Health Centered Spine & Wellness New Patient Packet

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 are you taking and for what conditions (Please list dosage and amounts, etc)

____

What vitamins, minerals, or herbs do you currently take? Please list for what conditions, dosage, and frequency.

____

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					Please write any additional information you wish to share in this space.
Coffee					
Tobacco					
Drugs					
Exercise					
Sleep					
Appetite					
Soft Drinks					
Water					
Salty Foods					
Sugary Foods					
Artificial Sweeteners					

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: ___________________________________

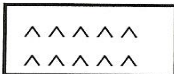
____

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

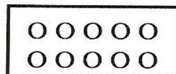
Do you have a current (6 months or later) x-ray for this condition? No ◯ Yes ◯ If yes, can you bring those to us along with a report? ______________________________

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

Ache

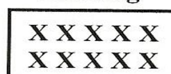


Numbness

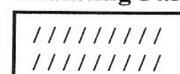


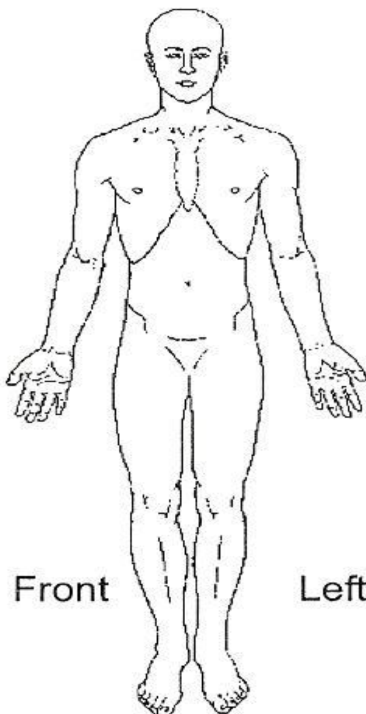
Pins & Needles

Burning

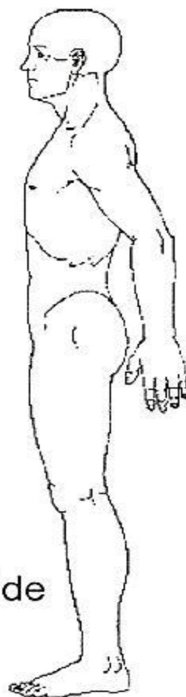


Radiating Pain

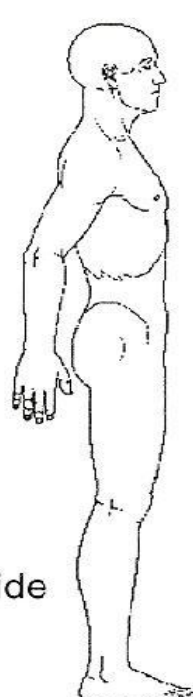




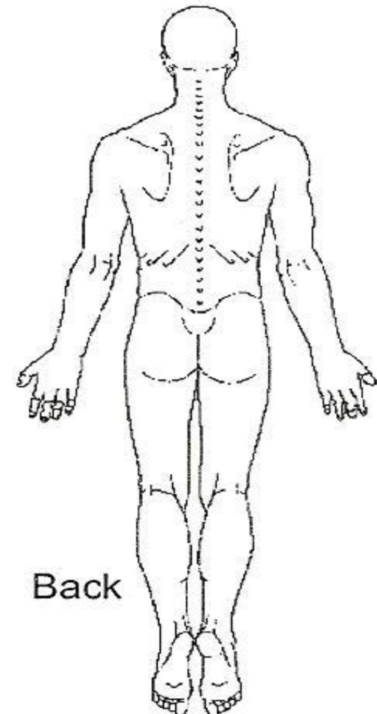
Front



Left Side



Right Side



Back

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 Health Centered Spine & Wellness Group, 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 health Centered Spine & Wellness Group, 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 Health Centered Spine and Wellness Group. 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 Health Centered Spine and Wellness.
*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 Health Centered Spine and Wellness 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

Health Centered Spine and Wellness Group 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 Health Centered Spine and Wellness 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 agree to purchase this equipment at Health Centered Spine and Wellness.

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 ____ DATE ____________________

Signature of Patient or Responsible Party

X ____ DATE ____________________

Signature of HCSW Employee

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

It is the policy of Health Centered Spine and Wellness 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 Health Centered Spine and Wellness 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:

Name **Relationship (spouse, parents, friend, neighbor)**

____

____

____

_________________________________ _____________________________

Patient Signature/Legal Representative Witness Signature

_________________________________ _____________________________

Date Date

600 S. Jackson Park Drive

Seymour, IN 47274

812-519-2963

To all Health Centered Spine and Wellness patients receiving medical massage therapy:

All patients will be allowed to miss a maximum of two (2) visits without giving twenty-four (24) hour notice. Upon missing two (2) visits, the patient may be asked to discontinue massage therapy or pay for their massage therapy in advance. We also reserve the right to charge a $48.00 fee for any missed massage therapy appointments without prior notice.

Thank you for your cooperation.

Dr. James Galyen

Dr. Ted Freidline

Diana L. Brackin, NP

I understand the request of giving notice if I am not able to keep my appointment(s) with the massage therapist.

____

Patient Signature Date

HIPAA Notice of Privacy Policies

Health Centered Spine & Wellness Group

600 S. Jackson Park Drive Seymour, IN 47274 812-519-2963

Health Centered Spin & Wellness

905 W. Keegan's Way #7 Greensburg, IN 47240 812-663-7640

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.

(OVER)

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.

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 812-663-7640 in Greensburg or at 812-519-2963 in Seymour.

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

Print Name: ________________________________ Signature ____________________________________ Date __________________________