



9780 Lantern Rd., Ste. 230 • Fishers, IN 46037

Welcome to our Chiropractic Wellness Center!

PATIENT INFORMATION FORM

Here at Stillpoint, we are here to help you experience the optimal health and wellbeing! In order to help us do so, please answer the following questions:

On a scale of 1 – 10, , rate the importance for you to achieve the following:

(1 = not important 10 = necessary)

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|----|
| Get fit | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Eat better | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Reduce stress | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Stop smoking | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Reduce pain | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Increase my mobility | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Improve my posture | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Improve my sleep | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Learn about wellness | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Learn about wellness products that are right for me | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Other _____ | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Name: _____ Phone: _____

Cell phone: _____ E-mail _____ PLEASE PRINT CLEARLY

Address: _____ City: _____

State: _____ Zip Code: _____

Social Security #: _____ Date of Birth: _____ Sex: M F

Place of Employment: _____ Phone: _____

Employment Address: _____ City: _____ Zip: _____ # of years _____

Type of Work Performed: _____

Marital Status: Single Married Widowed Divorced Number of Children: _____

Spouse: _____ Social Security #: _____

Contact in Case of Emergency _____ Phone: _____

MEDICAL HISTORY

What brings you in today? _____

When did you notice this condition? _____

Is this condition due to: Work Auto Accident Fall Unknown Other _____

If condition is due to an accident, describe how the accident occurred: _____

DESCRIBE YOUR CONDITION:

Quality: Dull Sharp Burning Aching

Radiate to: R Arm L Arm R Leg L Leg Head Body Other _____

Severity: Place a mark on the line which indicates pain

|-----|
No pain Severe

What portion of the day is the pain present?

0-25% 26-50% 50-75% 100%
[Intermittent] [Occasional] [Frequent] [Constant]

Who have you seen previously for this condition?

Name: _____ DC MD DO

Have you had this condition in the past? Y N

How does dealing with this condition impact your life? (i.e. what can you not do?) _____

Have you ever been diagnosed with? High Blood Pressure Arthritis
Stroke Disc Herniation

Do you have a history of?
Seizures Fainting Dizziness Pain
Double vision Bowel or Dysfunction

List any other illnesses you have had: _____

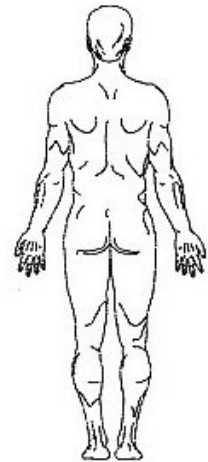
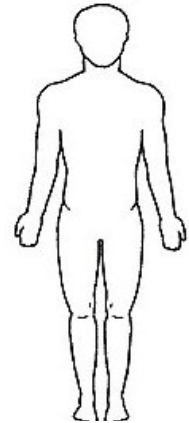
List any surgeries/hospital stays: _____

List any accidents/broken bones etc: _____

List all prescription drugs you are currently taking and conditions for which they have been prescribed and approximately how long have you been taking them? _____

List all supplements/vitamins you are currently taking: _____

Place an X on the diagram to indicate areas of pain



FOR FEMALES ONLY:

Do you have any menstrual pains? Y N

If so, when was first menses? _____ Pain during: Cycle or at Ovulation

Do you have any children? Y N

If so, how old are they? _____

Number of pregnancies: _____

Have you had a cesarean birth? Y N

Complications with pregnancy or delivery? _____

TO THE BEST OF MY KNOWLEDGE, AT PRESENT, I AM NOT PREGNANT AND I HEREBY RELEASE STILLPOINT FAMILY CHIROPRACTIC AND RADIOLOGICAL STAFF FROM ANY AND ALL RESPONSIBILITY OR LIABILITY UPON MY BEING X-RAYED FOR THE PURPOSE OF DIAGNOSTIC EVALUATION.

Patient Signature

Date

Describe your childhood activities (i.e. any big bumps or bruises, accidents, sports injuries, etc):

Who may we thank for referring you to our office? _____

Authori zati on to Proceed wi th Treatment

I understand that if I am accepted by the chiropractors of Stillpoint Family Chiropractic, Inc. for treatment, I authorize them to proceed with any treatment they deem necessary. Furthermore, any risks regarding chiropractic treatments will be explained to me upon request.

Signature _____ Date _____

I. Appointment Policy

Office visits are scheduled according to the program of chiropractic care that the doctor feels is best for you. Because your condition requires numerous appointments over the next few weeks or months, we have designed a Multiple Appointment Program for your convenience. This procedure minimizes your time in the office and facilitates incorporating your appointments into your daily routine.

The frequency of your visitation schedule is of paramount importance to your results, so we ask that each patient assume the responsibility of strict adherence to the appointment program as it is designed for optimum results.

If, for any reason, you are unable to keep an appointment, we require that you telephone immediately to reschedule that visit. Also, this office reserves the right to charge \$45 for missed appointments and those appointments cancelled without 4 hours notice.

When entering the office on any given visit, please go directly to the front desk and "sign-in." We sincerely attempt to honor all appointments at the scheduled time. If you are late, you may be asked to wait for the next available appointment. If we are unexpectedly running behind, we will attempt to call you and advise you on the status of your appointment time. If you have any questions regarding our office policy or your appointments, please do not hesitate to ask.

_____Initials

II. Wellness Orientation Workshop - WOW!

The purpose of requiring all new patients to attend a Wellness Orientation Workshop is to enlighten you about your body, especially the spine and nerve system. Since chiropractic is clearly not the practice of medicine, and is probably new to you, it is essential to understand how to help us help you get well faster. We have found that patients who have attended seem to respond better, because they understand the cause of their problem and what we are attempting to do to correct it.

Proper health care is a two-way street, meaning that both the doctor and the patient have various responsibilities to uphold, if you are to receive maximum benefits in the minimum amount of time. Natural healing requires our joint cooperation!

Your attendance at the Special Consultation is requested! It is part of your program of care. Further, we request that you bring your spouse/significant other or another family member, so he/she can understand too and learn to assist you in your quest to regain your health. Friends and relatives may also attend, as this is a terrific way for them to find out the value of chiropractic care. Just ask at the Front Desk to reserve a place for you and your guests. Wellness Orientation Workshops are held twice a month on Wednesdays at 1:15 pm or 6:15 pm.

_____Initials

III. Financial Policy

It is the policy of this office that all services rendered are charged directly to you, the patient, and that ultimately the patient is responsible for all services, including those not reimbursed by third party payers.

All payments are expected at the time of service, or at the end of each week. Patient balances may not exceed \$200 at any time. Returned checks and balances over 30 days may be subject to additional collection fees and interest charges of 1.5% per month as well as attorney fees and court costs.

"Our CASH PLAN is available as a long term plan and is a way to assist you financially during this time. The Cash Plan explains the number of visits you will be expected to complete and the fee for services rendered. This fee can be paid in advance, or monthly. At the end of the agreement period, you and the doctor will discuss future care including wellness care".

_____Initials

PAYMENT OPTIONS

I agree to pay Stillpoint Family Chiropractic, Inc. for the service received using one of the following payment options which best fits my situation.

_____ PRIVATE PAY: Payment is made by cash, check or credit card.

- ~ payment in full for services on first visit
- ~ payment is due when services are rendered
- ~ an itemized statement will be provided to the patient should the patient choose to file insurance privately
- ~ payment plan available see office manager

_____ INSURANCE: Private or group health insurance.

- ~ payment in full for services on the first visit and every visit there after
- ~ all usual and customary insurance forms are completed and submitted to the insurance company weekly

Health Insurance? Y N Insurance Co: _____

Policy # _____ Group # _____ Deductible: _____

Secondary Insurance? Y N Insurance Co: _____

Policy # _____ Group # _____

_____ PERSONAL INJURY: Automobile or other liability injury

- ~ patient must provide Stillpoint Family Chiropractic with information on the accident and insurance carrier
- ~ alternate payment information must be submitted for coverage through Med Pay Clause of patient's automobile insurance, or patient's health insurance, or both
- ~ patient is responsible for payment in full, regardless of coverage through any of the above methods

_____ MEDICAID: Eligible for public assistance

- ~ current eligibility card must be presented by patient before any services are rendered
- ~ evidence of eligibility is the responsibility of the patient and must be presented on a monthly basis
- ~ failure to show proper eligibility on a monthly basis may result in the patient being personally responsible for all charges
- ~ cards showing a co-payment is the patient's responsibility and due at the time of service

_____ MEDICARE: 65 years of age and/or enrolled in Medicare; Beginning 10/01/2009, patient will pay Medicare rate at time of service and be reimbursed directly by Medicare.

- ~ we will complete and file all usual and customary Medicare claims
- ~ patient agrees to pay any amount determined by Medicare to be the patient's responsibility

~~I have read and understand the terms of the above-named option which I have chosen. I understand that I am personally responsible for any and all services rendered by Stillpoint Family Chiropractic or my doctor, regardless of expected insurance payment or claim settlements.~~

Patient or Legal Guardian Signature

Date