Integrated Chiropractic Rehab

Confidential Patient Information

Name _____ Birth Date _____ Age ____ Sex M F

Address_____ Apt.# _____

City_____ State _____ Zip Code (+4 if known)_____

Cell Phone( )_____Home Phone ( )_____

Best # to call: Cell Home Your Social Security Number _____ Marital Status S M D W

Occupation _____ Employer _____

Email address _____
(We only send informational emails (i.e. office news). We will never share your email address!)

Emergency Contact Information

Emergency contact person (other than your spouse) _____

That person's telephone number at home ( ) _____ Work ( ) _____

Guarantor Information

Guarantor's Name _____

Birth Date_____ Social Security Number_____

Guarantor's Occupation _____ Employer_____

PLEASE READ CAREFULLY

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Integrated Chiropractic Rehab will prepare any necessary reports and forms to assist me in making collection from my insurance company and that any amount authorized to be paid directly to Integrated Chiropractic Rehab will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that all past, present, and future bills incurred at Integrated Chiropractic Rehab are my responsibility for payment. In the event that my bill must be turned over to an attorney for collection, I understand that I am liable for the balance due plus interest at the current rate, reasonable attorney fees, and court costs. I authorize the release of any medical information necessary to process my claims.

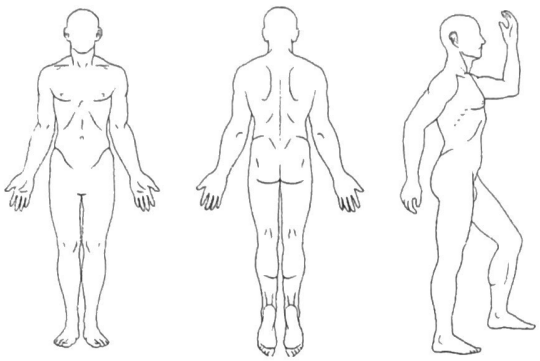
PAYMENT IS DUE AT THE TIME OF THE VISIT

Patient's Signature _____ Date_____

Guarantor's Signature_____ Date_____

Patient Name _____ Date _____ File _____

Please mark the area(s) you are currently experiencing pain/symptoms:



What caused this pain/symptom? _____
When did this pain/symptom begin? _____
Have you had this before? _____

Rate your pain level on a scale of zero (no pain) to 10 (worst pain imaginable): 0 1 2 3 4 5 6 7 8 9 10

Circle the qualities of your pain: Sharp Dull Aching Stiff Tingling Burning Other _____

How frequently do you experience pain/symptoms?
[] Constantly 76-100% of the day
[] Frequently 50-75% of the day
[] Intermittently 26-49% of the day
[] Occasionally 0-25% of the day

What relieves the pain/symptoms? (Circle all that apply.)
Rest Medication Walking Lying Down Stretching
Other _____

What makes the pain worse? Circle all that apply.
Bending Lifting Twisting Coughing Sneezing Sitting Standing Temperature Changes Other _____

Thinking about how this condition impacts your life, what activity or activities can you not do as much as you would like because of the pain/symptoms? _____
_____

How much does this condition impact your ability to enjoy life? (Circle ONE) None A little Moderately Completely

What do you value most about your health? (For example, ability to work, enjoying leisure activity, helping family...)
_____

Past Medical History
[] Please check here if you have a copy of your medical history, medications, etc. to provide to us today. If you have such a list, you may skip the following sections.

Please list any current or past (with dates if possible):
Surgery: _____
_____
Serious illness: _____
Broken bones: _____
_____
Accidents: _____
_____
Injuries: _____
_____
Allergies: _____
_____
History of smoking? [] No [] Yes _____ packs for _____ years. Year you quit _____

Medications: Please list ALL CURRENT medications (dosages not necessary):
1. _____
2. _____
3. _____
4. _____
5. _____

Do you take supplements? [] Yes [] No

We find nutrition often speeds up the healing process. Are you interested in incorporating nutrition in your care? [] Yes [] No

Family History
Please list immediate blood relatives who have or had any of the following:
Musculoskeletal disease_____
Cancer _____
Heart disease _____
Lung disease _____
Diabetes _____
Thyroid disorders _____
Nervous disorders _____
Other (specify) _____
_____

Integrated Chiropractic Rehab

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Merrillville, Indiana 46410

(219) 738-1925
Fax (219) 736-9456

Financial Policy

Integrated Chiropractic Rehab (ICR) is a fee-for-service facility. Payment is expected when services are rendered. Please choose one of the following options:

[ ] Cash Patient: Patient pays for each visit as charges are incurred or on a pre-determined schedule agreed to by ICR and the patient.

[ ] Private Insurance: Patients accepted on an insurance basis must pay deductibles and any co-pay or percentage not covered by the insurance company as required by law. These charges are due at the time of the visit. The balance will be billed to the insurance company. As a service to you, ICR will prepare any forms or reports necessary to assist you in making collection from your insurance company and any amount authorized to be paid directly to ICR will be credited to your account upon receipt. ICR reserves the right to demand immediate payment in full for unpaid insurance balances 60 days or later.

[ ] Personal Injury: Where liability has been established and verified by ICR staff, we may or may not elect to accept your case on this basis.

All assignment and subrogation forms and a Physician's Lien must be signed prior to acceptance of any case. Additionally, all supplies, supplements, braces, etc., must be paid for by the patient. Please note that under no circumstances will we reduce our bill at the time of settlement or accept partial payment from an attorney or insurance company as payment in full. Situations in which a patient may not have personal health insurance, monthly payments of not less than $50 on any outstanding balance must be made. Please note that fees for depositions, narrative reports, and court appearance must be paid in advance at our current rates. Current fees may be obtained from the Office Manager.

[ ] Workman's Compensation: All Workman's Compensation (WC) cases must be verified by the patient's employer or insurance carrier. Patients accepted on WC will be allowed to continue treatment without payment. If the case is not paid by the WC insurance company, the patient will be held responsible for all charges incurred.

Patients are ultimately responsible for all charges incurred at ICR. Insurance coverage is not a guarantee of payment.

Date of Financial Consultation _____

Patient Signature _____

ICR Staff Signature _____