PEAK PERFORMANCE CHIROPRACTIC * 815 WESTFIELD ROAD NOBLESVILLE, IN * 317-219-5214

Patient Information

LAST NAME_____ FIRST NAME_____ HOME PHONE_____

ADDRESS_____ CITY/ STATE/ ZIP_____

CELL PHONE_____ EMAIL ADDRESS_____

DATE OF BIRTH_____ AGE_____ SEX: M OR F SS#_____

MARRIED_____ SINGLE _____ WIDOWED_____ DIVORCED_____

EMPLOYER_____ OCCUPATION_____ WORK PHONE_____

WHO IS YOUR FAMILY MEDICAL DOCTOR_____

WHAT TYPES OF HOBBIES/ ACTIVITES DO YOU ENJOY_____

WHO REFFERED YOU INTO THE OFFICE_____

SCREENING QUESTIONS:

1. HAVE YOU EVER/ PRESENTLY HAVE CANCER? Y or N, IF YES WHEN AND WHERE? _____

_____

2.	ARE YOU LOSING WEIGHT WITHOUT TRYING (10+ POUNDS/ MONTH?)	Y	or	N
3.	DO YOU HAVE ANY UNUSUAL BLEEDING OR DISCHARGE?	Y	or	N
4.	DO YOU HAVE A SOAR THROAT THAT WILL NOT HEAL?	Y	or	N
5.	DO YOU HAVE INDIGESTION OR DIFFICULTY SWALLOWING?	Y	or	N
6.	HAVE YOU NOTICED A CHANGE IN A WORT OR MOLE?	Y	or	N

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 adjustment 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 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 regimen. I understand that if a Chiropractic Physician at Peak Performance Chiropractic accepts me as a patient, 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.

According to Indiana Access to Health Records statute, (IC 16-4-8 et, seq.) I authorize the release of any documentation form my insurance company to the provider, which determines the payment or limitations of such on submitted claims, including but not limited to a copy of the chiropractic, medical or other reviews, which were done. I waiver the Statute of Limitations regarding my doctor's rights to cover.

My signature is an acknowledgment that I have read the policies above and agree to abide by the policies stated.

Patients Signature_____ Date_____

SPECIFIC AND IRREVOCABLE AUTHORIZATION AND ASSIGNMENT OF RIGHTS AND BENEFITS

TO: PEAK PERFORMANCE CHIROPRACTIC

1. You are authorized to release any information you deem appropriate concerning my health condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement or charges incurred at Peak Performance Chiropractic by myself.

2. I authorize and assign the direct payment to you of any sum I now or hereafter owe you by attorney out of 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 in whole or part upon the charges made for your services.

3. I give assignment and lien against any claims a third party whose negligence may have caused the patient's injury, up to the amount of the bill for treatment.

4. 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 refuses 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 of which is believed correctly set forth under pertinent date below) and authorize you to comprise, settle, or otherwise resolve said claim as you see fit. However, It is understood that until all reasonable efforts have been made to collect the sums due from the insurance company (or companies) contractually obligated, you will refrain from attempts and efforts to collect from the insurance proceeds (whether it be all or part of).

5. For good and valuable consideration, I do hereby designate, authorize, and convey to Peak Performance Chiropractic to the full extent permissible under the law and under any applicable insurance policy and/or employee health care benefit plan: A. the right and ability to act on my behalf in connection with any claim, right or choice in action that I may have under such insurance policy and/or any employee health care benefit plan: B. the right and ability to act on my behalf to pursue such claim, right or choice in action in connection with said insurance policy and/or employee health care benefit plan (including but not limited to, the right to act in my behalf in respect to an employee health care benefit plan governed by the provisions of the Employee Retirement Income Security Act of 1974 as provided in 29 CFR 2560.503-1(b)(4)) with respect to any medical or other health care expense incurred as a result of the services I received from the above-named doctor and, to the extent permissible under the law, to claim on my behalf, such medial or other health care service benefits, insurance or health care benefit plan reimbursement and any other applicable remedy.

SIGNATURE_____DATE_____