PATIENT PERSONAL HISTORY

Date: ____________________

Name: ______________________________ Social Security #: ____________________

Address: ______________________________ City: ____________________ State: ______ Zip: ________

Phone #'s: Home ____________________ Work ____________________ Cell ____________________

E-Mail Address: ______________________________ Your Appointment Reminder: ☐ Home ☐ Work ☐ Cell

Birthdate: ______________ Age: ________ Sex: ☐ M ☐ F Height: __________ Weight: __________ BP: __________

Business/Employer: ______________________________ Type of Work: ______________________________

Check One: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated No. of Children: ______________

Name of Emergency Contact: ______________________________ Phone #: ____________________

Who is responsible for your bill: ☐ Self ☐ Spouse ☐ Parent ☐ Workman's Comp. ☐ Medicare ☐ Auto Insurance

☐ Personal Health Insurance Company: ______________________________ ID #: ____________ Group #: __________

☐ Other ______________________________

CURRENT HEALTH CONDITION

Purpose of this appointment: ______________________________

Other Doctors seen for this condition: ______________________________

When did this condition begin: ______________________________

If disabled from work please give dates: ______________________________ ☐ Job related ☐ Auto related ☐ Other

PAST HEALTH HISTORY (Including fractures, hospitalizations, surgeries or out-patient treatment)

Incident ______________________________ Date ____________

Incident ______________________________ Date ____________

Incident ______________________________ Date ____________

Incident ______________________________ Date ____________

Incident ______________________________ Date ____________

Major Accidents or Falls: ______________________________ Date ____________

Medical Doctor's Name & Approx. Date of Last Visit ______________________________

Previous Chiropractic Care: ☐ No ☐ Yes, Provide Drs. Name & Approx. Date of Last Visit ______________________________

____

Have you been treated for any health condition in the last year? ☐ No ☐ Yes, please explain: ______________________________

____

Are you currently taking any medications? ☐ **Yes** ☐ **No** If yes, please list (Use back side of sheet if needed)

____

Are you allergic to any medications or anything else? ☐ **Yes** ☐ **No** If yes, please list (Use back side of sheet if needed)

____

How did you hear about us? ______________________________ ☐ Referral (please provide name) ______________________________

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However these questions must be answered carefully as these problems can effect your overall diagnosis, treatment plan and possibly of being accepted for care.

CHECK THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Appendicitis
- ☐ Malaria
- ☐ Chicken Pox
- ☐ Alcoholism
- ☐ Scarlet Fever
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Venereal Infection
- ☐ Diptheria
- ☐ Whooping Cough
- ☐ Cancer
- ☐ Arthritis
- ☐ Typhoid Fever
- ☐ Anemia
- ☐ Heart Disease
- ☐ Epilepsy
- ☐ Pneumonia
- ☐ Measles
- ☐ Goiter
- ☐ Mental Disorder
- ☐ Rheumatic Fever
- ☐ Mumps
- ☐ Influenza
- ☐ Lumbago
- ☐ Polio
- ☐ Small Pox
- ☐ Pleurisy
- ☐ Eczema

CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD IN THE PAST 6 MONTHS:

GASTRO INTESTINAL

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Trouble
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

NERVOUS SYSTEM

- ☐ Headaches
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities

MUSCULO SKELETAL

- ☐ Neck Pain
- ☐ Jaw Pain
- ☐ Difficult Chewing/Clicking Jaw
- ☐ Pain Between Shoulders
- ☐ Shoulder Pain ☐ Right ☐ Left
- ☐ Arm Pain/Tingling ☐ Right ☐ Left
- ☐ Low Back Pain
- ☐ Hip Pain ☐ Right ☐ Left
- ☐ Leg Pain/Tingling ☐ Right ☐ Left
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Scar from Surgical Procedure
- ☐ Sciatic Pain

SURGICAL SCAR

If Yes, Where: ________________________________

____

GENITO-URINARY

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

CHEST LUNG HEART

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling

EAR NOSE THROAT

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

MALE/FEMALE

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain/Infections
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Genital Herpes

GENERAL

Is your condition getting progressively worse? ☐ yes ☐ no

Is your condition: ☐ Constant (76 -100%) ☐ Frequent (51 - 75%) ☐ Occasional (26 - 50%) ☐ Intermittent (0 - 25%)

How much has pain interfered with your normal work (Including your job and work at home):

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

☐ Loss of Sleep

Other Concerns: ____

____

____

FEMALES ONLY

When was your last period? ________________________________

Are you pregnant? Yes No Maybe

If Yes or Maybe please check any of the following you are experiencing:

☐ Vaginal Bleeding ☐ Morning sickness (nausea or vomiting) ☐ Headaches

☐ Sciatic Pain ☐ Edema (swelling hands/feet) ☐ Pain or Discomfort

If Pain or Discomfort, where and what kind? ________________________________

____

____

Have you had Multiple Miscarriages? ☐ yes ☐ no

DO NOT WRITE BELOW THIS LINE

Patient Accepted: ☐ Yes ☐ No

Height:__________ Weight:__________ BP:__________ P:__________

____

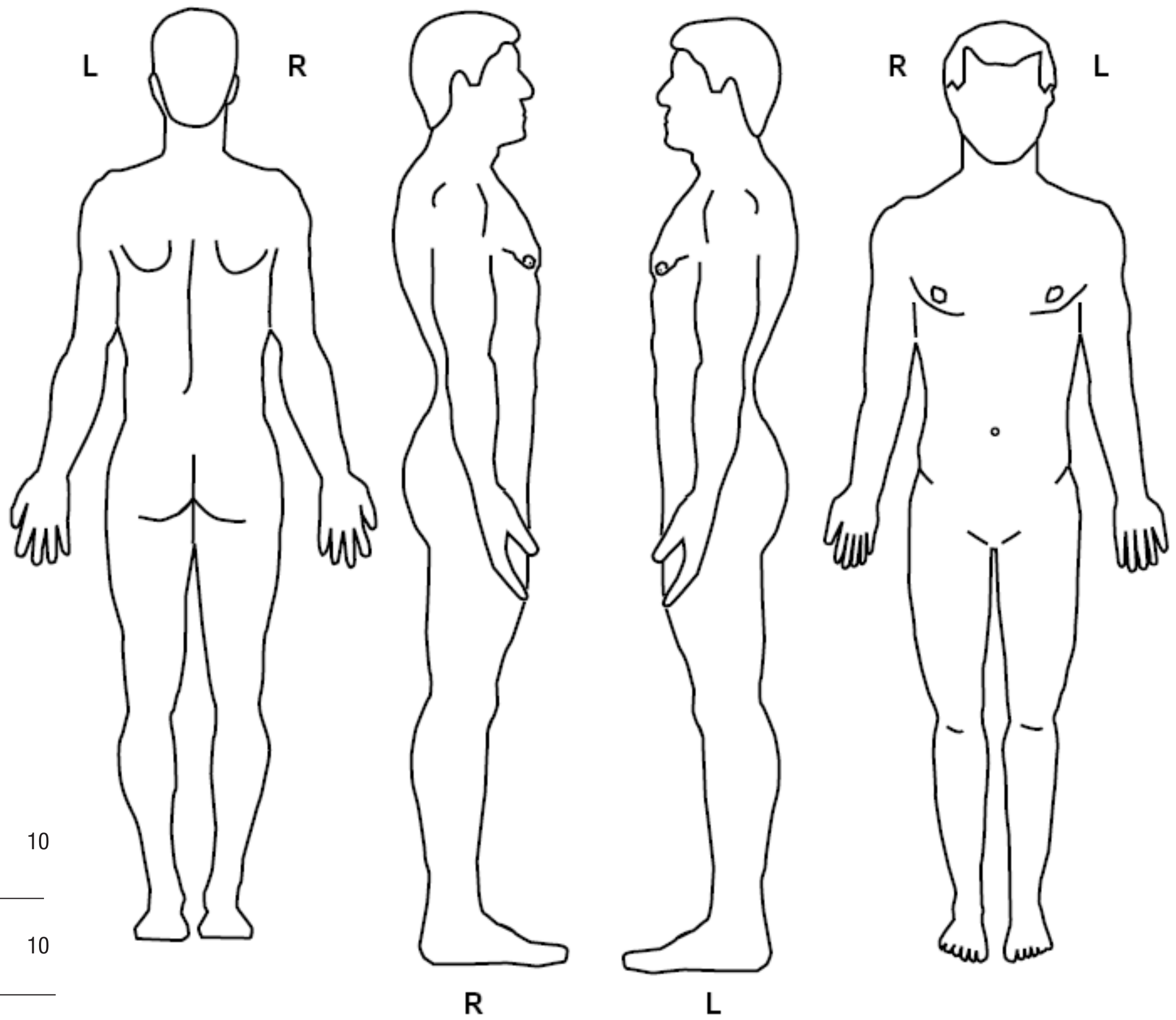
Doctor's Signature Date Patient Name

Current Issues

Name: ______________________ Date: ____________

Please be sure to fill this out accurately. Mark the area on your body where you feel the described sensation(s).

