



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 of our office? _____

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

MEDICAL HISTORY

Have you been treated for any conditions in the last year? No Yes

If yes, please describe: _____

Date of last physical exam: _____ Is there a chance you are pregnant? No Yes

Have you had x-rays taken? No Yes If yes, where? _____

What medications, vitamins, minerals or herbs are you taking and for what conditions (Please list dosage and amounts, etc)

Who is your current Primary Physician? Please list name and phone number.

HAVE YOU EVER:

NO YES

BRIEFLY EXPLAIN

Broken bones?

Been hospitalized?

Been in an auto accident?

Had sprains/strains?

Been struck unconscious?

Had surgery?

FAMILY HISTORY

Please list family members with present or past health conditions (Ex. heart disease, cancer, diabetes, arthritis, etc.)

Do you experience pain every day? No Yes

Do your symptoms interfere with daily life? No Yes

Does pain wake you up at night? No Yes

Are your symptoms worse during certain times of the day? No Yes

Do changes in weather affect your symptoms? No Yes

Do you wear orthodontics? No Yes

What activities aggravate your symptoms? _____

HABITS

NONE

LIGHT

MODERATE

HEAVY

Alcohol

Coffee

Tobacco

Drugs

Exercise

Sleep

Appetite

Soft Drinks

Water

Salty Foods

Sugary Foods

Artificial Sweeteners

Please write any additional information you wish to share in this space.

CURRENT MEDICAL CONDITION INFORMATION

What is your main area of complaint? HA, Neck, Upper Back, Middle Back, Lower Back, Hips, Shoulders, Arms, Legs, Other

Have you been treated for your current condition? No Yes

How often does this complaint bother you? ___Constant ___Daily ___3x Week ___1xWeek ___1x Month

Do you know what may have caused this complaint? ___Auto ___Work ___Fall

When it's at its worst, describe how it feels (sharp, dull, achey, constant, comes and goes) _____

Has it been bothering you for more than a couple of days? No Yes If Yes, How long? _____

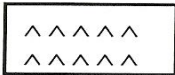
Have you tried any treatment for this problem, such as ice, heat, rest, over-the-counter medication, muscle relaxers, physical therapy, or anything else which has not resolved this complaint as of yet? If yes, please describe: _____

Have you seen other doctors for this condition? No Yes If yes, Who? _____

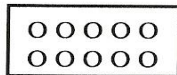
Do you have a current (6 months or later) x-ray for this condition? No Yes If yes, can you bring those to us along with a report? _____

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

Ache



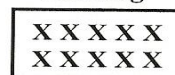
Numbness



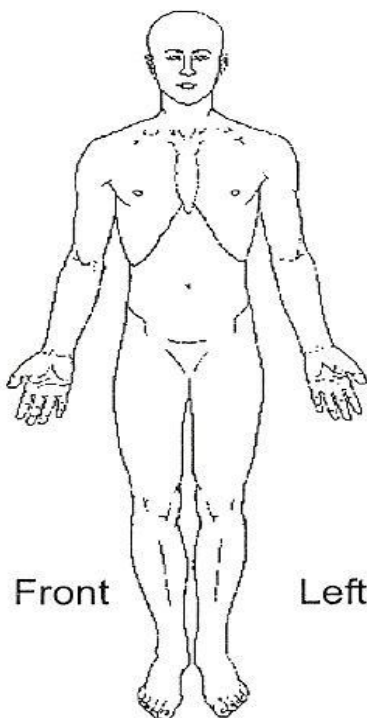
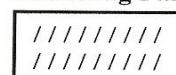
Pins & Needles



