# Insurance Information

*Orland Park Chiropractic*
*And Sports Rehabilitation*

10751 West 143rd Street
Orland Park, IL 60462
708-460-8688

Patient Name: _____ Today's Date: _____

**Insured's Information:**

Name: _____

Address: _____ City: _____ State: _____

Zip: _____ Phone (home): _____ E-Mail: _____

Date of Birth: _____

Occupation: _____ Employer _____

Phone (work): _____ Insured's Soc. Sec. # _____

Insured's relationship to patient: _____

Insurance Company: _____ Phone: _____

## GENERAL CONSENT FOR TREATMENT AND RELEASE OF INFORMATION

I certify that the above information has been accurately answered.

I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payors and / or health practioners.

I hereby authorize the Doctor to examine and treat my condition as he deems appropriate through the use of Chiropractic Health Care and I give authority for these procedures to be performed. I understand that in some cases these procedures will be carried out by staff other than the physician, but that they will be under the supervision of the physician in this facility.

I understand all original x-rays remain on file in the clinic. If they need to be used for an outside consultation, a digitial copy of the images will be produced and copied onto a CD that I can take to my outside doctor for review. The fee for an imaging CD is $5.00 and must be paid in advance. 72 hours notice is required for imaging duplication.

By signing below, I authorize the Doctors of Orland Park Chiropractic to carry out all verbally authorized care.

**Signature:** _____ **Date:** _____

# Patient History

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TODAY'S DATE: _____ E - Mail: _____

NAME: _____ HOW WOULD YOU LIKE TO BE ADDRESSED? _____

DATE OF BIRTH: _____ AGE: _____ GENDER: _____

YOUR ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ SS #: _____ HOME #: _____

YOUR OCCUPATION: _____ WK #: _____

EMERGENCY CONTACT _____ PH #: _____ CELL #: _____

MARITIAL STATUS **S M W D** How Were You Referred To Our Office?: _____

HOW MANY CHILDREN DO YOU HAVE? _____ WHAT ARE THEIR AGES? _____

HAVE THEY OR ANY OTHER MEMBERS OF YOUR FAMILY RECEIVED CHIROPRACTIC CARE? ❑ Yes ❑ No

HAVE YOU EVER HAD CHIROPRACTIC CARE? ❑ Yes ❑ No HOW LONG HAS IT BEEN? _____

THE PURPOSE OR REASON FOR THIS APPOINTMENT? _____

HOW OFTEN DO YOU DRINK ALCOHOLIC BEVERAGES? _____

DO YOU SMOKE? ❑ Yes ❑ No HOW MUCH? _____

DO YOU EXERCISE ❑ Yes ❑ No HOW OFTEN? _____ TYPE? _____

**DO YOU HAVE ANY ALLERGIES?** (SPECIFY): _____

HAVE YOU EVER SUFFERED FROM OR BEEN DIAGNOSED AS HAVING: (CIRCLE YES OR NO FOR EACH)

| | | | | | |
|---|---|---|---|---|---|
| Y N | *Broken or Fractured Bones | Y N | *Osteoarthritis | Y N | Eating Disorder |
| Y N | Circulatory Problems | Y N | Epilepsy | Y N | Alcoholism |
| Y N | *Rheumatoid Arthritis | Y N | Pacemaker | Y N | Drug Addiction |
| Y N | Seizures/Convulsions | Y N | Strokes | Y N | HIV Positive |
| Y N | A Congenital Disease | Y N | *Cancer | Y N | Gall Bladder |
| Y N | Excessive Bleeding | Y N | Ulcers | Y N | *Head Problems |
| Y N | High/Low Blood Pressure | Y N | Ruptures | Y N | Depression |
| Y N | *Diabetes | Y N | Coughing Blood | Y N | Tumors |

* Explanation: _____

WHEN WAS YOUR LAST PHYSICAL EXAM? _____

WHEN WAS THE LAST TIME YOU WERE INVOLVED IN AN ACCIDENT OF ANY KIND? _____

**FOR DOCTOR'S USE ONLY**

❑ GENERAL

INJURY TYPE:

❑ NDRA

DRUG ALLERGIES:

❑ SEE MEDS ADDENDUM

## MEDICATION LIST

| NAMES OF MEDICATION | NAMES OF VITAMINS | NON-Rx STRENGTH | Rx STRENGTH | DATE STARTED | DATE STOPPED | WHO PRESCRIBED DR. / SELF | |
|---|---|---|---|---|---|---|---|
| | | | | | | D | S |
| | | | | | | D | S |
| | | | | | | D | S |
| | | | | | | D | S |
| | | | | | | D | S |

**Orland Park Chiropractic**
**10751 West 143rd Street**
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**708.460.8688**

# Financial Policy

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment. If my insurance requires a referral from my primary physician (**HMO policy**), I understand that I am responsible for payment if I do not obtain a referral.

I understand I am responsible for payment of all deductibles, co-payments / patient portions related to my care. **I understand my portion is due and will be paid at the time services are rendered.** If my balance is not paid in a timely manner, I promise to pay any and all collection, court, and attorney's fees in the collection of my account. I further understand if my treatment is associated with a personal injury or accident claim, all medical bills will be paid at 100% of the fee schedule regardless of the outcome of my case. I understand if a check or debit is returned for insufficient funds, I will be charged a $25 service charge.

I further understand if my insurance company declines payment, I authorize Orland Park Chiropractic to file claims on my behalf against my insurance company as a method of collection. Additionally, I understand that I will be present at the court date if necessary.

**I have read and fully understand the above financial terms.**

**Signature** _____ **Date** _____

## Assignment and Instruction for Direct Payment To Doctor Private & Group Accident & Health Insurance

I hereby instruct and direct the _____ Insurance Company to pay by check made out and mailed directly to:

**Orland Park Chiropractic**
**10751 West 143rd Street**
**Orland Park, Il 60462**

If my current policy prohibits direct payment to the doctor, then I hereby also instruct and direct you to make out the check to me and mail it to the above address.

I authorize the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

_____ _____
**Name of Policyholder (Printed)** **Signature of Policyholder**

_____ _____
**Signature of Claimant, if other than Policyholder** **Date**

**The following signature indicates the co-payment of my chiropractic treatment would be a financial hardship to me:** _____

Orland Park Chiropractic
10751 West 143rd Street
Orland Park, IL 60462
708.460.8688
www.orlandparkchiropractic.com

# Notice of Privacy Practices

## This Notice Describes How Medical Information About You May Be Used And Disclosed And How You Can Get Access To This Information.
## Please Review This Notice Carefully.

**EFFECTIVE DATE:** This Notice is in effect as of ____/____/20____.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, to be kept confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. For example, another physician treating you may need to know the results of your examination and treatments rendered at this office.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be us sending a bill and records of your treatment to your insurance company for payment.
- **Health Care Operations** include the business aspects of running our Practice, such as conducting quality assessment and improvement activities, auditing functions, and patient service reviews in order to operate in accordance with applicable law and insurance requirements. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may disclose your health information to a business associate if we obtain a satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your information. A business associate is an entity that assists us in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers

We may disclose your health information to a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

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# Notice Of Privacy Practices Acknowledgement

I understand under the Health Insurance Portability & Accountability Act of 1996 ("*HIPAA*"), I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers, who may be involved in my treatment directly or indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as assessments and physician certifications.

