



Morter HealthCenter New Patient Information

Hello!

Thank you for choosing Morter HealthCenter for your health care needs. Dr. Sue Morter established our clinic in Indianapolis, Indiana in October 1987, and we relocated to nearby Carmel, Indiana in May 2007 to accommodate our expanding patient base. We have been serving the Indianapolis community and surrounding area for over 20 years and are happy to welcome you to our growing family. We are committed to feeling better, attaining vibrant health, and experiencing lifetime wellness.

Our Team

Dr. Sue Morter, Doctor of Chiropractic and Founder of the clinic in 1987

Dr. Scott Cooper, Doctor of Chiropractic and member of the team since 1991

Andrea Townley, Chiropractic Assistant/Front Desk

Diana Vela, Chiropractic Assistant & Therapy/X-Ray Technologist

Becky Walton, Insurance Specialist & Chiropractic Assistant

Your first visit:

Your first visit will last approximately 90 minutes and includes a private consultation with one of our doctors, a physical examination, two neurological scans, and a pH saliva test. The initial consultation will be based on the confidential patient information forms downloaded from our website and completed prior to your visit. Completed forms may be faxed to 317-872-9303 or e-mailed to andrea@morterhealthcenter.com. If you intend to complete the forms in person at our clinic, please arrive 15-20 minutes prior to your scheduled appointment time.

During your consultation, the doctor will discuss your needs in greater detail and share with you what our clinic has to offer. You will then receive a complete examination. This will include the following *painless* procedures: two neurological scans, reflex and range-of-motion testing, and standard orthopedic and postural tests. If necessary, the doctor may request x-rays as an additional diagnostic procedure. Lastly, a pH saliva test will be collected to determine the alkalinity level of your body. To ensure the accuracy of your pH test, **please do not eat or drink anything except water for two hours prior to your appointment time.**

No unnecessary tests will be performed. All tests we administer are necessary to the complete understanding of what is involved with your case and will assist your doctor in prescribing a complete wellness program.

Payment is expected at the time of service. It is important to us that our financial arrangement be clear. It is our desire to support you in any way we can to meet your financial obligations while you make a choice toward more perfect health.

Our office participates in numerous insurance programs. We also accept auto accident, Medicare, and workman compensation cases. To determine if and to what extent your insurance policy covers chiropractic care, please download our “Health Insurance Chiropractic Policy” form online or request a copy at the front desk. You will then need to contact your insurance provider and complete the questions on the form based on your particular plan of coverage. **We cannot file claims directly to your insurance provider until the Chiropractic Policy form is completed, signed, and returned to us.**

Please bring with you:

- A photo ID.
- Your insurance card if you would like us to file claims on your behalf.
- A list of any medications or nutritional supplements you are currently taking.
- All relevant confidential patient information forms, completed and signed. (Available for download at www.morterhealthcenter.com.)

B.E.S.T Technique:

We utilize a state of the art healing practice and comprehensive chiropractic technique called **Bio Energetic Synchronization Technique** or **B.E.S.T**. It is a gentle, non-force procedure focused on neuro-emotional and neuro-musculoskeletal repatterning that not only relieves pain quickly, but also addresses the cause of the pain.

Treatment Schedule:

Once the consultation and all testing procedures have been performed, the doctor will ask you to schedule your next appointment as soon as possible. At your second appointment, your doctor will go over his or her ‘report of findings,’ including wellness recommendations and your customized treatment program, designed specifically for you so that you may achieve maximum correction in the shortest amount of time. Adhering to the treatment schedule prescribed assists you in getting better faster and staying well longer.

Questions

If you have any questions about your involvement with our clinic, please do not hesitate to contact our office. We are happy to be of assistance in any way that we can.

Thank you for choosing:

Morter HealthCenter

Teaching you to live well.

Dr. Sue Morter
Dr. Scott Cooper
10439 Commerce Drive, Ste 140
Carmel, IN 46032
877-I-Am-The-1 (877-426-8431)
317-872-9300
317-872-9303 (fax)
www.morterhealthcenter.com



CONFIDENTIAL PATIENT INFORMATION

Date: _____

IS VISIT ACCIDENT RELATED? Yes No
(If YES, please notify the receptionist)

Name _____

Social Security Number _____ - _____ - _____

Address _____ City _____ State _____ Zip _____

Home Phone (____) ____-____ Work (____) ____-____ Cell (____) ____-____ e-Mail _____

