Wellness. Your Goal. Our Mission.

Health Centered
SPINE & WELLNESS GROUP

Patient Name _____ Address _____

City _____ State _____ Zip _____ Home Phone _____

Email address _____ Cell Phone _____

DOB _____ Age _____ M F SS# _____ Marital Status: M S D W

How did you hear about our office? **Newspaper Radio Internet Friend Phonebook Physician Health Fair**

Circle: Employed FT Employed PT Self Employed Homemaker Retired Unemployed due to pain Unemployed for other reasons

Are you on disability? Reason and when did it start _____

Is your visit following an automobile accident? Yes No If yes, what is the date of the accident?_____

Employer _____ Employer's Address_____

Work Phone _____ Type of Work_____ # of Hours Worked per Week _____

Spouse Name _____ Name/Ages of Children _____

Name of Emergency Contact _____ Relationship _____

Emergency Contact Phone Number _____ Cell Phone Number _____

Responsible party/ Parent/ Guardian (if different from above) Name _____

Address _____ City _____ State ____ Zip _____ DOB_____

Employer _____ Address_____ Work Phone _____

PRIMARY INSURANCE			
NAME OF PRIMARY INSURANCE COMPANY		POLICY #	
NAME OF INSURED		GROUP #	
ADDRESS OF INSURANCE COMPANY		COPAY $	
CITY, STATE, ZIP	PHONE	DEDUCTIBLE	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (IF APPLICABLE)			
NAME OF PRIMARY INSURANCE COMPANY		POLICY #	
NAME OF INSURED		GROUP #	
ADDRESS OF INSURANCE COMPANY		COPAY $	
CITY, STATE, ZIP	PHONE	DEDUCTIBLE	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

CURRENT MEDICAL CONDITION INFORMATION

Your answers on this form will help your health care provider better understand your medical concern and conditions. If you cannot remember specific details, please approximate. Add any notes you think are important. **ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.**

Main reason for today's visit: _____

Other concerns: _____

_____

HEALTH HISTORY

ALLERGIES (Medications, Food, Bee Stings, Etc…)

Allergy	Reaction
1 _____	_____
2 _____	_____
3 _____	_____
4 _____	_____

MEDICATIONS/VITAMINS/HERBAL SUPPLEMENTS

Drug Name	Strength	Frequency Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

REVIEW OF SYSTEMS

Please check all that apply:

Allergic/Immunologic
- ○ Frequent Sneezing
- ○ Hives
- ○ Itching
- ○ Runny Nose
- ○ Sinus Pressure

Endocrine
- ○ Fatigue
- ○ Increased Thirst/Hunger/Urination

Hematologic/Lymphatic
- ○ Easy Bruising/Bleeding
- ○ Swollen Glands

Psychiatric
- ○ Alcohol Overuse
- ○ Anxiety/Stress
- ○ Depression
- ○ Do Not Feel Safe in Relationship
- ○ Mania
- ○ Sleep Problems

Cardiovascular
- ○ Arm Pain on Exertion
- ○ Chest Pain on Exertion
- ○ Chest Heaviness/Pressure on Exertion
- ○ Irregular Heart Beats (Palpitations)
- ○ Light-headed on Standing
- ○ Shortness of Breath when lying down
- ○ Shortness of Breath when walking
- ○ Swelling (Edema)

Gastrointestinal
- ○ Abdominal Pain
- ○ Black or Tarry Stool
- ○ Blood in Stool
- ○ Change in Appetite
- ○ Frequent Indigestion
- ○ Hemorrhoids
- ○ Trouble Swallowing
- ○ Vomiting
- ○ Vomiting Blood

Integumentary (Skin)
- ○ Changes in Moles
- ○ Dry Skin
- ○ Eczema
- ○ Growth/Lesions
- ○ Itching
- ○ Jaundice (Yellow Skin/Eyes)
- ○ Rash

Respiratory
- ○ Cough
- ○ Coughing Up Blood
- ○ Shortness of Breath
- ○ Sleep Apnea
- ○ Snoring
- ○ Wheezing

Constitutional
- ○ Exercise Intolerance
- ○ Fatigue
- ○ Fever
- ○ Weight Gain (___lbs)
- ○ Weight Loss (___lbs)

Musculoskeletal
- ○ Back Pain
- ○ Joint Pain
- ○ Muscle Aches
- ○ Muscle Weakness

Eyes
- ○ Dry Eyes
- ○ Irritation
- ○ Vision Change

Date of Last Exam: _____

Ears/Nose/Mouth/Throat
- ○ Bleeding Gums
- ○ Difficulty Hearing
- ○ Dizziness
- ○ Dry Mouth
- ○ Ear Pain
- ○ Frequent Infections
- ○ Frequent Nosebleeds
- ○ Hoarseness
- ○ Mouth Breathing
- ○ Mouth Ulcers
- ○ Nose/Sinus Problems
- ○ Ringing in Ears

