's Signature: _____ Date Signed: _____

Translated by: _____ Date Signed: _____

(A scanned copy of this document shall serve as the original.)

AGREEMENTS and AUTHORIZATION

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

_____ initial

Payment Guarantee

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

_____ initial

Notice of Non-Coverage

If you have insurance, insurance companies will only pay what is covered in each individual's insurance policy. Your insurance does not pay for all of your healthcare costs, specifically as it relates to treatment in a chiropractic office. Your insurance policy will only cover services that it deems are "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 ($45 per visit), nutritional supplements ($25-40), therapeutic modalities used for maintenance ($25), massage ($35-95) and any service beyond your benefit plan visit limitations or services that are excluded from the benefit plan.

_____ initial

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

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

_____ initial

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.

SIGNATURE of Patient, Parent or Guardian: _____

PRINTED Name of Patient, Parent or Guardian: _____

Date: _____ Relationship to Patient: _____

Witness Signature: _____ Date: _____

(A scanned copy of this document shall serve as the original.)

AUTHORIZATION and HIPAA PRIVACY NOTICE

Consent To Release Information

Here at Back to Health Wellness Center, we do not sell or release your information to third parties. There will be cases along the course of your care where information will need to be released in certain circumstances. You authorize Back to Health Wellness Center to release to employer groups, government agencies (Medicare, Medicaid, Champus, State or Federal government, etc.), insurance companies, or other third-party payers and their agents, and its collection representatives and attorneys, the following "Patient Information": medical history, diagnosis and procedures performed, course of treatment , plan of care, prognosis, supplies and/or such other information that may be requested for the purpose of determining eligibility and availability of Patient's benefits, obtaining authorization/payment for Patient's health care services, or billing and collection of amounts due to Back to Health Wellness Center for services rendered. In the case of Patient Information released for purposes of payment of Patient Charges, this authorization shall be valid only for the period of time necessary to process payment claims. You agree to pay any Patient Charges that are denied or are ineligible for medical reimbursement benefits as a result of your refusal or revocation of consent to disclose Patient Information.

You further authorize any individual health care professional, including treating physician(s), to provide Back to Health Wellness Center or its designee with Patient Information for quality assurance and, or risk management purposes. Finally, in the event that the Patient's employer, or an insurance company representing such employer, requests Patient Information relating to healthcare services provided for worker's compensation injuries, it is understood and agreed that Back to Health Wellness Center is required, under state law, to release copies of such information to such employer or insurance company without the authorization of Patient or Patient's representative. Again, here at Back to Health Wellness Center, we strive to provide you with the best care possible and in order to do that this consent is necessary.

_____ initial

HIPAA Privacy Notice Patient Acknowledgment

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

I hereby state that by signing this Consent I acknowledge and agree as follows:

1) The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request and that a copy of it is always available at the Front Desk.
2) The Practice's Privacy Notice has been provided to me prior to my signing this Consent and a copy of it has been shown to me at the Front Desk. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations.
3) The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law and Federal Law.
4) The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
5) The Practice's "Notice of Privacy Practices" is also provided in the reception area display table and on the Practice's web sit at www.LaPorteWellnesss.com. I may also request a copy from this office at any time via US Mail.

This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.

_____ initial

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

PRINTED Name of Patient, Parent or Guardian: _____

SIGNATURE of Patient, Parent or Guardian: _____

Date: _____ Relationship to Patient: _____

Witness Signature: _____ Date: _____

(A scanned copy of this document shall serve as the original.)

NOTICE OF DOCTOR'S LIEN

I do hereby authorize Back to Health Wellness Center, PC and its providers to furnish you, my attorney, with a full report of their case history, examination, diagnosis, treatment, and prognosis of myself in regard to the injury which occurred on: _____.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical services rendered me both by reason of this accident and by reason of any other bills that are due this office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. And I hereby give a Lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be pain to you, my attorney, or myself, as a result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this Lien as inherent to the settlement and enforceable upon the case as if it were executed by him or her.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I further agree to be fully responsible for reasonable attorney's fees and costs that have accrued due to the pursuance of payment of my account. Also, that in the event of noncompliance to payment agreement I understand the amount of balance due will be subject to a 1.5% per month service charge.

I accept the terms stated above. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable.

Patient's Printed Name:_____

Patient's Signature:_____ Date:_____

The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms of the above Lien and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor above named. Attorney further agrees that in the event this Lien is litigated that the prevailing party will be awarded attorney fees and costs.

Attorney's Printed Name:_____

Attorney's Signature:_____ Date:_____

Please sign, retain a copy for your records, and return this copy to us promptly.

OFFICE FINANCIAL POLICY

Back to Health
Wellness Center

Your understanding of our financial policy is an essential part of your care and treatment. If you have any questions, please don't hesitate to discuss them with our office staff.