Age ____ Birth Date _____ Sex ____ Marital Status _____ Number of Children _____

Occupation _____ Employer _____

Name of Spouse _____ Spouse Social Security Number _____ - _____ - _____

Spouse's Occupation _____ Employer _____

Name of nearest relative not living with you _____

Address _____ Phone Number (____) ____-____

Whom may we thank for referring you to us? _____

Whom may we contact in the case of an emergency? _____

Purpose of this appointment (briefly describe symptoms) _____

How has this affected your daily activities? _____

Date symptoms appeared or accident happened _____

Have you ever had a similar condition? Yes No If Yes, when and describe _____

List any operations you have had and dates _____

Have you ever seen a chiropractor? Yes No

Date of last physical examination _____ Doctor's Name _____

Are you allergic to any medication? Yes No If Yes, list _____

Are you taking any medication? Yes No If Yes, list _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare, operations, and coordination of care. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that I will be financially responsible for all collection/legal fees incurred for the collection of any unpaid balance. I understand that a \$25 fee will be applied to my account if I do not cancel my appointment within a 24 hour period.

Patient Signature _____ Date _____

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information (PHI) we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any Time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

Our office reserves the right to amend the terms of our HIPAA NOTICE.

I have read and understand how my Patient Health Information (PHI) will be used and I agree to these policies and procedures.

Print Name of Patient: _____

Signature: _____ Date: _____

If you are signing as the patient's representative:

Print your Name: _____

Relationship: _____ Signature: _____

Name: _____ Date: _____

CHEMICAL BALANCE QUESTIONNAIRE

Speed of healing is determined by **chemical balance** in the body. Chemical balance is determined, in large, by **what you eat**. Please indicate the amounts and frequencies you partake in the following:

BE HONEST!

	Per Day	Per Week
1. Coffee (caff/decaff)	_____ cups	_____ cups
2. Tea (herbal/regular)	_____ cups	_____ cups
3. Sugar, sweets, desserts, candy artificial sweetener	_____ times	_____ times
4. Salt, salty snacks, chips, etc.	_____ servings	_____ servings
5. Do you add salt to food at meal time?	___yes ___no	_____ occasionally
6. Red meat (beef, pork, bacon, ham, etc.)	_____ times	_____ times
7. Chicken/Fish	_____ times	_____ times
8. Dairy (milk, cheese, ice cream, etc.)	_____ glasses/times	_____ glasses/times
9. Water	_____ glasses	_____ glasses
10. Fresh fruits	_____ pieces	_____ pieces
11. Fresh vegetables (non-canned)	_____ servings	_____ servings
12. Alcoholic Beverages	_____ servings	_____ servings
13. Soft Drinks (caff/decaff)	_____ servings	_____ servings
14. Smoking	_____ packs	_____ packs

What is a typical breakfast for you? _____

What is a typical lunch for you? _____

What is a typical evening meal for you? _____

List any vitamins/herbs you are currently taking _____

ACCIDENTAL INJURY INSURANCE INFORMATION

Date of Accident: _____

Attorney's Name: _____

Firm Name: _____

Date You Verified Ins. Info: _____

Phone #: _____

AUTOMOBILE INSURANCE INFORMATION

It is the policy of this office to file medical claims to the MED PAY portion of your automobile insurance. This part of your insurance policy can be utilized for direct payment while settlement is pending.

PLEASE PROVIDE THIS OFFICE WITH A COPY OF THE POLICE REPORT

Date you reported the accident to your insurance company: _____

Agent's Name: _____ Agency Name: _____

Street: _____ City: _____ State: _____ Zip Code: _____

Phone #: _____ Policy #: _____ Name policy is under: _____

Med Pay Amount: _____ Is there a deductible? YES _____ NO _____ If yes, \$ _____

Has Med Pay been paid to any other Provider for this claim? YES _____ NO _____ If yes, \$ _____

Name of Insurance Company where claims are to be sent: _____

Street: _____ City: _____ State: _____ Zip Code: _____

Adjuster's Name: _____ Phone #: _____ Claim #: _____

AT FAULT INSURANCE COMPANY

Same As Above

Name of Person At Fault: _____

Street: _____ City: _____ State: _____ Zip Code: _____

Name of Insurance Company: _____ Phone #: _____

Street: _____ City: _____ State: _____ Zip Code: _____

Agent/Agency Name: _____ Phone #: _____

FALL/OTHER INSURANCE INFORMATION

Type of Policy: Homeowner's Property Liability Other: _____

Name of responsible party: _____ Phone #: _____

Person whom you spoke to: _____

Name of Insurance Company where claims are to be sent: _____

Street: _____ City: _____ State: _____ Zip Code: _____

Adjuster's Name: _____ Phone #: _____ Claim #: _____

ACCIDENTAL INJURY REPORT

Date of Accident: _____

Time of Injury: _____ AM PM

Have you retained an attorney? Yes No

Patient's Name _____

Nature of Accident Auto Fall Work Related Other _____

Have you informed an Insurance Co.? Yes No

Name of Ins Co. _____

Relationship to Accident _____

Did you go to the Doctor _____ Hospital _____ after the accident?

