ALLEN COUNTY Chiropractic Wellness Center

6324 CONSTITUTION DRIVE
FORT WAYNE, INDIANA 46804
TELEPHONE (260) 432-7339
FACSIMILE (260) 969-0114
www.accwellnesscenter.com

PATIENT CONFIDENTIAL INFORMATION

PATIENT ID# _____ TODAY'S DATE: _____

NAME (FIRST, MI, LAST): _____ SEX: M ☐ F ☐

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____

MOBILE PHONE: _____

EMAIL: _____

SSN: _____ AGE: _____ D.O.B.: _____ MARITAL STATUS: S☐ M☐ D☐ W☐

YOUR OCCUPATION: _____ EMPLOYER: _____

EMPLOYER ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SPOUSE'S NAME: _____ D.O.B.: _____

SPOUSE'S OCCUPATION: _____ EMPLOYER: _____

PHONE: _____

OR EMERGENCY CONTACT:

CONTACT NAME: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE OF EMERGENCY CONTACT: _____

ACCIDENT: YES☐ NO☐ IF YES: → AUTO ACCIDENT ☐ WORKER'S COMP ☐ PERSONAL INJURY ☐

REFERRED BY: _____

NOTE: IF YOU HAVE YOUR INSURANCE CARD WITH YOU, PLEASE HAVE THE FRONT DESK ASSISTANT MAKE A COPY OF IT AT THIS TIME. THANK YOU.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, _____, acknowledge and agree that I was offered a copy of Allen County Chiropractic Wellness Center's Notice of Privacy Practices.

I will allow the following people access to my medical records:

NAME: _____ RELATIONSHIP: _____ PHONE #: _____

NAME: _____ RELATIONSHIP: _____ PHONE #: _____

Your office can leave a voice message for me regarding my healthcare: YES ☐ NO ☐

_____ _____

SIGNATURE OF PATIENT **DATE**

_____ _____

SIGNATURE OF PATIENT'S LEGAL REPRESENTATIVE (IF APPLICABLE) **DATE**

_____ _____

PRINT NAME OF LEGAL REPRESENTATIVE **RELATIONSHIP TO PATIENT**

NAME OF LEGAL GUARDIAN

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OFFICE POLICIES

1. Any X-rays taken at this office will remain the permanent physical property of this office for a minimum of seven years as required by Indiana State Law. Copies of the patient's X-rays and/or records will be provided to you when a minimum advance notice of one working day is given. We reserve the right to charge a "copying" fee for the reproduction of the above X-rays and/or records.
2. Payment is expected at the time of service. We accept cash, check or VISA/MASTERCARD/DISCOVER.
3. There will be a $20.00 no show/no call fee charged to your account if you do not give 24-hour notice of cancellation for **massage therapy** appointments only.
4. All accounts 90 days past due will be turned over to an outside agency for collection and/or be filed in and with the appropriate small claims court. The patient assumes responsibility for attorney fees and court costs for unpaid balances turned over for collection/small claims. A 12% per annum fee (unpaid balance will accrue interest at a rate of 1% per month) will be added to all accounts 30 days past due.
5. Medicare payments go directly to the patient. We do not accept assignment from Medicare.
6. As a courtesy to you we will accept insurance assignment (payment from your insurance company directly) under the following conditions:
    a. This courtesy may be withdrawn if circumstances warrant it.
    b. If you discontinue your care, your account is due and payable in full immediately, even if your insurance has been filed. (If the insurance does send us payment, it will be refunded to you if you have a zero balance.)
    c. We will bill your insurance at least monthly during active care at this office.
    d. Your insurance should pay within 45 days. If your insurance has not paid within 60 days, you must pay the balance due and be reimbursed by your insurance company when and if it pays.
    e. You may choose a co-insurance plan for your care after payment has been made in full on the first visit.
    f. Our office does not guarantee that your insurance will pay. We will make every attempt at the beginning of your healthcare to receive verification of your policy and what services it covers.
    g. However, if for some reason your insurance claim is denied you are responsible for the full amount of the bill.
    h. Our office will not enter into a dispute with your insurance company over your claim. This is your responsibility and obligation.
7. I hereby state that a photocopy of this document will be deemed as valid and binding on all parties involved as the original copy.

If you understand and agree with the above stated office policies, please sign and date below.

SIGNATURE OF PATIENT **DATE**

(IF THE RESPONSIBLE PARTY IS NOT THE SAME PERSON AS THE PATIENT, THEY MUST SIGN BELOW. IF THE PATIENT IS A MINOR, THE LEGAL GUARDIAN MUST SIGN.)

SIGNATURE OF RESPONSIBLE PARTY (IF APPLICABLE) **DATE**

NAME OF RESPONSIBLE PARTY (IF APPLICABLE)

SIGNATURE OF WITNESS **DATE**

CONSENT TO TREATMENT OF A MINOR CHILD

If the patient is a minor: Permission is hereby given by me to the doctors of this office and whomever they designate to treat the patient. I am his/her legal guardian.

