p. 309-693-2225 5001 N University St. Suite A
f. 309-693-2228 Peoria IL 61614

PAIN & INJURY PROFILE

First Name________________________ Last Name________________________

DOB________________________ Sex ☐ Male ☐ Female

Address________________________ City____________ State______ Zip______

Home Phone________________________ CelL Phone________________________

Soc Security Number:________________________ Email:________________________

In order to help determine if you are good candidate for regenerative medicine treatments, please fill in the information below to the best of your ability.

What is your area of greatest pain?________________________

What other areas of your body give you pain?________________________

Have you been given a diagnosis in the past? Yes | No

If yes, what was it?________________________

What made you want to do something about your pain today?________________________

Please check any of the following if you have or have had any:

☐ Cancer
☐ Platelet Dysfunction Syndrome
☐ Critical thrombocytopenia
☐ Hemodynamic instability
☐ Septicemia
☐ Consistent use of NSAIDs
☐ Systemic use of corticosteroids
☐ Corticosteroid injection
☐ Tobacco Use
☐ Recent fever or illness
☐ Hemoglobin less than 10 g/dl
☐ Platelet count under 105 g/dl
☐ Arthritis
☐ Kidney/Liver Disease
☐ Metabolic Disease
☐ Osteoporosis
☐ Sleeping Disorders
☐ Ulcers
☐ Acid Reflux Disease
☐ Numbing/tingling arms/hands
☐ Pain in legs
☐ Pain in feet
☐ Digestive problems
☐ Carpal Tunnel Disorder
☐ Diabetes
☐ Fibromyalgia
☐ Bone/Joint Problems
☐ Heart Disease
☐ Immune System Disease
☐ Gastrointestinal Disease
☐ Hypertension
☐ Lung/Pulmonary Disease
☐ Migraines
☐ Stroke
☐ Neuromuscular Disease
☐ Low back pain
☐ Neck pain
☐ Tension/Headaches
☐ Other: ____________

Which of the above bothers you the most?________________________

What activities would you like to do if this was not a problem?________________________

What have you tried to relieve/get rid of this problem? (Circle all that apply)

Medications
Exercise
Nothing
Physical Therapy
Nutrition
Other________________________
Chiropractic Care
Stretching

Name (print)________________________**Signature**________________________**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 Greater Peoria Physical Medicine & Rehabilitation (Office) such sums as may be owing to Greater Peoria Physical Medicine & Rehabilitation for charges incurred by me at the office. I further grant a contractual lien to 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 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 Greater Peoria Physical Medicine & Rehabilitation, I hereby assign, insofar as permitted by law, all of my rights, remedies and benefits to 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 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 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 dependants. I further authorize 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 dependants, 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 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 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 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____________________________

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 & Hishon Chiropractic & Acupuncture Center 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___________________________________