J. CLAYTON SPINE & HEALTH

Patient Name _____ Address _____

City _____ State _____ Zip _____ Home Phone _____

Email address _____ Cell Phone _____

DOB _____ Age _____ : Male Female SS# _____ Marital Status: M S D W

How did you hear about our office? **Newspaper Radio Internet Friend Google Search Physician Referral**

Circle: Employed FT Employed PT Self Employed Homemaker Retired Unemployed due to pain Unemployed for other reasons

Are you on disability? Y N 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 _____

CONSENT FOR CARE

As a patient of J. Clayton Spine and Health, 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 the patient 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.

I understand that if I am accepted as a patient by a provider at J. Clayton Spine and Health,, 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.

I hereby give my consent for evaluation and treatment to J. Clayton Spine and Health.. In the event the patient is a minor, I hereby consent to treatment of the minor patient.

_____ _____

Signature of Patient/Guardian Date

CURRENT MEDICAL CONDITION INFORMATION

Your answers on this form will help your health care provider better understand your medical concern and conditions. If you cannot remember specific details, please approximate. Add any notes you think are important. **ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.**

Main reason for today's visit:

_____ Other concerns:

_____

_____

HEALTH HISTORY

ALLERGIES (Medications, Food, Bee Stings, Etc…)

Allergy Reaction

1 _____ _____

2 _____ _____

3 _____ _____

4 _____ _____

MEDICATIONS/VITAMINS/HERBAL SUPPLEMENTS

(Can attach a list of medications if you have several)

Drug Name Strength Frequency Taken

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

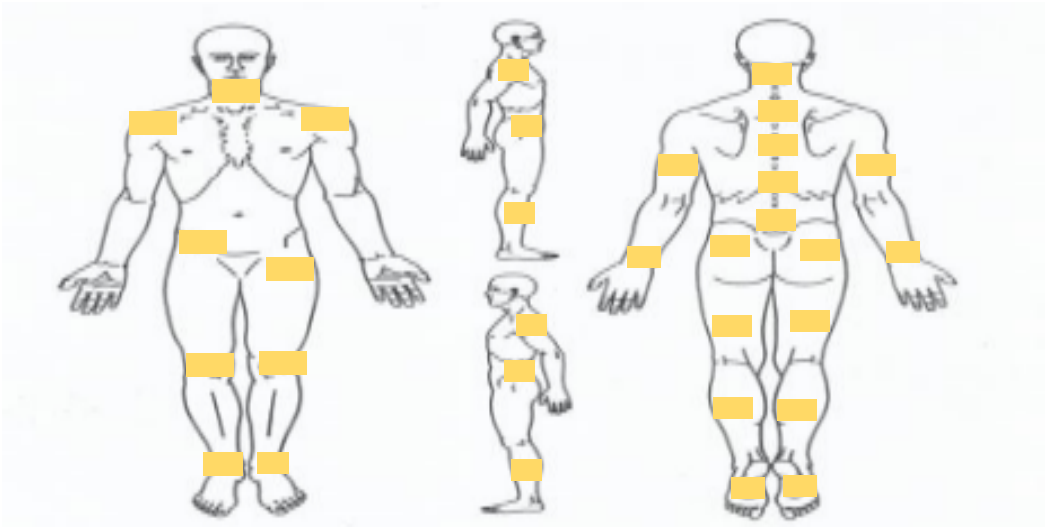
Exacerbation Form

Name: _____ Date: _____

Patient's present complaint/ problem, (Begin with most severe): _____

_____

On the drawing below, check the area(s) where you have pain. Then for each area that you have circled, **designate a number from 0 to 10** (with 10 being the most pain) that corresponds to your current pain level.



Your pain or soreness is: Spread out or Localized

Character of Pain: Achy Boring Burning Dull Lancing Numb Sharp Shooting Sore Stiff Tingling

Severity: Minimal Mild Moderate Severe Extreme

When did your pain start? _____ **Was it:** Gradual or Sudden

What caused your pain? **Auto Accident** **Work Accident** **Other** _____

Frequency of Pain: Occasional Intermittent Frequent Episodic Constant

Symptom: Neck Pain Mid Back Pain Headaches Low Back Pain R/L Arm Pain R/L Leg Pain

Have Radiating Pain to: R/L Inside/Outside Front/ Back of: Shoulder Elbow Hand Hip Knee Ankle Foot

Same problem in the past? (Yes No **When:** _____

Past Treatment: _____

Past Dr.: _____ **Past Testing:** _____

Better With: Sit Stand Lying down Movement Rest Use Walk Run Work

Worse With: Sit Stand Lying down Movement Rest Use Walk Run Work

Timing: Better/ Worse AM PM Sleeping Menstrual Cycle Weather Other _____

What home remedies have you tried to relieve your condition? _____

_____

Have you ever had X-rays for this condition? (Yes / No)

Have you ever had, for this or any other conditions prior CAT Scan? (Yes/ No) MRI (Yes/ No)

When/ Why : _____

Have you had any surgeries since your last visit? (What/ When) _____

Have you had any accidents or broken bones since your last visit? (What/ When) _____

Are you currently taking any medication/ supplements (what/ condition) _____

_____

What specific things do you look forward to being able to do again when this problem is solved?

_____

PAST MEDICAL HISTORY

Please check all that apply:

- Anxiety Disorder
- Arthritis
- Asthma
- Bleeding Disorder
- Blood Clots (or DVT)
- Cancer
- Coronary Artery Disease
- Claustrophobic
- Diabetes - Insulin
- Diabetes – Non-Insulin
- Dialysis
- Diverticulitis
- Fibromyalgia
- Gout
- Has Pacemaker
- Heart Attack
- Heart Murmur
- Hiatal Hernia or Reflux Disease
- HIV or AIDS
- High Cholesterol
- High Blood Pressure
- Overactive Thyroid
- Kidney Disease
- Kidney Stones
- Leg/Foot Ulcers
- Liver Disease
- Osteoporosis
- Polio
- Pulmonary Embolism
- Reflux
- Stroke
- Tuberculosis
- Other

PAST SURGICAL HISTORY

Surgery Reason Year Hospital

FAMILY HEALTH HISTORY Circle condition

Grandmother (Maternal)	Living: Y / N	Age:	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart Disease Hypertension Osteoporosis Stroke Scoliosis
Grandfather (Maternal)	Living: Y / N	Age:	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart Disease Hypertension Osteoporosis Stroke Scoliosis
Grandmother (Paternal)	Living: Y / N	Age:	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart Disease Hypertension Osteoporosis Stroke Scoliosis
Grandfather (Paternal)	Living: Y / N	Age:	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart Disease Hypertension Osteoporosis Stroke Scoliosis
Father	Living: Y / N	Age:	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart Disease Hypertension Osteoporosis Stroke Scoliosis
Mother	Living: Y / N	Age:	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart Disease Hypertension Osteoporosis Stroke Scoliosis
Brother/Sister	Living: Y / N	Age:	Alcoholism Arthritis Depression Cancer Diabetes Genetic disease Heart Disease Hypertension Osteoporosis Stroke Scoliosis

SOCIAL HISTORY

Caffeine	None Occasional Moderate Heavy # of cups/cans per day? _____
Alcohol	Do you drink alcohol? Yes No If Yes, how often? Occasionally < 3 times a week > 3 times a week How many weekly? _____
Tobacco	Do you use tobacco? Yes No If not currently, have you ever used tobacco? Yes No Cigarettes _____ pks/day Chew _____/day Cigars _____/day # of years _____ Month/Year Quit ____/____
Drugs	Do you currently use recreational or street drugs? Yes No

PREFERRED PHARMACY

Pharmacy: _____

Address: _____

City/State: _____

Phone: _____

HAVE YOU EVER: YES NO BRIEFLY EXPLAIN

Broken bones?	Yes No	If yes, what bones?
Had X-Rays?	Yes No	If yes, where taken: Date:
Been hospitalized?	Yes No	If yes, when?
Been in an auto accident?	Yes No	If yes, when?
Had sprains/strains?	Yes No	If yes, where?
Been struck unconscious?	Yes No	If yes, when?
Had surgery?	Yes No	If yes, when? what?

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

It is the policy of J. Clayton Spine and Health to not release confidential patient information about you, unless it is for 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 voice mail, work telephone, cell phone or to any other person, then you must complete the following:

I authorize J. Clayton Spine and Health 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 voice mail? Yes No
We can call you at work? Yes No
We can leave a message on your cell phone? Yes No
We can fax copies of information to other offices if necessary? Yes No

Please list the names of 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 **Date** **Witness Signature** **Date**

STATEMENT TO PERMIT PAYMENT OF MEDICAL BENEFITS TO PROVIDER

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 to J. Clayton Spine and Health.

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 J. Clayton Spine and Health.
*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 J. Clayton Spine and Health as your healthcare 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, MASTERCARD, AND VISA. PAYMENTS PLANS ARE ALSO AVAILABLE.

Regarding Insurance

J. Clayton Spine and Health may accept assignment of insurance benefits after your first visit. **However, we do require your copay 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. 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 J. Clayton Spine and Health 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, you will be required to pay the full cost of treatments.

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 and covered by a parent or guardian. Visa/MasterCard, or payment of cash 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 agreed to purchase this equipment at J. Clayton Spine and Health.

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

ALL APPOINTMENTS must be canceled within 24 HOURS of the appointment or we reserve the right to charge $25 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 JCSH Employee

J. CLAYTON
SPINE & HEALTH

To all J. Clayton Spine and Health 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 $25.00 fee for any missed massage therapy appointments without prior notice.

Thank you for your cooperation.

James Galyen, D.C.
Eric Lux, D.C.
Sarah Ramey FNP-C
Beth Von Dielingen FNP-C

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

J. Clayton Spine and Health
905 W. Keegan's Way, Ste. 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, 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.

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.

HIPAA Notice Cont.

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 the 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 became 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 HIPAA Compliance Officer in person or by phone at 812-663-7640..

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

Signature	Print Name	Date