SIGNATURE OF LEGAL GUARDIAN **DATE**

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AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to treat me, I agree to the following:

1. Dr. Monique Levesque-Hartle and Allen County Chiropractic Wellness Center, ("You") are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred for services rendered me by you or any member of your staff acting on your behalf.
2. If I do not have health insurance or my health insurance does not cover chiropractic services, I agree to be fully responsible for payment of services rendered to me by either Dr. Monique Levesque-Hartle and/or Allen County Chiropractic Wellness Center.
3. I hereby authorize my insurance company to pay by check made out and mailed directly to either Dr. Monique Levesque-Hartle and/or Allen County Chiropractic Wellness Center, the expense benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. This payment shall not exceed my indebtedness to above named assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above the insurance payments. All services performed that are not covered by my insurance policy are my responsibility.
4. I authorize the direct payment to you of any sum I now owe or hereafter owe you by my attorney out of the proceeds of any settlement of my case and by any insurance company obligated to reimburse me for the charges for your services or otherwise obligated to make payment to me or you based on whole or in part upon the charges made for your services.
5. Medicare patients: I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by or in Dr. Monique Levesque-Hartle and/or Allen County Chiropractic Wellness Center, including my physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration, and its agents, information needed to determine these benefits or any benefits for related services.
6. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refused to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company [the name(s) of which is believed to be correctly set forth under pertinent data below] and authorize you to prosecute said actions either in my name or your name as you see fit and further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance proceeds [whether it be all or part of what is due] I personally owe you.
7. Unpaid balance will accrue interest at a rate of 1% per month.
8. I agree to be financially responsible for all missed massage appointments when 24-hour notice of cancellation is not given.
9. I hereby state that a photocopy of this document will be deemed as valid and binding on all parties involved as the original copy.
10. I assign to you, as security for payment of my account, that portion on any claim, whether in contract or tort, that I may have against any person or entity, including, but not limited to, any insurance carrier including an assignment of any right I may have against any person or entity arising out of an occurrence which took place on or about the date of injury so stated here or in any other document signed by me. I authorize direct payment of your account by the person or entity legally obligated to pay, but you will provide me with an accounting of the services provided and paid for at my request.

If you understand and agree with all of the above office policies, please sign your name below and we will accept your insurance assignment. (IF THE RESPONSIBLE PARTY IS NOT THE SAME PERSON AS THE PATIENT, THEY MUST SIGN BELOW. IF THE PATIENT IS A MINOR, THE LEGAL GUARDIAN MUST SIGN.)

_____ _____

SIGNATURE OF PATIENT **DATE**

_____ _____

SIGNATURE OF RESPONSIBLE PARTY (IF APPLICABLE) **DATE**

_____

NAME OF RESPONSIBLE PARTY (IF APPLICABLE)

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HEALTH HISTORY FORM

Have you ever had chiropractic care? YES☐ NO☐ Doctor's name: _____
If yes to above, when was your last chiropractic treatment/visit? _____

List your major complaints in order of severity:
1. _____ How long? _____
2. _____ How long? _____
3. _____ How long? _____

List other doctors/health professionals consulted for this condition (name/address/phone number):
1. _____
2. _____

Family physician: _____

List any/all hospitalizations/surgeries:
1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____

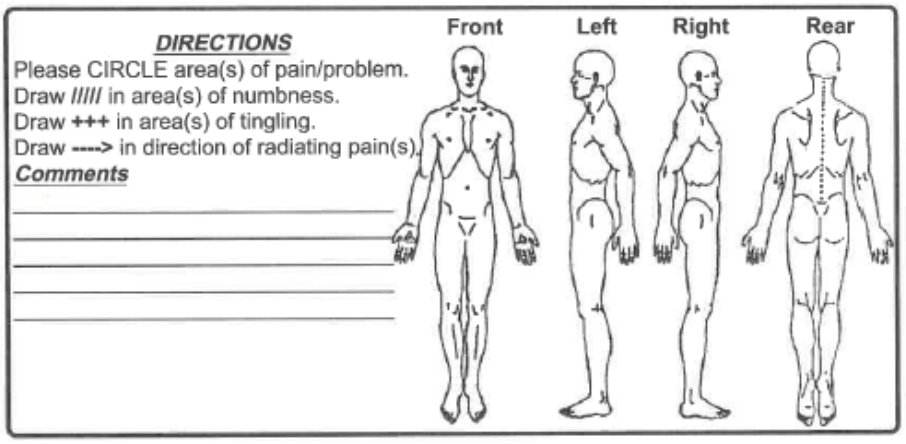
List all current medications:
1. _____ Dose: _____
2. _____ Dose: _____
3. _____ Dose: _____
4. _____ Dose: _____

Check box for conditions you have/currently suffered from.

