Dynamic Spine and Rehabilitation Center

106 E. Pickwick Dr. – Syracuse, IN 46567
O: (574) 457-7472 ~ F: (574) 457-7103

Date: _____

Confidential Patient Information

Patient Name: _____ Chief Complaint: _____

Address: _____ Home Phone: _____

City: _____State: _____Zip_____ Cell Phone: _____

SS#: _____ Email: _____

Date of Birth: _____ Marital Status: M S W D Sex: M F

Occupation: _____ Employer: _____

Address of Insured (if different than above): _____

Are your present symptoms or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) ___ Yes ___No

Ins. Company: _____ Ins. Phone #: _____

ID#: _____ Group #: _____

Name of Policy Holder: _____ Policy Holder DOB: _____

Policy Holders Employer: _____

Family Physician: _____ (Note: May we send your health information to this provider Y / **N**)

Person to contact in case of emergency (Name and Phone): _____

Have you ever been under Chiropractic Care? Y N If so, Who? _____

Have you had any SPINAL X-Rays / MRI's / CT's taken in the last year? Y N If so, Where? _____

What operations have you had? _____ When? _____

Serious Illness: _____ When? _____

Infectious Diseases: _____ When? _____

Do you have a pace maker? **Y / N** Have you ever had any Hip or Knee Replacements Y / **N**

What medications or drugs are you taking? (Check those that apply): Pain Killers ____ Insulin _____ Cholesterol Meds _____
Blood Pressure Meds ___ Muscle Relaxers ___ Birth Control ___ Other: _____

What is your goal in our office? _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to **Dynamic Spine and Rehabilitation Center** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____

Signature of Insured / Guardian Date

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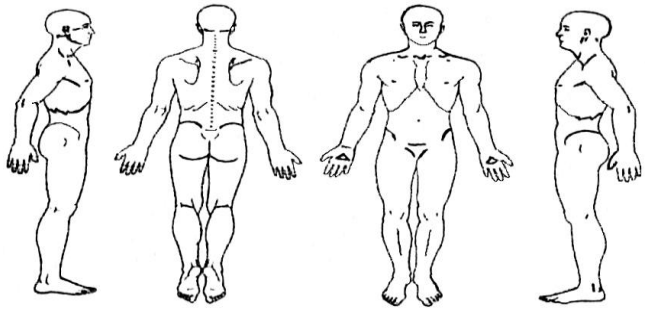
CASE HISTORY

Name: _____

1. Circle the severity (0 = No Pain to 10 = Very Severe Pain) and Frequency of pain (% of the week you experience the pain).

Condition / Problem	Severity (Minimal … Severe)	Frequency (% of week) (Occasional … Constant)
a. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
b. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
c. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
d. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100
e. _____	0 1 2 3 4 5 6 7 8 9 10	0 10 20 30 40 50 60 70 80 90 100

(Please mark the figures where you experience pain.)



2. Symptoms are worse in the (circle what applies)

-morning -Increase during the day
-afternoon -same all day
-night -decrease during the day

3. Symptom (a.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
4. Symptom (b.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
5. When did your symptoms begin (onset date)? _____
6. How did your symptoms begin? _____
7. Have you experienced these before? _____
8. Do your symptoms radiate? _____
9. Has your condition? ____ Improved ____ Gotten Worse ____ Stayed the same since it began
10. Circle the things that make your problems worse:

Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping

11. Is there anything you can do to relieve the problems? ____No ____Yes Describe: _____

If No, what have you tried that has not helped? _____

12. Have you been treated for this before? ____No ____Yes, how long ago? _____
13. What treatment did you receive? _____
14. Results of previous treatment? ____Good ____Poor Comments _____
15. Were you referred to our office by anyone? _____
16. Is this condition interfering with ____ Work ____Sleep ____Daily Routine ____Recreation?
17. List any other major injuries you have had, other than those mentioned above: _____

_____

18. Any other Musculoskeletal problems? ____No ____Yes …Neurological problems? ____No ____ Yes

_____Additional information on back side of sheet.

I certify that the above information is accurate to the best of my knowledge.

Patient/Guardian Signature _____ Date: _____

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Patient Name: _____ **Date:** _____

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this, we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions, please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic doctor, 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 any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at **Dynamic Spine and Rehabilitation Center**, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Missed Appointments:

There is a possible fee charged for all appointments that are not canceled prior to scheduled visit.

