



Morter Institute & HealthCenter

Hello!

Thank you for choosing Morter Institute & HealthCenter for your health care needs. Dr. Sue Morter established our clinic in Indianapolis, Indiana in October 1987. 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

Dr. Andrew Giordano, Doctor of Chiropractic and member of the team since 2011

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

Kris Conlin, Chiropractic Assistant/Front Desk and Insurance

Andrea Townley, Executive Assistant to Dr. Sue Morter

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 kris@morterinstitute.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.

Please bring the following with you to your first visit:

- 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.)

Payment and insurance:

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 will file insurance for our patients; however, we are not “in-network” with the providers. If your policy covers chiropractic, we would be considered an “out-of-network” provider. 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 do not file claims directly to your insurance provider until the Health Insurance Chiropractic Policy form is signed and returned to us.**

We also accept auto accident and Workman Compensation cases.

We currently do not accept Medicare patients.

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 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.

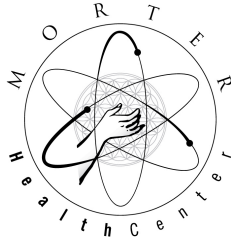
Thank you for choosing

Morter HealthCenter !

Teaching you to live well.

Dr. Sue Morter
Dr. Scott Cooper
Dr. Andrew Giordano
10439 Commerce Drive, Ste 140
Carmel, IN 46032
Phone 317-872-9300 Fax 317-872-9303
www.morterinstitute.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 Phone _____ Cell Phone _____

Email address _____ May we add you to our e-mail list? ____ Yes ____ No

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

Occupation _____

Employer _____

Name of Spouse _____

Spouse's Occupation _____ Employer _____

Spouse's Phone Number _____

Emergency Contact Name & Phone Number _____

Who may we thank for referring you to us? _____

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 me. 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 provide 24 hours notice of cancellation of my appointment.

Patient Signature _____ Date _____

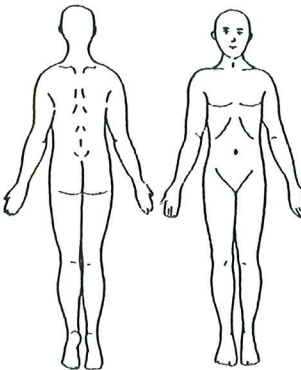
Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can effect your overall diagnosis, treatment plan, and the possibility of being accepted for care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Malaria | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Venereal Infection |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Typhoid Fever | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Measles | <input type="checkbox"/> Goiter | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Eczema |

CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD THE PAST 6 MONTHS:

- | | | |
|--|--|--|
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Stuffy Nose |
| <input type="checkbox"/> Pain Between Shoulders | <input type="checkbox"/> Abdominal Cramps | <input type="checkbox"/> Menstrual Irregularity |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Gas/Bloating After Meals | <input type="checkbox"/> Menstrual Cramping |
| <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Vaginal Pain/Infections |
| <input type="checkbox"/> Joint Pain/Stiffness | <input type="checkbox"/> Black/Bloody Stool | <input type="checkbox"/> Breast Pain/Lumps |
| <input type="checkbox"/> Walking Problems | <input type="checkbox"/> Colitis | <input type="checkbox"/> Prostate/Sexual Dysfunction |
| <input type="checkbox"/> Difficulty Chewing/Clicking Jaw | <input type="checkbox"/> Bladder Trouble | <input type="checkbox"/> Genital Herpes |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Liver Trouble | |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Gall Bladder Problems | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Weight Trouble | |
| <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Painful/Excessive Urination | |
| <input type="checkbox"/> Confusion/Depression | <input type="checkbox"/> Discolored Urine | |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Chest Pain | |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Short Breath | |
| <input type="checkbox"/> Cold/Tingling Extremities | <input type="checkbox"/> Blood Pressure Problems | |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Irregular Heartbeat | |
| <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Heart Problems | |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Lung Problems/Congestion | |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Varicose Veins | |
| <input type="checkbox"/> Poor/Excessive Appetite | <input type="checkbox"/> Ankle Swelling | |
| <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Vision Problems | |
| <input type="checkbox"/> Frequent Nausea | <input type="checkbox"/> Dental Problems | |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Sore Throat | |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Ear Aches | |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Hearing Difficulty | |



Please mark on the diagram the area of your discomfort.