Neurological
- ○ Dizziness
- ○ Fainting
- ○ Headaches
- ○ Memory Loss
- ○ Migraines
- ○ Numbness
- ○ Restless Legs
- ○ Seizures
- ○ Weakness

Genitourinary
- ○ Blood in Urine
- ○ Difficulty Urinating
- ○ Incomplete Emptying
- ○ Increased Urinary Frequency
- ○ Urinary Loss of Control

*WOMEN ONLY - OBSETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear: _____ ○ Abnormal

Last Mammogram: _____ ○ Abnormal

Age of first menstrual period: _____

Date of last menstrual period or age of menopause: _____

Number of Pregnancies: _____ Births: _____

Miscarriages: _____ Abortions: _____

○ Cesarean sections If yes, number: _____

- ○ Bleeding between periods
- ○ Heavy periods
- ○ Extreme menstrual pain
- ○ Vaginal itching, burning or discharge
- ○ Wake in the night to go to the bathroom
- ○ Hot flashes
- ○ Breast lump or nipple discharge
- ○ Painful intercourse
- ○ Sexually active

Current Sexual Partner:
- ○ Female
- ○ Male

Do you use condoms?
- ○ Yes
- ○ No

Other Birth Control method used: _____

_____

- ○ Interested in being screened for STD's

PAST MEDICAL HISTORY

Please check all that apply:

- ○ Anxiety Disorder
- ○ Arthritis
- ○ Asthma
- ○ Bleeding Disorder
- ○ Blood Clots (or DVT)
- ○ Cancer
- ○ Coronary Artery Disease
- ○ Claustrophobic
- ○ Diabetes - Insulin
- ○ Diabetes – Non-Insulin
- ○ Dialysis
- ○ Diverticulitis
- ○ Fibromyalgia
- ○ Gout
- ○ Has Pacemaker
- ○ Heart Attack
- ○ Heart Murmur
- ○ Hiatal Hernia or Reflux Disease
- ○ HIV or AIDS
- ○ High Cholesterol
- ○ High Blood Pressure
- ○ Overactive Thyroid
- ○ Kidney Disease
- ○ Kidney Stones
- ○ Leg/Foot Ulcers
- ○ Liver Disease
- ○ Osteoporosis
- ○ Polio
- ○ Pulmonary Embolism
- ○ Reflux
- ○ Stroke
- ○ Tuberculosis
- ○ Other

PAST SURGICAL HISTORY

Surgery	Reason	Year	Hospital
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY HEALTH HISTORY

