JOSEPH HEALTH GROUP

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PAIN & INJURY PROFILE

Please complete this form to the best of your ability.
If you need help our receptionist will be glad to assist you!

Your Info

Full Name_____Address_____

City _____State _____Zip_____

Phone (Home)_____ Phone (Work) _____ Email _____

Phone (Cel) _____ Cel Carrier: Verizon Sprint US Cellular Other: _____ Sex: M | F

Birth _____Social Security# _____ Your Medical Doctor_____

☐ Employed ☐ Student ☐ Other ☐ Employer _____HR Director of Company_____

Emergency Contact _____Phone_____Relationship_____

How did you hear about our office_____

Your Family

Spouse's Name_____ Date Of Birth _____

Name and age of children _____

Your Injury, Illness, or Condition

What is your injury, illness or condition _____

_____

Names of other doctors seen for this condition_____

Type of previous treatment and/or surgery for this condition_____

Results of previous treatment (circle): ☐ Good ☐ Fair ☐ Poor ☐ Other_____

Medications, vitamins and herbs you are presently taking_____

Do you suffer from any condition other than that which you are now consulting us?_____

_____

Have you been treated for any health condition in the last year? ☐ Y ☐ N - If YES please explain_____

_____

Previous Chiropractic Care

Name of chiropractor_____ Condition treated_____

Results of treatment_____Date of last visit_____

Health Problems

Circle conditions you have NOW

Underline conditions you have had PREVIOUSLY:

Low Back Pain	Fractured Bones	Spinal Taps	Fainting
Arm Pain	Dislocation	Scoliosis	Birth Defects
Headaches	Joint Replacement	Diabetes	Osteoporosis
Neck Pain	Metal Screws/implants	High Blood Pressure	Cancer
Pain Between Shoulders	Cervical Whiplash	Stroke	Tumor
Leg Pain	Electronic Implant	Aneurysm	Cyst
Cold/Tingling Fingers or Toes	Pacemaker	Convulsions	Ear Infections
Numbness	Ruptured Spinal Disc	Seizures	Birth Complications
Allergies	Slipped spinal disc	Memory Lapse	Asthma
Loss of Sleep	Pinched Nerve	Dizziness	Bed Wetting
Stomach/Digestive Problems	Spinal Surgery	Concussion	Heart Disease
Walking problems	Spinal Infections	Knocked Unconscious	Fever

Are you Pregnant? ☐ Y ☐ N Other serious illness_____

Criteria to be accepted as a Patient

Unfortunately, we cannot accept everyone as a patient so patients are accepted on a necessity and patient commitment criteria.

1. We must feel your condition is serious enough to necessitate treatment
2. We must feel we will have very favorable results from your treatment.
3. In the event you cannot make an appointment you agree to call in advance to reschedule that appointment.

HIPAA

I have been offered and understand the HIPAA Law.

Patient's Signature (X)_____ Date_____

Treatment Authorization

I hereby authorize this office and its staff and doctors to examine and treat my condition as the doctors deem appropriate and I give authority for these procedures to be performed. I clearly understand and agree that all services rendered me are charged directly to me and that I am responsible for payment of services by this office and all outside laboratory or radiology services performed on my behalf. Should collection of past due amount become necessary, I will become responsible for all charges, fees and attorney fees. I (we) hereby authorize the doctor to release all information necessary to secure payment of benefits. I understand that statements made in any video presentation are made by non-doctors. I authorize the use of this signature on all insurance submissions and I certify my sole purpose of entering this office is for healthcare.

Patient's signature (x)_____ Date_____

NO ACCIDENT OR INJURY

I, _____, hereby state with my signature below that I was not involved in any motor vehicle accident, slip and fall incident, or work related injury. My treatment here at Joseph Health Group/Greater Peoria Physical Medicine & Rehab is in no way associated with any 3rd party, and no other party is responsible or liable for the cost of my treatment; therefore, please process and pay all claims immediately.

Signature (X)_____ Date_____

Consent To Treat a Minor

I (we) being the parents, guardian or custodian of the minor being_____, Age____, do hereby authorize, request, and direct this office, its doctors and staff to perform examinations, diagnostic X-rays, laboratory tests, and any treatment that in their judgment is deemed advisable or is required while said minor child is under care of this office's doctors and staff until legal age. All charges for service and care given to said minor child will be charged directly to me (us) and I (we) will be personally responsible for payment of them. I (we) hereby authorize the doctor to release all information necessary to secure payments of benefits. I authorized the use of this signature on all insurance submissions.

