Seland Chiropractic Center, PC
Dr Trond Seland
Dr Philip Hallett
Dr Dan Bartley

Dear New Patient,

Thank you for choosing Seland Chiropractic Center.

We look forward to introducing you to the benefits of chiropractic care.

When you come for your appointment, please bring the following:

- Attached forms
- Your insurance card
- Any MRI's or recent x-rays you may have.

If you are unable to complete your paperwork prior to your arrival, please arrive 15 minutes early to complete the necessary paperwork.

Looking forward to meeting you!

With warm regards,

The Staff at Seland Chiropractic Center

Seland Chiropractic Center, PC
Dr Trond Seland
Dr Philip Hallett
Dr Dan Bartley

Date:

Name:	What do you prefer to be called:	
Address:		
City/State/Zip:		
Home Phone:	Work Phone:	Cell Phone:
Birthdate:	Age:	Social Security #
Marital Status: M W D S	E-mail address:	
Your Employer:	Occupation:	
Spouse's Name:	Spouse's Employer:	
Children's Names & Ages:		
Emergency Contact:	Phone:	
Who may we thank for referring you to our Practice:		

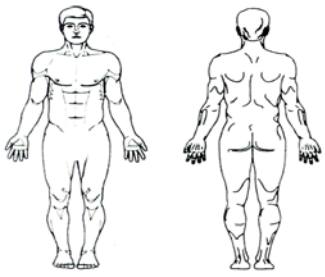
Main reason for your visit today?

Did it happen: Suddenly Gradually Progressively Date Occurred:

How often does it bother you? Constantly Frequently Intermittently Seldom

Describe the pain: Throbbing Aching Tingling
Burning Stabbing Numbness
Other:_____

PLEASE MARK PAIN LOCATIONS ON THE DIAGRAM



Does the pain radiate (hurt/affect anywhere else)?_____

What makes it feel better?_____

What makes if feel worse?_____

What have you done for it?_____

Was the injury related to: Work Auto Accident Sports

Any other issues you would like to address today? _____

For a Lifetime of Health, Healing, and Hope!

7350 Village Square Lane | Fishers, IN 46038 | (317) 598-1410 |
www.SelandChiropractic.com

Primary Care Doctor Name & Address:_____

How do you want us to handle your problems?

_____Temporary Relief (Help the symptom but do not fix the cause of the problem, symptoms will come back)
_____Maximum Correction (Correct the cause of the problem so it does not return)

On a scale of 1-10 (10 being the most and 1 being the least)

_____ How committed are you at being at your maximum health potential?
_____ How important is it for your family to at their maximum health potential?

The Stress Test

The following areas of stress can cause mis-aligned vertebra (subluxation). Which of these stresses do you recognize? Please circle when you experienced these stresses: **C** (Child) **T** (Teenager) **A** (Adult)

Physical/ Emotional /Chemical Stress:				**Please Explain/List Briefly:**
Birth Trauma	C			_____
Slips/Falls	C	T	A	_____
Car Accidents (indicate# of occasions)	C	T	A	_____
Sports Injuries	C	T	A	_____
Physical Abuse	C	T	A	
Poor Posture	C	T	A	
Work Injuries		T	A	_____
Sleeping on Stomach		T	A	
Carrying Heavy Purse/Bookbag/Child		T	A	
Repetitive Lifting/ Bending		T	A	_____
Driving for Many Hours		T	A	_____
Continuous Hours Sitting/Standing		T	A	
Children Stress OR Career Stress			A	_____
Relationship Stress	C	T	A	
Concealed Feelings	C	T	A	
Smoker/Second Hand Smoke	C	T	A	Amount: _____
Excessive Sugar	C	T	A	
Caffeine	C	T	A	Amount: _____
Artificial Sweeteners	C	T	A	Amount: _____

Which do you feel are your primary stresses?_____

Does this cause you to be: Moody Irritable Interrupted Sleep Restricted on Daily Activities
Does this affect your work: Decision Making Poor Attitude Decreased Productivity Exhausted at End of Day
Does this affect your life: Loss of Patience Restricted Household Duties Hinders Ability to Exercise
Interferes with Ability to Participate Affect your Hobbies

Other Symptoms

Please mark an **(X)** next to present conditions, or that you had in the past 6 months.
Please **circle** past conditions, over 6 months ago, but not now.

Headaches	Arthritis	Loss Of Smell	Nervousness	Tension
Sinus Problems	Loss of Taste	Face Flushes	Asthma	Dizziness
Neck Pain	Insomnia	Stomach Upset	Buzzing in Ear	Heart Disease
Shoulder Pain	Loss of Balance	Constipation	Stress	Stroke
Back Pain	Chest Pain	Fatigue	Depression	Blood Pressure
Neck Stiffness	Short of Breath	Light Sensitivity	Fainting	Menstrual Pain
Mid Back Stiffness	Skin Problems	Loss of Memory	Diabetes	Pain with Coughing
Low Back Stiffness	Ears Ring	Frequent Colds	Cold Hands	Frequent Urination
Legs Tingle	Fever	Cancer	Cold Feet	Cold Sweats
Arms Tingle	Allergies	Hepatitis	AIDS/HIV	Diarrhea
Numb Fingers	Numb Toes			

Check the conditions that are common to FAMILY MEMBERS:

___Cancer ___Diabetes ___Epilepsy ___Heart Disease ___Lung Disease ___Multiple Sclerosis

___Ulcers ___Scoliosis ___Hyper/Hypothyroidism

Health Goals:

1)_____ _____

2)_____

3)_____

ASSIGNMENT & RELEASE:

1. All first visit charges are payable when services are rendered.
2. The fee paid for treatment x-rays is for analysis only. The film itself is the property of this office. Once films are used for treatment purposes, they cannot be released. Digitized copies are available for a fee.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand Seland Chiropractic Center, P.C. will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Seland Chiropractic Center, P.C. will be credited to my account upon receipt. However, I clearly understand and agree that I am personally responsible for payment.

It is important that our patients and our office have the same health objectives concerning chiropractic care. Regardless of what a disease or condition is called, we do not offer to treat it. Our only practice objective is to eliminate a major interference to the expression of the body's internal wisdom. Our only method is specific adjusting to correct vertebral subluxations. We believe that the greatest doctor is the one already inside of each of our patients and we only help to maximize that inherent healing power, without using drugs or surgery. Your signature verifies that the information given in this form is complete and correct and that you accept, if eligible, chiropractic care on this basis.

_____ _____
Patient's Signature Date

_____ _____
Guardian's Signature Authorizing Care for Minor Date

Seland Chiropractic Center, PC
Dr Trond Seland
Dr Philip Hallett
Dr Dan Bartley

WELCOME TO SELAND CHIROPRACTIC CENTER, P.C.
Financial Policy

The following is information you should know to help you have a more satisfying relationship with our office staff and chiropractor. Please review this information as well as the enclosed financial policy. For additional information including maps to our office, please visit our website at www.selandchiropractic.com.

ARRIVAL:
New patients should arrive 5 minutes prior to the appointment time. This will give our office time to complete your chart without delaying your visit with the doctor.

Patients scheduled to review x-rays with the doctor should arrive 10 minutes early and notify the front desk of any changes since last visit.

PLEASE NOTE:
If you are late, you may be asked to reschedule your appointment. Our doctor makes every effort to stay on schedule and late arrivals will not allow us to do so.

CHECK-IN:
After you check-in, new patients will be asked to turn in the paperwork received via e-mail or fax. Patients may be asked to verify current information such as your address and insurance. You may be asked to update our patient information form if we do not have a current one on file. If you have brought with you any MRI'S or other X-rays, these should be given to the front desk.

- Payment is expected at the time of service unless other arrangements are made in advance. Payments may be made with cash, check, Visa, Mastercard, or Discover. We will file all claims with the insurance company. You are responsible for payment of all co-insurance, deductibles, and co-pays. If a dispute with the insurance company arises, you are responsible for settling the dispute with your insurance company.

- There will be a twenty-five dollar ($25) fee for all returned checks.

- There is a twenty-five dollar ($25) charge for all missed appointments. You can leave a message on our voice mail 24 hours a day.

- There is a $26 service fee for accounts that are sent to the collection agency or that are over 60 days past due. I guarantee payment in full of the patients account in accordance with the financial arrangements made at the time of discharge or, if no such arrangements are made, then payment shall be made in full within thirty (30) days of discharge. I agree that in the event of default in payment, reasonable collection agency fees equal to fifty (50) percent of the delinquent balance and reasonable attorney fees, shall be added to the amount due on the account, plus any applicable court costs. Accounts that are not settled within 30 days of being sent to the collection agency will incur additional collection agency fees.

- You may obtain a copy of your digital x-rays for a fee of $5.00.

- A copy of your medical records may be provided for a fee (Indiana Title 16-39-9-3). The fee structure is as follows:
  Fifteen dollar ($15) copying fee for each medical record request
  Twenty-five cent ($0.25) per page charge after the first ten (10) pages
  Actual postage costs

- If you are requesting services and/or treatment as a result of an accident, by executing this document you are granting Seland Chiropractic Center P.C. a lien on any recovery resulting from such accident, including but not limited to, insurance, litigation, compromise, arbitration, for the FULL AMOUNT due Seland Chiropractic Center, P.C._____(initial)

I have read and understand the above financial policy.

_____ _____
Patient or guardian signature Date

Seland Chiropractic Center, PC
Dr Trond Seland
Dr Philip Hallett
Dr Dan Bartley

Patient/Guardian Authorization to Disclose Protected Health Information to Others

Patient Name:_____DOB:_____Today's Date:_____

To the patient: Seland Chiropractic Center will attempt to follow your instructions to the extent the healthcare provider believes such disclosure will not interfere with your treatment. Please note that Seland Chiropractic Center does not need specific authorization to disclose information for treatment, operations of payment purposes consistent with its Notice of Privacy Practices.

Authorization by: ____Patient ____Legal Guardian:_____

Seland Chiropractic Center may disclose all of my Protected Health Information (including that about alcohol/substance abuse, HIV and/or AIDS, or information related to psychiatric treatment or counseling unless I limit below) to:

__Spouse (name)_____

__Children: All _____or by name _____

Others (name):_____

Request for Electronic Communications

I request that the following communications form the practice be delivered to me by the provided electronic means. I understand that this form of communication may not be secure, creating the risk of improper disclosure to unauthorized individuals. I am willing to accept that risk and will not hold the practice responsible should such incident occur.

Communications: __ Appointment Reminders ___Protected Health Information

Method: ___ Email to the following Address:_____

___Text to Phone Number(s):_____

____Voice Messages to Phone Number(s):_____

Limitation-The following Protected Health Information may NOT be disclosed:

_____

_____

Expiration: I understand this Authorization will stay in effect during my treatment at Seland Chiropractic Center unless it is revoked/revised by me in writing. I understand that Seland Chiropractic Center is not responsible for information that might be re-disclosed by those persons who I have authorized to receive information.

Patient/Guardian Signature:_____

Seland Chiropractic Center, PC
Dr Trond Seland
Dr Philip Hallett
Dr Dan Bartley

INFORMED CONSENT FOR SELAND CHIROPRACTIC CENTER, P.C.
DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC

CHIROPRACTIC
It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

ANALYSIS
A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS
Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE
A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or health care, if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS
The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal. In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions which do not respond to chiropractic care may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT
Please discuss any questions or problems with the doctor **before** signing this statement of policy.

I have read and understand the foregoing.

_____ _____
DATE SIGNATURE