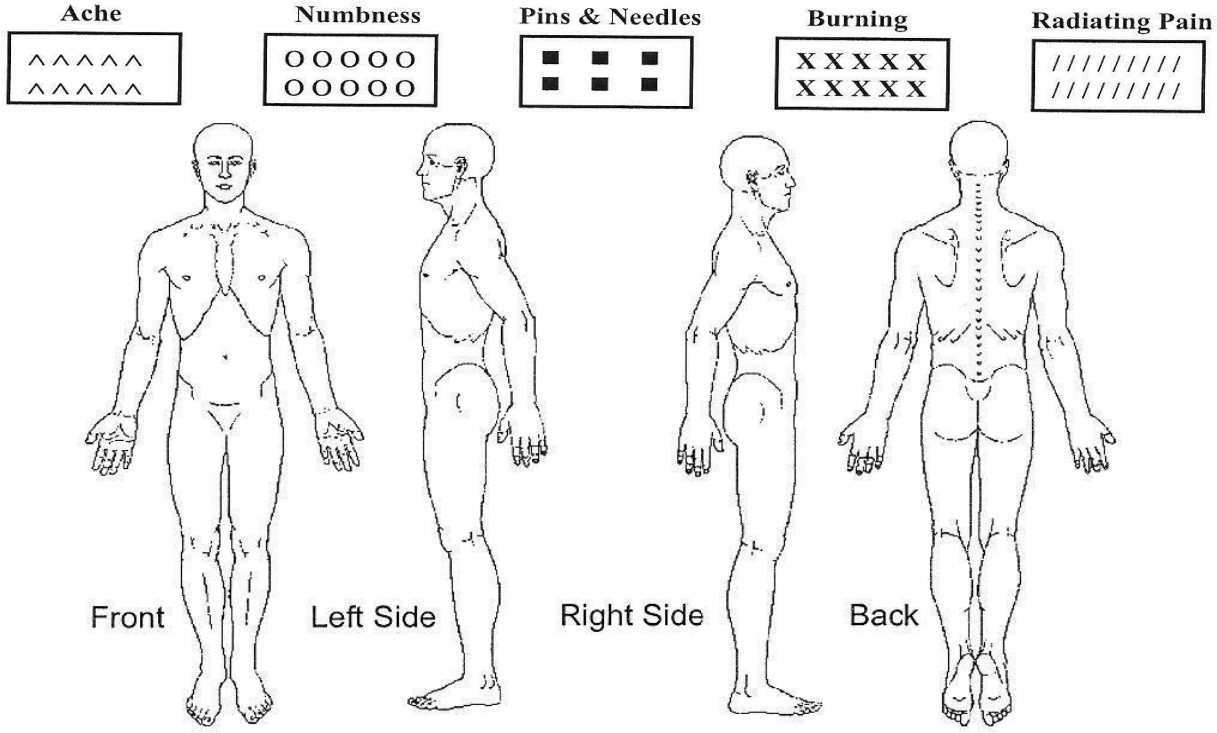
Grandmother (Maternal)	Living: Y / N	Age:	○ Alcoholism ○ Arthritis ○ Depression ○ Cancer ○ Diabetes ○ Genetic disease ○ Heart Disease ○ Hypertension ○ Osteoporosis ○ Stroke ○ Scoliosis
Grandfather (Maternal)	Living: Y / N	Age:	○ Alcoholism ○ Arthritis ○ Depression ○ Cancer ○ Diabetes ○ Genetic disease ○ Heart Disease ○ Hypertension ○ Osteoporosis ○ Stroke ○ Scoliosis
Grandmother (Paternal)	Living: Y / N	Age:	○ Alcoholism ○ Arthritis ○ Depression ○ Cancer ○ Diabetes ○ Genetic disease ○ Heart Disease ○ Hypertension ○ Osteoporosis ○ Stroke ○ Scoliosis
Grandfather (Paternal)	Living: Y / N	Age:	○ Alcoholism ○ Arthritis ○ Depression ○ Cancer ○ Diabetes ○ Genetic disease ○ Heart Disease ○ Hypertension ○ Osteoporosis ○ Stroke ○ Scoliosis
Father	Living: Y / N	Age:	○ Alcoholism ○ Arthritis ○ Depression ○ Cancer ○ Diabetes ○ Genetic disease ○ Heart Disease ○ Hypertension ○ Osteoporosis ○ Stroke ○ Scoliosis
Mother	Living: Y / N	Age:	○ Alcoholism ○ Arthritis ○ Depression ○ Cancer ○ Diabetes ○ Genetic disease ○ Heart Disease ○ Hypertension ○ Osteoporosis ○ Stroke ○ Scoliosis
Brother/Sister	Living: Y / N	Age:	○ Alcoholism ○ Arthritis ○ Depression ○ Cancer ○ Diabetes ○ Genetic disease ○ Heart Disease ○ Hypertension ○ Osteoporosis ○ Stroke ○ Scoliosis
Brother/Sister	Living: Y / N	Age:	○ Alcoholism ○ Arthritis ○ Depression ○ Cancer ○ Diabetes ○ Genetic disease ○ Heart Disease ○ Hypertension ○ Osteoporosis ○ Stroke ○ Scoliosis

SOCIAL HISTORY

Caffeine	○ None ○ Occasional ○ Moderate ○ Heavy # of cups/cans per day? _____
Alcohol	Do you drink alcohol? ○ Yes ○ No If Yes, how often? ○ Occasionally ○ < 3 times a week ○ > 3 times a week How many weekly? _____
Tobacco	Do you use tobacco? ○ Yes ○ No If not currently, have you ever used tobacco? ○ Yes ○ No ○ Cigarettes ___ pks/day ○ Chew _____/day ○ Cigars ____/day # of years _____ Month/Year Quit ____/____
Drugs	Do you currently use recreational or street drugs? ○ Yes ○ No

HAVE YOU EVER:	YES	NO	BRIEFLY EXPLAIN
Broken bones?	◯	◯	
Had X-Rays?	◯	◯	If Yes, Where: Date:
Been hospitalized?	◯	◯	
Been in an auto accident?	◯	◯	
Had sprains/strains?	◯	◯	
Been struck unconscious?	◯	◯	
Had surgery?	◯	◯	

Please indicate where you have pain by marking the areas on your body where you have described sensations. Use the appropriate symbol:



STATEMENT TO PERMIT PAYMENT OF MEDICAL BENEFITS TO PROVIDER

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the service or authorize such physician or organization to submit to Medicare for payment to me.

I request that the payment under the medical insurance program be made to Health Centered Spine & Wellness Group.