☐ Concussion
☐ Whiplash
☐ Numbness
☐ Back injury
☐ Back surgery
☐ Neck injury
☐ Neck surgery
☐ Shoulder pain
☐ Arm/elbow/hand pain
☐ Hip/Leg/Knee pain
☐ Ankle/foot pain
☐ Flat feet
☐ Arthritis
☐ Gout
☐ Sinus trouble
☐ Headaches
☐ Dizziness
☐ Fainting
☐ Anemia
☐ High blood pressure
☐ Chest pain
☐ Stroke
☐ Heart attack
☐ Kidney disease
☐ Thyroid disease
☐ Cancer
☐ Pneumonia
☐ Insomnia
☐ AIDS/HIV
☐ Chemical dependency
☐ Emotional disorders
☐ Stomach trouble
☐ Ulcers
☐ Chronic constipation
☐ Diabetes
☐Hypoglycemia
☐ Liver disease
☐ Gallbladder disease
☐ Gall stones
☐ Hiatal hernia

Men only:
☐ Prostate disease
☐ Vasectomy

Women only:
☐ Menstrual disorders
☐ Tubal ligation
Hysterectomy:
Full ☐ Partial ☐
Pregnant? YES☐ NO☐
(We need to know this before x-rays)



**What is the most important thing your lack of health has affected?
_____
_____
_____

**What is your treatment goal?
_____
_____
_____

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INFORMED CONSENT TO CHIROPRACTIC AND/OR ACUPUNCTURE TREATMENT

Chiropractic

Doctors of chiropractic, medical doctors, and physical therapists who use manual therapy techniques such as spinal adjustments are required to advise patients that there may be some risks associated with such treatment. In particular you should note:

a) While rare, some patients have experienced rib fractures, or muscle and ligament strains or sprains following spinal adjustments.
b) Some types of spinal adjustments of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying there is a one-in-a-million chance of such an outcome. We employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury.
c) There have been rare reported cases of disc injuries following cervical or lumbar spinal adjustments although no scientific study has ever demonstrated such injuries are caused or may be caused, by spinal adjustments or chiropractic treatment.
d) Our doctors use a myofascial release technique that often requires direct contact with the skin to treat the involved muscle area. You may be asked to wear shorts or a tank top in order that the doctor have access to the involved muscle areas to deliver proper treatment. The doctor will always ask permission before treating these areas.

Chiropractic treatment, including spinal adjustments, has been the subject of government reports and multidisciplinary studies conducted over many years and have been demonstrated to be highly effective in treating spinal pain, headaches, and other symptoms. Chiropractic care contributes to your overall well-being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications and procedures given for the same symptoms.

Acupuncture

I understand and am informed that in the practice of acupuncture there are some risks to treatment, including, but not limited to, minor bleeding or bruising, minor pain or soreness, nausea, dizziness, fainting, infection, shock, convulsions and stuck or bent/broken needles.

I have been advised that only sterilized needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

Please Read Before Signing

I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I wish to rely on the doctor to exercise his/her best judgment during the course of treatment which the doctor feels at that time, based upon the facts then known, is in my best interest. I understand that the results are not guaranteed.

_____ _____
PATIENT NAME **DATE**

_____
PATIENT SIGNATURE

_____ _____
WITNESS SIGNATURE **DATE**

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INFORMED CONSENT TO CHIROPRACTIC AND/OR ACUPUNCTURE TREATMENT (CONTINUED)

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor/acupuncturist the nature and purpose of the chiropractic and/or acupuncture treatment, including spinal adjustment, as well as the contents of this Consent.

I consent to the chiropractic and/or acupuncture treatments offered or recommended to me by Dr. Monique Levesque-Hartle and/or Dr. Shannon Nierman.

PATIENT NAME **DATE**

PATIENT SIGNATURE

WITNESS NAME **DATE**

WITNESS SIGNATURE

LATE TO APPOINTMENT POLICY

If you are an established patient and you arrive 10 minutes late or more to your appointment you will likely be asked to reschedule unless the physician's schedule can still accommodate you. Priority will be given to the patients who arrive on time, and you may have to be worked in between them. This may mean you will have a considerable wait. If this is not convenient for you, you may choose to reschedule. One or two late patients cause the entire daily schedule to fall behind. This is an inconvenience to everyone. We strive to see every patient as close to their appointment time as possible.

Likewise, if you are a new patient and you arrive at the scheduled appointment time and not early to complete your forms as instructed, and it takes more than 15 minutes to complete the forms and the registration process, you may also be asked to reschedule. We ask that you please be courteous of your provider's valuable time and attention. The physicians, office staff, as well as your fellow patients will thank you.

PATIENT NAME **DATE**

PATIENT SIGNATURE

WITNESS NAME **DATE**

WITNESS SIGNATURE