I acknowledge I was provided a copy of the *Notice of Privacy Practices* and I have read and understand them or I declined the opportunity to read the *Notice of Privacy Practices*. I understand this organization has the right to change its *Notice of Privacy Practices* from time to time and I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

**I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.**

**Patient Name (Printed)**_____

**Parent, Guardian or Patient's Legal Representative**_____

**Signature**_____

**Date**_____

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SEVEN YEARS

**OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement on this *Notice of Privacy Practices Acknowledgement*, but was unable to do so as documented below:

| Date: | Initials: | Reason: |
|---|---|---|
| | | |

# Patient History - Chief Complaint

*Orland Park Chiropractic*
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10751 West 143rd Street
Orland Park, IL 60462



**Patient Name:** _____ **Date:** _____

Current E-Mail Address: _____

1. What is your **main complaint?** _____
2. On the scale below, please **circle** the **severity** of your **main complaint** (At its worst)

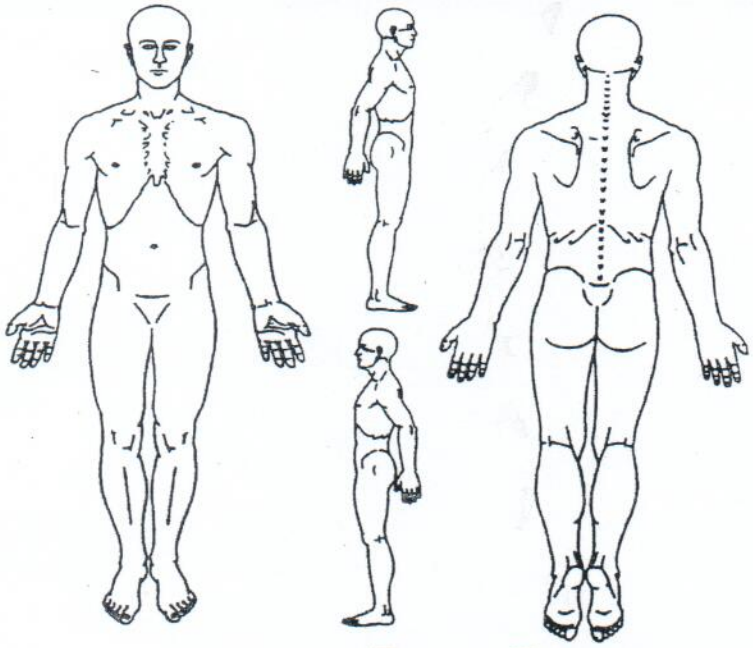
| *None* | | *Slight* | | *Mild* | | *Moderate* | | | *Severe* |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

3. On the scale below please **circle** the **percentage of time** you experience your **main complaint:**

| | *Occasional* | | | *Intermittent* | | | *Frequent* | | | *Constant* | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 0 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 | % |

4. How **long** have you been experiencing your **main complaint?** _____
5. On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters:

**A:** ache **B:** burning pain **C:** cramping **D:** dull pain **R:** throbbing pain **N:** numbness **T:** tingling



6. When do you notice it most? ❑ AM ❑ PM
   How long does it last? _____Mins _____Hrs
7. What makes it feel better? _____
8. What makes it feel worse? _____
9. Have you ever had this problem in the past? Yes No
10. I have ❑ been hospitalized ❑ been treated by another chiropractor ❑ been treated by another specialty provider ❑ never received care for this problem.
11. Have you lost time from work because of it? ❑ Yes ❑ No
    Dates?_____ to _____
12. Are you Pregnant? ❑ Yes ❑ No
13. What was the first day of your last menstrual cycle? _____
14. Number of pregnancies? _____ Miscarriages? _____

Do you have **pain** and/or **difficulty** performing any of the following activities: (Check)

personal care ____
lifting ____
reading ____
concentrating ____
work ____
driving ____
sleeping ____
recreation ____
walking ____
sitting ____
standing ____
social life ____

**Signature:** _____

**Date:** ____/____/____

# Patient History - Systems Review

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**Patient Name:** _____ **Date:** _____

In the left-hand column, please indicate with a (C) Conditions you have now or with a (P) the conditions you have had in the Past. If neither apply, mark (NA), don't leave any blanks.

