Date : ___/___/___ Acct #: _____

Name: _____ Date of Birth : ___/___/____ ⬜ Male ⬜ Female

Address: _____ City: _____ State: _____ ZIP: _____

Cell Phone : _____ Other number: _____ Email: _____

⬜ Married ⬜ Single Name of Spouse _____ Are you Pregnant? ⬜ Yes ⬜ No

Called / nickname _____ Nature of Work / Place of Employment: _____

How did you find our office? ⬜ Google ⬜ Facebook ⬜ Other Recommendation from _____

Reason for today's visit: _____

How / When did it start? _____

Have you had this problem before? _____

What makes it feel better? (position, ice, etc.) _____

What worsens it? _____

What treatment have you received for this issue previously? _____

Primary Physician: _____ Past surgeries and scars: _____

Are you taking any medications at this time? _____

Indicate any of the following areas that have caused or currently cause problems for you:

Allergies & Sensitivities: Seasonal Allergies Rashes / Hives Sinusitis Metals Fabrics Skin issues Acne Eczema Psoriasis	**Allergies & Sensitivities:** Coffee / tea Dairy Crustaceans Fruits/berries Nuts Gluten / grains Perfume / cosmetics / oils Pollen / grass / trees/ molds Other: _____	**Other:** Digestive Problems Bloat / Gas Diarrhea IBS Colitis Asthma Difficulty breathing	**Other:** Neuralgia Neuropathy Chronic Fatigue Candida Overgrowth Bed Wetting Need to quit smoking Otro:
Head: ADHD / ADD Easily Distracted OCD Chronic Pain Concussion Brain Fog Excessive Rationalization Excessive Self Concern Migraine & Tension Headaches	**Head:** Amnesia Fibromialgia Hyper-vigilance Poor cognitive performance Rumination Brain doesn't shut off Insomnia / Restlessness Short Term Memory Issues Tics	**Emotions:** Emotional Trauma Depression Panic Attacks Stress Disorder PTSD Irritability Angry Outbursts Emotional Anxiety Dislike of Change	**Difficulty with:** —Organization —Problem solving —Concentration —Processing oral or verbal information —Processing Reading —Short term memory

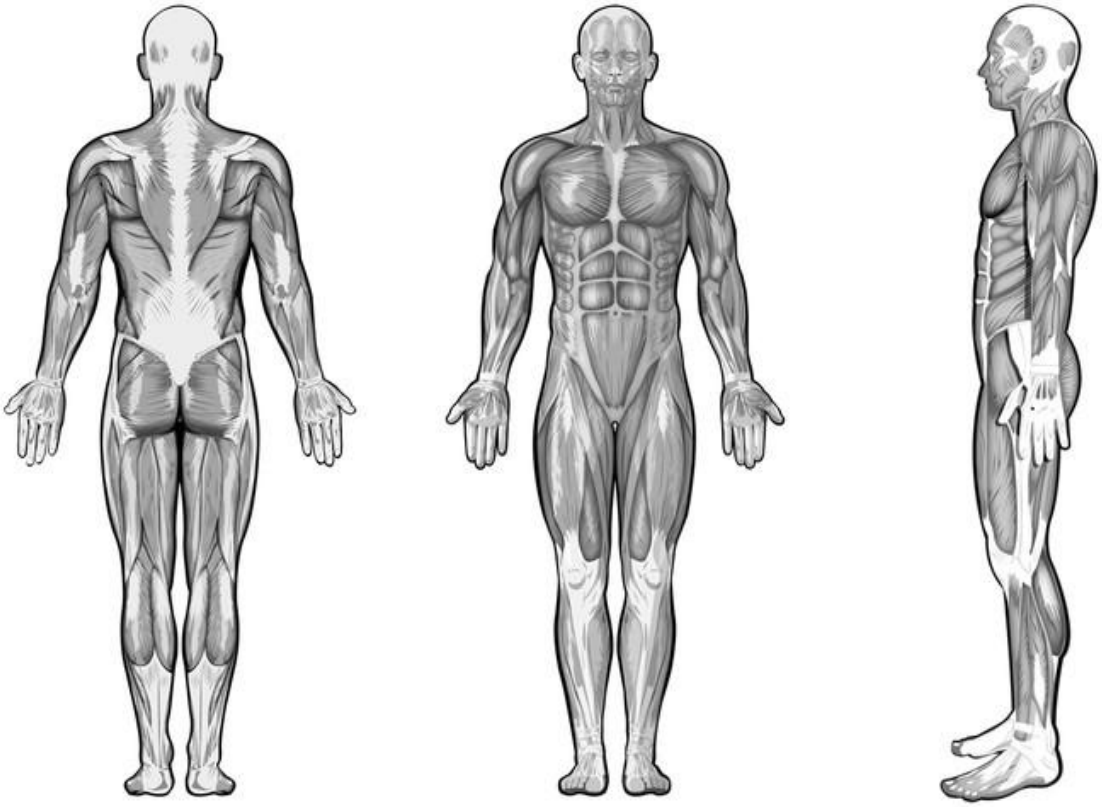
Indicate any other Health Problems

High Blood Pressure Cancer Diabetes Fatigue Brain trauma Stroke Spasms	Nausea Sciatica Muscle weakness Vertigo Double vision Cloudy vision Balance problems	AIDS Hepatitis Autoimmune Hiatal hernia Acid Reflux Heartburn Constipation

Patient Findings

Please mark areas of pain on the body chart below:

Aching - A	Numbness - N	Pain - X
Burning - B	Scars - S	Stiffness - O



O F F I C E U S E O N L Y

HRV. Symp ____ Para ____ Norm ____ NSpec Anabolic-Catabolic / Fat-Sugar / PH Acid / Alkaline

Labs: Principle Dutch

HT __ SI __ TH __ PC __ ST __ SP __ LI __ LU __ K __ BL __ LV __ GB __ LOCAL SYSTEMIC AURICULO
HT __ SI __ TH __ PC __ ST __ SP __ LI __ LU __ K __ BL __ LV __ GB __ LOCAL SYSTEMIC AURICULO
HT __ SI __ TH __ PC __ ST __ SP __ LI __ LU __ K __ BL __ LV __ GB __ LOCAL SYSTEMIC AURICULO

St Sm Int Liv Gb Pan Sp ICV VH LI Pit Thy Ad Ov/Test-Prost

SCM	Glut Max
Scalene	Glut Med
Trap Up / Mid / Low	Quad Lum
	Quad Fem
Serratus	Vastus Lat
Deltoid A M P	Add
Infraspin	Sart
Supraspin	Gracil
Teres MJ	Med Ham
Teres MN	Lat Ham
Tricep M L	Poplit
Bicep M L	Ant Tib
Pec Mj	Post Tib
Pec Mn	Peroneus Long
Subclav.	Peroneus Brev
Pronator T	Ext. Hal/
Ext. Carp Rad	Meta Tars
Ext Carp Uln	

How is your condition affecting your life?

- Home Life: _____
- Work Life: _____
- Recreational Life: _____
- Rest and Sleep Life: _____

Have you been in an automobile accident? ⬜ Past Year ⬜ Past 5 Years ⬜ Over 5 Years ⬜ Never

Any accidents, falls, or injuries that might have caused your problem? _____

Date of Injury _____ Any medical diagnosis of your complaint? _____

Any chiropractor consulted in the past? Name _____ Dates Consulted _____

Type of Insurance: ⬜ Health Insurance ⬜ Automobile Insurance ⬜ Workman's Comp

We are out of Network with all insurance carriers. We're happy to file with your insurance carrier on your behalf, but in order to know whether your insurance will cover any of your chiropractic treatments, you'll need to contact them to determine what your out of network benefits are. We collect at time of service, and any reimbursement from your carrier should be sent directly to you. **Please Present Insurance Cards to Staff along with a Photo ID.**

Fees are payable at the time examinations and treatments are received unless other arrangements are made in advance. In order to induce Dr. Steven Mangas, Dr. Chloe Tillman, and the Mangas Chiropractic office to provide _____ (patient name) with chiropractic services, examinations, treatment, and medical-legal correspondence and in consideration of such, I (we), the undersigned, hereby individually, jointly, and severally guarantee, agree and unconditionally promise to pay the full cost and expenses of examinations, laboratory work, therapy, treatments, consultations, and medical / legal reports, upon such services being rendered, together with the interest accrued of 1.5% per month on the unpaid balance, reasonable attorney fees, costs and expenses of billing, collection and litigation if necessary.

Patient's Full Name Printed Parent's Printed Name if Minor

Patient's Signature Date

Dr. Steven C. Mangas and Dr. Chloe H. Tillman
Chiropractic Physicians

6699 Rockville Rd
Indianapolis, IN 46214
317-247-1717

A Word About Insurance Payments:

Our fees reflect our services, not an insurance company's reimbursement schedule. Certain insurance companies may choose not to pay your medical fee in full. This is not uncommon and is unfortunate for those affected by this problem.

If your insurance company selects a level of reimbursement, (an arbitrary value sometimes referred to as "usual and customary") which is below our standard fees, the responsibility of the remainder of the payment is placed on you when applicable. The incentive of the insurance company is to hold their costs down. Consequently, they not only determine what is usual and customary, but they also frequently only pay a percent of a fee that *they* select based on your employer's contract with them. This sometimes creates a reimbursement schedule significantly below fees charged.

When applicable, our business office will assist you in working out a payment schedule. The payment schedule will be based upon the anticipated payment from the insurance company. Because this anticipated payment is not always paid by the insurance company, occasion adjustments may need to be made after receipt of final insurance payment.

The discrepancies created by some insurance companies are unfortunate, but we hope you will recognize we feel our fees are appropriate. Ultimately, what your insurance carrier pays is between you, the carrier, and the contract between your and the insurance carrier.

AUTHORIZATION STATEMENT

I authorize the release of the medical information necessary to process any claim for services provided by Dr. Mangas or Dr. Tillman. I further authorize medical benefits to Dr. Mangas and Dr. Tillman. A copy of the authorization may be used in the place of the original. I understand the doctor's charges may exceed the insurance carrier's allowable payment, and I shall be responsible for that amount when applicable.

Signature of Patient or Personal Representative _____

Date _____

Mangas Chiropractic
Consent for Purposes of Treatment, Payments, and Healthcare Operations

I consent to Mangas Chiropractic's use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations and purposes. Healthcare operations shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment, or healthcare operations of the Practice, but the Practice is not required to agree to those restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent in writing at any time, except to the extent that the Physician or the Practice has acted in reliance on this consent.

_____

Signature of Patient or Personal Representative Date

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received, reviewed, understand, and agree to the Notice of Privacy Practices of Mangas Chiropractic, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received, or maintained by the Practice.

_____

Signature of Patient or Personal Representative Date

_____

Printed Name