



Pala Chiropractic, L.L.C.
14701 Cumberland Road, Ste 350
Noblesville, IN 46060
Phone (317) 770-1970 Fax (317) 770-4386

CONFIDENTIAL PATIENT INFORMATION FORM – PLEASE PRINT

Full Name _____

Name of wife, husband, or guardian _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail _____

Married ___ Single ___ Divorced ___ Widow(er) ___ Number of Children ___ Pregnant: ___ Due Date: _____

Date of Birth _____ Age _____ Social Security Number _____

Employer _____ Employer Address _____

Spouse's Employer _____ Address _____

Whom may we thank for referring you? _____

Chiropractors you have seen before:

Name _____ City _____ State _____ When _____

Name _____ City _____ State _____ When _____

List medical doctors seen within the past year:

Name _____ City _____ State _____ When _____

Name _____ City _____ State _____ When _____

List all accidents or injuries:

Type _____ When _____ Hospitalized? _____

Type _____ When _____ Hospitalized? _____

List all surgeries:

Type _____ When _____

Type _____ When _____

List medications and/or vitamins and supplements you are taking

Name _____ For _____ How long _____

Name _____ For _____ How long _____

Use back of sheet for any additional space needed.

PAIN DRAWING

Name: _____ Date: _____

Please be sure to fill this out extremely accurately. Mark the area on your body where you feel the described sensation(s). Use the appropriate symbol(s), mark the area of radiating pain, and include all affected areas. You may draw on the face as well.

Pain Symbols:

Numbness

Pins & Needles

o o o o o o o

Burning Pain

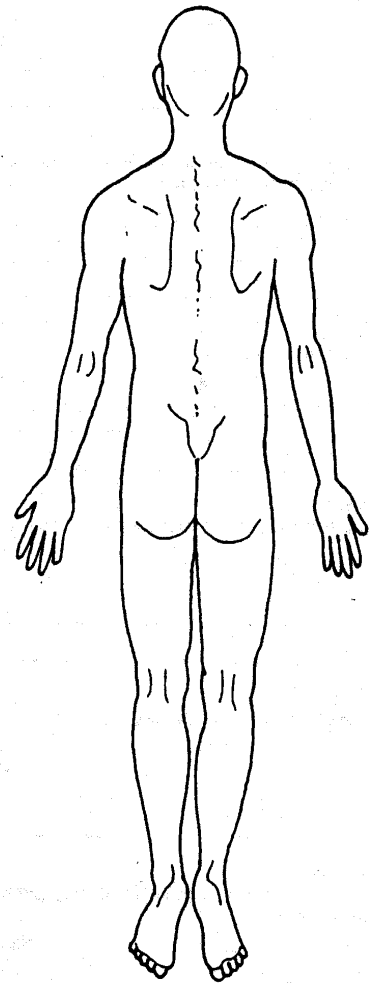
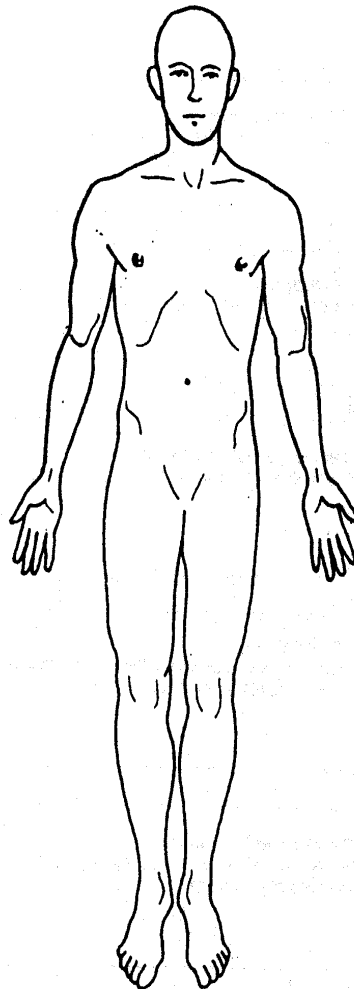
x x x x x x x

Stabbing Pain

/ / / / / / / / / /

Aching Pain

((((((((((



Chief Complaint: _____

Patient Explanation of Incident: _____

Date of Onset: _____ Did symptoms appear gradually or suddenly? _____

On the Job: _____ Yes _____ No Days off work: _____

Auto Accident: _____ Yes _____ No Days off work: _____

Patient Name: _____ Date: _____

Below are listed common symptoms which may suggest the presence of an ailment involving a particular body system. If you ever had a listed symptom in the past, please check that symptom in the left hand column. If you are presently troubled by a particular symptom, check that symptom in the right hand column.

| | | | | | |
|------|-----------------------------------|---------|------|------------------------------|---------|
| Past | Musculoskeletal | Present | Past | Respiratory | Present |
| [] | Neck pain | [] | [] | Shortness of breath | [] |
| [] | Shoulder pain | [] | [] | Chronic pain | [] |
| [] | Pain in upper arm or elbow | [] | [] | Chronic cough | [] |
| [] | Hand pain | [] | [] | Chronic sinusitis | [] |
| [] | Upper back pain | [] | | | |
| [] | Low back pain | [] | Past | Gynecologic | Present |
| [] | Pain in upper leg or hip | [] | [] | Pain during menstruation | [] |
| [] | Pain in lower leg or knee | [] | [] | Irregular menstrual flow | [] |
| [] | Pain in ankle or foot | [] | [] | Spotting | [] |
| [] | Jaw pain | [] | [] | Menopausal symptoms | [] |
| [] | Swelling in joints (list joints) | [] | | | |
| [] | Stiffness of joints (list joints) | [] | Past | Genito-Urinary | Present |
| | | | [] | Painful urination | [] |
| | | | [] | Loss of bladder control | [] |
| | | | [] | Frequent urination | [] |
| | | | [] | Urethral discharge | [] |
| Past | Nervous System | Present | Past | GI Tract | Present |
| [] | Depression | [] | [] | Abdominal pain | [] |
| [] | Insomnia | [] | [] | Difficult swallowing | [] |
| [] | Bed wetting | [] | [] | Heartburn/indigestion | [] |
| [] | Fainting | [] | [] | Constipation | [] |
| [] | Convulsions | [] | [] | Diarrhea | [] |
| [] | Dizziness | [] | | | |
| [] | Headache | [] | Past | Skin | Present |
| [] | Muscular incoordination | [] | [] | Rash | [] |
| [] | Hearing loss | [] | [] | Dermatitis or eczema | [] |
| [] | Tinnitus (ear noises) | [] | [] | Persistent itching | [] |
| [] | Ear pain | [] | | | |
| [] | Impaired vision | [] | | | |
| [] | Eye pain | [] | | | |
| [] | Paralysis | [] | | | |
| Past | Cardiovascular | Present | [] | Tobacco | |
| [] | Rapid heart beat | [] | [] | Alcohol, Qty/Frequency _____ | |
| [] | Chest pains | [] | [] | Tranquilizers/Sedatives | |
| | | | [] | Laxatives | |
| Past | Endocrine | Present | [] | Coffee, cups/day _____ | |
| [] | Loss of appetite | [] | [] | Regular soda, cans/day _____ | |
| [] | Abnormal weight gain | [] | [] | Diet soda, cans/day _____ | |
| [] | Abnormal weight loss | [] | [] | Water _____ | |

Please check any of the following that apply to you.

Listed below are common diseases and disorders. Please indicate whether you have had a particular disorder in the past or are presently troubled by a listed disorder.

| | | | | | |
|------|-------------------------|---------|------|----------------------------|---------|
| Past | Condition | Present | Past | Condition | Present |
| [] | Hemorrhoids | [] | [] | Emphysema | [] |
| [] | Rheumatic heart disease | [] | [] | Arthritis | [] |
| [] | High blood pressure | [] | [] | Drug or alcohol dependency | [] |
| [] | Angina | [] | [] | Diabetes | [] |
| [] | Heart attack | [] | [] | Ulcer | [] |
| [] | Stroke | [] | [] | Kidney stones | [] |
| [] | Asthma | [] | [] | Bladder infection | [] |
| [] | Gallbladder | [] | [] | Other _____ | [] |
| [] | Cancer | [] | [] | Other _____ | [] |
| [] | HIV positive/AIDS | [] | [] | Other _____ | [] |

OFFICE PROCEDURES AGREEMENT

Pala Chiropractic, L.L.C. has my permission to send me appointment reminders and/or missed appointment correspondence by phone or via US Mail or other similar methods.

Pala Chiropractic, L.L.C. has my permission to leave phone messages or verbal messages with whoever answers the provided phone numbers regarding appointment information.

I understand that patient health information will only be shared by phone with me as the patient or to legal guardians if the patient is a minor.

Pala Chiropractic, L.L.C. has my permission to send newsletters or other printed materials to me via US Mail or other similar methods. To be removed from this list, I may request to be released as an active patient.

Pala Chiropractic, L.L.C. will prepare and file insurance forms and reports if I wish to file with insurance. I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. Cash payments and insurance co-pays (and estimated insurance co-pays) are due at the time service is provided.

By signing below, I agree to the information above, services to be rendered, and responsibility of charges incurred at this office. If insurance does not cover filed charges, I understand that I will be full responsible for payment of all services provided. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. 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. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature: _____ Date: _____
Guardian's Signature Authorizing Care: _____ Date: _____

ELECTRONIC CORRESPONDENCE APPROVAL

Electronic newsletters or other electronic material may be sent to my email address(s).

_____ YES _____ NO _____ INITIALS



INFORMED CONSENT TO CHIROPRACTIC CARE

THE NATURE OF CHIROPRACTIC TREATMENT: The doctor will use his/her hands to move your joints. You will typically feel and hear the movement of the joints similar to popping your knuckles. Therapeutic ice may be used.

POSSIBLE RISKS: You may feel tired after your first adjustment. You may feel sore like you “used muscles you didn't know you had” like after your first workout at a gym. A very small percentage of people may feel pain, tingling, numbness, cramps or tightness in their extremities. There is a one in one million to one in ten million chance of stroke associated with certain types of cervical (neck) manipulation. The risks of complications due to chiropractic care have been described as “rare”.

OTHER TREATMENT OPTIONS: Other treatment options which could be considered may include the following:

- Over-the-counter analgesics- the risks of these medications include irritation to the stomach, bleeding ulcers, liver and kidney damage, heart attacks, and other side effects in a significant number of cases.
- Medical care- including prescribed 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.
- Surgery- (in conjunction with medical care) adds risk of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.
- Risk of remaining untreated- delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility, and include chronic pain cycles.

By signing below, I **agree** to the following:

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

Printed Patient Name

Signature(guardian if minor)

Date

FINANCIAL POLICY

FINANCIAL OBLIGATION:

I agree that I am financially responsible for payment of all amounts for services provided by Pala Chiropractic, L.L.C. I am responsible to pay for my services regardless of insurance coverage of other responsible parties. I will not be responsible to pay if my obligation is waived by contractual agreements between Pala Chiropractic, L.L.C. and my insurer, or if prohibited by state or federal laws or regulations. If my insurance plan is a Health Maintenance Organization (HMO) or Medicare, I understand that I am financially responsible for non-covered services or deductibles, co-pays or co-insurance as defined in my policy or plan. I further agree to pay all of Pala Chiropractic, L.L.C.'s costs of collection if collection action against me is reasonable or necessary, including but not limited to all of Pala Chiropractic, L.L.C.'s attorney fees, court costs, and litigation expenses. I agree that the venue for any collection action against me shall be the Circuit or Superior Courts of Hamilton County, Indiana.

I understand Pala Chiropractic, L.L.C. will provide routine and reasonable insurance claims processing to most carriers as a courtesy for me. In return, they expect cooperation from me, if necessary; to help collect any amounts due. I understand Pala Chiropractic, L.L.C. reserves the right to refuse this courtesy or withdraw it at any time. I understand Pala Chiropractic, L.L.C. charges for extraordinary processing such as reports, copies of records, etc.

It is understood and agreed that any amounts paid the doctor for x-rays are for examination only, the negatives will remain here as a property of this office as part of the permanent patient file.

I understand the doctor will not be held responsible for any pre-existing medically diagnosed conditions.

Consent to Bill Insurance:

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized is paid directly to this doctors office. I also understand that this amount will be credited directly to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees or outstanding balances for services I have received will be immediately due and payable.

Consent of Professional services and Release of Information:

I hereby authorize and release the doctor and whomever he/she may designate as his/her assistants, to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services he/she deems necessary in my case. I furthermore authorize him/her to disclose all or any part of my patient records to any person or corporation which is or may be liable under contract to this office or to the patient or to a family member or employer of the patient for all or part of the clinic's charges, including, and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

Printed Name: _____

Date: _____

Signature: _____

Date: _____

Patient, parent if minor child, or guardian

(If patient unable to sign, Representative name and relationship)