Mohr Chiropractic Clinic
4031 S. Crestview Dr.
Greencastle, Indiana
(765)653-4447

NEW PATIENT QUESTIONNAIRE

Patient Name: ______________________________ Today's Date: ______________
Gender: ________ Birth Date: __________ Email: ______________________
Address: __________________ City: ______________ State: ________ Zip: ______
Home Phone #: ____________ Cell Phone # ______________ Work Phone # ______________
Primary Care Physician: ______________________________________
Insurance Company: ______________________________________
Insurance Policy Holder's Name: ______________________________ Birth Date: __________
Policy Holder's Address (If Different than Above): ______________________________
Relationship to Patient (Circle One): Self/ Spouse/ Parent/ Other (Please Specify): ______________

Information Related to Condition

Approximately when did your symptoms start to occur? ______________________________
Describe the conditions, symptoms or purpose of the appointment ______________________________
____
____
____

Additional Information Related to Condition

Describe your pain: __Burning __Sharp __Dull __Ache
What caused it? ______________________________________
What aggravates it? ______________________________________
What relieves it? ______________________________________
Have you ever experienced the same condition before? __Yes __No If yes, when? ______________
Please describe: ______________________________________
Have you seen any other healthcare providers for your condition? __Yes __No
If yes, Name ______________, Type of Doctor ______________, Date of last visit __________

Please check any of the following symptoms you are now experiencing:

__Headache	__Dizziness	__Light bothers eyes	__Diarrhea
__Loss of memory	__Clumsiness	__Feet cold	__Neck stiff
__Hands cold	__Sleeping problems	__Tingling in legs/feet	__Face flushed
__Numbness arms/hands	__Buzzing in ears	__Constipation	__Nervousness
__Cold sweats	__Tension	__Shortness of breath	__Fainting
__Irritability	__Loss of smell	__Chest pain/rib pain	__Pain in arms/hands
__Loss of strength(arms)	__Burning muscle pain	__Loss of strength (legs)	__Difficulty swallowing
__Head seems too heavy	__Neck pain	__Tingling in arms/hands	__Ears ringing
__Nausea	__Back pain	__Numbness legs/feet	__Loss of balance
__Fever	__Fatigue	__Pain in legs/feet	__Jaw pain
__Sharp/shooting pain	__Other ______________		

Have you experienced changes to:

__Eyes (sight)	__Ears (hearing)	__Nose (smell)	__Mouth (taste)	__Bladder
__Bowels	__Sleep	__Emotions	__Appetite	

__Other (please explain) ______________________________________
Please explain changes: ______________________________________

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Have you missed work or school as a result of your injuries? __Yes __No
Do you smoke? __Yes __No If yes, how many packs per day? ________
Do you drink alcohol? __Yes __No If yes, how many drinks per day? _________

Past Medical History
Have you been in our office before? __Yes __No
List any previous accidents (automobile, on the job injuries, slips, falls, sports, etc) and provide the accident date:
1) ____
2) ____
3) ____

List any previous surgeries and/or hospitalizations:
1) ____
2) ____
3) ____

Allergies (please list all): ____
____

List all medications you are taking now and why: ____
____
____

Do you now or have you ever had?

__ Heart Disease	__Diabetes	__Cancer	__Stroke
__High Blood Pressure	__Thyroid Problem	__Tuberculosis	__Prostate Disorder
__Kidney Problems	__Asthma	__Ulcer	__Seizure Disorder

__Other ____

AUTHORIZATION AND RELEASE:
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. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. 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:______________.

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INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the Chiropractic Physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. 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/she 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/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the Chiropractic Physician. The Chiropractic Physician provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by a physician at Mohr Chiropractic Clinic, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

PATIENT ACKNOWLEDGEMENT OF NON-COVERED SERVICES

Under your health care plan, you are financially responsible for copayments, coinsurance, or deductibles for covered services, as well as those services that exceed benefit limits. You are also financially responsible for all non-covered services as defined by your health plan contract. This may include, but is not limited to, Vitamins & Supplements, Supports, Strapping, and Maintenance Care. Your signature below indicates that you have been advised of this information and that you agree to pay for any non-covered services according to your insurance contract.

Patient/Guardian Signature: ___________________________________ Date: ____________________

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I understand that parents or guardians are responsible for all fees and services rendered for treatment for myself and/or child. I accept full financial responsibility for all charges for services or items provided to me or the patient. I understand that filing claims with my insurance company does not relieve me from my responsibility for the payment of all charges.

____ ________________________
Signature of Patient, Parent, or Guardian Date

____ ________________________
Printed name of Patient, Parent, or Guardian Relationship to Patient

TIME OF SERVICE DISCOUNT AGREEMENT

Our office offers all patients a Time of Service discount. This discount is 15% off of our standard fees. The TOS discount does not include nutritional supplements, supports, orthotics, or hair analysis. In order to qualify for this discount, you must agree to the following:

- All services must be paid at the time the service is rendered.
- Your claim will not be submitted to insurance. We will provide you with a receipt and you can submit it to your insurance company if you so choose.
- If you choose to take the TOS discount, it will apply to ALL services rendered.
- Your choice regarding the TOS discount will remain in effect until you sign another TOS form stating your intentions to change.

______ I choose to take the TOS discount. I understand that Mohr Chiropractic Clinic will not bill my insurance company.

______ I choose not to take the TOS discount. I understand that Mohr Chiropractic Clinic will bill my insurance company and I will be responsible for any outstanding amounts applicable after my insurance company processes my claim.

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Patient Acknowledgement and receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name ________________________________
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy at their request of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is also available upon request.

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law and Federal Law.

Dated this ______ day of __________________________ , 20_____

By ____
Patient's Signature

If patient is a minor or under guardianship order as defined by State law:

By ____
Signature of Parent or Guardian