❑ No Insurance/Self Pay ❑ Group Health Insurance ❑ Managed Care ❑ HSA/HRA/Flex ❑ Medicaid
❑ Medicare ❑ Secondary Insurance ❑ Workers' Compensation ❑ Auto Accident ❑ Personal Injury
❑ Maintenance/Wellness Care (Not covered by insurance)

- As a courtesy we will contact your insurance carrier to verify your coverage, but this is only an estimate of what the insurance company will pay until we receive an actual payment. It is not a guarantee of payment.
- Your insurance policy is a contract between you and your insurance company. Also as a courtesy, we will file your insurance claims for you if you assign benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly.
- We are glad to assist you in billing your insurance, but you are ultimately responsible for full payment. Patients are encouraged to contact their carrier for clarification of benefits prior to services being rendered. You are considered a cash-based patient until we verify and determine the extent of benefits under your policy.
- Due to frequent erroneous information given to us from insurance carriers and the frequent difficulty in collecting payments from the carrier, we may ask for active assistance from you in rectifying the situation.
- All payments are due at the time of service. No personal balance is to exceed $150. We accept cash, checks, and most major credit cards.
- All deductibles and co-payments are due at the time of service or by an authorized payment plan. Most insurance does not cover 100% of services rendered. Because of this and the delay in payment common with insurance carriers, you will be asked to pay your deductible and your portion of your charges the day the service is rendered.
- After 60 days, any outstanding balances will be due in full by you. Balances over 60 days past due will be automatically debited from your checking account or credit card on file or through a third-party vendor. All balances past due 60 days or greater will be charged at a 1.5% monthly (18% annual) interest rate.
- You must inform this office of all insurance changes and referral requirements. In the event the office is not informed or the proper referral was not obtained by you in advance, you will be responsible for any charges denied as a result of not informing us or not obtaining the authorized referral.
- A 50% minimum down payment is required to place an order for products, supplies, orthotics, etc. with the remainder becoming due upon receiving such supplies or products. Full payment is required before receiving any products or supplies.
- Insurance is designed for sick care and only reimburses for services it deems "medically necessary" according to their guidelines. Unfortunately, prevention and health maintenance care is not reimbursable. When your schedule of visits exceeds 3 weeks or if the doctor releases you from active treatment, you will not be eligible for insurance benefits since maintenance/wellness care is a non-covered service.
- Non-compliance with a prescribed treatment plan may jeopardize insurance reimbursement. If you discontinue care or suspend care for any reason other than discharge by the doctor, any fees for professional services will become immediately due and payable in full by you, regardless of any claim submitted.
- There is a service fee of $35 for all returned checks. Your insurance company does not cover this fee.
- Past due accounts (those over 120 days) are subject to collection proceedings, which may affect your credit. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office.

Keep this copy for your information.

APPOINTMENT POLICY

Back to Health
Wellness Center

We want to thank you for choosing us as your chiropractic healthcare provider. We understand that your time is as valuable as ours. Because of this, it is our goal to provide to you with our highest quality care in the most cost effective and efficient manner. An understanding of our appointment guidelines is essential for a healthy relationship.

Advanced Multiple Appointments: As you know, healing takes time. Your care will likely require repeated visits as your body progresses through the healing process. As a means of reducing your costs and improving efficiency, advanced multiple appointments are established in order to limit your time in our office by reducing the need to schedule visit-by-visit with the front desk staff. Any deviation from the prescribed treatment schedule may potentially jeopardize insurance reimbursement.

Rescheduling Appointments: Please remember that we have reserved appointment times especially for you and that your appointments are "written in pencil", meaning that it is okay to reschedule if something unexpected arises. Please let us know at least 24 hours in advance of the need to reschedule an appointment. Giving us advance notice will allow time to fill in that appointment with someone else who needs it.

Cancelling Appointments: Please let us know at least 24 hours in advance of the need to cancel an appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. Canceled appointments will be recorded in your medical record.

Missed Appointments "No-Show": An appointment that is missed without at least a 12-hour advance notice to cancel or reschedule is considered a missed appointment. It is the policy of this office to assess a **$10** missed appointment fee. One missed visit will not result in the assessment of a fee, but you will be charged for any additional missed visits. This clinic provides care for many individuals and missed visits result in time lost that could have been used to provide care for others. This fee is not reimbursable by any insurance plan. Missed appointments will be recorded in your medical record.

Extra Visits: Adhering to your prescribed schedule of care is vitally important to your health recovery process. If you reschedule, cancel or miss any appointment, it is your obligation to complete an extra visit within 7 days in order to not delay your progress.

Arriving Early: You are more than welcome to arrive early for any appointment; however, you will be seen by the doctor at your reserved appointment time.

Arriving Late: If you arrive more than 10 minutes after your scheduled appointment time you will be worked into the schedule at the next available time slot in order to honor the appointment times of others.

Open Door Promise: We understand that life can get busy. So if at any time you get "sidetracked" and decide to put your healthcare on hold, please know that you are always welcome back at any time. Our door is always open to you whenever you decide to start again. Even though it is our duty to educate and encourage you to make the best decisions for your optimal health, we promise to never scold, lecture or yell at you for any decision you make in regards to your own healthcare.

Keep this copy for your information.

HIPAA PRIVACY NOTICE

Back to Health
Wellness Center

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. You understand and agree to allow this office to use your Patient Health Information for the purpose of treatment, payment, healthcare operations and coordination of care. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of a request to do so and a cost -based fee for photocopying, postage and preparation may apply.

You may request changes to your records which our practice has the right to accept or deny.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our office is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting Matthew Kirkham at 326-5100.

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 the consent on the Confidential Patient Case History form.

Thank You.

Keep this copy for your information.