SYNERGY CLINIC

6925 East 96th Street Suite 125
Indianapolis, IN 46250

1 Patient Information

Name: _____
First *Initial* *Last*

Address: _____

_____
City *State* *Zip*

Home: _____ Work: _____

Cell: _____ DOB: _____

Sex: ☐ Male ☐ Female SSN: _____

Email: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Employment Status: ☐ Full Time ☐ Part Time ☐ Student *(If student skip to section 2)*

Employer Name: _____

Employer Address: _____

_____
City *State* *Zip*

Spouse: _____
First *Initial* *Last*

How did you hear about our clinic?: _____

2 Insurance / Guarantor

Insurance Name: _____

Ins ID: _____

Group #: _____

Subscriber's Name: _____

Address: *(if different than patient)* _____

_____
City *State* *Zip*

DOB: _____ SSN: _____

Relationship to patient: _____

Subscriber's Employer: _____

Employee Address: _____

_____
City *State* *Zip*

3 Emergency Contact

Emergency Contact: _____

Emergency Phone: _____

Relationship: _____

4 Accident Information

Is your condition due to an accident? ☐No ☐Yes _____
Date

Type of accident: ☐Auto ☐Work ☐Home ☐Other

Have you reported the accident to one of the following?

☐Auto Insurance ☐Employer ☐Worker Comp. ☐Other

Attorney Name *(if applicable)*: _____

5 Patient Condition

Reason for visit: _____

When did symptoms first appear?: _____

Is the condition getting progressively worse?

☐Yes ☐No ☐Unknown

How would you describe your pain? Mark all that apply:

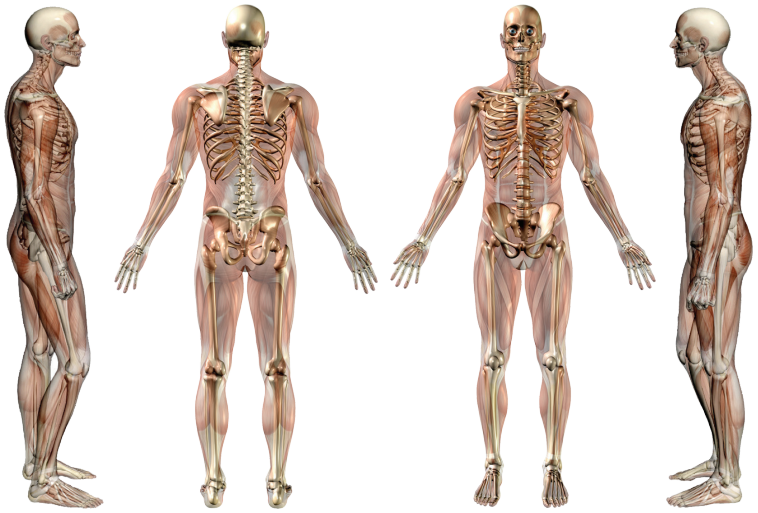
☐Sharp ☐Dull ☐Throbbing
☐Aching ☐Shooting ☐Burning
☐Stiffness ☐Cramping ☐Other

Is the pain: ☐Constant ☐Comes and Goes

Have you had similar pain in the past? ☐Yes ☐No

If so, when?: _____

Using the appropriate symbol, mark on the picture where you continue to have: Pain (X), Numbness (/), or Tingling (#)



Signature Date

6 Health History

Check treatments received for this condition? Chiropractic Medication None Physical Therapy Surgery

Name and location of other Doctor(s) treating you for this condition: _____

_____

Date of last: X-ray: _____ MRI: _____ CT-Scan: _____ Bone Scan: _____

Other (Specify): _____

Place a "✓" to indicate if you currently have or have had any of the following:

Alcoholism	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Allergy	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No
Anorexia / Bulimia	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No
Anxiety Attacks	☐ Yes	☐ No	Headaches	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
Auto Immune Disease	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Bleeding Disorder	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No
Breast Lumps	☐ Yes	☐ No	Osteporosis	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Prostate Problems (Men)	☐ Yes	☐ No
Chronic Fatigue	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Crohn's Disease	☐ Yes	☐ No	Sleep Problems	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Digestion Problems	☐ Yes	☐ No	Tumor/Growth (non-cancer)	☐ Yes	☐ No
Fibromyalgia	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Herniated Disc	☐ Yes	☐ No		☐ Yes	☐ No

EXERCISE		WORK ACTIVITY		HABITS
☐ None	☐ Moderate	☐ Mostly Sitting	☐ Moderate Labor	☐ Smoking: Packs/Day ( )
☐ Daily	☐ Heavy	☐ Light Labor	☐ High Labor	☐ Alcohol: Drinks/Week ( )
Are you PREGNANT? ☐ Yes (Due Date:) ☐ No ☐ Maybe				☐ Coffee/Pop # per day ( )

Please describe any of your **SURGERIES** or **BROKEN BONES**? Give dates.

