Chiropractic Wellness Center
Dr. Maxim I. Ivanov
1609 Elkhart Rd. Goshen, IN 46526

PATIENT INFORMATION

PLEASE PRINT CLEARLY and FILL IN COMPLETELY

Date ____________

Print Name____ SS#_________________________
Address____________________________________City______________________State____Zip_________
Email ____ Age________ Date of Birth_____________
Home Phone (___)_____________ Cell Phone (___)_____________Work Phone (___)______________
Do you prefer to receive calls at: Home Work Cell No Preference
Please Check Sex: Male____ Female____ Right handed___ Left handed____
Marital Status: Single____ Married____ Widower____ Divorced____
Patient Employer/School ___________________________ Occupation________________ How Long_________
Employer/School Address_______________________________ Employer/School Phone (___)______________
Spouse or parent's name______________________ Employer_________________ Work Phone (___)_________
Children (Name and Age) ____
Whom may we thank for referring you to us? ____
In case of emergency who should be notified? _______________________________ Phone (___)___________

RESPONSIBLE PARTY

If patient is 18 yrs. old or younger

Name of person responsible for this account____
Relationship to patient _______________________________________ Phone (___)_______________________
Address____________________________________City______________________State______Zip_____________
Name of employer ____Work Phone (___)__________________

PRIMARY INSURANCE INFORMATION

Name of Insured ____
Relation to Patient ___________________________________ Birthdate_______________ SS#_____________
Address (if different from patient's)____________________________________ Phone (___)______________
City ____State _________ Zip _______________
Name of Employer ____ Occupation________________________
Business Address ____ Business Phone (___)_______________
Insurance Company ____
Subscriber ID# __________________________ Group # _____________________ Contract#________________
Name of other dependents covered under this plan ____
How much is your deductible? __________How much have you used? _______ Max. annual benefit?__________

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes No

Name of Insured ____
Relation to Patient ___________________________________ Birthdate_______________ SS#_______________
Address (if different from patient's)____________________________________ Phone (___)________________
City ____State _________ Zip _________________
Name of Employer ____ Occupation________________________
Business Address ____ Business Phone (___)_______________
Insurance Company ____
Subscriber ID# __________________________ Group # ___________________ Contract#___________________
Name of other dependents covered under this plan ____
How much is your deductible? __________How much have you used? ________ Max. annual benefit?__________

SYMPTOMS

*** WHAT IS YOUR MAJOR COMPLAINT?** ____

How did this problem begin (fall, lifting, etc.)? ____

How long have you had this condition? ____

Have you had this or similar conditions in the past? ____

What activities aggravate your condition (working, exercise, etc.)? ____

What relieves your condition (ice, heat, massage, etc.)? ____

Other doctors who treated this condition: ____

How long has it been since you really felt good?____

How often do you experience your symptoms?

□Constantly (76-100% of the day) □Frequently (51-75% of the day)

□Occasionally (26-50% of the day) □Intermittently (0-25% of the day)

Describe the nature of your symptoms: □Sharp □Dull □Numb □Burning □Shooting □Tingling

□Radiating Pain □Tightness □ Stabbing □Throbbing □Other: ____

Please Rate your pain on a scale of 1 to 10 (0-no pain and 10- excruciating pain)

0 1 2 3 4 5 6 7 8 9 10

What do your daily work habits include (sitting, standing, light labor, heavy labor, computer work)?

____

How do your symptoms affect your abilities to perform daily activities such as working or driving?

(0- no effect and 10 no possible activities) 0 1 2 3 4 5 6 7 8 9 10

(**Women**) Are you pregnant? □ No □ Yes When are you due? ___________ Nursing? □No □Yes

*** OTHER COMPLAINTS:**____

Have you ever been in a motor vehicle accident? □ No □Yes When? ____

Where you injured? No Yes describe: ____

Have you had any other personal injury or accident? □No □Yes When? ____

Describe: ____

*** LIST SURGICAL OPERATIONS AND YEARS:**____

Is there a current health condition? ____

Is there a family history of: □Heart disease □Cancer □Stroke describe: ____

Date of last physical examination: ____

Do you exercise? □No □Yes (what forms and how often): ____

Vitamins/supplements you now take: ____

Drugs you now take: □Nerve pills □Muscles relaxers □ Pain killers □ Insulin

□Tranquilizers □Birth control pills □Other: ____

Allergies: ____

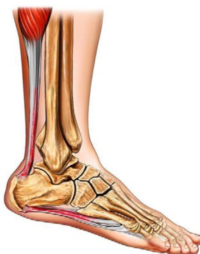
Sleeping position: Back Side Stomach Do you wear: Heel lifts Arch supports

Do you smoke? □No □Yes How much per day? ____

How much liquor do you consume on a weekly basis? ____

How much coffee or caffeinated beverages do you consume on a daily basis? ____

PLEASE MARK YOUR AREAS OF PAIN ON THE FIGURES BELOW



Have you suffer from any of the following?

Past	Present	
□	□	1. Dizziness
□	□	2. Backaches
□	□	3. Heart Trouble
□	□	4. Diabetes
□	□	5. Arthritis
□	□	6. Headaches
□	□	7. Asthma
□	□	8. Nervousness
□	□	9. Digestive Disorders
□	□	10. Sinus Trouble
□	□	11. Neck Pain
□	□	12. High Blood Pressure
□	□	13. Painful Menstrual Cycle
□	□	14. Cancer

CHIROPRATIC HISTORY

Have you ever had chiropractic care? □No □ Yes
When? ______________________ Why? ______________________
Where? ______________________ Doctor's name: ______________________
Were X-rays taken? □ No □ Yes
When was your last adjustment? ____________How long were you under care? ______________

Present reason for consulting the office:
- □ Improving self and/or family health
- □ Maximizing personal health potentials
- □ Preventing disease and/or symptoms
- □ Disease and/or symptoms

PREGNANCY RELEASE FOR X-RAYS

This is to certify that to the best of my knowledge I am not pregnant and Dr. Ivanov and his associates have my permission to perform an X-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.
Date of last menstrual cycle __________________

Signature____ Date ________________

CERTIFICATION AND ASSIGNMENT

To the best of my knowledge, the above information is completed and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and or my dependent(s), have insurance coverage with______________________________
Name of Insurance Company (ies)

And assign directly to Dr. Ivanov all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for the related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Forms of Payment

Patients are responsible for payment at the time of service. Returned checks are subject to a $30 fee.

Billing

Any outstanding balances are billed monthly and considered past due 10 days after the invoice date. Balances older than 30 days will accrue interest charges of 1.5% per month and unpaid balances will be turned over to the credit bureau or our attorney for collection.

In addition the Patient promises and agrees to pay any and all costs of collection, including court costs and all reasonable attorney fees, incurred by Chiropractic Wellness Center in the event it becomes necessary to institute proceedings for the collection of past due balances.

We accept cash, personal checks, Visa and MasterCard.

Signature of Patient ____ Date _______________

Signature of Guardian Authorizing Care ________________________________ Date ______________

Chiropractic Wellness Center
Dr. Maxim I. Ivanov
1609 Elkhart Rd
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(574) 533-7363

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art that concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and maintenance of health. **Health** is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called **vertebral subluxation**. This occurs when one or more of the 24 vertebra in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

______________________________	______________________________	________________
Print Name	Signature	Date

Consent to evaluate and adjust a minor child:

I,______________________being the parent or legal guardian of ______________________ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

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HIPAA CONSENT FORM

Chiropractic Wellness Center of Goshen, provides this Consent to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act 1996 (HIPAA).

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

This is a summary of and consent for the privacy practices and patient care at Chiropractic Wellness Center of Goshen, and services as a condensed version of our Notice of Privacy Practices. You have the right to review our Notice before signing this Consent upon request. The terms of our Notice may change and you may obtain a revised copy by contacting our office.

If you ever believe your privacy rights have been violated, you may file a complaint with the Compliance Officer of Chiropractic Wellness Center of Goshen, or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filling complaints.

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.

How will we use or disclose your information? Here are a few examples:

- •To obtain payment and file insurance
- •In emergency situations
- •For appointment and patient recall reminders
- •To run our Practice more efficiently and ensure all our patients receive quality care
- •For organ and tissue donation
- •For research and education
- •Prevent serious threats to health safety
- •For workers' compensation programs
- •In response to certain requests arising out of lawsuits or other disputes

You have certain right regarding the information we maintain about you. These rights include:

- •The right to inspect and copy
- •The right to amend
- •The right to an accounting of disclosures
- •The right to request restrictions
- •The right to a paper copy of this notice
- •The right request confidential communications

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Chiropractic Wellness Center of Goshen, may condition treatment upon the execution of this Consent.

Additionally, by signing this form, you acknowledge that by presenting yourself as a patient or child you consent for chiropractic care by the doctor and staff of Chiropractic Wellness Center of Goshen. You hereby grant full authority to the chiropractor and their respective assistants to administer and perform any and all treatments, test, or diagnostic procedures to or upon me, which may be advised, or necessary.

This information and Notice of Privacy Practices is made available on request.

Patient____ Birthdate____________________

Signature ____ Date____________________

Patient or Representative

Relationship (if other than patient)______________________________