FINANCIAL AGREEMENT
*I authorize the use of this information for insurance billing.
*I authorize the release of information to the insurance company.
*I understand that I am responsible for my charges for services.
*I authorize payment to Health Centered Spine and Wellness Group.
*I permit a copy of this authorization to be used in place of the original.

_____ _____
Signature of Patient/Guardian Date

Our Financial Policy

Thank you for choosing Health Centered Spine and Wellness Group as your health care 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 read and sign prior to any treatment. All patients must complete our New Patient Information form before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE. WE ACCEPT CASH, MASTERCARD, AND VISA. PAYMENTS PLANS ARE ALSO AVAILABLE.

Regarding Insurance

Health Centered Spine and Wellness Group may accept assignment of insurance benefits after your first visit. However, we do require your co-pay or deductible to be paid at time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits, we require you be pre-approved on our extended payment plan or provide a credit card with authorization to bill that account for the balance. If your insurance company has not paid your account in full within 45 days, the balance will automatically be transferred to your credit card or the extended payment plan. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. Regarding insurance plans in which Health Centered Spine and Wellness is a participating provider: All co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and the fees that we charge are usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Minor Patients

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MasterCard, or payment of cash at the time service has been verified.

Durable Medical Equipment

You may be able to find durable medical equipment elsewhere for a less expensive purchase price, but you agreed to purchase this equipment at Health Centered Spine and Wellness Group.

Interest

We reserve the right to charge interest in the amount of 9% monthly as provided by state law. Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

Missed Appointments

ALL APPOINTMENTS must be cancelled within 24 HOURS of the appointment or we reserve the right to charge $25 as a MISSED APPOINTMENT CHARGE.

I have read the Financial Policy. I understand and agree to this Financial Policy.

X _____ DATE _____

Signature of Patient or Responsible Party

X _____ DATE _____

Signature of HCSWG Employee

HIPAA Notice of Privacy Policies

Health Centered Spine & Wellness Group

600 S. Jackson Park Drive Seymour, IN 47274 812-519-2963

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.

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, 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.

HIPPA Notice Cont.

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 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 the 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 all alternative means or at any 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 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 with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at 812-519-2963.

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

_____	_____	_____
Signature	Print Name	Date

PREFERRED PHARMACY

Pharmacy: _____

Address: _____

City/State: _____ **Phone**: _____

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION TO OTHER PERSONS AND/OR LEAVE MESSAGES

It is the policy of Health Centered Spine and Wellness Group to not release confidential patient information about you, unless it is for the patient care and treatment, payment, or operations. If you wish for our physician and/or office staff to leave messages for you on your home voice mail, work telephone, cell phone or to any other person, then you must complete the following:

I authorize Health Centered Spine and Wellness Group to release confidential patient information about me by the following methods and agree it is my responsibility for notifying my physician or office staff whenever I want this to change:

We can call your home?	Yes	No
We can leave a message on your home voice mail?	Yes	No
We can call you at work?	Yes	No
We can leave a message on your cell phone?	Yes	No
We can fax copies of information to other offices if necessary?	Yes	No

Please list the names of people and their relationship to you, if you wish us to release confidential patient information to them:

Name **Relationship (spouse, parents, friend, neighbor)**

_____

_____

_____

_____ / _____ _____ / _____

Patient Signature/Legal Representative **Date** **Witness Signature** **Date**

CONSENT FOR CARE

As a patient of Health Centered Spine & Wellness Group, I give the providers permission and authority to care for me or the above named minor in accordance with tests, diagnosis, and analysis. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever the patient is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the provider. The Provider provides a specialized, non-duplicating health care service.

I understand that if I am accepted as a patient by a provider at Health Centered Spine & Wellness Group, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding treatment, will be explained to me upon my request.

I hereby give my consent for evaluation and treatment to Health Centered Spine and Wellness Group. In the event the patient is a minor, I hereby consent to treatment of the minor patient.

_____ _____

Signature of Patient/Guardian Date

600 S. Jackson Park Drive
Seymour, IN 47274
812-519-2963

To all Health Centered Spine and Wellness Group patients receiving medical massage therapy:

All patients will be allowed to miss a maximum of two (2) visits without giving twenty-four (24) hour notice. Upon missing two (2) visits, the patient may be asked to discontinue massage therapy or pay for their massage therapy in advance. We also reserve the right to charge a $25.00 fee for any missed massage therapy appointments without prior notice.

Thank you for your cooperation.

James Galyen, D.C.
Ted Freidline, D.C.
Sally Daggy, F.N.P.B.C.
Joseph Koenigsmark, D.O.
Andrea Keane, F.N.P.- C

I understand the request of giving notice if I am not able to keep my appointment(s) with the massage therapist.

_____ _____

Patient Signature Date