Area	Check One or More if Needed			Left or Right Side	
Headache	☐ Tension	☐ Migraine	☐ Aura	☐ L	☐ R
	☐ >72 Hours	☐ OTC/Meds Help			
Jaw	☐ Click	☐ Lock	☐ Pain	☐ L	☐ R
Neck	☐ Pain	☐ Stiffness	☐ Spasm	☐ L	☐ R
Shoulder	☐ Pain	☐ Stiffness	☐ Spasm	☐ L	☐ R
Arm Radiation	☐ Pain	☐ Tingle	☐ Spasm	☐ L	☐ R
Elbow	☐ Pain	☐ Stiffness	☐ Spasm	☐ L	☐ R
Hand	☐ Pain	☐ Stiffness	☐ Spasm	☐ L	☐ R
Mid-Back	☐ Pain	☐ Stiffness	☐ Spasm	☐ L	☐ R
Low-Back	☐ Pain	☐ Stiffness	☐ Spasm	☐ L	☐ R
Leg Radiation/ Sciatica	☐ Pain	☐ Tingle	☐ Spasm	☐ L	☐ R
Hip	☐ Pain	☐ Stiffness	☐ Spasm	☐ L	☐ R
Knee	☐ Pain	☐ Stiffness	☐ Spasm	☐ L	☐ R
Foot/Ankle	☐ Pain	☐ Stiffness	☐ Spasm	☐ L	☐ R



Visual Analogue Scale

As accurately as possible please circle 1-10 your pain level
with “0” being no pain and “10” being unbearable pain.

a) Right Now	0	1	2	3	4	5	6	7	8	9	10
b) Average Pain	0	1	2	3	4	5	6	7	8	9	10
c) At Best	0	1	2	3	4	5	6	7	8	9	10
d) At Worst	0	1	2	3	4	5	6	7	8	9	10

Natural Care Chiropractic, PC
Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: ______________________ **Patient ID #:** __________

I hereby acknowledge that I have received a copy of Natural Care Chiropractic, PC's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

____
Signature of Patient or Legal Representative

____
Date

____
Printed Name of Patient's Representative (if applicable)

Relationship to Patient (if applicable)

- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

ACCESS TO PATIENT CARE AND PROTECTED HEALTH INFORMATION

☐ **I hereby give permission to the person(s) listed below to inquire about information regarding my medical care. In order to obtain information by telephone, the party calling the practice must share date of birth.****
(Please circle medical or billing per person).

☐ **I do not give permission for my medical information to be shared**

______________________ **Medical / Billing**

______________________ **Medical / Billing**

______________________ **Medical / Billing**

** With this authorization, Natural Care Chiropractic may call home or other designated location and leave a voice mail message, in person or by mail in reference to appointment, labs/test, insurance/billing items, forms, letters, general office correspondence, etc.

- -

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date, ______________________ but acknowledgment could not be obtained because:

- ☐ Patient/representative refused to sign
- ☐ Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a later date)
- ☐ Communication barriers prohibited obtaining acknowledgement (Explain)

____

____

____

☐ Other (Specify) ______________________

____

New Pat. RI15cfd

Doctor-Patient Relationship to Chiropractic — Informed Consent

Natural Care Chiropractic, PC

Chiropractic

It is important to acknowledge the difference between the health care specialties of Chiropractic, Osteopathy and Medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the Chiropractic Doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

Acupuncture

Acupuncture seeks to restore health through the insertion of needles at specific points that lie just below the skin surface.

Analysis

A Doctor of Chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence or Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, Chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the Chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

Diagnosis

Although Doctors of Chiropractic are experts in Chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every Chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your Doctor of Chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

Informed Consent for Chiropractic Care

A patient, in coming to the Doctor of Chiropractic, gives the Doctor permission and authority to care for the patient in accordance with the Chiropractic tests, diagnosis and analysis. The Chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a Chiropractic adjustment, or health care, if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the Doctor of Chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Doctor of Chiropractic provides a specialized, non-duplicating health service. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

Results

The purpose of Chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the Chiropractic procedures. Sometimes the response is phenomenal. In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same Chiropractic care. Many medical failures find quick relief through Chiropractic. In turn, we must admit that conditions which do not respond to Chiropractic care may come under the control or be helped through medical science. The fact is that the science of Chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have great strides in alleviating pain and controlling disease.

To the Patient

Please discuss any questions or problems with the Doctor before signing this statement of policy.

I have read, and understand the foregoing.

Patient's Signature Date

Financial Agreement

The undersigned agree that **FULL PAYMENT** of the patient's portion of charges is **DUE AT THE TIME OF SERVICE.** Natural Care Chiropractic is required to collect co-pays and deductibles.

With respect to the remainder of the fee, we both acknowledge that YOUR INSURANCE POLICY is a contract between you and your insurance company. We are **NOT** a party to that contract unless we are a participating provider. We file claims as a courtesy for our patients.

IT IS TOO DISRUPTIVE TO OUR DELIVERY OF HEALTHCARE to be involved in disputes between you and your insurance company i.e., involving deductibles, co-payments, whether our services are covered charges, secondary insurance or your insurance company's definition of "usual and customary charges." Of course, we will provide all factual information as you have authorized us to do. You will need to do your part in pursuing your rights under your insurance contract.

NORMALLY, after this office receives insurance benefits and appropriate managed care or Medicare reductions have been applied, you will be asked to forward payment of any remaining balance due **WITHIN THIRTY (30) DAYS**. Reductions do not apply to co-pays and/or portions of balance applied to deductibles.

Insurance Companies make questionable, unexplained determinations of what are usual and customary fees. These are methods of cost containment. Rest assured, Natural Care Chiropractic's charges are well within the norm of usual and customary fee schedules.

Even though you have insurance coverage, **YOU ARE RESPONSIBLE FOR THE TIMELY AND FULL PAYMENT OF YOUR ACCOUNT.** Payment plans may be established for balances over $500.00. Natural Care Chiropractic accepts cash, checks, Visa, MasterCard and Discover.

You may get an Explanation of Benefits Form (EOB) from your insurance carrier which indicates that our healthcare services are "Experimental" "Maintenance" "Not Medically Necessary" or "Not Covered" under your insurance policy. **YOU HEREBY ACKNOWLEDGE THAT YOU ARE STILL RESPONSIBLE FOR PAYMENT OF THESE SERVICES.**

IF WE RECEIVE A CHECK MADE PAYABLE TO YOU, for payment of our healthcare services rendered, you hereby authorize us to deposit said check when received.

Further, **IN THE EVENT THAT YOUR INSURANCE COMPANY PAYS YOU DIRECTLY** for our healthcare services, you hereby agree to immediately pay this office for same.

Natural Care Chiropractic, P.C., will charge a **$30.00** fee for all returned checks due to "NON-SUFFICIENT FUNDS" or "CLOSED ACCOUNT" status.

Natural Care Chiropractic, P.C., reserves the right to turn all delinquent accounts over to a collection agency and /or pursue all legal avenues to collect its fees for healthcare services. You agree to pay all legal fees and other costs associated with our collection activity.

Finally, our professionals and the management of Natural Care Chiropractic believe that appointments are a mutual benefit to and a mutual obligation of both Natural Care Chiropractic and its patients. Appointments allow our professionals to provide individual, quality care to each and every patient and to provide adequate time to perform scheduled procedures. You are provided the reserved time and attention of the doctor, therapists and support staff, generally at a time that you have previously selected. Our office will call and verify your appointment(s) as a courtesy to you. You are responsible for arriving to your appointment on time. ***Notice must be given for any cancellation of nutrition and/or therapy appointments at least 24 hours in advance. SHORT NOTICE CANCELLATIONS will be charged payable by you.***

THANK YOU FOR YOUR COOPERATION, NATURAL CARE CHIROPRACTIC, P.C. By: ________________________________

Mark J. Freund, D.C.-Its President

I have read and BEEN GIVEN A COPY of this Natural Care Chiropractic, P.C., Financial Agreement. I hereby acknowledge that I have been given an opportunity to discuss the Financial Agreement with Dr. Freund. I understand that my signature on this Financial Agreement acknowledges my duties to pay as stated above and I hereby agree to the same. Natural Care Chiropractic, P.C., reserves the right to change its financial policy if it is deemed necessary.

_____ **WELLNESS MAINTENANCE** I will pay all charges at time of service as they are rendered. If applicable, I will submit my own expenses to my HSA or MSA.

_____ **INSURANCE** I would like to assign my benefits to your office and have you submit my insurance claims for me, either in-network or out-of-network participation. 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 in the case, my rights may have been violated and I have the option to seek legal counsel.

_____ **MEDICARE** I am a Medicare participant and will pay for services as they are rendered. I understand that your office does not accept assignment of benefits for Medicare but will submit all charges to Medicare for me.

Print Patient Name ______________________________ Signature ______________________________ Date____________________