FEMALES ONLY:
When was your last period? _____
Are you pregnant? Yes No Maybe

Why chiropractic? People go to chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (**Relief Care**). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved. (**Corrective Care**). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with chiropractic care (**Comprehensive Care**). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

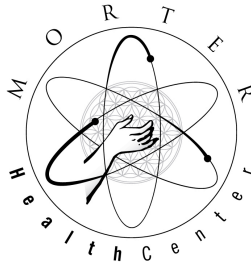
- Relief Care Corrective Care Comprehensive Care Doctor to select type of care appropriate for my condition

I hereby authorize the Doctor to treat my condition as he/she deems appropriate through the use of manipulations, therapy, and such additional procedures as are considered therapeutically necessary in the course of said treatment. I hereby certify that I have read and fully understand this Authorization for chiropractic treatment. It is understood and agreed the amount paid the Doctor, for x-rays, is for examination only, and x-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor any medical diagnosis.

Patient's Signature X _____ Date _____

Guardian or Spouse's Signature Authorizing Care _____ 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 affect 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: _____

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Health Insurance Chiropractic Policy Verification Form

PATIENT'S NAME (PLEASE PRINT) _____

Our office is set up to utilize direct payment from your insurance company. Insurance filing is a service provided as a courtesy to our patients with no additional charge. It is important that you understand, however, that health and accident insurance policies are an agreement between **you and your insurance company**. You are ultimately **responsible** for payment of your account should your insurance company fail to pay. **We require payment in full until your insurance coverage has been verified.**

Morter HealthCenter is currently an out-of-network provider. The following outline will help you to verify the **OUT-OF-NETWORK CHIROPRACTIC COVERAGE** in your policy. **Please contact your insurance company to complete the following questions and return this to the front desk at your next office visit.**

If this is an injury due to an accident, be sure to inform your insurance company. Our staff is ready to help if you have any questions or problems.

Is this accident related?	YES _____	NO _____	If yes, DATE: _____
Is your case Personal Injury?	YES _____	NO _____	
Is your case Worker's Compensation?	YES _____	NO _____	
Is your case Major Medical?	YES _____	NO _____	

OUT OF NETWORK CHIROPRACTIC BENEFITS

DATE you called your insurance company: _____

NAME of person who gave you the information: _____

CALL and ask the following questions:

- Does my policy cover **OUT-OF-NETWORK CHIROPRACTIC**? YES _____ NO _____
If NO, you do not have to continue with the rest of the questions. We will not need to file insurance. You will be a CASH only patient. Sign and date this form and return it to the front desk.
- If **YES**, are there any **LIMITS** to my coverage? YES _____ NO _____
- If **YES**, **WHAT ARE THEY?** (be specific) _____
- Does chiropractic treatment by an out of network provider require pre-certification? _____
- Is there a limit to the **NUMBER** of visits allowable? _____
- What is the **DEDUCTIBLE**? _____
- When does the deductible **START OVER**? _____
- Has the deductible been paid? YES _____ NO _____ How much has been paid? _____
- What **PERCENTAGE** of my bills will my policy cover? _____
- What **PERCENTAGE** of **massage therapy (CPT CODE 97124)** will my policy cover? _____
- What **PERCENTAGE** of **EMS therapy (CPT CODE 97014)** will my policy cover? _____
- What **PERCENTAGE** of **therapeutic exercise (CPT CODE 97110)** will my policy cover? _____
- What **PERCENTAGE** of my **x-rays** will my policy cover? _____
- Are **X-RAYS** subject to the deductible? YES _____ NO _____
- What is the **EFFECTIVE DATE** of my policy? _____
- Can **BENEFITS BE ASSIGNED** to my Chiropractor's office? YES _____ NO _____
- What is the **ADDRESS** where the claims should be sent? _____

NAME: _____

STREET: _____

CITY STATE ZIP: _____

18. To whose **ATTENTION** should it be addressed? _____

19. **INSURANCE CO. NAME:** _____

20. **INSURANCE CO. PHONE NUMBER:** _____

21. **POLICY TYPE:** GROUP INDIVIDUAL

22. **POLICY #:** _____ **GROUP #:** _____

23. **NAME and SOCIAL SECURITY #** of Policyholder: _____

I hereby certify that I have contacted my insurance company and have verified my Medical Coverage.

Date: _____ Patient Signature _____

Pre-Scan Questionnaire

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 *(please list)* _____

Many prescription drugs and muscle relaxers affect the nervous system.

Have you taken any type of prescription medication today?

- No
- Yes *(please list)* _____

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? (Extensive walking, cardiovascular, weightlifting, etc.)