| | |
|---|---|
| High Blood Pressure | ____ |
| Dizziness/Fainting | ____ |
| Insomnia | ____ |
| Low Resistance | ____ |
| Tension | ____ |
| Confusion | ____ |
| Fatigue | ____ |
| Ulcers | ____ |
| Eye/Vision Problems | ____ |
| Ear/Hearing Problems | ____ |
| Difficulty Breathing | ____ |
| Heart Problems | ____ |
| Loss of Bladder Control | ____ |
| Constipation | ____ |
| Diarrhea | ____ |
| Digestion Problems | ____ |
| Nausea | ____ |
| Female Problems | ____ |
| Prostate Problems | ____ |
| Diabetes | ____ |
| Hands/Feet Cold | ____ |
| Hand Tremors | ____ |
| Loss of Memory | ____ |
| Nervousness | ____ |
| Sweaty Palms | ____ |
| Speech Difficulty | ____ |
| Anxiety | ____ |
| Depression | ____ |
| Irritablility | ____ |

## FOR DOCTORS'S USE ONLY

| DR. REVIEWED | SYSTEMS | SYMPTOMS |
|---|---|---|
| _____ | General | Weight changes, fatigue, anorexia, weakness, fever, chills changes in activity |
| _____ | Skin | Rashes, eruptions, changes in warts or moles, pigmentation changes, bruising, itching, hair loss, nail changes |
| _____ | Head | Trauma, headaches, dizziness, light headed |
| _____ | Eyes | Change in acuity of vision, use of corrective lensed, loss of diplopia, photophobia, blurred vision, scotomata, pain, excessive lacrimation, redness, discharge |
| _____ | Nose | Rhinorrhea, epistaxis, allergies, airway obstruction |
| _____ | Mouth & Throat | Ulcers, tooth pain/extractions, temporomandibular joint (TMJ), pain, gum bleeding, soreness, swelling, enlarged glands, sore throat, strep throat |
| _____ | Neck | Stiffness, lumps/swelling/masses, pain |
| _____ | Lungs | Cough (productive/nonproductive), hemoptysis, dyspnea, pain with respiration, wheezing, night sweats |
| _____ | Cardiac | Palpitations, chest pain, orthopnea, paroxysmal nocturnal dyspnea, ankle swelling, syncope |
| _____ | Vascular | Raynaud's phenomenon, intermittent claudication, hypertension, rheumatic fever |
| _____ | Breasts | Self-examination frequency/results, pain, nipple discharge, lumps/masses, skin dimpling |
| _____ | Gastrointestinal | Unusal diet, sysphagia, regurgitation, dyspepsia, nausia, vomiting, belching, abdominal pain, cramps, hematemasis, stool color changes, diarrhea, sonstipation, change in bowel habits, jaundice, abdominal swelling |
| _____ | Genitournary | Polyuria, nocturia, oliguria, dysuria, uregency, incontinence, urine color changes, hematurea, sexually transmitted diseases, dyspareunia, scrotal mass (male), hernia |
| _____ | Endocrine | Polydipsia, polyphagia, temperature intolerance, tremors, goiter, alopecia, hirsuitism, menstration, history, pregnancy history, dysmenorrhea, premenstrual syndrome, climacteric |
| _____ | Hematopoietic | Anemia, abdominal bleeding, lymph node elargement/pain |
| _____ | Musculoskelatal | Bone/Joint pain, swelling, joint deformity, trauma, restricted range of motion, weakness, atrophy |
| _____ | Neurological | Cranial nerve deficits, seizures, loss of consciousness, paralysis, tremors, staxis, loss of balance, numbness, paresthesia |
| _____ | Psychological | Mood swings, depression, anxiety, phobias |

Please identify all facilities/providers you have seen for these conditions and those you are currently seeing, if any, for your presenting problem(s)

## PROBLEM LIST

| DR NAME/ FACILITY | PROBLEM | TYPE OF TREATMENT RECIEVED | FROM WHEN TO WHEN |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**FOR DOCTORS USE ONLY**

- ❑ Reviewed External H P
- ❑ Release Records H P
- ❑ Request Records H P

EXTERNAL DX'D: _____

DISABILITIES:

IMPAIRMENTS: