Chiropractic Rehabilitation & Acupuncture

Patient Registration Form

Date: _____

Name: _____ **Age:** _____ **Birth Date:**_____

[__] Male [__] Female [__] Married [__] Single **Social Security #**_____

Home Phone #:_____ **Cell Phone #:** _____**Work Phone #:**_____

Email address: _____

_____

Home Street Address **City** **State** **ZIP**

Occupation: _____ **Employer:** _____

Family Physician: _____ **OB/GYN** _____

Other Physicians: _____

Is your problem: [__] Work-Related [__] Auto-Related

[__] Other *(Please explain)* _____

How were your referred to this office? _____

What sort of care do you want? ***(Please check those that apply)***

[__] Pain relief only [__] Rehabilitation [__] Maintenance

Insurance Information: (If the insurance is through someone other than patient)

Name of Insured:_____ **Relationship to Patient:** _____

Insured's address: _____

Date of Birth:_____ **Employer:** _____ _

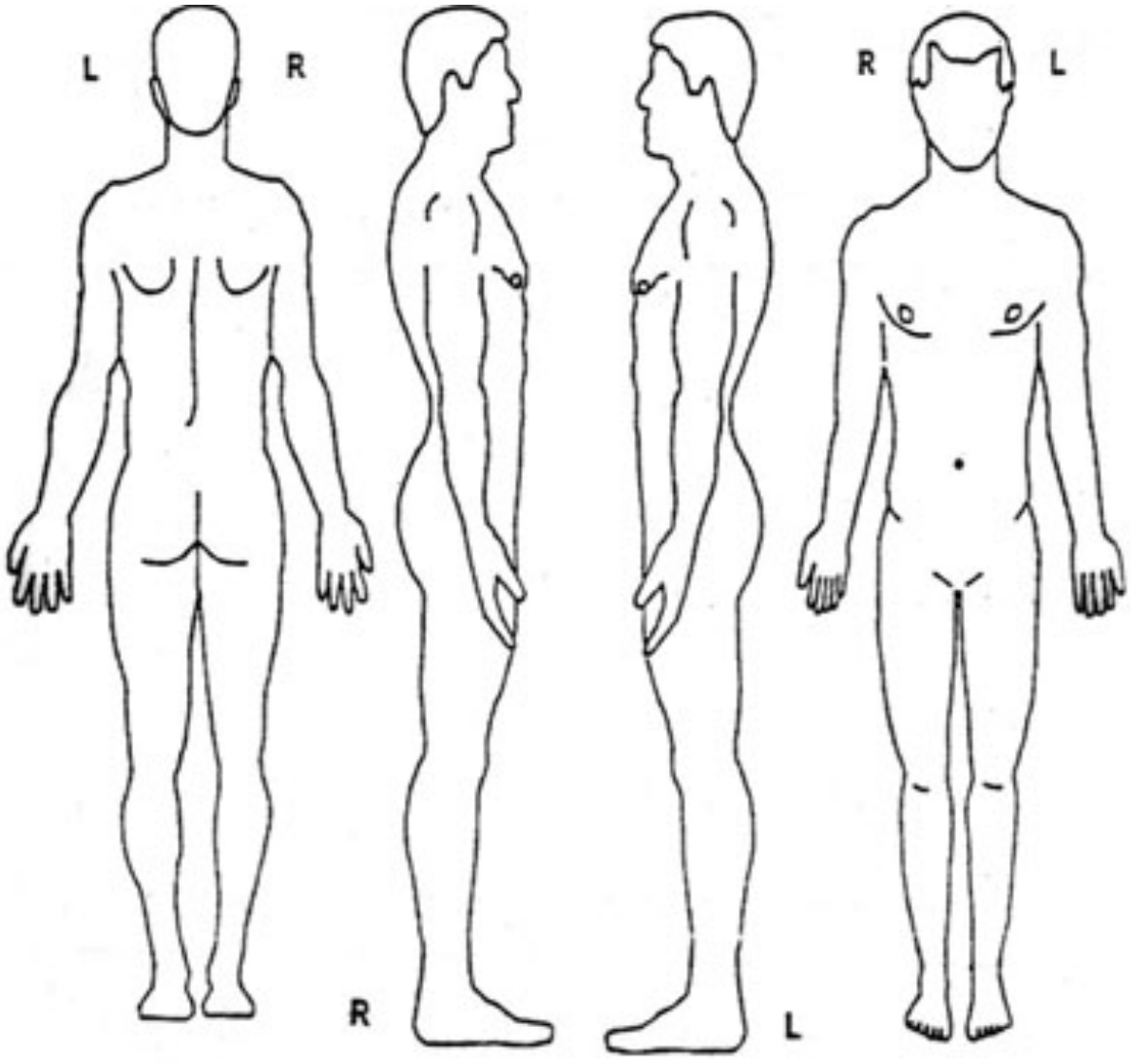
Pain Drawing

Name: _____ **Date:** _____

Please mark the drawings below describing the type of pain you are experiencing as follows:

A = Ache B = Burning N = Numbness P = Pins and Needles S = Stabbing

O = Other ***(Please describe)***_____



Patient Name:	Date:

Adult Health History Form

Your answers on this form will help your health care provider better understand you medical concerns and condition. This form will not be put directly into your medical chart. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please provide your best guess. Thank you!

Age: ___ How would you rate your general health? ***(Please check one)*** [__] Excellent [__] Good [__] Fair [__] Poor

Main reason for today's visit:

_____

_____

Other concerns: _____

_____

CONSTITUTIONAL	RESPIRATORY	SKIN	EYES