- No
- Yes

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

- No
- Yes

Chemical Balance Questionnaire

Name: _____ Date: _____

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	_____ 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.)	_____ servings	_____ servings
7. Chicken/fish	_____ servings	_____ servings
8. Milk	_____ glasses/times	_____ glasses/times
Other Dairy (cheese, ice cream, etc.)	_____ oz	_____ oz
9. Water	_____ glasses	_____ glasses
10. Fresh fruits	_____ servings	_____ servings
11. Fresh vegetables (non-canned)	_____ servings	_____ servings
12. Pasta, breads (made with white flour)	_____ servings	_____ servings
13. Whole grain foods	_____ servings	_____ servings
14. Artificially sweetened products (Splenda, Sweet-N-Low, Equal, Aspartame, etc.)	_____ servings	_____ servings
15. Fast Food (McDonalds, Hardees, etc.)	_____ times	_____ times
16. Fats (nuts, avocado, coconut, oils, etc.)	_____ times	_____ times
17. Processed Foods (cereals, boxed or frozen meals)	_____ times	_____ times
18. Alcoholic beverages	_____ servings	_____ servings
19. Soft drinks (regular/caffeine-free)	_____ oz	_____ oz
Diet Soda	_____ oz	_____ oz
20. Smoking	_____ packs	_____ packs

Cravings (circle ones that apply): salt sugar chocolate bitter carbs/starches ice

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 _____

Major life changes (divorce, losses, trauma, etc.): _____

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It is important to us that you read and understand our financial policy as it relates to your particular situation. Out-of-network chiropractic care may be covered under your insurance plan.

1. Patients without Insurance (Cash Pay)

Payment is expected at the time of service. We accept cash, personal checks, MasterCard, Visa, Discover and American Express.

2. Premier Plan (Cash Pay)

We offer a pre-paid bundled care plan that allows for a 20% discount on a 12-visit treatment program. By filing your own insurance claims and saving us processing time, we are able to offer our services at a reduced rate. See the premier plan documents in your patient folder.

3. Group or Individual Health Insurance

You must call to verify your health insurance benefits using our Health Insurance Chiropractic Policy Verification Form. This form must be returned to our office by your second visit. If we do not receive this form, we will consider you a Cash Pay patient. The benefits quoted to you by your insurance company are not a guarantee of payment. We collect in full until your insurance begins to pay for claims filed, then payment is expected for any non-covered services, deductibles, co-payments or patient percentages.

4. Personal Injury or Automobile Accidents

Please notify your auto insurance carrier of your visit to our office immediately and complete our Accidental Injury Insurance Information Form for your automobile insurance Med Pay. This form must be returned to our office by the 2nd visit. If this form is not returned, you will be considered a Cash Pay patient. We do not file to at fault payers. If you do not go through the Med Pay portion of your automobile insurance, you will be expected to pay at the time of service and submit to at fault payer. Notify our insurance department immediately if an attorney is representing you. Although you are ultimately responsible for your bill, we will file a lien with your attorney and wait for settlement of your claim for up to six months after your care is completed if an attorney is involved and your Med Pay is exhausted. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

5. “On the Job” Injury (Worker’s Compensation)

If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and have approval from your employer prior to being treated in this office. You must have your employer sign a release (that you receive from your employer) for you to be treated. We also require the name and address of the employer's Workers Compensation insurance carrier. If you suspend or terminate care, any fees and services are due immediately.

6. Medicare

We accept assignment from Medicare for our current patients that transition to Medicare. For Chiropractic treatment, Medicare will cover ONLY manual manipulation of the spine. Medicare does not cover manual manipulation of the spine for maintenance/supportive care. Medicare does NOT cover X-rays, exams, and therapy. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20% as well as any non-covered service at the time of service.

7. Secondary Insurance

Please inform us of any secondary insurance you may have. We will file after primary insurance pays. If your primary insurance sends the checks and Explanation of Benefits (EOB) to you only, you must bring the EOBs into the office in order for us to file with secondary insurance.

I have read and understand the payment policy of Morter HealthCenter. I understand that my insurance is an arrangement between me and my insurance company, **NOT** between Morter HealthCenter and my insurance company. I request that Morter HealthCenter file insurance claims on my behalf. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my treatment plan as prescribed by the doctors at Morter HealthCenter, the charges for services received will be due and payable immediately.

Patient's signature (or guardian if patient is a minor)

Date

