Northern Illinois Chiropractic

PATIENT INFORMATION

Date ______________________________

SS/HIC/Patient ID# ______________________________

Patient Name ______________________________
Last Name

____
First Name Middle Initial

Address ______________________________

City ______________________________

State ______________ Zip ______________

E-mail ______________________________

Sex ❒M ❒F Age ________

Birthdate ______________________________

❒Married ❒Widowed ❒Single ❒Minor

❒Separated ❒Divorced ❒Partnered for ____ years

Occupation ______________________________

Patient Employer/School ______________________________

Employer/School Address ______________________________

____

Employer/School Phone (_____) ______________________________

Spouse's Name ______________________________

Birthdate ______________________________

SS# ______________________________

Spouse's Employer ______________________________

Whom may we thank for referring you? ______________________________

INSURANCE

Who is responsible for this account? ______________________________

Relationship to Patient ______________________________

Insurance Co. ______________________________

ID # ______________________________

Is patient covered by additional insurance? ❒Yes ❒No

Subscriber's Name ______________________________

Birthdate ______________ SS# ______________

Relationship to Patient ______________________________

Insurance Co. ______________________________

Group # ______________________________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with

______________________________ and assign directly to
Name or Insurance Company

Dr. ______________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Please print name of Patient, Parent, Guardian or Personal Representative

______________ ______________________
Date Relationship to Patient

PHONE NUMBERS

Home Phone (_____)__________ Cell Phone (_____)__________

Best time and place to reach you ______________________________

IN CASE OF EMERGENCY, CONTACT

Name ______________________ Relationship ______________

Home Phone (_____)__________ Cell Phone (_____)__________

ACCIDENT INFORMATION

Is condition due to an accident? ❒Yes ❒No Date ________

Type of accident ❒Auto ❒Work ❒Home ❒Other

To whom have you made a report of your accident?

❒Auto Insurance ❒Employer ❒Worker Comp. ❒Other

Attorney Name (iff applicable) ______________________________

PATIENT CONDITION

Reason for Visit ______________________________

When did your symptoms appear? ______________________________

Is this condition getting progressively worse? ❒Yes ❒No ❒Unknown

Mark an ***"X"*** on the picture where you continue to have pain, numbness or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) ______________

Type of pain ❒Sharp ❒Dull ❒Throbbing ❒Numbness ❒Aching ❒Shooting
❒Burning ❒Tingling ❒Cramps ❒Stiffness ❒Swelling ❒Other

How often do you have this pain? ______________________________

Is it constant or does it come and go? ______________________________

Does it interfere with your ❒Work ❒Sleep ❒Daily Routine ❒Recreation

Activities or movements that are painful to perform ❒Sitting ❒Standing ❒Walking ❒Bending ❒Lying Down

PATIENT HISTORY

❐ I would like to have electronic access to my health information

What treatment have you already received for your condition? ❐Medications ❐Surgery ❐Physical Therapy ❐Chiropractic Services ❐None ❐Other ________________

Name and address of other doctor(s) who have treated you for your condition________________

Date of Last: Physical Exam________ Spinal X-Ray________ Height________

Spinal Exam________ Chest X-Ray________ Weight ________

Dental X-Ray________ MRI, CT-Scan, Bone Scan________________

Place a mark on ***"Yes"*** or ***"No"*** to indicate if you have had any of the following:

Condition			Condition			Condition		
Allergy Shots	❐Yes	❐No	High Blood Pressure	❐Yes	❐No	Prostate Problem	❐Yes	❐No
Anemia	❐Yes	❐No	High Cholesterol	❐Yes	❐No	Prosthesis	❐Yes	❐No
Arthritis	❐Yes	❐No	Kidney Disease	❐Yes	❐No	Psychiatric Care	❐Yes	❐No
ASTHMA	❐Yes	❐No	Liver Disease	❐Yes	❐No	Rheumatoid Arthritis	❐Yes	❐No
Bleeding Disorders	❐Yes	❐No	Migraine Headaches	❐Yes	❐No	Stroke	❐Yes	❐No
Bronchitis	❐Yes	❐No	Miscarriage	❐Yes	❐No	Thyroid Problems	❐Yes	❐No
DIABETES	❐Yes	❐No	Multiple Sclerosis	❐Yes	❐No	Tonsillitis	❐Yes	❐No
Emphysema	❐Yes	❐No	Osteoporosis	❐Yes	❐No	Ulcers	❐Yes	❐No
Epilepsy	❐Yes	❐No	Pacemaker	❐Yes	❐No	Vaginal Infections	❐Yes	❐No
Fractures	❐Yes	❐No	Parkinson's Disease	❐Yes	❐No	Other ________		
Gout	❐Yes	❐No	Pinched Nerve	❐Yes	❐No	________		
Heart Disease	❐Yes	❐No	Pneumonia	❐Yes	❐No	________		
Hernia	❐Yes	❐No	Polio	❐Yes	❐No	________		

