ALL CARE HEALTH & REHABILITATION CENTER

221 W. Court Ave | Jeffersonville, IN 47130 | 812-288-7000

1 PATIENT INFORMATION

Today's Date: ___/___/___ Name:(legal first)_____ (full middle)_____ (last)_____

Preferred Name:_____ Maiden Name:_____ D.O.B.: ___/___/___ Sex: ☐Male ☐Female

SSN:(required)___-___-___ Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated ☐Partnered for____years

Choose one: ☐White/Caucasian ☐Latin ☐Asian ☐African American ☐Hispanic ☐Native American ☐Other_____

Address:_____ City:_____ State:_____ Zip:_____

Email:_____

Please check preferred method of contact:

☐Home Phone:(area code) (___)_____ ☐Mobile:(___)_____ ☐Work:(___)_____

Emergency contact info:

Name:_____ Relationship:_____

Address:_____ City:_____ State:_____ Zip:_____

☐Home Phone:(area code) (___)_____ ☐Mobile:(___)_____ ☐Work:(___)_____

How were you referred to our office?:

☐Friend ☐Relative ☐Doctor ☐Patient ☐Attorney ☐Yellow Pages ☐Other_____

Name of referral:(if applicable)_____ Phone:(area code) (___)_____

Address:_____ City:_____ State:_____ Zip:_____

2 PLEASE LIST YOUR MEDICAL DOCTOR

Name: (first)_____ (last)_____ Phone: (area code) (___)_____

Address:_____ City:_____ State:_____ Zip:_____

3 SPOUSE OR PARENT/GUARDIAN INFORMATION

Name:(legal first)_____ (full middle)_____ (last)_____

Address:_____ City:_____ State:_____ Zip:_____

SSN:___-___-___ D.O.B.: ___/___/___ Relationship to Patient:_____

Employer:_____

Employer's Address:_____ City:_____ State:_____ Zip:_____

☐Home Phone:(area code) (___)_____ ☐Mobile:(___)_____ ☐Work:(___)_____

4 PATIENT EMPLOYMENT INFORMATION

Employer: _____

Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Work Phone: (area code) (___) _____ Ext: _____

Does your company hold Health Screenings or Health fairs? ☐Yes ☐No

I voluntarily consent to receive medical/chiropractic care services that may include diagnostic procedures, examination, and treatment.

I hereby assign, transfer, and set over to All Care Health & Rehabilitation Center all of my health rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

I certify that I have read this form and understand its contents.

_____ Date: __/__/____

Signature of Patient, Parent, Guardian or Personal Representative

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

5 INSURANCE INFORMATION

Name of insured (This is either you or the primary person whom insurance is under.)

(legal first) _____ (full middle) _____ (last) _____

Insured's D.O.B.: __/__/____ Insured's SSN: ___-___-____ Relationship to Insured: _____

Primary Insurance Co. _____ ID# _____

Secondary Insurance Co. _____ ID# _____

Is your illness/injury related to: Y/N Auto Accident Employment Emergency Slip/Fall

If employment related, has employer been notified? Yes/No Employer Contact Name: _____

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. _____ 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 related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ Date: __/__/____

Signature of Patient, Parent, Guardian or Personal Representative

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None

☐ Other (Please Explain)_____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____

Spinal Exam _____ Chest X-Ray_____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV ☐Yes ☐No	Chicken Pox ☐Yes ☐No	Liver Disease ☐Yes ☐No	Rheumatoid Arthritis ☐Yes ☐No
Alcoholism ☐Yes ☐No	Diabetes ☐Yes ☐No	Measles ☐Yes ☐No	Rheumatic Fever ☐Yes ☐No
Allergy Shots ☐Yes ☐No	Emphysema ☐Yes ☐No	Migraine Headaches ☐Yes ☐No	Scarlet Fever ☐Yes ☐No
Anemia ☐Yes ☐No	Epilepsy ☐Yes ☐No	Miscarriage ☐Yes ☐No	Stroke ☐Yes ☐No
Anorexia ☐Yes ☐No	Fractures ☐Yes ☐No	Mononucleosis ☐Yes ☐No	Suicide Attempt ☐Yes ☐No
Appendicitis ☐Yes ☐No	Glaucoma ☐Yes ☐No	Multiple Sclerosis ☐Yes ☐No	Thyroid Problems ☐Yes ☐No
Arthritis ☐Yes ☐No	Goiter ☐Yes ☐No	Mumps ☐Yes ☐No	Tonsillitis ☐Yes ☐No
Asthma ☐Yes ☐No	Gonorrhea ☐Yes ☐No	Osteoporosis ☐Yes ☐No	Tuberculosis ☐Yes ☐No
Bleeding Disorders ☐Yes ☐No	Gout ☐Yes ☐No	Pacemaker ☐Yes ☐No	Tumors, Growths ☐Yes ☐No
Breast Lump ☐Yes ☐No	Heart Disease ☐Yes ☐No	Parkinson's Disease ☐Yes ☐No	Typhoid Fever ☐Yes ☐No
Bronchitis ☐Yes ☐No	Hepatitis ☐Yes ☐No	Pinched Nerve ☐Yes ☐No	Ulcers ☐Yes ☐No
Bulimia ☐Yes ☐No	Hernia ☐Yes ☐No	Pneumonia ☐Yes ☐No	Vaginal Infections ☐Yes ☐No
Cancer ☐Yes ☐No	Herniated Disk ☐Yes ☐No	Polio ☐Yes ☐No	Venereal Disease ☐Yes ☐No
Cataracts ☐Yes ☐No	Herpes ☐Yes ☐No	Prostate Problem ☐Yes ☐No	Whooping Cough ☐Yes ☐No
Chemical Dependency ☐Yes ☐No	High Cholesterol ☐Yes ☐No	Prosthesis ☐Yes ☐No	Other ☐Yes ☐No
	Kidney Disease ☐Yes ☐No	Psychiatric Care ☐Yes ☐No	☐Yes ☐No

