LC Chiropractic, p.c.
8483 Fishers Center Dr.
Fishers, IN 46038
317-576-9620

PATIENT INFORMATION

Welcome to our practice. Please answer the following questions. This will give the doctor valuable information needed to help you. Please be as accurate and complete as possible.

PERSONAL INFORMATION

Name: _____ Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Date of Birth: ____ /____/_____ Age: _____ Sex: M F
Business/Employer: _____ Work Phone: _____ SSN: _____-____-_____
Type of Work Performed: _____
Marital Status: __ M __ S __ W __ D Children _____ Spouse's Name: _____
In Case of Emergency Notify: _____ Phone: _____
Name of Family Physician: _____
Who referred you to our office? _____
E-mail address: _____ Alternate Phone (cell) _____

CURRENT HEALTH CONDITION

Main or Primary Complaint:

_____
_____

How Severe Is This Problem:_ Mild _ Moderate _ Severe
Previous Occurrences: _ Yes _ No
When Did This Condition Begin:_____
Other Doctors Seen For this Complaint: _____
Previous Doctor's Opinion/Diagnosis: _____
Is Condition:_ Job Related _ Auto Related _ Injury Other: _____
Other or Secondary Complaints: _____
Other Health Problems: _ Yes _ No If "Yes", please describe: _____
Drugs or Medicines Now Taking:
_ Pain Killers / Muscle Relaxers _ Blood Pressure Medicine _ Stomach Medicine
_ Tranquilizers _ Antibiotics Other: _____

PAST HEALTH HISTORY

Major Surgeries/Operations: _ Head _ Neck/Throat _ Chest/Heart/Lung _ Back _ Abdominal
Other:_____
Previous Fractures or Broken Bones: _ Yes _ No What: _____
Previous Falls or Accidents: _ Yes _ No When:_____
Previous Hospitalization: _ Yes _ No Why:_____
Previous Chiropractic Care: _ Yes _ No Doctor:_____
Has Anyone Else In Your Family Had A Similar Problem? _ Yes _ No
Has Anyone With Whom You've Worked Had A Similar Problem? _ Yes _ No
Do You Participate In Any Sports or Exercise Programs? _ Yes _ No

PLEASE COMPLETE OTHER SIDE

Below is a list of diseases and disorders that may seem unrelated to the purpose of your appointment. However, the following information may affect your response to our care as well as our approach to handling your case. Please complete the following as carefully as possible.

Check any of the following that applies to you:

_ Polio
_ Diabetes
_ Cancer
_ Other:_____
_ Heart Disease
_ Chronic Fatigue
_ Arthritis
_ Epilepsy
_ AIDS or ARC
_ Frequent Illnesses
_ Allergies

INTAKE or *USE*
_ Alcohol
_ Recreational Drugs
_ Tobacco
_ Pain Relievers
_ Prescribed Drugs

Check any problem that you have had in the past 6 months:

Muscles-Skeleton
_ Low Back Pain
_ Pain Between Shoulders
_ Neck Pain
_ Arm Pain
_ Joint Pain/Stiffness
_ Problems Walking
_ Difficulty Chewing - TMJ
_ General *Stiffness*

Circulation-Breathing
_ Chest Pain
_ Shortness of Breath
_ Blood Pressure Problems
_ Irregular Heart Rate
_ Heart Problems
_ Lung Problems
_ Stroke

Eye-Ear-Nose-Throat
_ Visual Disturbances
_ Dental Problems
_ Sore Throat
_ Ear Aches
_ Difficulty Hearing
_ Stuffy Nose
_ Sinus Drainage/Pain
_ Pain - Forehead or Face

Nerve System
_ Headaches
_ Nervousness
_ Numbness/Tingling
_ Muscular Weakness
_ Dizziness
_ Forgetfulness
_ Depression
_ Fainting
_ Convulsions/Seizures
_ Cold Hands Feet
_ Stress
_ Shaking/Tremors

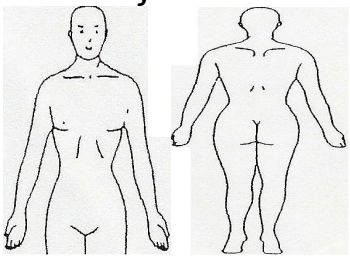
Digestion-Elimination
_ Poor Appetite
_ Excessive Thirst
_ Frequent Nausea
_ Diarrhea
_ Constipation
_ Hemorrhoids
_ Weight Loss/Gain
_ Gas/Bloating
_ Heartburn
_ Change in Stools

Urinary-Genitals
_ Pain with Urination
_ Infrequent Urination
_ Frequent Urination
_ Weak Urine Stream
_ Loss Of Bladder Control
_ Pain in Genitals

Female Only
_ Menstrual Pain/Irregularity
_ Low Back Pain w/ Periods
_ Breast Pain/Lumps

Are You Pregnant? _ Yes _ No _ Not Sure

Please mark your areas of complaint:



(X) Pain (0) Spasm (*) Numb

I understand that my care in this office may involve the making of judgments that are based upon the facts known by the doctor. Therefore, the above information is true and complete to the best of my knowledge. I also understand that the practice of any healing art is not an exact science and that no guarantee of results will be made by the doctor nor relied upon by me. I further understand that the doctor's professional expertise lies in detecting and correcting structural and mechanical aberrations of the spine. I agree that he will not be held responsible for the diagnosis or treatment of any medical condition.

Patient's Signature: _____ Date: _____

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Assignment of Benefits

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered, assigns to the physician or facility named above the following rights, power, and authority.

RELEASE INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney, or insurance adjuster, for the purpose of processing my claim for benefits and payment of service rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive irrevocable right to any cause of action that exists in my favor against any insurance company for benefits to the extent of your bill for total services if such benefits are owed within the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court costs, or other legally compassable amounts owed by an insurance or state statute. I, as the patient and/or the responsible party, further agree to cooperate and provide information as needed, and appear as needed wherever, to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above, you are hereby tendered demand for pay in full the bill for services rendered by the physician/facility named above within 60 days following your receipt of such bill for services to the extent such bills are payable under the terms of my/our policy for benefits, less any amounts which I/we owe personally which are not payable under the terms of your policy. In consideration of the services to be provided to the patient, I/we hereby guarantee payment in full of the patient's account in accordance with the financial arrangements made at the time of discharge or, if no such arrangements are made, then payment shall be made in full within thirty (30) days of discharge. I/we agree that in event of default in payment, reasonable collection agency fees equal to fifty (50%) percent of the delinquent balance and reasonable attorney fees, shall be added to the amount due on the account, plus any applicable court costs.

THIRD PARTY LIABILITY: If patient(s)' treatments for injuries are the result of the negligence of any third party, then patient(s) grant a lien and assignment of cause of action against any right of recovery from such third party(s) to the extent of the bills for treatment, in favor of the physician/facility named above.

INSURANCE AGREEMENT: I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare my necessary reports and forms to assist me in making collection from the insurance company, and that any amount authorized to be paid directly to co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. This demand specifically conforms with this state's insurance code, providing for attorney fees, penalty, court costs, and interest from judgment, upon violation. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

A photocopy of this instrument shall serve as original.

Signature of patient and/or responsible party **Date**

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Patient Health Information Consent Form
(Notice of HIPAA Privacy Practices)

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. 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 this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, the staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name:_____ Date:_____