Parent, Guardian, or Custodian Signature_____Date_____

Witness_____Date_____

ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN & AUTHORIZATION

I, the undersigned, hereby authorize and direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals and/or other legal entities (payers), which may elect or be obligated to pay benefits to me for any medical conditions, accidents, injuries or illnesses past, present or future (condition) to pay directly to and exclusively in the name of Joseph Health Group/Greater Peoria Physical Medicine & Rehabilitation (Office) such sums as may be owing to Joseph Health Group/Greater Peoria Physical Medicine & Rehabilitation for charges incurred by me at the office. I further grant a contractual lien to Joseph Health Group/Greater Peoria Physical Medicine & Rehabilitation with respect to my charges, applicable to all payers, however, I understand that nothing in this Agreement shall be construed as an election by Joseph Health Group/Greater Peoria Physical Medicine & Rehabilitation to claim protection under any statutory lien law. For the purposes of this Agreement, benefits shall include, but not limited to, proceeds from any settlement, judgment or verdict, as well as proceeds relating to commercial health or group insurance, lost wage benefits, lost services benefits, attorney retainer agreements, medical payments benefits, personal injury protection, no fault coverage, uninsured and underinsured motorist coverage, 3rd party liability distributions, disability benefits, workers compensation benefits, malpractice proceeds and any other benefits or proceeds payable to me for the purpose stated herein, regardless of whether such proceeds are related to my charges or not.

I further agree that, in the event a payer refuses to pay Joseph Health Group/Greater Peoria Physical Medicine & Rehabilitation, I hereby assign, insofar as permitted by law, all of my rights, remedies and benefits to Joseph Health Group/Greater Peoria Physical Medicine & Rehabilitation to the extent of my charges, as well as any and all causes of action that I might have against such payer, to prosecute such causes or action either in my name or the Office's name, and to settle or otherwise resolve such causes of action as the Office sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I will direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby accept that such letter(s) of protection cannot be revoked or modified without the expressed written consent of this office. I further direct each attorney to provide immediate notice to the office regarding any funds received by the attorney relating to my accident, to promptly pay such Office and to provide full accounting of such funds to the Office upon its request.

I hereby direct all payers to release to Joseph Health Group/Greater Peoria Physical Medicine & Rehabilitation any information regarding any coverage or benefits which I may have including, but not limited to, the amount of coverage, the amount paid thus far and the amount of any outstanding claims.

I authorize this Office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Agreement. I hereby direct this Office to file a copy of this Agreement, together with any applicable charges, with any or all payers, regardless of whether a claim had been established with said payers. I hereby authorize Joseph Health Group/Greater Peoria Physical Medicine & Rehabilitation to endorse/sign my name on any or all checks listing me as a payee, which are presented to this Office for payment of an account relating to me, my spouse and/or dependents. I further authorize Joseph Health Group/Greater Peoria Physical Medicine & Rehabilitation to apply any credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse and/or dependents, regardless of these other charges are related to my condition.

I understand that I remain personally responsible for the total amounts due to this Office for their services. This Assignment & Lien does not constitute any consideration for this Office to await payments and it may demand payments from me immediately upon rendering services at its option. If this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse Joseph Health Group/Greater Peoria Physical Medicine & Rehabilitation for all costs of such collection efforts, including, but not limited to all court costs and all attorney fees.

This Assignment and Lien shall not be modified or revoked without written mutual consent of Joseph Health Group/Greater Peoria Physical Medicine & Rehabilitation and myself. I hereby revoke any previously signed authorizations, whether executed at this office or any other office to the extent that the terms of those authorizations conflict with the terms of this Assignment and Lien.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interest of Joseph Health Group/Greater Peoria Physical Medicine & Rehabilitation and me. However, should any provision of this Agreement be found invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect.

Patient Name (Print) _____

Patient Signature _____ Today's Date _____

Name of Parent/Guardian if patient is a Minor (Print) _____

Parent/Guardian Signature _____ Today's Date _____

Witness _____ Today's Date _____

Informed Consent For Chiropractic Care

Chiropractic care, like all forms of health care, may have some level of risk all while offering considerable benefit. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at the rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to a stroke.

Prior to receiving chiropractic care at this office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you, along with a care plan, prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary and to the chiropractic care (including spinal manipulations).

Patient Name (Signature) _____ **Relationship to Patient** _____

Parent or Legal Guardian Signature _____ **Date** _____