Surgeries: _____

Broken Bones: _____

Any other conditions not covered on this form? _____

_____

MEDICATIONS	ALLERGIES	VITAMINS/HERBS

7 Assignment & Release

If you have insurance, please make sure that you give your card to the front desk person so they can make a copy of your information.

I, the undersigned, certify that I (or my dependent) have Insurance coverage and assign directly to Symmergy Clinic, P.C. 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 hereby authorize the Doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all Insurance submissions.

Guarantor's Signature: _____ Date: _____

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QUADRUPLE VISUAL ANALOGUE SCALE

Circle the number that best describes the pain you are experiencing. If you have more than one chief complaint, feel free to circle a number for each complaint and note which score is for which complaint.

1. What is your pain right now?

0 1 2 3 4 5 6 7 8 9 10

2. What is your pain level on an average day?

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level on your best days?

0 1 2 3 4 5 6 7 8 9 10

4. What is your pain at its worst?

0 1 2 3 4 5 6 7 8 9 10

Name:_____ Date:_____

6925 East 96th Street Suite 125
Indianapolis, IN 46250

Your signature is required for us to process insurance claims and receive payment for services rendered in this facility.

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I acknowledge that I have received a copy of the *Notice of Privacy Practices* from the staff at Symmergy Clinic.

I authorize the release of all medical information necessary to process claims pertinent to my medical care, and I request that my insurance company honor my assignment of insurance benefits applicable to the services and pay all insurance benefits directly to my physician, on my behalf.

I acknowledge and understand that all accounts are the full responsibility of the patient. I understand that deductibles, co-pays, co-insurance and non-covered services are my responsibility Symmergy Clinic will prepare and file your insurance claims directly with your primary and secondary insurance carriers. It is your responsibility to ensure that insurance payments are processed and paid in a timely fashion. In case of default of payment, I agree to pay legal fees on the balance due, collection costs, and reasonable attorney fees incurred to recover such payments.

Symmergy Clinic will send statements regularly to keep you informed of any outstanding balances owed to the clinic. Any balance not paid within 90 days will be forwarded on to a collection agency. Financial hardships are available and terms will be reached between doctor and patient for a timeframe agreed upon by both parties. Payment plans are available if you contact our clinic and take initiative to set one up.

Returned checks will be charged $20 (non-sufficient funds) fee.

Name: _____ Date: _____

Signature: _____

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CHIROPRACTIC INSURANCE COVERAGE

While our office staff is eager to help you with insurance questions, it is ultimately your responsibility to know your insurance coverage prior to receiving chiropractic care. Understanding your insurance benefits is not always easy so our staff will work with you to ensure that you are provided with the best option for care. If you do not have chiropractic benefits, our clinic has very reasonable cash prices to guarantee that each patient is able to afford care in our facility.

Please call the customer service phone number on the back of your insurance card. Use these questions to guide you through determining your coverage.

Questions To Ask You Insurance Company Representative		Answers
1.	The name of the representative you spoke with.	
2.	What is the effective date on my policy?	
3.	Do I have chiropractic coverage on my policy?	**Yes** / **No**
4.	What is my co-pay for chiropractic care?	**$**
5.	Do I have a deductible? How much of my deductible has been met?	**Yes** / **No** **$**
6.	How many chiropractic visits am I allowed?	
7.	Is there a per-visit dollar limit for chiropractic care?	**$**
8	Do I have coverage for custom made orthotics? (Code L3000) How much?	**Yes** / **No** **$**
9.	Do I have coverage for therapeutic exercise? (Code 97110)	**Yes** / **No**
10.	Do I have coverage for massage therapy? (Code 97124)	**Yes** / **No**

Notes:

_____

_____

_____

_____

Your Name: _____ Date: _____

Please print this form, fill it out and bring it to your next visit. We will scan it into your permanent file for further reference.

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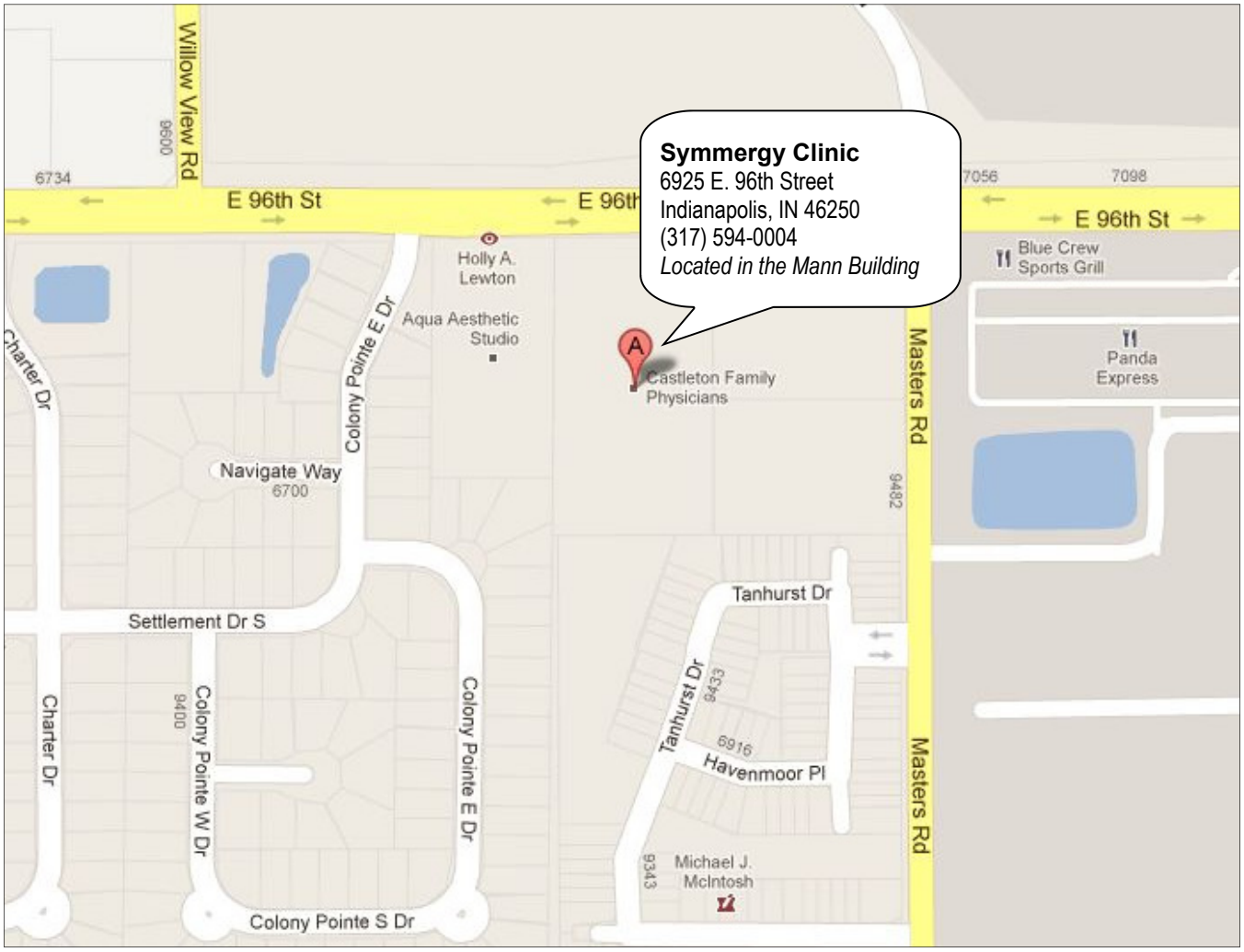

From I-465

Take I-465 to the I-69 North / Fort Wayne exit
Take I-69 North to the 96th Street exit and turn WEST (left)
Turn SOUTH (left) on Masters Road located before Gordon Food Service
Turn WEST (right) at your first street immediately after Gordon Food Service
Symmergy Clinic is located in the MANN building on the south side of the building

North of Fishers

Take I-69 South to the 96th Street exit and turn WEST (right)
Turn SOUTH (left) on Masters Road located before Gordon Food Service
Turn WEST (right) at your first street immediately after Gordon Food Service
Symmergy Clinic is located in the MANN building on the south side of the building

If you need more in-depth directions, please contact our clinic at 317.594.0004