Exercise
- ☐ None
- ☐ Moderate
- ☐ Daily
- ☐ Heavy

Work Activity
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

Habits
- ☐ Smoking Packs/Day_____
- ☐ Alcohol Drinks/Week_____
- ☐ Coffee/Caffeine Drinks Cups/Day_____
- ☐ High Stress Level Reason_____

Are you pregnant?
☐ Yes ☐ No
Due Date:_____

Injuries/Surgeries	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

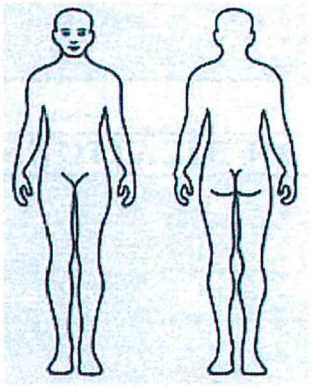
7 PATIENT CONDITION

Reason for visit: _____

When did symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture to the right where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

8 MEDICATIONS, ALLERGIES & VITAMINS

Pharmacy Name: _____ Pharmacy Phone #: ( ) _____

Medications	Allergies	Vitamins/Herbs/Minerals

All Care Health and Rehabilitation
221 West Court Ave.
Jeffersonville, IN 47130
(812) 288-7000

I understand and agree that health and accident insurance polices are an arrangement between an insurance carrier and me. I Understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to All Care Health and Rehabilitation Center and will be credited to my account. 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. However, I clearly understand and agree that all services rendered to me will be billed to my insurance company if applicable and that I am responsible for any unpaid balance. I understand that an interest is charged on overdue accounts at the annual rate of 26%.

I hereby authorize the doctor to examine me and treat mu condition as he deems appropriate through the use of chiropractic health care and/or acupuncture and I give authority for these procedures to be performed. The doctor will not be held accountable for any pre-medically diagnosed condition nor for any medical diagnosis.

The patient understands and agrees to allow All Care Health & Rehabilitation Center to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of Care with providers. 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 polices and procedures concerning the privacy of our Patient Health Information we encourage you to read the HIPPA 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 list here

_____

and inform our office.

*PATIENT'S NAME PRINTED*_____ *DATE*_____

*PATIENT/GUARDIAN SIGNATURE*_____ *DATE*_____

ALL CARE

Health & Rehabilitation Center

Gabe Spruch, D.C.
Chiropractic Physician
Licensed Professional Acupuncturist

221 W. Court Ave.
Jeffersonville, IN 47130
(812) 288-7000

I understand as a courtesy to me, ALL CARE HEALTH AND REHABILITAION CNETER will file my insurance claims for me. It is my responsibility to ensure that my insurance company has all information necessary to process my claims.
ALL CARE HEALTH AND REHABILITATION CENTER will verify my insurance benefits. I understand that the insurance contract is between myself and my carrier. ALL CARE HEALTH AND REHABILITATION CENTER recommends that all patients verify their own insurance coverage as well, and will provide the information needed to verify my insurance.
I understand that ALL CARE HEALTH AND REHABILITAION CENTER will not become involved in disputes with my insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information. I understand that I am personally responsible for any unmet insurance deductible and co- pays as well as for any charges for services not covered by my insurance contract, for any reason, whether the reason being my insurance benefits are exhausted or the insurance company deems my treatment or services not medically necessary. I will be responsible for paying those services rendered that are not paid by my insurance carrier.
I, _____understand that I am responsible for paying any yearly deductible of $_____ and a co-payment of $_____ per visit. I also agree to surrender any insurance checks and explanations from the insurance company sent to me for services rendered by ALL CARE HEALRTH AND REHABILITAITON CENTER.
If my account should be turned over to a collection agency, I will be responsible for the balance of my account and any attorney fees and collection fees. I also understand that I will be responsible for interest at a rate of 1.5% per month or 18% per year. I understand that all original x-ray films are and shall remain the sole property of ALL CARE HEALTH AND REHABILITAION CENTER. ALL CARE HEALTH AND REHBILITAION CENTER will provide written information regarding these x-rays to me at no charge, and will allow me to see them by appointment. I understand that I may obtain copies of digital x-rays on C.D. for a fee payable in advance. This fee is $10.00 per C.D.
Any patient who fails to keep an appointment without notice of cancellation will be charged a $40.00 missed appointment fee. Any patient who fails to keep an acupuncture appointment without a 24 hour notice of cancellation will be charged $75.00 for that missed appointment. I understand that these said payments can be paid by cash, check, Visa or MasterCard.
The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

SIGNATURE_____ DATE_____

ALL CARE
Health & Rehabilitation Center

I hereby request and authorize you, your employees and agents to furnish to the person(s) listed below or anyone designated in writing by him/her/them, all records and reports, including x-rays and photostatic copies, abstract or excerpts of all records and any other information he/she/they may request relating to any examination, treatment or opinion concerning and condition that I may have had in the past or now have.

Please forward the reports and information requested to:

Dr. Gabe Spruch
221 W. Court Ave.
Jeffersonville, IN 47130

_____ _____
Signature Witness

_____
Printed Name

_____
Address

_____
City, State, Zip

Date: _____

Dr. Gabe Spruch
Chiropractic Physician
Licensed Professional Acupuncturist

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www.allcarehealthandrehab.com

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

Name_____ Date_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy 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 available upon request.

The undersign 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 a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)