HOLISTIC CHIROPRACTIC & REHABILITATION CENTER (618) 624-9384
4965 STONE FALLS CENTER, #7, O' FALLON, ILLINOIS 62269 FAX: (618) 624-9386

Welcome to Holistic Chiropractic & Rehabilitation Center. All new patients are requested to fill out a personal health questionnaire. The first visit will entail a diagnostic, chiropractic, orthopedic, and neurological examination to determine if chiropractic care is appropriate for your condition. The doctor will advise you as to the need of additional procedures such as laboratory and x-ray tests, if necessary. If your case requires immediate attention, emergency care will be administered. On your follow-up visit the doctor will give a report of findings when she will inform you of the examination results and whether or not your case has been accepted. After receiving a "report of findings," a recommended treatment program will be explained to you. Treatments will begin and continue as scheduled until your condition has been fully corrected, or until the maximum possible improvement has been obtained.

Our providers accept most insurance companies. All claims will be filed for covered services appropriately. Co-payments & deductibles are due when services are rendered. We look forward to you joining our family-oriented practice.

Yours in health,
Holistic Chiropractic & Rehabilitation Center

Patient Evaluation Questionnaire

1) Please rate on a scale of 0 to 10 how serious you are about getting well.
   0 1 2 3 4 5 6 7 8 9 10
   Not serious **Serious**

2) Are you willing to follow a treatment program designed to help you return to health? **Yes** **No**

3) Are you willing to take supplements and make dietary changes? **Yes** **No**

4) Are you willing to start / alter an exercise program? **Yes** **No**

5) Please rate how serious you are about staying healthy.
   0 1 2 3 4 5 6 7 8 9 10
   Not serious **Serious**

6) Please rate your stress level on the scale.
   0 1 2 3 4 5 6 7 8 9 10
   No stress **High Stress**

Reminder Calls

We need written permission to call you and leave a message. We may call you for any number of reasons but the message we will leave will be very similar to the following:

- Just calling to remind you about your appointment tomorrow at 2:00, please call us if there is a problem, we will see you tomorrow.
- Just calling to let you know your test results are in, please call our office for the results.
- Just calling to check on you, we haven't heard from you in a while, please call and let us know how you are doing.

Please check the options that apply below:

☐ Yes, you may leave me a message on my answering machine.

☐ Yes, you may leave me a message with someone at my home.

☐ No, do not leave me any messages.

Contact Number (s): ______________________________

Patient name: ______________________________

Patient Signature: ______________________________

Date Signed: ______________________________

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NEW PATIENT INFORMATION

Please Print all Answers

Name ______ Age ______ Sex ______ Date ______

Address ______ City ______ Zip ______

Phone ______ Work ______ Cell ______

Best time to Call ______ Which # ______ E-mail ______

Social Security # ______ Birthdate ______ Family Doctor ______

Married ☐ Single ☐ Sep ☐ Divorced ☐ Widowed Spouse's Name ______

Employer ______ Spouse's Employer ______

Employer Address ______ Spouse's Birthdate ______

Employer Phone ______ Spouse's Social Security ______

Parent's Employer If Patient Is Minor / Child ______

Parents Social Security # If Patient Is Child ______

Emergency: Who Do We Call? ______ Relationship ______

Name of Relative or Friend Not Living with You ______ Phone ______

HEALTH INSURANCE INFORMATION

Name of Insurance Company ______ Group Number ______

Name of Insured (Policy Holder) ______ Policy Number ______

Insured's Birthdate ______

ACCIDENT INSURANCE INFORMATION

Name of YOUR Auto Insurance Company ______

Agent Name ______ Adjuster's Name ______

Accident Claim Number ______ Phone Number ______

Name of LIABLE Insurance Company ______ Adjuster's Name ______

Claim Number ______ Phone Number ______

Attorney Name ______ Phone Number ______

WORK OR INJURY INSURANCE INFORMATION

Employer or Responsible Party ______

Contact Person ______ Phone Number ______

Please provide the receptionist with your driver's license & insurance card to be photocopied for your permanent medical record.