[__] Recent fevers/sweats [__] Unexplained Weight loss/gain [__] Unexplained fatigue/weakness	[__] Cough/wheeze [__] Coughing up blood	[__] Rash [__] New or change in mole	[__] Change in Vision
GASTROINTESTINAL	**NEUROLOGICAL**	**EARS/NOSE/THROAT/MOUTH**	**GENITOURINARY**
[__]Heartburn/reflux [__] Blood/change in bowel movement [__] Nausea/vomiting/diarrhea [__] Pain in abdomen	[__] Headaches [__] Memory loss [__] Fainting	[__]Difficulty Hearing/ringing in the ears [__] Hay Fever/allergies/ congestion [__] Trouble swallowing	[__] Painful/Bloody Urination [__] Leaking urine [__] Night time urination [__] Discharge: Penis/Vagina [__] Unusual Vaginal Bleeding [__] Concern with Sexual Functions
CARDIOVASCULAR	**BLOOD / LYMPHATIC**	**BREAST**	**ENDO**
[__] Chest Pains [__] Palpitations [__] Shortness of Breath with Exertion	[__] Unexplained Lumps [__] Easy Bruising/Bleeding	[__] Breast Lump [__] Nipple Discharge	[__] Cold/Heat Intolerance [__] Increase Thirst/Appetite
MUSCULOSKELETAL	**PHYCHIATRIC**		
[__] Muscle/Joint Pain [__] Recent Back Pain	[__] Anxiety/ Stress [__] Sleep Problems		

How often do you experience your symptoms? *(Please check one)*

[__] Constantly (76% to 100% of the day) [__] Frequently (51% to 75% of the day)

[__] Occasionally (26% to 50% of the day) [__] Intermittently (0% to 25% of the day)

How would you describe the nature of your symptoms? ***(Please check all that apply)***

[__] Sharp [__] Dull Ache [__] Numb [__] Shooting [__] Burning [__] Tingling

How are your symptoms changing? ***(Please check one)*** [__] Getting Better [__] Not Getting Better [__] Getting Worse

Personal Medical History:

Please indicate whether you have had any of the following medical problems (please include dates).