EXERCISE
❐None
❐Moderate
❐Daily
❐Heavy

WORK ACTIVITY
❐Sitting
❐Standing
❐Light Labor
❐Heavy Labor

ARE YOU PREGNANT?
❐Yes
❐No
Due Date: ________________

SMOKING
❐YES
❐NO

ETHNICITY
❐White ❐African American ❐Hispanic ❐Asian ❐American Indian ❐Other ________ ❐Preferred Language ________

INJURIES/SURGERIES

	Description	Date
Falls	________	________
Head Injuries	________	________
Broken Bones	________	________
Dislocations	________	________
Surgeries	________	________

MEDICATIONS	ALLERGIES TO MEDICATIONS	VITAMINS/HERBS/MINERALS
________	________	________
________	________	________
________	________	________
________	________	________

Pharmacy Name ________________

Pharmacy Phone (______)________________

DOCTOR USE ONLY: Blood Pressure: ________________

FINANCIAL POLICY

As a courtesy to our patients, we offer the following billing options.
Please initial the one that applies to you and sign below.

PRIVATE PAY
____ I will pay for all services, as they are rendered, and submit my own insurance claims.

GROUP HEALTH/PPO
____ I would like to assign my benefits to your office and have you submit my insurance claims for me. I will pay for initial services rendered and any co-payment for subsequent services. If my deductible has not been met, I will pay the full amount until it is met. I understand that if my insurance company does not pay the balance within 45 days of submission, I am responsible for the entire balance overdue.

AUTO ACCIDENT/PERSONAL INJURY
____ I was involved in an automobile accident/personal injury and would like to assign benefits to your office and have you submit all charges to my insurance company for me. I will sign all liens necessary to protect your office. I also understand that regardless of settlement, I am personally responsible for the entire balance. If for some unforeseen reason your office is not paid within 45 days of claim submission, I will personally pay the entire overdue balance.

WORKERS COMPENSATION
____ I was involved in an injury at work. I will see to it that all appropriate paper work is filed by my employer (i.e. accident report, etc.). I understand that it is my right as an Illinois citizen to have any bills incurred as a result of a work related accident paid for. I will read the Illinois worker's compensation pamphlet to better understand my rights. If after 60 days my claim is not paid, I will personally pay the overdue balance. I understand that if this is the case, my rights may have been violated and I have the option to seek legal counsel.

MEDICARE
____ I am a Medicare participant. I understand that your office accepts assignment of benefits for Medicare.

____

Patient Signature *Date* *Witness Signature*

FEDERAL HIPPA PATIENT PRIVACY ACT
Consent for Use or Disclosure of Health Information
Our Privacy Pledge

We are very concerned with protecting your privacy. While law requires us to give you this disclosure, please understand that we have and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practices for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (S 164.520). We reserve the right to change our privacy practices; we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have a right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. ________________
Initials

Appointment Reminders and Health Care Information Authorization

Your chiropractor and members of the practice staff may need to use your name, address, and phone number to contact you with appointment reminders, information about treatment alternatives, or other health-related information that may be of interest to you. If this contact is made by phone and you are not home, a message will be left on your answering machine. We may also send an appointment reminder postcard to your home. By signing this form, you are giving us authorization to contact you with these reminders and information.

I authorize you to use or disclose my health information in the manner described above. ________________
Initials

______________________________________ ______________________
Patient name printed (or personal representative) Date

______________________________________ ______________________
Patient signature (or personal representative) Authorized Provider Representative

____
Description of personal representative's authority to act for the patient