Welcome to our multi-specialty group practice, offering Holistic medical care, chiropractic, physical therapy, rehabilitation, acupuncture, massage therapy, nutritional & psychological counseling. We will strive to help restore or improve your health but there are no guarantees or promises of improvement or complete recovery. Patients are encouraged to leave valuables at home or with an accompanying family member or friend. This Facility shall not be liable for the loss of or damage to any personal property including, but not limited to money, credit cards, clothing, jewelry, glasses/contacts, dental devices, hearing aids, furs, documents or any other items.

Your signature on this document fully authorizes our staff & doctors to perform any examinations, diagnostic tests &/or treatment as we may consider medically necessary & to release all information pertinent to your health, insurance or benefits to any & all applicable parties on your behalf. Our office and staff are committed to providing all patients regardless of race, color, national origin, age, sex, disability or religious or political beliefs quality health care services delivered with dignity and concern. HIPAA requires that we have you read & sign the federally governed Health Care Privacy Notice. This Notice is detailed on page -3- of this document. The Health Care Privacy Notice will explain when, where and why your confidential health information may be used, stored and/or shared and is a part of this document that is a permanent part of your medical records which is maintained in this office. You may receive a free photocopy of this document that you have signed just by asking one of our staff.

Your signature on this document confirms that you have read, understand and agree to comply with all of the terms & conditions of the Health Care Privacy Notice and all policies, consents, terms & conditions regarding your responsibilities to this Facility and that you grant the physicians, therapists and/or all staff of this Facility to use and share your confidential health information with others in order to treat you and/or in order to arrange for payment of your bill and/or for issues that concern this Facility operations and responsibilities. Please direct any questions or concerns to a member of our staff. We encourage questions and/or concerns to avoid misunderstandings. Office hours allow our patients convenience to schedule appointments before & after work as well as during lunch. If you must miss an appointment please notify us. We are available to immediately see new patients the same day. As a courtesy for you, we may call you on the telephone when an appointment is missed and/or you have not been in for a while. If you do not wish for us to call you or mail you reminder cards please let us know in writing for your file.

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SYMPTONS SURVEY

What is your chief problem or symptoms? ____________________
What caused the problem or symptoms to occur? ____________________
When did the problem or symptoms begin? ____________________
Have you seen another doctor for this problem? ☐ No, If yes, who ____________________
What tests/procedures have been performed? ☐ X-Ray ☐ MRI ☐ Surgery ☐ Hospitalization ☐ _________
Have you had this problem or symptoms in the past? ☐ No, If yes, explain ____________________
Have you tried any other treatments for this? ☐ No, If yes, explain ____________________
Is the problem or symptoms getting worse? ☐ No, If yes, explain ____________________

✓ ALL OF THE ITEMS THAT APPLY TO YOU NOW AND IN THE PAST:

☐ Arthritis / Gout	☐ Depression/Anxiety	☐ Pregnancy	☐ Seasonal Allergies	☐ Headaches
☐ Eye Pain–Strain	☐ Dizziness	☐ Seizures	☐ Ringing in Ears	☐ Blurred Vision
☐ Jaw Pain	☐ Bleeding Gums	☐ Neck Pain / Spasms	☐ Chronic Fatigue	☐ Heart Disease
☐ Gall Stones	☐ Swallowing Difficulty	☐ Thyroid Problems	☐ Chest Pain	☐ Chest Congestion
☐ Anemia	☐ Hypertension	☐ Stroke	☐ Kidney Stones	☐ Pancreatitis
☐ Shortness of Breath	☐ Irregular Heart Beat	☐ HIV / AIDS	☐ Asthma/Bronchitis	☐ Mid-Back Pain
☐ Shoulder/Elbow Pain	☐ Wrist or Hand Pain	☐ Low Back Pain	☐ Hip/Knee/Leg Pain	☐ Foot or Ankle Pain
☐ Abdominal Pain	☐ Diabetes	☐ Groin or Rectal Pain	☐ Female Disorders	☐ Urinary Problems
☐ Skin Problems	☐ Broken Bones	☐ Digestive Problems	☐ Nausea – Vomiting	☐ Irregular Bowels