If yes Name: _____

Type of treatment received: _____

Were you knocked unconscious? Yes No If yes, how long? _____

Have you been involved in a similar type of accident before? Yes No If yes, please describe (include injuries sustained). _____

Please describe any illnesses, injuries or conditions you had prior to this accident. _____

Was anyone else involved in the accident with you? Yes No

If yes, who? _____ Relationship to you _____

Description of involvement: _____

Have you lost time from work due to this injury? Yes No If Yes, please complete the following:

Type of employment _____ Last day worked _____

Are you being compensated for the time lost from work: Yes No If Yes, type of compensation? _____

Please describe how you felt:

During the accident: _____

Immediately after the accident: _____

The following day: _____

Check the symptoms you have noticed since the accident:

- | | | | | |
|--|---------------------------------------|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Irritability | <input type="checkbox"/> Short of Breath | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Depression | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Arms Tingle | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Pain After Meals |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Legs Tingle | <input type="checkbox"/> Fainting | <input type="checkbox"/> Cold Feet | <input type="checkbox"/> Other (Describe): _____ |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Hands Numb | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Fever | _____ |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Feet Numb | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Stomach Upset | _____ |

Please list the extent of injuries as you know them at this time: _____

Since the accident have you symptoms become: Better Worse Remained the same

Do you notice any activity restrictions as a result of this injury? Yes No If Yes, please describe: _____

Other pertinent information: _____

Please complete reverse side

Auto

Were you the Driver Front Seat Passenger Back Seat Passenger Pedestrian?

Number of people in your vehicle: _____ Number of people in the other vehicle? _____

What direction were you headed North South East West on (Street) _____

Other vehicle was headed: North South East West on (Street) _____

Were you struck from: Behind Front Left Side Right Side

or did you strike the other car with your Front End Rear End

Were you wearing your seat belt? Yes No

Briefly describe the accident including cause(s) and surrounding circumstances: _____

Other

Where were you at the time of the accident? _____

Briefly describe the accident including cause(s) and surrounding circumstances: _____

Name of anyone else involved in or a witness to the accident: _____

Name of responsible party: _____ Phone: _____

Street: _____ City: _____ State: _____ Zip: _____

Fall

Where were you at the time of the accident? _____

Briefly describe the accident including cause(s) and surrounding circumstances: _____

If appropriate, which body part struck the surface, floor, etc.? _____

If in a public place, was property manager notified? Yes No

Property Name: _____ Property Manager's Name: _____

Manager's Response: _____

Work Related Accident

Employer: _____ Phone: _____

Street: _____ City: _____ State: _____ Zip: _____

Your job title: _____ Dept: _____

Was any equipment, machinery, and/or object related to the accident? Yes No

If yes, what kind? _____

Was the accident reported to the supervisor/employer? Yes No

Was a Workers' Compensation claim filed? Yes No

Did your supervisor/employer recommend any specific type of care? Yes No

If yes, please explain? _____

Patient's Signature: _____ Date: _____

Name: _____ Date: _____

Your nervous system controls and regulates every cell of your body. We use an instrument that reveals how well your nervous system is functioning.

Please let us know if we need to be mindful of the following:

Drinking coffee or tea can excite the nervous system.
Have you had any of these caffeinated beverages today?

- No
- Yes

About _____ cups.

Cola drinks contain caffeine and chemicals that can affect the nervous system.
How many sodas have you had today?: _____.

Nicotine is a nervous system stimulant.
Have you used any tobacco today?

- No
- Yes How much: _____ .

Common over-the-counter medications can impact the nervous system.
Have you taken any of these types of medications today?

- No
- Yes _____

Many prescription drugs and muscle relaxers affect the nervous system.
Have you taken any type of prescription medication today?

- No
- Yes _____

Excessive exposure to the sun affects the accuracy of your scan.
Have you had a sunburn in the last five days?

- No
- Yes

Bath salts, oils or sunscreen on your skin can influence instrument sensitivity.
Have you used any of these products today?

- No
- Yes

Have you had a workout today? Walking, exercise, weightlifting....

- No
- Yes

Compared to a typical day, are you currently experiencing any type of emotional turmoil or stress?

- No
- Yes

