Patient Information

ACUCARE Total Health

❒ New Patient ❒ Update on Current Patient

Name _____ Date of Birth _____/_____/_____
First M.I. Last

Mailing Address _____
street apt city state zip

Home Phone _____-_____ Cell Phone _____-_____ Work Phone _____-_____
❒ Primary ❒ Secondary ❒ Primary ❒ Secondary

Is it ok to leave messages regarding appointments and/or medical information? ❒ Yes ❒ No

❒ Male ❒ Female ❒ Single ❒ Married Spouse/Significant Other _____

EMAIL address _____

Is it ok that AcuCare Total Health uses your email for appointment reminders: ❒ Yes ❒ No

Emergency Contact _____ Phone _____-_____ Relation _____

Primary Care Physician_____

How did you hear about our practice? ❒Physician ❒Internet ❒Insurance Website ❒Friend/Family ❒Other

Please Specify _____

Insurance Carrier Information – Please Provide Card(s) to Front Desk

Primary Insurance _____ Secondary Insurance_____ OR ❒ Self Pay

Guarantor- Who Carries Insurance

❒Self ❒Parent ❒Spouse ❒Responsible Party (describe relationship to patient) _____

Name _____ Date of Birth _____/_____/_____
First M.I. Last

Address _____
❒Same as above street city state zip

Home Phone _____-_____ Cell Phone _____-_____ Work Phone _____-_____

Auto / Worker's Compensation

Is this injury due to an accident/injury on the job or auto: ❒ Yes ❒ No

❒Auto ❒Worker's Comp ❒Other _____ **Please fill out paperwork provided for full details.**

Patient/Guardian Signature _____ Date_____/_____/_____

If Guardian, relationship to patient _____ Witness _____

Patient Health Questionnaire

ACUCARE Total Health

Patient Name _____ **Date** _____

1. Describe your symptoms: _____

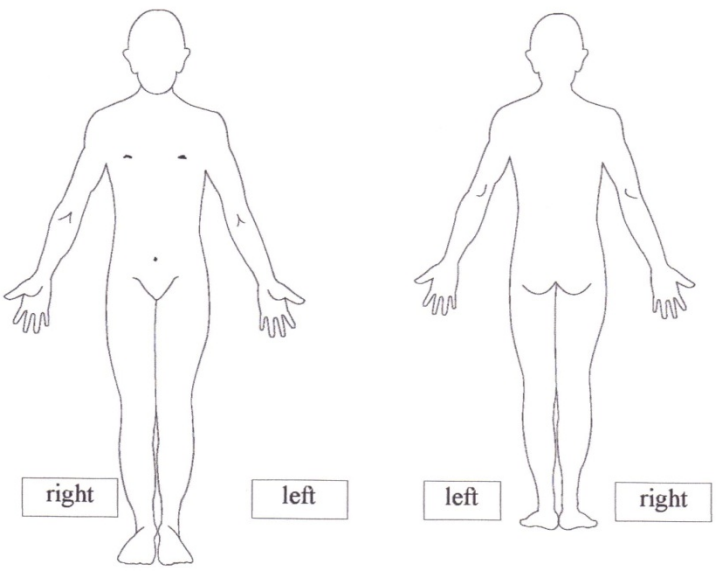
When did your symptoms begin: _____

How did your symptoms start:_____

Are your symptoms due to a work related injury or auto accident? Yes No If so, which one? _____

2. How often do you experience your symptoms? *Indicate where you have pain or other symptoms.*

- Constantly (76-100% of the day)
- Frequently (51-75% of the day)
- Occasionally (26-50% of the day)
- Intermittently (0-25% of the day)



3. What describes the nature of your symptoms?
Please indicate type of pain on the pictures

- Sharp (S)
- Dull ache (D)
- Numb (N)
- Shooting (O)
- Burning (B)
- Tingling (T)

4. How are your symptoms changing?

- Getting Better
- Not Changing
- Getting Worse

5. Regarding your symptoms:

	None										**Unbearable**
a. Indicate the intensity of your symptoms	0	1	2	3	4	5	6	7	8	9	10

b. How much has pain interfered with your normal work (including both work, outside the home, and housework)
Not at all A little bit Moderately Quite a bit Extremely

6. How much of the time has your condition interfered with your social activities?

All of the time Most of the time Some of the time A little of the time None of the time

7. Because of this EPISODE, how has this affected your sleeping? (circle all that apply)

No problem / Hard to go to sleep / Toss and turn all night / Wake up in pain/stiffness / Can't sleep at all in bed

8. Who have you seen for your current symptoms? No One Medical Doctor Other
Other Chiropractor Physical Therapist

a. What treatment did you receive and when?_____

b. What tests have you had for your symptoms and when were they performed? Xrays date:_____ CT Scan date:_____
MRI date: _____ Other date: _____

9. Have you had similar symptoms in the past? Yes No

10. What is your occupation?_____ Professional/Executive Laborer Retired
White Collar/Secretarial Homemaker Other
Employer _____ Tradesperson FT Student

a. What is your current work status if applicable? Fulltime Self- employed Off Work
Part-time Unemployed Other

Patient Signature _____ **Date** _____

Health History

ACUCARE Total Health

Name of other Doctor(s) you see:_____

_____

Date of last: Physical Exam_____ Spinal Exam_____ MRI/CT/bone scan_____

Spinal X-ray_____ Blood/Urine test_____

Mark with an X to indicate if you have/had any of the following. Please also mark any that apply to immediate family, and indicate the relationship to you.

( ) AIDS/HIV	( ) Goiter	( ) Pneumonia
( ) Alcoholism	( ) Gonorrhea	( ) Polio
( ) Allergy Shots	( ) Gout	( ) Prostate problems
( ) Anemia	( ) Heart Disease	( ) Prosthesis
( ) Anorexia	( ) Hepatitis	( ) Psychiatric Care
( ) Appendicitis	( ) Hernia	( ) Rheumatoid Arthritis
( ) Arthritis	( ) Herniated Disc	( ) Rheumatic Fever
( ) Asthma	( ) Herpes	( ) Scarlet Fever
( ) Bleeding disorders	( ) High Blood Pressure	( ) Stroke
( ) Breast Lump	( ) High Cholesterol	( ) STD
( ) Bronchitis	( ) Kidney Disease	( ) Suicide attempts
( ) Bulimia	( ) Liver Disease	( ) Thyroid problem
( ) Cancer	( ) Measles	( ) Tonsillitis
( ) Cataracts	( ) Migraines	( ) Tuberculosis
( ) Chemical dependency	( ) Mononucleosis	( ) Tumors
( ) Chicken Pox	( ) Multiple Sclerosis	( ) Typhoid Fever
( ) Diabetes	( ) Mumps	( ) Ulcers
( ) Emphysema	( ) Osteoporosis	( ) Vaginal Infections
( ) Epilepsy	( ) Pacemaker	( ) Whooping Cough
( ) Fractures	( ) Parkinson	( ) Other:
( ) Glaucoma	( ) Pinched Nerve	

Exercise:	**Work Habits:**	**Other Habits:**	
( ) none	( ) sitting	( ) smoking	Packs/Day_____
( ) mild	( ) standing	( ) drinking	Drinks/Week_____
( ) moderate	( ) light labor	( ) coffee/caffeine	Cups/Day_____
( ) heavy	( ) heavy labor	( ) stress	Reason_____

Pregnancy history: # of pregnancies_____ # of live births_____

# of miscarriages? _____ How many via C-section?_____ Pregnant now?_____ If yes, due date?_____

Injuries/Surgeries you have had	**Description**	**Date**
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS	**ALLERGIES**	**VITAMINS/HERBS/MINERALS**
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4. _____	_____	_____

Patient Name _____ **Date** _____

HIPAA AGREEMENT ACUCARE Total Health

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

_____ acknowledges and agrees as follows:
Patient's Name

The Privacy Notice is a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out it's health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

1. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
2. I understand that, and consent to, the following appointment reminders used by the Practice: a) email; b) a postcard mailed to me at the address provided by me; and c) telephoning and leaving a message on my voicemail/answering machine or with the individual answering the phone.
3. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
4. I understand that I have the right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding to the Practice.
5. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
6. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
7. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.
8. **DISCLAIMER**: Each physician and therapist are professionally licensed in the State of IL and assumes their own liability as tenants of AcuCare Total Health. Each doctor and/or therapist individually participates in various insurance plans. AcuCare Total Health assumes no liability for the treatment of patients performed at 750 Fletcher Dr., Ste 304, Elgin, IL 60123.