PATIENT & FAMILY HISTORY

What is your occupation? ____________________ ☐ Full Time ☐ Part Time
What is your employment status? ☐ Working ☐ Sick Leave ☐ Unemployed ☐Retired
☐ Temp Disability ☐ Perm Disability Last Day of Work _________
Do you use tobacco? ☐ No ☐Yes Explain: ____________________
Do you consume alcohol? ☐ No ☐Yes Explain: ____________________
Do you have a history of substance abuse? ☐ No ☐Yes Explain: ____________________
List all past surgeries ____________________
List all drug allergies ____________________
List all current and past medications / drugs
Drug Name: ____________________ ____________________

List all physicians you have seen in the past 5 years?
Name ____________________ For What? ____________________

Family History

Father	☐ Living	Age: ______	☐ Deceased – Cause of Death	____________
Mother	☐ Living	Age: ______	☐ Deceased – Cause of Death	____________
Brother	☐ Living	Age: ______	☐ Deceased – Cause of Death	____________
Brother	☐ Living	Age: ______	☐ Deceased – Cause of Death	____________
Sister	☐ Living	Age: ______	☐ Deceased – Cause of Death	____________
Sister	☐ Living	Age: ______	☐ Deceased – Cause of Death	____________

☐ Other problem(s) not listed ____________________

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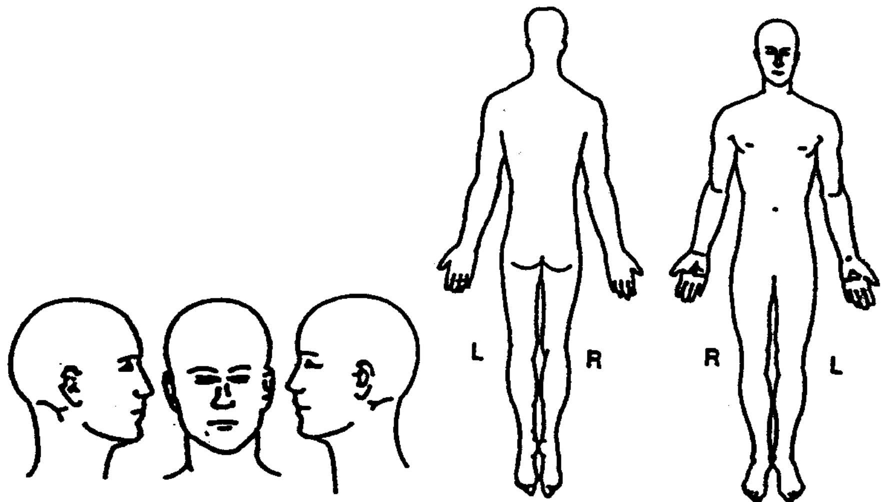
PAIN DRAWING

Circle location(s) of your symptoms on body drawing. Outline using the symbols for the type of sensation.

Pain	: : : : : : : : : : :
Numbness	+ + + + + +
Burning	/ / / / / / / / / /
Ache	X X X X X X

Describe your pain (check all that apply):

- ☐ Constant
- ☐ Intermittent
- ☐ Recurring
- ☐ Stabbing
- ☐ Dull Ache
- ☐ Sharp
- ☐ Deep Ache
- ☐ Throbbing
- ☐ Tingling
- ☐ While Resting
- ☐ Daily
- ☐ During Exercise
- ☐ Nightly
- ☐ ____________________



Onset of Pain:

- ☐ Sudden
- ☐ Gradual

On a scale of 1 to 10 how would you rate your pain level? _________ (1 = Mild, 10 = Intense)

What if anything gives you relief? ____

IF YOUR PROBLEM OR SYMPTOMS ARE DUE TO AN ACCIDENT OR INJURY PLEASE COMPLETE BELOW

AUTO ACCIDENT Date ___________ Time ____ [am] [pm] Location ______________________________

Were You	☐ Driver	☐ Passenger
	☐ Unconscious	☐ Treated in E.R.
	☐ Wearing a Seat Belt	☐ YES ☐ NO
	☐ Transported by Ambulance	☐ YES ☐ NO
Vehicle Damage	☐ Minimal – Moderate	☐ Severe - Totaled
Was the vehicle towed away?		☐ YES ☐ NO
Police Report	☐ None	☐ Yes with Police Dept___________________
Activities	☐ No restrictions	☐ Missed ____ days of work or school
	☐ I felt fine before the accident	

WORK RELATED Date ___________ Time ____ [am] [pm] Location ______________________________
or Other Injury

Describe injury and how it happened:

____

____

____

Accident Reported to ____ on _____________(date)

☐ No restrictions ☐ Missed ____ days of work or school

☐ I felt fine before the injury

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HEALTH CARE PRIVACY NOTICE – INFORMED CONSENT – ASSIGNMENT OF BENEFITS – AUTHORIZATION & LIEN

This office is committed to providing patients with quality health care services delivered with dignity and concern. Fulfilling this commitment requires the efforts of the doctors, therapists, staff and patient working together as a team to obtain the maximum results. Patient satisfaction is a vital interest to our staff.

This Facility is required by law to abide by the terms of this Health Care Privacy Notice as well as other applicable federal and state laws governing privacy practices in health care. Our Facility may change and/or modify the terms of this Notice at anytime without additional notice to you except to publicly post in our Facility and/or make available to patients any updated notices. Photocopy of this Notice is available to you upon request. The term Facility refers to this office or clinic. The term Provider refers to doctors and/or licensed professionals of this Facility.

Our Facility & staff are committed to maintaining the privacy of your protected health information (PHI). PHI is information about you, including demographic information that may identify you and that may be related to your present, future and past physical or mental health or condition and the care and treatment you receive from our practice. This Notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read this Notice and direct questions, misunderstandings or concern to the Compliance Officer of this Facility.

Our Facility may use & disclose your PHI for health care delivery purposes. Your PHI may be used and/or disclosed without your written authorization by the doctors and staff of this Facility for the purposes of your care and treatment; paying your health care bills; and to support the operations of this practice. Your doctor and the staff will take all reasonable measures to maintain the confidentiality of your PHI.

The Privacy Rule allows you the right to review and receive copies of your health care records as it relates to your health care. The request must in writing, allowing your provider 30 days to respond. Your provider may deny your request if it will cause harm to you or to another person. Your provider may charge a copy fee, which will be in compliance with State law. Your provider will comply with any reasonable request to have confidential communication by alternative means or at an alternative location if not doing so endangers you.

You may request to have an amendment placed in your record if you disagree with anything in your record. This does not mean that anything will be removed or changed and the provider has the right to respond with a rebuttal statement if he/she feels it is necessary. You may revoke authorization, in writing, at any time, except in the event that the provider has acted as indicated in the doctor's Authorization Notice.

You have the right to file a written complaint with our Compliance Officer if you believe that any of your privacy rights have been violated. You can obtain a complaint form from the Compliance Officer and/or the Office of the Civil Rights. All complaints must be filed within 180 days of when you knew or should have known that the violation occurred. The Privacy Law prohibits our Facility from taking any retaliatory actions against anyone who files a complaint. A more detailed, updated & comprehensive Health Care Privacy Notice is available for your review in this Facility.

I understand that this Facility, its doctors & staff are accepting my case based on examination findings & believe the outlined treatment should produce change and/or improvement. However as with any diagnostic test, procedure, examination or doctors care a guarantee of improvement or complete recovery cannot be made and it is even possible that no change will occur.

I further understand that in the practice of medicine, chiropractic, psychological counseling, massage therapy & physical therapy there are some risks including but not limited to fractures, disk injuries, strokes, dislocations, sprains-strains, drug interactions & reactions and/or other injuries or side effects which cannot be pre-determined.

I do not expect the doctor/provider to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor/provider to exercise judgment during the course of the procedure(s) which the doctor/provider feels at the time is in my best interest.

In addition, because psycho-social, spiritual, and cultural values affect a patient's response to care, patients are allowed to express and follow spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of treatment.

Patients have the right to refuse treatment, but must be aware of the probable consequences of refusing treatment and/or failing to cooperate with the prescribed treatment. Should you refuse and/or fail to comply with prescribed treatment your provider will discuss specific consequences with you.

Therefore I give my full consent to the doctor/provider to render treatment on me or the minor for whom I am legally responsible by a health care provider of this Facility.

I, the assignee, being the patient or legal guardian for said minor listed below, do hereby irrevocably authorize, direct, assign and give a full lien to the office named above and listed below, hereinafter referred to as the "Facility" against any & all insurance benefits, proceeds of any settlement, judgment or verdict which may be paid to the undersigned as a result of the injuries or illness for which I have been treated by the Facility.

I, the assignee further authorizes any and all insurance company, attorney and any & all third party payer to pay directly to the Facility all sums of money due them for any & all services rendered to me or minor by whom I am responsible for by reason of accident, illness and by any & all reason of any other bills that are due or may become due, and to withhold such sums from any health & accident, workers compensation and or including all insurance or third party benefits.

Assignee agrees that this Facility & staff may deliver medical records, consultations, depositions and/or court appearances which must be paid in full in advance and authorizes this Facility to release any information pertinent to said health care to any insurance company, adjuster, attorney or legal service bureau to facilitate collections under the terms of this document. Assignee grants the Facility a full power of attorney to endorse &/or sign my name on any & all checks for payment of any indebtedness owed this office & assignee.

INSURANCE BENEFITS – CREDIT POLICIES – PAYMENT TERMS & CONDITIONS

As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us but some third party payers misquote benefits, coverage and liability. Our Facility & staff are not responsible for what a third party payer and/or representative may tell us. Any contractual, written, verbal or other obligations or arrangements between you and an attorney, insurance company, liable or third party payer are between you and said person.

1. Our Facility will file initial insurance claims for you. Secondary claim submission and/or additional reports or documents sent for your benefit may result in an additional filing or medical report charges, which you are responsible to pay.
2. Co-pays, deductibles and all supplement charges are due the day the service is rendered.
3. Patients are responsible for charges on all service(s) and/or product(s) which may exceed the maximum allowable and/or when a third party and/or insurance carrier does not reimburse this Facility enough to meet our cost of service.
4. All account balances, including automobile and work injury claims must be paid in full within 90 days of treatment. Patients are fully responsible for all money owed this office and such payment is not contingent on any settlement, claim, judgment, or verdict by which they may eventually recover said fee and it is also regardless of any attorney liens or pending settlement(s). If a third party payer fails to pay said balance in full within the 90-day period, the patient must pay the balance in full. Assignee is fully responsible for all money owed this Facility for any and all treatment, products & services rendered to the patient or minor shown below.
5. A non-discriminatory "Time of Service Discount" is offered to anyone who pays for services the day they are rendered. The "TOS" is only offered on the day the service is rendered. This discount does not apply to orthopedic supports, orthotics, physical therapy equipment rentals or purchases, vitamins, supplements, ointments, acupuncture treatments, weight loss programs, psychological counseling services and massage therapy.
6. A service charge is computed by a 'periodic rate' of 1½ % per month – 18% per annum & is added to all balances owed 60+ days. Any balance past due 90 days or more may be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all monthly service charges, interest, costs related to but not limited to all collection related expenses, attorney fees, court & filing fee's. Returned checks, debit & credit charges made payable to this Facility for insufficient funds, stop payments or other reasons of non-payment will be assessed a $30.00 charge.
8. For your convenience we accept most major credit cards, Care Credit & debit cards.

PATIENT CONSENT & SIGNATURE

By my signature below I acknowledge that I have read or have had read to me and have received a photocopy upon my request of this document including the Health Care Privacy Notice, Facility terms & conditions, credit policies and Informed Consent and fully understand and have had all of my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valid as an original.

____
Print Name of Patient

____ ____________________
Signature (if minor, parent must sign) Date