SCHNEIDER CLINIC P.C.
1178 Fremont Court
Elkhart, IN 46516
(574) 293-7000
SchneiderClinic.com

PATIENT INFORMATION

First		M.I.
Last		
Nickname		
Street		
City		
State		Zip
Social Security #		
Date of Birth		
Spouse's Name		
Spouse's Social Security #		
Spouse's Date of Birth		
Home Phone #		
Work Phone #		
Cell Phone #	Verizon AT&T Sprint TMobile Other	
	Please circle primary phone #	
E-Mail Address (For Patient-Doctor communication) *Remains Confidential*		

EMPLOYER INFORMATION

Occupation	
Company How long at Employer?	
Address	
Emergency Contact	Name: Address: Phone #:
Is your condition due to:	Auto Accident Personal Injury Work Injury Other:
Do you have health insurance?	Relationship to Insured? Self, Spouse, Child, Other:
Employer of Insured Person – if not self:	
I will be paying today by:	Cash Check Credit Card
Referred by:	

AUTHORIZATIONS:

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.

B. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.

C. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this 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 this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are changed directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

Patient's Signature: ______________________________ Date: ______________

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PATIENT COMPLAINT FORM

Main Complaint: ____ Date Began: ____________________

How did this begin (falling, lifting, etc.)**?** ____

How is your condition changing? ☐ Getting better ☐Getting worse ☐ Not changing

Have you had this condition in the past? ☐ Yes ☐ No If yes, how long ago? ________________

How often do you experience your symptoms? ☐ Intermittent (0-25% of the day) ☐ Occasional (26-50% of the day)
☐ Frequent (51-75% of the day) ☐ Constant (76-100% of the day)

Describe the nature of your symptoms:

☐ Burning ☐ Dull Ache ☐ Numb ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Tight
☐ Tingling ☐ Throbbing ☐ Stiffness ☐ Soreness ☐ Radiates to: ______________________________

Please rate your pain on a scale from 0 to 10 (0=no pain and 10=excruciating pain):

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What are your expectations? ☐ Become pain free ☐ Explanation of my condition
☐ Reduce symptoms ☐ Resume normal activity
☐ Learn how to care for this condition on my own

What aggravates your condition? (circle all that apply): Bending, Sitting, Reaching, Walking long distances, Caring for children, Climbing stairs, Concentrating, Cleaning, Dressing, Exercise/sports, Balance, Lying down, Computer work, Sexual activity, Turning, Sleeping, Other: ____

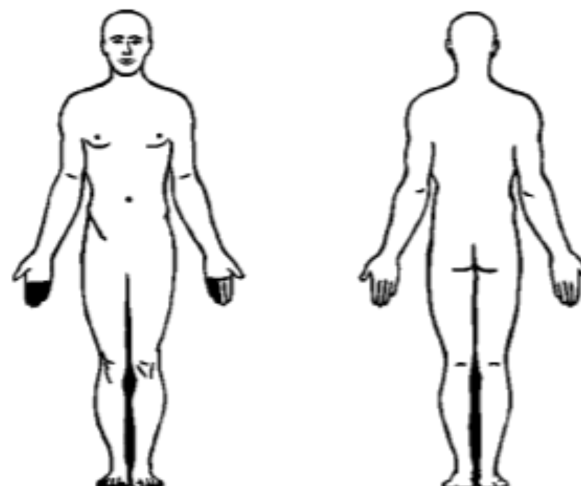
Please write any other activities that aggravate your condition: ____________________________________

What makes your pain better (ice, heat, massage, sitting, lying, certain position, certain food)? ____________

Were any diagnostic studies done (x-rays, MRI, CT scan, Bone density, Blood draw)? ___________________

PLEASE MARK YOUR AREAS OF PAIN ON THE DIAGRAM (BODY) USING THE FOLLOWING SYMBOLS:

0 = Ache / Dull / Sore
X = Sharp / Burning / Shooting
- - - = Numbness / Tingling
= Tension / Tightness



FOR OFFICE USE ONLY

Last x-ray ___________
Last seen ___________
Last cond tx __________

Patient Signature: ____________________________________ Date: ________________________________

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PATIENT HEALTH HISTORY

Name: ________________________ **Date of Birth:** ________________

Do you smoke/use tobacco? ☐ No ☐ Yes – how often? ________________
Do you drink alcohol? ☐ No ☐ Yes – how many glasses per day? __________
Do you drink caffeine? ☐ No ☐ Yes – how many glasses per day? __________
Do you exercise? ☐ No ☐ Yes – how often? ________________
Are you pregnant? ☐ No ☐ Yes – how many weeks? ______________
Do you have children? ☐ No ☐ Yes – how many? ________________

Allergies (check all boxes that apply)**:**

☐ Animals ☐ Dust ☐ Mold ☐ Shellfish
☐ Aspirin ☐ Dye ☐ Penicillin ☐ Soap
☐ Chocolate ☐ Eggs ☐ Ragweed/Pollen ☐ Wheat/Barley
☐ Dairy ☐ Fish ☐ Seasonal Allergies ☐ X-Ray ☐ Other: ________

List any past surgeries and dates of surgeries: ______________________________

Medical History (check all boxes that apply)**:**

☐ Ankle pain ☐ Arm pain ☐ Arthritis ☐ Asthma ☐ Back pain
☐ Broken bones ☐ Cancer ☐ Chest pain ☐ Depression ☐ Diabetes
☐ Dizziness ☐ Elbow pain ☐ Epilepsy ☐ Eye/vision ☐ Fainting
☐ Fatigue ☐ Foot pain ☐ Genetic Spinal ☐ Hand pain ☐ Headaches
☐ Hearing ☐ Hepatitis ☐ High blood pressure ☐ Hip pain ☐ HIV
☐ Jaw pain ☐ Joint stiffness ☐ Knee pain ☐ Leg pain ☐ Menstrual problems
☐ Mid-back pain ☐ Minor heart pain ☐ Multiple Sclerosis ☐ Neck pain ☐ Neurological problems
☐ Pacemaker ☐ Parkinson's ☐ Polio ☐ Prostate problems ☐ Shoulder pain
☐ Spinal cord injury ☐ Sprain/strain ☐ Stroke/heart attack ☐ Other: ________________

List all medications you are taking: ______________________________

Family History (write the appropriate letter: **F**=father, **M**=mother, **S**=sibling, **C**=child)**:**

_______ Arthritis _______ Asthma _______ Back pain
_______ Cancer _______ Epilepsy _______ Genetic spinal condition
_______ High blood pressure _______ Heart problems _______ Multiple Sclerosis
_______ Neurological problems _______ Parkinson's _______ Polio
_______ Prostate problems _______ Stroke/heart attack _______ Other: __________

Describe any auto accidents you have been in: ______________________________

Approx: Height: ______________ Weight: ______________

Name of Family Physician: ______________________ **Date of last exam:** __________

Patient Signature: ______________________ Date: ______________________

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CONSENT FOR RELEASE OF MEDICAL INFORMATION

Patient Name: ______________________________ Date of Birth: ______________________

I, ____, give my permission to have any/and or all of my medical information, including financial, released to the following persons:

1. Name: ______________________________ Relationship to Patient: ______________

   Address: ____

   Phone Number: _______________________

2. Name: ______________________________ Relationship to Patient: ______________

   Address: ____

   Phone Number: _______________________

3. Name: ______________________________ Relationship to Patient: ______________

   Address: ____

   Phone Number: _______________________

4. Name: ______________________________ Relationship to Patient: ______________

   Address: ____

   Phone Number: _______________________

Patient Signature: ____

Date: ______________________________________ Witnessed By: ______________________

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CONSENT FOR TREATMENT OF MINOR

I hereby authorize:

DR. SCHNEIDER

and whomever he may designate as assistants to administer examinations and chiropractic care as deemed necessary to:

____

Name of Minor Child

______________________________ ______________

Signature of Parent/Guardian **Date**

______________________________ ______________

Witness **Date**

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PATIENT ACKNOWLEDGMENT FORM

PATIENT ACKNOWLEDGMENT OF UNDERSTANDING OF SCHNEIDER CLINIC P.C.'S PRIVACY PRACTICES

Patient's Name (last, first, M.I.)**:** ____

Date of Birth: ____________ **Social Security Number:** ____________ **Previous Name:** _______________

I understand that the patient's health information is private and confidential. I understand that Schneider Clinic P.C. works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Schneider Clinic P.C. may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations.

(* In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.)

Schneider Clinic P.C. has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and is available upon request. I understand that I have the right to read the "Notice" before signing this Acknowledgment.

Schneider Clinic P.C. may update this Acknowledgment and "Notice of Privacy Practices". If I ask, Schneider Clinic P.C. will provide me with the most current "Notice of Privacy Practices".

Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications or alternative location.

Schneider Clinic P.C. has established procedures which help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgments, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist Schneider Clinic P.C. by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

MY SIGNATURE BELOW INDICATES THAT I HAVE BEEN GIVEN THE CHANCE TO REVIEW A CURRENT COPY OF SCHNEIDER CLINIC PC. 's "NOTICE OF PRIVACY PRACTICES".

Patient/Guardian Printed Name: ____

Patient/Guardian Signature: ____

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AUTHORIZATION TO CONTACT PRIMARY CARE PHYSICIAN

Who is your Primary Care Physician? ____

Primary Care Physician's address: ____

Primary Care Physician's phone number: ____

Schneider Clinic would like to send an initial report and follow up reports to your Primary Care Physician and discuss your case if any questions arise. We are asking for your permission to send these reports to him/her.

I authorize that Schneider Clinic, P.C. has my permission to contact my Primary Care Physician.

Patient Signature: _________________________________ Date: _____________________________

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEATH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect October 14, 2014, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice affective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new copies of this notice, please contact us using the information listed in this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations.
For Example:

● TREATMENT: We may use or disclose your health information to a physician or other healthcare provider providing treatment for you.

● PAYMENT: We may use and disclose your health information to obtain payment for services we provide to you.

● HEALTHCARE OPERATIONS: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluation practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

● YOUR AUTHORIZATION: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while still in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

● TO YOUR FAMILY AND FRIENDS: We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment to your healthcare, but only if you agree that we may do so.

● PERSONS INVOLVED IN CARE: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information this is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

● MARKETING HEALTH-RELATED SERVICES: We will not use your health information for marketing communications without your written authorization.

● REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law.

● ABUSE OR NEGLECT: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

● NATIONAL SECURITY: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

● APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

PATIENT RIGHTS

● ACCESS: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1.00 for each page, $20.00 per hour (with a minimum of $20.00) for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

● DISCLOSURE ACCOUNTING: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before October 14, 2014. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

● RESTRICTION: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency.)

● ALTERNATIVE COMMUNICATION: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative mans or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

● AMENDMENT: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

● ELECTRONIC NOTICE: If you receive this Notice on our Web site or by electronic mail (E-Mail) you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

CONTACT INFORMATION

● OFFICER: Dr. Mark Schneider. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the US Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S Department of Health and Human Services.

CONTACT OFFICER
Dr. Mark Schneider

ADDRESS
Schneider Clinic P.C. 1178 Fremont Court Elkhart, IN 46516

TELEPHONE
574-293-7000