[__] Heart Disease _____ [__] High Blood Pressure _____ [__] High Cholesterol _____

[__] Diabetes *(Type)* _____ [__] Thyroid problem *(Type)* _____ [__] Asthma/Lung Disease _____

[__] Kidney Disease _____ [__] Cancer *(Specify)*_____

[__] Other: *(Specify)*

_____

_____

Surgical History: *Please list all prior operations with dates.*

_____

_____

_____

Family History: *Please indicate the current health status of your immediate family members.*

Please check all that apply and indicate relationship (mother, father, sibling, grandparent, aunt or uncle) with any of the following conditions:

[__] Alcoholism_____

[__] Cancer, specify type _____

[__] Heart Disease _____

[__] Depression/Suicide _____

[__]Genetic Disorders _____

[__] Diabetes _____

[__] High Cholesterol _____

[__] High Blood Pressure_____

[__] Stroke _____

[__] Bleeding or Clotting Disorder _____

[__] Asthma/COPD_____

[__] Other _____

Social History: (Please check all that apply)

Tobacco Use: Cigarettes: [__] Never [__] Former Smoker – Quit Date: _____ [__] Current Smoker: # of packs per day ____ # of years smoking _____

Other Tobacco: [__] Pipe [__] Cigar [__] Snuff [__] Chew

Are you interested in quitting? [__] Yes [__] No

Alcohol Use: Do you drink alcohol? [__] Yes [__] No # of drinks per week _____

Is your alcohol use a concern for you or others? [__] YES [__] NO

Do you use recreational drugs? [__] Yes [__] No

Have you ever used needles to inject drugs: [__] Yes [__] No

Socioeconomics:

Occupation: _____ Employer: _____

Years of Education/Highest degree _____ Marital Status: _____

Spouse/Partner's name: _____

Children/Ages: _____

Who lives at home with you? _____

Women's Health History:

# of Pregnancies _____ # of Deliveries_____ # of Abortions _____ # of Miscarriages _____

Age at start of periods: _____ Age at end of periods: _____ Other: *(Explain)* _____

_____

_____

Other Concerns: Please check all that apply.

Caffeine intake: [__] None *or* # cups per day: _____ Type: [__] Coffee [__] Tea [__] Soda

Weight: Are you satisfied with your weight? [__] Yes [__] No

Exercise: Do you exercise regularly? [__] Yes [__] No

How long *(Minutes)*? _____ How often: _____

If you do not exercise regularly, why not?

_____

_____

_____

_____

In the past month, have you had little interest or pleasure in doing things, or felt down, depressed or hopeless? [__] Yes [__] No

Medications: Please list all prescription and nonprescription medicines, vitamins, home remedies, birth control pills, herbs, etc.

Medication or supplement	Dose (mg/pill)	How many times per day?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Online Scheduling Program

For your convenience, you can schedule appointments online 24 hours a day seven days a week by going through our website at www.chirorehab.net or www.Facebook.com/chirorehabindy. Just select "Scheduling" in the left-hand column. You can still call and schedule during office hours.

As part of the online scheduling program, it does several things automatically. It will send you a reminder email one day before your appointment and can send you a text six hours before your next appointment. For our patients who want to come in on a regular basis, reminder emails will be sent at one, two, three, six and twelve months after your last appointment. If you do not want to receive these emails please let us know and we will take your email out of the system.

If you want to receive updates about this practice and the services that we offer, "like" us at www.Facebook/chirorehabindy.net, "follow" us on Twitter @chirorehab and/or visit our website at www.chirorehab.net.

No-Show or Late Cancellation Policy

There is a $25.00 no-show/late-cancellation fee. To avoid no-show/late-cancellation fees, all appointments must be cancelled 24 hours in advance (or by 3:00 p.m. on Friday for a Monday appointment). Insurance will not cover charges for no-show/late-cancellation fees.

I have read and understand the above policies that Robert W. Ferguson, DC, FIAMA, maintains at Chiropractic Rehabilitation & Acupuncture, Inc., 2250 W. 86th St., Ste. 100, Indianapolis, IN 46260.

_____

Signature **Printed Name** **Date**

Chiropractic Rehabilitation and Acupuncture, Inc.

2250 W. 86th St., Ste. 100, Indianapolis, IN 46260

Financial Policy

We are dedicated to providing the best possible care for you and we want you to completely understand our financial policies.

1. Payment is due at the time of service unless arrangements have been made in advance by your carrier. For your convenience we accept Cash, Check and most Credit Cards with the exception of American Express.
2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor…in other words, if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.
3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to pay a co-payment at the time of your visit.
4. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an unassigned basis. This means the insurer will send the payment directly to you. Therefore our charges for your care are due at the time of service.
5. Not all insurance plans cover all services. In the event your insurance plan determines a service to be *"not covered,"* you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
6. We will bill your insurance company for all services. You are responsible for any balance due.
7. A finance charge will be imposed on each item of your account which has not been paid within sixty (60) days of the time the item was added to the account. The *Finance Charge* will be computed at the rate of 1.5% per month or an annual percentage rate of *eighteen percent* (18%).
8. Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we need to refer your account to a collection agency, you agree to pay all of the collection costs, which are incurred. If we need to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees, which we incur plus all court costs.

Please initial boxes and sign below:

[____] I have read and understand the practices of your financial policy and I agree to be bound by its terms.

[____] I also understand and agree that such terms may be amended by the practice from time to time.

_____ _____

Signature of patient (or responsible party if minor) **Date**

_____ _____

Please print name of patient **Print name of responsible party (if other than patient)**

Chiropractic Rehabilitation and Acupuncture, Inc.

2250 W. 86th St., Ste. 100, Indianapolis, IN 46260

Informed Consent for Chiropractic Treatment

The Nature of Chiropractic Treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked" and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Other treatment options may include the following*:*

- ***Over-the-counter analgesics.*** The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- ***Medical Care,*** typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- ***Hospitalization*** in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- ***Surgery*** in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of Remaining Untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual Risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

_____

Patient Signature Date Printed Name

_____

Witness Signature Date Printed Name

Chiropractic Rehabilitation and Acupuncture, Inc.
Informed Consent for Acupuncture Treatment
2250 W. 86th St., Ste. 100, Indianapolis, IN 46260

I, the signer of this document, freely choose to undergo acupuncture treatment, knowing that there are no guaranteed results, and that I am free to stop acupuncture treatment at any time.

I understand that while acupuncture is generally a safe method of treatment, certain adverse effects may result from such treatment. These may be, but are not limited to, fainting, some local bruising, puffiness, redness, blood and temporary pain or discomfort at the site of the needles during or after treatment. I understand the methods of treatment in the scope of Chinese medicine may include but are not limited to acupuncture, cupping, moxibustion (applying heat to acupuncture points), electro-acupuncture (electrical stimulation on the needles), Tui-Na (Chinese massage), and herbal medicine.

I understand the acupuncturist is not providing Western medical care, and I should see my Western primary care physician (MD) for those services and routine checkups.

I understand all fees for services are due at the time of service, and I will be charged the full fee for any appointment that is cancelled with less than a 24-hour notice.

I have read, or have had read to me, and completely understand the risks and benefits of acupuncture treatment and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

_____

Patient Signature Date Printed Name

_____

Witness Signature Date Printed Name

CHIROPRACTIC REHABILITATION & ACUPUNCTURE, INC
Robert W. Ferguson, DC, FIAMA
2250 West 86th Street, Suite 100
Indianapolis, IN 46260
Phone (317) 876-7826
Fax (317) 876-7170

Patient Consent to use of Protected Health Information

I, _____, do hereby state that by signing this form I acknowledge and agree as follows:

1. The Privacy Policy employed by this facility has been offered to me and I:
   _____Declined to accept a copy
   _____Have received a copy
2. I understand and consent to the following appointment reminders or communications that will be used:
   A. Telephoning my home and leaving a message on my machine or with the person answering the phone.
   B. An electronic message (email) sent to the internet address provided by me.
3. This office may use and/or disclose any personal medical information (PMI) in order to receive payment for this treatment and as necessary to conduct its specific healthcare operations.
4. I understand that I have the right to limit the use of my PMI for the purpose of receiving payment and/or treatment. I further understand that this office does not have to agree to my request and that any agreement is binding to me as well as this office.
5. I understand that this consent is good for SEVEN years, and that I may revoke this consent for FUTURE transactions.
6. I understand that if I revoke this consent at anytime, this office has the right to refuse treatment.
7. I understand that refusal to sign this consent will result in this office refusing to treat me.

I have read and understand all forgoing information and all of my questions have been answered to my satisfaction in a way that I can understand.

_____ _____
Printed Name of Patient Signature of Patient

_____ _____
Signature of Legal Representative* Relationship
*Attorney, Guardian, or Parent if minor