PATIENT PROFILE

DATE: _____

Last Name _____ First Name _____

Address _____ Birthdate _____ Gender: _____

Email _____ City / ST / Zip _____

Employer: _____ Phone: (H) _____ (C) _____

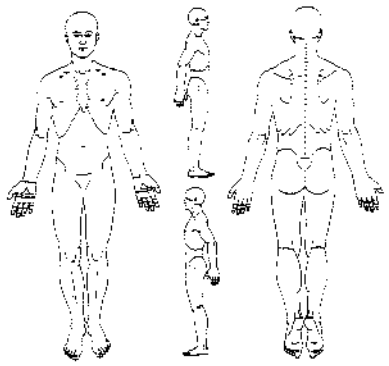
Employer Phone: _____ Reminders: Text Email Phone Call

Note to our patients: Please complete this 2-sided questionnaire as thoroughly as possible in order to aid your clinician in their diagnosis and treatment. This is a confidential record of your medical treatment and will not be released, except when you

PRESENT HEALTH CONCERNS

Please list most important health concerns in order of	Prior diagnosis of this problem?
1.	
2.	
3.	
4.	
5.	

Indicate painful or distressed areas:



What goals do you have for your visit at the clinic today? _____

_____

Have you ever consulted a Naturopathic physician, and acupuncturist, a nutritionist, a chiropractor or a counselor before?

PLEASE CIRCLE ALL THAT APPLY

Do you have any questions about our clinic or the care that you've chosen today? _____

_____

Please list prescription medications you are currently taking, with dosages (if possible):

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Please list vitamins, minerals, herbs, homeopathic remedies you are currently taking, with dosages (if possible):

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Please list any severe or life-threatening allergies: _____

Personal Habits

Please circle any of the following substances that you use r **Tobacco** **Coffee/black tea/soda**

Alcohol **Recreational drugs**

Do you follow any particular diet regimens or restrictions? If yes, please describe: _____

_____

Do you exercise regularly? **YES** or **NO** (circl What type? _____

How long? _____ How often? _____

Past Medical History

Hospitalizations: _____

_____

Serious Illnesses and injuries: _____

_____

Date of last physical / annual exam: _____ Date of last blood tests: _____

Personal and Family History

Please check the "YES" box next to each condition that applies to you or one of your family members. Please note whether the condition applied to you or your family member in the past by denoting a "P for past or "C" for current. Indicate the relationship or the word "Self" in the relationship column

CONDITION	YES	RELATION	PAST (P) CURRENT (C)	CONDITION	YES	RELATION	PAST (P) CURRENT (C)
Alcoholism / Drug Addiction				Headaches			
Allergies				Heart Disease			
Anemia				Hepatitis			
Arthritis				High Blood Pressure			
Asthma				Kidney Disease			
Cancer				Mental Illness			
Depression				Stroke			
Diabetes				Tuberculosis			
Eczema				Other			
Epilepsy							

Social History

Please circle those that apply: Single/Married/Widow/Widower/Partner

Do you have any children? Yes No Please list ages: _____

How did you hear of us? _____

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INFORMED CONSENT FOR TREATMENT

I, _____, hereby request and voluntarily consent to care and treatment by Orchard Natural Medicine.

I understand that care and treatment provided by Orchard Natural Medicine will not involve the use of drugs or operative surgery, but may include the following: physical exam, venipuncture, PAP smears, laboratory testing, wound dressing, ear cleansing, prescription of therapeutic nutrition and nutritional supplementation, use of botanical medicine (such as teas, alcohol tinctures, capsules, tablets, creams, plaster or suppositories), nutrition counseling, acupuncture, hydrotherapy, massage, chiropractic manipulation, and homeopathic or other alternative remedies. I understand that the foregoing is not an exhaustive list of the care/treatment(s)/procedure(s) that may be provided or recommended by Orchard Natural Medicine. Additionally, I understand that my provider will explain the specific risks and benefits of any treatment(s)/procedure(s) provided or recommended.

I understand that it is my responsibility to keep my provider up to date on all current medication and supplements, and any changes in health information or conditions, including pregnancy or suspected pregnancy, so that my provider can appropriately assess risks and benefits and make informed recommendations for my care.

I understand that I have the opportunity to ask questions and discuss with my provider to my satisfaction:

- my suspected diagnosis or condition;
- the nature, purpose, and potential benefit of any recommended care/treatment/procedure;
- the inherited risks, complications, potential hazards, or side effects of the treatment/procedure
- the probability or likelihood of success;
- reasonable available alternatives to the proposed treatment/procedure; and
- the possible consequences if treatment or advise is not followed and/or nothing is done.