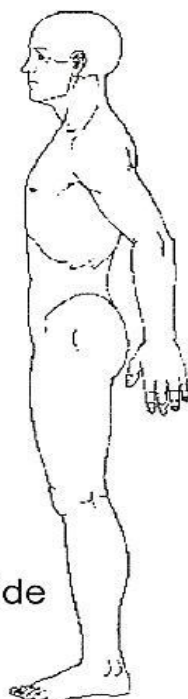
Burning



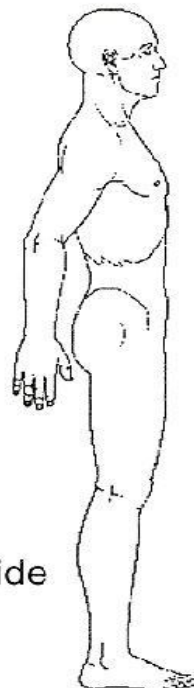
Radiating Pain



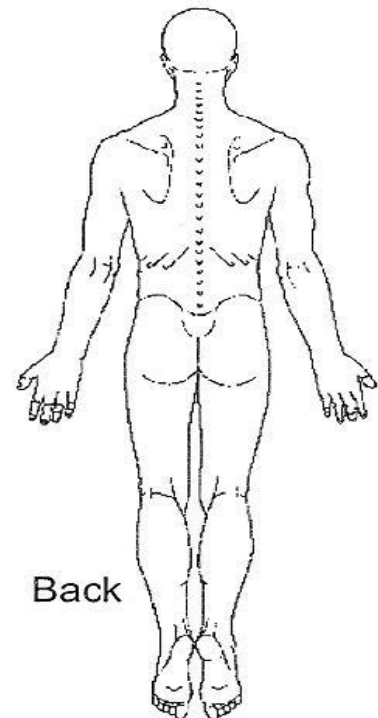
Front



Left Side



Right Side



Back

On a scale of 1-10, with 10 being the worst pain, where would you rate your level of pain? _____

Most patients that come to our office have one of two objectives in mind concerning their healthcare. Some patients come for symptomatic relief of pain or discomfort (RELIEF CARE). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (CORRECTIVE CARE). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

Relief Corrective Check here if you want the Doctor to select the type of care appropriate for your condition.

STATEMENT OF CONSENT FOR CARE

As a patient of Hoosier Health Plus, 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 he 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. Your Provider is licensed in a special practice and is available to work with other types of providers in your health care regimen.

I understand that if I am accepted as a patient by a provider at Hoosier Health Plus, 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.

STATEMENT TO PERMIT PAYMENT OF MEDICAL BENEFITS TO PROVIDER, PHYSICIAN, AND PATIENT:

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 either to me or to the above named physician's office. I also hereby give my consent for evaluation and treatment Hoosier Health Plus. In addition, I also give my consent to the treatment of the above named minor patient.

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 Hoosier Health Plus.
- *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 Hoosier Health Plus 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, CHECK, MASTERCARD, AND VISA. PAYMENTS PLANS ARE ALSO AVAILABLE.

Regarding Insurance

Hoosier Health Plus 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 Hoosier Health Plus 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 by cash or check 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 Hoosier Health Plus.

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

We do not charge for missed chiropractic appointments but we do appreciate that you let us know if you cannot make one of your appointments. **MASSAGE APPOINTMENTS** must be cancelled within **24 HOURS** of the appointment or we reserve the right to charge **\$48** as a **MISSED APPOINTMENT CHARGE**.

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

X _____

Signature of Patient or Responsible Party

DATE _____

X _____

Signature of HHP Employee

DATE _____

HIPAA Notice of Privacy Policies

Hoosier Health Plus, LLC.

520 East 8th St., Anderson, IN 46012 765.641.7700

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, and 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 CONTINUED

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 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 765-641-7700.

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

:
Print Name: _____ Signature _____ Date _____

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

It is the policy of Hoosier Health Plus, LLC 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 telephone answering machine, work telephone, voice mail, cell phone or pager, or to any other person, then you must complete the following:

I authorize Hoosier Health Plus 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 answering machine	Yes	No
We can call you at work	Yes	No
We can leave a message on your voice mail	Yes	No
We can call your cell phone which is _____	Yes	No
We can page you	Yes	No
We can fax copies of information to other offices if necessary	Yes	No

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

<u>Name</u>	<u>Relationship (spouse, parents, friend, neighbor)</u>
_____	_____
_____	_____
_____	_____

Patient Signature/Legal Representative

Witness Signature

Date

Date

AMERICAN RADIOLOGICAL SERVICES

(419) 269-2140 (800) 442-1202

PATIENT _____ OFFICE HOOSIER HEALTH PLUS LLC

AGE _____ SEX M ___ F ___ SOCIAL SECURITY# _____

DATE OF BIRTH _____ DATE OF FILM _____

PATIENT ADDRESS _____ CITY _____ STATE/ZIP _____

X-RAY ASSIGNMENT AGREEMENT

I understand that the services of a chiropractic radiologist are being utilized to insure the highest quality interpretation of my x-rays. I acknowledge that these services are separate from those of the office where I am receiving care, and that the charges for these services will be submitted to my insurance carrier, Worker's Compensation carrier or State Bureau, and/or to my attorney in the case of personal injury.

In the event that I receive payment for these services, I agree to promptly remit payment to American Radiological Services (ARS).

I assign my insurance benefits and rights to payment to ARS to the extent of their charges, and authorize them, or their agents, to bill and release information to my insurance company, attorney, and/or any third party payer. I authorize my treating physician, insurance company, attorney, and/or any third party payer to provide ARS or their agents with any information concerning my claim, their services, and/or payment for their services provided.

By my signature below, I acknowledge that I have read, understand, and agree to the above provisions, and I assign my insurance benefits as described above.

SIGNATURE: _____ **DATE:** _____

WITNESS: _____