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

No one: ____

May we leave messages regarding your personal healthcare information on any answering device, i.e., home answering machines or voicemails? Yes [ ] No [ ]

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____

Signature: _____ Date: _____

Patient Financial Policy

Please read our financial policy in its entirety. If you have any questions or concerns, please feel free to ask any questions that you may have. Your clear understanding of our Patient Financial Policy is important to our professional relationship.

Insurance

We are no longer accepting assignment for insurance policy claims except for Medicare and Medicaid claims.

Your insurance policy is a contract between you and the insurance company. As a courtesy we will provide a Superbill for all services provided. Services that are paid for on the date of service will be awarded a 20% time of service discount. However, we will not become involved in any disputes between you and your insurance carrier.

Medicare

If you are a Medicare patient you will be responsible to pay for your exam on your first visit, at the time of service. While Medicare requires an exam, they do not cover it. Exams are typically $81.25. A 20% time of service discount will be applied to services that are paid for on the date of service.

Supplements/Merchandise

Payments for supplements and merchandise purchased in our office are due at the point of sale. We cannot bill insurance, worker's compensation, or personal injury accounts for these items. These charges are the patient's responsibility and are not covered by any insurance carrier. These items include but are not limited to, Swiss balls, supplements, pillows, braces, heel lifts, orthotics, and cold packs.

Unpaid/Outstanding Balances

We ask that full payment be made at the time of service unless prior arrangements have been made, either with your doctor or our billing office. Services that are not paid for on the date of service will not be eligible for the 20% time of service discount. You may call our billing office to set up a payment plan if necessary. Any overdue balances will be considered for collections.

Returned Checks

The charge for a returned check is $25. This can be paid by cash, money order, or charge. This will be applied to your account in addition to the original amount owed.

Missed Appointments

We ask that you keep all scheduled appointments. In the event that you are unable to keep your appointment we ask that you provide at least a 24-hour notice.

I have read Dynamic Spine and Rehabilitation Center's Patient Financial Policy and acknowledge my responsibility with my signature below.

_____ _____

Patient Name (Please Print) Date

_____ _____

Patient/Responsible Party Signature DSRC Staff Witness

A photo copy of this document will be treated as an original

Dynamic
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2026 Chiropractic Fee Schedule

Effective January 1, 2026, the following fees will change:

Initial Exam:	$81.25 ($65 w/ TOS Discount)
Chiropractic Manipulation:	$45.00 ($36 w/ TOS Discount)
Therapeutic Exercise:	$36.25 ($29 w/ TOS Discount)
Therapeutic Activities :	$36.25 ($29 w/ TOS Discount)

New Patient:	$130
Follow-Up:	$65/visit

*A 20% time of service discount will be applied to all services paid the day of the service. *

***Cancellation fees and policies:**

Cancellations with in a 24 hour period:	$30.00
Failure to cancel (no-shows):	$65.00

***These fees must be paid before you will be allowed to reschedule.**

I have read and understand the above changes to the fee schedule and cancellation policy.

_____ _____

Patient Name (Please Print) Date

_____ _____

Patient/Responsible Party Signature DSRC Staff Witness

A photo copy of this document will be treated as an original.

Dynamic Spine and Rehabilitation Center
Erick Leffler, D.C. Cert. MDT
Aceria Banet-Myers, D.C.
(574)-457-7472

Dynamic
Spine and Rehabilitation Center

Name: _____

Which appointment reminder method would you prefer? Please **ONLY** choose 1.

___ Text Message ___ E-mail

Text Message:

Name of Cellular Carrier: _____

Cellular Phone Number: _____

When would you like your reminder? ___ 30 minutes prior to appointment time

___ 1 hour prior to appointment time

OR ___ 2 hours prior to appointment time

___ 4 hours prior to appointment time

___ 1 day before appointment time

E-mail:

E-mail Address: _____

When would you like your reminder? ___ 30 minutes prior to appointment time

___ 1 hour prior to appointment time

___ 2 hours prior to appointment time

___ 4 hours prior to appointment time

___ 1 day before appointment time

**** These reminders are a courtesy only. The patient is responsible for any applicable fees associated with missed appointments.**