I understand that the providers at Orchard Natural Medicine have been trained in alternative treatment methods, including holistic and natural medicine. Diagnosis and treatment may include some services that are considered non-traditional, non-conventional or alternative medicine and may not be recognized as standard medical practices.

I understand that the U.S. Food and Drug Administration has not fully evaluated or approved nutritional, herbal and homeopathic supplements and therapies that might be provided or recommended by Orchard Natural Medicine; however, they have been widely used in Europe and the U.S. for many years. I understand that, as with drugs, herbal, homeopathic, and other natural remedies, in addition to the side effects described above, may interact with certain allopathic medications or lab tests, or show symptoms due to certain pre-existing disease conditions.

I wish to rely on the providers at Orchard Natural Medicine to exercise judgment in recommending any treatment or procedure that he or she feels at the time, based on the facts then known, is in my best interest. I

understand that if I do not follow a treatment as recommended, I may not get the desired result or may increase chances of an adverse effect.

I understand that the providers at Orchard Natural Medicine are licensed Chiropractic Physicians and that the care and treatment that they will provide is limited to that which is within the scope of practice for Chiropractic Physicians as set forth in the Illinois Medical Practice Act, 225 ILCS 60/1 *et seq*. I understand that the providers at Orchard Natural Medicine also hold degrees in naturopathic medicine, that naturopathic medicine is not a licensed profession in the State of Illinois, and that the care and treatment provided by the providers at Orchard Natural Medicine will be limited to the scope of practice for Chiropractic Physicians. Where appropriate and necessary the providers at Orchard Natural Medicine may refer me to another healthcare provider if they believe that I would benefit from additional treatment that is not within the scope of practice for Chiropractic Physicians.

I acknowledge that no guarantees have been made to me by Orchard Natural Medicine or any of its representatives regarding cure or improvement of my condition, or the results intended from any treatment or procedure.

By signing this form, I voluntarily consent to authorize the providers at Orchard Natural Medicine to provide necessary care and treatment including but not limited to those described above. I intend this consent form to cover the entire course of care and treatment for my present condition and for any future condition(s) for which I seek care and treatment. I understand that I may ask my provider for a more detailed explanation of the risks/benefits of any given treatment or procedure recommended at any time. I understand that I am free to withdraw my consent and to discontinue participation in any treatment or procedure at any time.

I understand that Orchard Natural Medicine will keep a record of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or myself or unless required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of seven years, in accordance with Illinois law, after the date of my last visit.

Signature of Patient or Guardian X_____ Date _____

Printed name or Patient or Guardian _____

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NATURAL MEDICINE

Clinic Policies

Patient Name: _____ Date of Birth: _____

Release of Information
All information provided herein is true and correct; I hereby consent to treatment. I give permission to my provider and staff to release information, verbal and written, contained in my medical record and other related information ONLY to related healthcare providers, assignee's, and/or beneficiaries and other related persons. I have read and understood this release.

Insurance and Bill Payment Information:

1. **Payment is your responsibility:** Knowledge of your insurance policy is very important! We will take a copy of your insurance card when you first come into our office. If there are any changes with your insurance coverage, or if you switch insurance companies, please notify our office. We will submit your insurance claim for you. ***You, however, are responsible to determine whether services provided or to be provided are covered by your insurance.*** Once your claim is submitted to insurance, we are ***unable to change billing or coding to help you get coverage,*** so you need to let the doctor know ***ahead of time*** about a high deductible or no coverage for preventive care services. In any event, you are also responsible for your bill, including any deductible and/or copay, and you must pay any balance not covered by insurance within 30 days of billing. Payment is due at the time of service.
2. **Balance to be paid** with 30 days of billing invoice date sent to you. You may call our office and pay with your credit card (we accept Visa MC AmEx & Discover), or you may send a check.
3. **Unpaid Account:** If payment is not obtainable by credit card or check at the time of services, we will charge you 9% interest on any unpaid balance. Any check returned unpaid will be subject to a $30.00 fee. In the event your account must be sent to collection, you will be responsible for any costs and attorney's fees incurred as a result of any collection action taken.
4. **Missed Appointments:** In the event you cannot make an appointment, please give 24 hours notice. (You may leave messages on our phone recording after hours). If you fail to notify us of your intention to miss an appointment, you authorize us to charge your account $50.00/per 30 minutes. You understand that repeatedly missing appointments will cause us to terminate you as a patient. This fee is in addition to and exclusive from any insurance coverage you may have. This fee will be subject to the collection procedures outlined above.

I understand the terms of payment to the office Orchard Natural Medicine. I authorize payment of medical benefits to my physician. I also consent to the performance of any office procedure or treatment that may be necessary to make an appropriate diagnosis.

I acknowledge that I have read and understood the above information:

Date: _____ Patient or Guardian Signature: _____

Printed Patient Name: _____

FINANCIAL POLICY

2418 West Indian Trail, Suite A
Aurora, IL 60506
Orchardnaturalmedicine.com

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Patient Name: _____ Date of Birth: _____

IF YOU DO NOT HAVE INSURANCE: All payments are expected at the time of service.

FOR PATIENTS WITH INSURANCE: All deductibles and copayments are expected at the time of service or by a mutually agreeable payment plan. We will bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary companies for you. Copayments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you. Your personal balance may not exceed $150.00 at any time or care may be suspended.

Our fees are considered usual, customary, and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

Please check one: I have paid my insurance deductible for the calendar year _____. ☐ Yes ☐ No ☐ Don't know

NON-COVERED SERVICES: Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

PERSONAL INJURY CASES: This office does not bill for third party auto accidents or other liability or lawsuit-related cases. You are responsible for payment at the time of service. We do not accept liens. We will however bill your medical payment portion of your personal auto insurance or your major medical insurance carrier for services related to your personal injury case.

WORKER'S COMPENSATION: If your injury is work-related, we will need the case number and carrier name prior to your visits in order to bill the worker's compensation insurance company.

ASSIGNMENT OF INSURANCE BENEFITS: Patients with insurances, please read and sign below.
I hereby assign all medical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans to Orchard Natural Medicine. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature: _____ Date: _____

If you discontinue care for any reason other than discharge by your provider, all outstanding balances will become immediately due and payable in full by you.

If a payment is returned by your bank or creditor unpaid for any reason, we reserve the right to automatically withdraw that payment in-full by electronic funds transfer from that account or the credit account we have on file, along with an additional fee of $30.00. Any and all financial information provided by you will be protected as part of your Personal Health Information and additionally protected under federal HIPAA regulation and therefore subject to a $10,000 fine to anyone who misuses this information.

I have read, understood, and agreed to the above financial policy for payment of professional fees.
The patient is ultimately responsible for all professional fees.

Signature: _____Date: _____

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Patient Name: _____ Responsible Party Name: _____

Insurance Company: BCBS Aetna Cigna United Healthcare _____
Insurance ID: _____

NOTICE OF NON-COVERAGE OR POSSIBLE NON-COVERAGE UNDER PRIVATE INSURANCE OR HEALTH PLAN

NOTE: ***If your private insurance carrier or health plan doesn't pay for services rendered, you are responsible and you agree to pay.*** Your private insurance carrier or health plan does not pay for everything, even some care that you and/or your health care provider have good reason to think you need. Your carrier or plan does not pay for care that it determines to be "medically unnecessary" or "experimental and/or investigational", even if you or your health care provider deems the care to be necessary or beneficial and its effectiveness substantiated.

To the best of our information at this time (including information that may have been provided by your insurance carrier or health plan), we expect and believe your private insurance carrier or health plan may not pay for the:

- MTPT (Myofascial Physical Therapy) – 99212, 97140-59, 97032, 97125-59, 97110, 97112 or 97530
- CMT (Chiropractic Adjustment) – 99212, 98940, 98941, 98942, 98943
- Hydro-Therapy – 99212, 97032 or 97140
- Acupuncture – 99212, 97810, 97811, 97813, 97814, 97036

In addition to the procedures listed above, we may perform other procedures that we believe are covered by your insurance carrier or health plan, to the best of our information at this time (including information that may have been provided by your insurance carrier or health plan). Prior to the rendering of services, our office staff has shared with you to the best of our ability the information provided by your carrier or plan regarding coverage for these procedures.

HOWEVER, please be aware of the following:

1. Insurance carriers and health plans do not guarantee that they will pay for services even when they have verified coverage prior to the rendering of services. There are some situations in which a plan representative verifies coverage for a service but the company later refuses coverage.
2. Insurance carriers and health plans sometimes provide coverage for a particular service during a period of medical improvement, but at a point at which the carrier or plan determines medical improvement has ceased, the carrier or plan can determine the exact same services to be non-covered. This is often referred to as non-covered "maintenance care". Our office will exercise its best professional judgment by following substantiated treatment protocols. However, health care providers and insurance carriers and plans do not always agree about the exact point at which improvement is maximized for a patient. Therefore, you are aware that your insurance carrier or plan may cover certain services initially, but during the course of treatment may deem the same services to be non-covered. You agree to pay for all such services if your carrier or plan determines them to be non-covered.
3. Insurance carriers and health plans have the right to conduct patient records audits of doctors in their network. These audits often occur after treatment has concluded and/or the carrier or plan has paid the doctor. Following an audit, the insurance carrier or health plan in some cases may determine it should not have paid for certain services because the carrier or plan determines them to be non-covered. In these cases the carrier or plan may demand a refund from the doctor after the carrier or plan has paid the doctor. Please be advised that this office

has made every effort to determine and share coverage information with you to notify you when we in good faith believe a service or services will be non-covered. However, we cannot anticipate every action your carrier or plan may take in the future regarding a post-payment determination of non-coverage. Therefore, you are aware your carrier or plan may pay for certain services by conducting a post-payment audit and demand a refund from this office. You agree to pay for all such services if your carrier or plan determines them to be non-covered.

In light of the above possible reasons for non-coverage for any and all services, we are providing you with the attached fee schedule for services that may or may not be covered by your carrier or health plan, so that you are fully apprised as to all potential out-of-pocket costs. Although we have made our best effort to identify the procedures we believe to be non-covered based on information your insurance carrier or health plan has given us, your carrier or plan may ultimately make a different determination as to coverage. You understand and agree to assume all financial responsibility for payment, regardless of your carrier or plan's ultimate coverage decision for any specific procedure.

The expected approximate cost of the procedure(s) is:

- MTPT: $100
- Hydro-Therapy: $80.00
- CMT: $55
- Acupuncture: $65.00 - $125.00

WHAT YOU NEED TO DO NOW:

- Read this notice so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the procedure listed above.

_____ Option 1: I want the procedure(s) listed above. Orchard Natural Medicine may ask to be paid now, but I also want my private insurance carrier or health plan to be billed for an official decision on payment, which is sent to me on an explanation of benefits. I understand that if my private insurance carrier or health plan does not pay, I am responsible for payment, but I can appeal to my private insurance carrier or health plan by following the directions on the explanation of benefits. If the insurance company does pay, Orchard Natural Medicine will refund payments I made to you, less co-pays, coinsurance, deductibles, or prior account balances.
_____ Option 2: I want the procedure listed above, but do not bill my private insurance carrier or health plan. Payment is expected now, at time of services rendered. I cannot appeal if my private insurance carrier or health plan is not billed.
_____ Option 3: I do not want the procedure listed above. I understand with this choice I am not responsible for payment and I cannot appeal to see if my private insurance carrier or health play would pay.

Signing below means that I have received and understand the notice ***prior to the services being rendered.*** I also intend for this document to serve as a binding agreement between Orchard Natural Medicine and myself that supersedes any document or policy to the contrary, in consideration of my health care provider's agreement to provide care. Orchard Natural Medicine will receive and retain a copy of this Notice.

Signature of Patient or Authorized Representative/Responsible Party	Print Name	Date Signed

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NATURAL MEDICINE

APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Your physician and members of the practice staff may need to use your name, address, phone number, and your clinical records 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 available, a message will be left on your answering machine or with the person answering the phone. By signing this form, you are giving us the authorization to contact you with these reminders and information and to leave a message on your answering machine or with individuals at your home or place of employment.

You may restrict the individuals or organizations to which you health care information is released or you may revoke your authorization to us at any time: however, your revocation must be in writing and mailed to us at our office address. 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. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information, and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health information at any time.

This notice is effective, as of _____. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_____ _____
Patient Name Printed Date

X_____ X_____
Patient Signature Authorized Provider Representative

_____ _____
Personal Representative Print Personal Representative Signature

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

Orchard
NATURAL MEDICINE

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you a copy of our privacy notice, 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 need to use your health information within our practice for quality control or other operational purposes.

Along with this consent form, you will be given a copy of our privacy policies in detail. You have the right to review that notice before you sign this consent form. We reserve the right to review to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by email.

Your right to limit uses or disclosures
You have the right to request that we 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 authorization
You may revoke any of your authorizations 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 a 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. I am also acknowledging that I have received a copy of this consent form and a copy of your privacy notice (Notice of Privacy Practices for Protected Health Information)

Print Patient Name _____

Patient Signature X_____ Date_____

Authorized Provider Representative Signature X_____