Name: _____

Please let us know how you prefer to be reminded for appointments.

____ I prefer a text reminder

Cell # _____

Carrier _____

____ I prefer an email reminder

Email address _____

____ I prefer a phone call reminder to my

___ home number

___ cell number

NEW PATIENT CHECKLIST
(for office use only)

	COPY INSURANCE CARD AND PHOTO ID
	VERIFY INSURANCE BENEFITS
	SEND THANK YOU CARD IF PATIENT WAS REFERRED

CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Cell Phone (_____) _____ Home Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

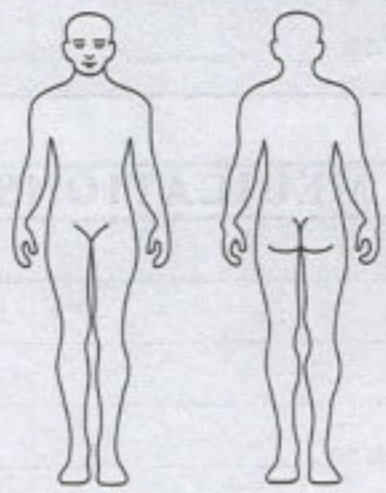
5 PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

6 HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Sexually Transmitted Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No	Other _____		
Chemical Dependency	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No			
Chicken Pox	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			
						Rheumatoid Arthritis	☐ Yes	☐ No			

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking — Packs/Day _____
☐ Alcohol — Drinks/Week _____
☐ Coffee/Caffeine Drinks — Cups/Day _____
☐ High Stress Level — Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

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

7

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy Name _____		
Pharmacy Phone (____) _____		

Informed Consent for Examination and Treatment

I (we) hereby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____.

_____
Patient's Name (Print)

_____
Patient's Signature

_____
Date

_____
Relationship or authority if not signed
By patient

_____
Witness

INFORMED CONSENT TO PARTICIPATE IN ACTIVE REHABILITATION

THE GOALS OF THE REHABILITATION PROGRAM INCLUDE:

1. Determining the cause and extent of your problem.
2. Providing a therapeutic exercise program to strengthen you, increase your cardiovascular endurance, range of motion and flexibility, and decrease your pain.
3. Return you to full-duty, non-restricted work status and lifestyle.

THE EQUIPMENT USED TO TEST YOU AND THE PROCESS WE WILL BE USING WILL BE EXPLAINED TO YOU.

Your participation in the rehabilitation program is voluntary. You can stop at any point in the program. Should you stop your program, we are obligated to notify your doctor, insurance company, attorney, and DVR manager, if it is applicable.

If at any point during the evaluation or rehabilitation process you have any questions, we will answer them to the best of our ability or refer you to someone more qualified. Please be advised that there are no guarantees that your personal goals and/or those listed above will be met to your satisfaction. The success of any rehabilitation process lies in the combined efforts of you and your provider. The "team" approach has the best chance of attaining your goals, so please ask as many questions as necessary for you to gain the maximum benefit from your rehabilitation program.

Since the process of strengthening and conditioning are a form of "controlled strain", there is a chance of aggravation or injury. It is therefore imperative that you communicate to your provider any aggravation or injury that you may observe during the rehabilitation process. For example, the *best* exercise for you, if performed too early in your condition, may be your *worst* enemy if performed too soon. Communication with your provider will help put into perspective problems that may occur. Failure to discuss problems may only foster additional problems down the road.

I HAVE READ THE ABOVE AND UNDERSTAND THE RISKS AND BENEFITS OF THE REHABILITATION PROGRAM. I AGREE TO PARTICIPATE AND HAVE MY REHABILITATION INFORMATION RELEASED TO MY DOCTOR, INSURANCE CARRIER, ATTORNEY, OR DVR PERSONNEL IF REQUESTED.

_____ DATE_____

SIGNATURE OF PARTICIPANT

_____ DATE_____

SIGNATURE OF WITNESS

RESEARCH CONCERNING THE REHABILITATION PROGRAM AND RESULTS MAY BE CONDUCTED. DATA WILL BE USED FROM THE PARTICIPANT'S EVALUATIONS AND EXERCISE PROGRAM. NO NAMES WILL BE USED AND ALL INFORMATION IS STRICTLY CONFIDENTIAL. PLEASE INITIAL BELOW.

_____ I AGREE TO PARTICIPATE

_____ I DO NOT WISH TO PARTICIPATE

Office Financial and Cancellation Policy

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care.

1. **If You Do Not Have Insurance:** All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $100 at any time or care may be terminated. Our payment plans make care an affordable part of your family budget.

2. **If You Have Insurance:** All deductibles and co-payments are expected at the time of service or by an authorized payment plan. *You will be responsible for any purchased products and/or non-covered service.* Your co-insurance balance may not exceed $100 or care may be terminated. Our payment plans make care an affordable part of your family budget.

You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage.

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 and of care in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90)days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

Massage Patients: Please be advised that we require at least a 24 hour notice to cancel an appointment for massage. The full amount of the massage will be assessed to your account with a cancellation of less than 24 hours' notice and will be charged to the credit card on file.

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

For your convenience we accept cash, checks, Visa, MasterCard, and Discover as payment options. If you have any questions about coverage and/or payment, feel free to ask in advance of services being rendered.

Please provide your credit card number on the line below:

_____	_____	_____
Credit Card Number	Exp. Date	3 Digit Code

I certify that I have been provided the Patient Financial & Cancellation Policies.

I authorize Chiropractic Rehabilitation and Wellness Center to charge my credit card the appropriate cancellation fee if needed.

I authorize payment of medical benefits to the named provider for professional services rendered.

Date __/__/__ Signature of Patient (or Legal Representative) _____

Date __/__/__ Signature of Staff Member _____

NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager.

Name _____ Phone _____

The effective date of this Notice of Information Practices is _____.

Thank you.

Chiropractic Rehabilitation
WELLNESS CENTER

Christopher J. Horak, D.C., C.C.S.P.

706 S. Butterfield Road
Mundelein, IL 60060

Office: 847-362-8882
Fax: 847-362-8889
www.myfamilychiro.net

PAPERLESS BILLING AUTHORIZATION FORM

Name: _____

Address: _____

Phone Number: _____

Email Address: _____

Email Bill ____ **Email & Paper Bill ___**

I authorize, Dr. Christopher J. Horak D.C, to email my monthly bill. I agree that it is my responsibility to review the monthly bill. I further agree to notify Dr. Christopher J. Horak D.C, of any changes to my mailing address, email address or contact information. Failure to notify Dr. Christopher J. Horak D.C, of any changes or failure to receive the bill does not waive penalties for fees due to nonpayment.

_____ _____

Signature **Date**

Once you sign up for paperless billing your statements will be emailed to the email address you have provided. There are no charges for going paperless. At your request we can also send a paper bill. Failure to receive an email or paper bill does not waive any past due penalty. Late notices will be mailed.

What to do if you do not see an email from us:

- Check your spam folder, deleted mail folder or junk folder.
- Please give us a call if you are having any issues receiving or viewing your paperless bill.

Go Paperless