INITIALS: _____ In rare circumstances your records may need to be released to someone other than yourself. I authorize the release of information including the diagnosis, records, examination, and claims information rendered to me. This ***Release of Information*** will remain in effect until terminated by me in writing. This information may be released to:

❒ Name: _____ relationship _____

❒ Information is not to be released to anyone.

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.

_____ ____/____/_____ _____
Signature of Patient/Guardian Date Printed Name

_____ _____
If Guardian, relationship to patient Witness

FINANCIAL AGREEMENT ACUCARE Total Health

Please read the following carefully and 'X' the appropriate selection:

IT IS OUR OFFICE POLICY TO COLLECT CHARGES FOR SERVICES AS THEY ARE RENDERED.

_____1. **In Network Insurance-** ACUCARE Total Health will bill your insurance company directly for services rendered in a timely fashion. When benefits are determined, the patient will receive a statement from ACUCARE for the balance due on the account, payable immediately.
_____2. **Medicare-** Medicare pays for only the Chiropractic adjustment and then (after the yearly deductible has been met) only 80% on an amount that they select. Therefore, payment will be made on the account and Medicare will make reimbursements payable to ACUCARE Total Health.
_____3. **Self or Private Pay-** The patient is not utilizing insurance and therefore is responsible for all health care costs at time of service unless otherwise worked out.
_____4. **Auto Accident/Worker's Comp/Personal Injury-** ACUCARE Total Health will bill the insurance company provided directly. Patient is still ultimately responsible if their provider does NOT pay.
_____5. **Out-of-Network Health Insurance-** If the charges for services are not covered by insurance we suggest utilizing self-pay options. Otherwise we will attempt to bill your out of network insurance but payment is due at the time of service.

Cancellation/Missed Note Policy. We understand some circumstances are out of your control and cancellations do occur. It is not our hope to charge a cancellation fee but if there is a trend of consistently missed/cancelled appointments on the day of the appointment we will enforce our cancellation fee at the discretion of the Dr./Therapist. The cancellation fee is $40.00.

AUTHORIZATION FOR PAYMENT STATEMENT

- I hereby assign the benefits that I am eligible to receive for the care rendered in the office to this office. In consideration of this assignment, the office will extend credit. Any balance due will be paid immediately upon receipt of statement.
- I fully understand and agree that insurance policies are an arrangement between the insurance carrier and me. **I will be responsible for any expenses not paid by insurance**. Sometimes the patients insurance company may delay payments and anything beyond 60 days ACUCARE has the right to ask for payment from the patient.
- I hereby authorize the release of any information regarding my health care and treatment.

PATIENT AGREEMENT, IRREVOCABLE ASSIGNMENT OF BENEFITS & RELEASE OF MEDICAL DOCUMENTS

In consideration of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to ACUCARE all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges and outstanding balances regardless of any applicable insurance or benefit payments. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement of any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submission.

I hereby convey to ACUCARE to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chosen in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named clinic and claim and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any attempts by such doctor and clinic to pursue such claim, chosen in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but such doctor and clinic's expense. In the event my account is forwarded to an outside collection agency, I will be held responsible for any additional fees incurred to recover payment.

- **All co-pays, self-pay and insurance deductibles are due at the time of service.**
- **I have read and fully understand this agreement.**

A photocopy of this form shall be as valid as the original and valid until treatment is complete and all accounts are closed.

_____ _____/_____/_____
Patient/Guardian Signature Date

_____ _____
If Guardian, relationship to patient Witness

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper/lower) GI tract was 1219 events/per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____Date:

Parent/Guardian: _____ Signature: _____Date:

Witness Name: _____ Signature: _____Date: