CONCEPT CARE CHIROPRACTIC AND WELLNESS CENTER

6230 MAIN ST DOWNERS GROVE, IL 60516 T: 630.960.9914 office@well-adjusted.com
314 W SUPERIOR ST, #LL-E CHICAGO, IL 60654 T: 630.960.9914 office@well-adjusted.com

PATIENT INFORMATION DATE ____/____/_____

Patient Name (last, first)_____ Referred By: _____

Address_____ City_____ State_____ Zip Code_____

Home Phone_____ Cell #_____Work #_____

Social Security #_____ Email _____

Date of Birth_____/_____/_____ Sex M / F Height _____feet _____inches Weight _____ lbs

Employer_____ Occupation_____

Insured Name_____ Insured's DOB_____

Describe your current problem: _____

_____

When did your problem begin: _____

What concerns you the most about your problem? What does it prevent you from doing? _____

_____

_____

Have you seen any other doctors for this condition? If so, who? _____

_____

What makes it better? _____ Worse? _____

Name of Primary Care Physician: _____ City, State: _____

☐ Please check if you would NOT like us to send a report to your Primary Care Physician

HOSPITALIZATIONS/SURGERIES: (please list procedures, dates and locations)

_____

_____

PREVIOUS INJURIES: (sprains, fractures, auto accidents, etc) _____

_____

Have you seen a Chiropractor before? ____YES ____NO If yes, how long ago? _____

CURRENT MEDICATIONS AND SUPPLEMENTS (please list the name and dosages, if possible)

(Include all vitamins, herbal supplements and over-the-counter medications)

1. _____ 4._____

2. _____ 5._____

3. _____ 6._____

ALLERGIES (medication, food, other substances)

_____

DO YOU SMOKE? _____NO _____YES If yes, how many packs/day? _____

DO YOU DRINK ALCOHOL? _____NO _____YES If yes, how many drinks/week? _____

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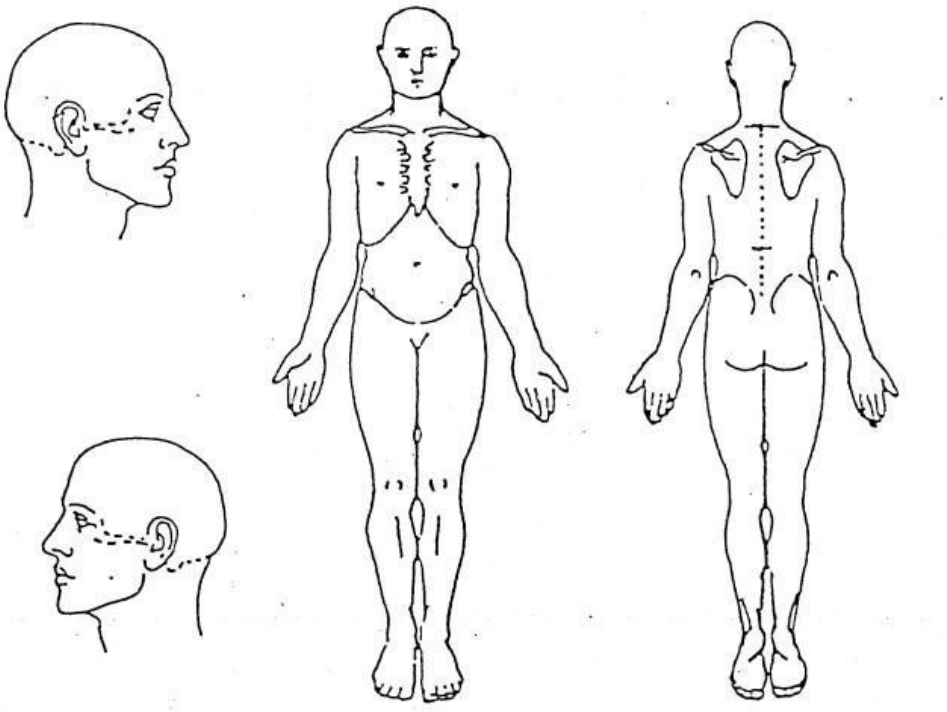
FAMILY HISTORY Check any diseases which your relatives have had (if known):

Relatives	Arthritis	Cancer	Diabetes	Heart Disease/Stroke	Kidney Disease	Nerve Disease	Thyroid Disease
Father							
Mother							



PAIN DIAGRAM

Please mark the areas on the diagram with the appropriate symbols for the sensations that you feel. Include all affected areas.

++++	Numbness
000000	Pins & Needles
xxxxxx	Burning
*****	Aching
//////	Sharp & Stabbing

Please Circle your level of pain below: (1=minimal pain; 10=worst pain imaginable)

PAIN CURRENTLY

1 2 3 4 5 6 7 8 9 10

PAIN TYPICALLY

1 2 3 4 5 6 7 8 9 10

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REVIEW OF SYSTEMS: Please write in a number: 1. PRESENTLY HAVE 2. PREVIOUSLY HAD

GENERAL
___Allergy
___Chills
___Convulsions
___Dizziness
___Fainting
___Fatigue
___Fever
___Headache
___Sleep loss
___Weight gain/loss
___Nervousness/Depression
___Neuralgia
___Numbness
___Sweats
___Tremors
___Anxiety/Depression

EYES, EARS, NOSE & THROAT
___Asthma
___Colds
___Sore throat
___Deafness
___Dental decay
___Earache/noises
___Ear discharge
___Sinus infection
___Enlarged glands
___Enlarged thyroid
___Nose Bleeds
___Failing Vision
___Far Sighted
___Gum trouble
___Near Sighted
___Hoarseness
___Nasal obstruction

MUSCULOSKELETAL
___Arthritis
___Bursitis
___Foot trouble
___Hernia
___Low Back Pain
___Neck pain/Stiffness
___Shoulder Blade Pain
Pain or numbness in:
___ Shoulders
___ Arms
___ Elbows
___ Hands
___ Hips
___ Legs
___ Knees
___ Ankles
___ Feet
___ Tailbone
___Poor Posture
___Sciatica
___Spinal curvature

GENITO-URINARY
___Bedwetting
___Blood in urine
___Frequent urination
___Inability to control bladder
___Kidney infection or stones
___Painful urination
___Prostate trouble
___Painful menstruation
___Hot flashes
___Irregular cycle
___Lumps in breasts
_____Date of Last menstrual cycle

CARDIOVASCULAR
___Hardening of arteries
___High blood pressure
___Low blood pressure
___Diabetes
___Pain over heart
___Poor circulation
___Rapid heart beat
___Slow heart beat
___Swelling of ankles

RESPIRATORY
___Chest Pain
___Chronic cough
___Difficult breathing
___Spitting up food
___Spitting up phlegm
___Wheezing

GASTROINTESTINAL
___Colitis
___Colon Trouble
___Constipation
___Diarrhea
___Difficult digestion
___Distention of abdomen
___Excessive hunger
___Heartburn / Reflux
___Gall Bladder Trouble
___Hemorrhoids
___Intestinal worms
___Jaundice
___Liver trouble
___Nausea
___Pain over stomach
___Poor appetite
___Vomiting

Concept Care Chiropractic & Wellness Center
6230 Main Street
Downers Grove, Illinois 60516
630.960.9914

Effective date of notice: January 2016

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

We respect our legal obligation to keep health information that identifies you private. This notice describes how we protect your health information and what rights you have regarding it. Please review it carefully.

USES AND DISCLOSURES

We may use or disclose your protected health information without your written consent, written authorization or oral agreement for the following purposes.

Treatment. Example: We may use your health information within our office to provide health care services to you or we may disclose your health information to another provider if it is necessary to refer you to them for services.
Payment. Example: We may disclose your health information to a third party such as an insurance carrier, an HMO, a PPO, or your employer, in order to obtain payment for services provided to you.
Health Care Operations. Example: We may use your health information to conduct internal quality assessment and improvement activities and for business management and general administrative activities.

We may use or disclose your protected health information without your written consent, written authorization or oral agreement under the following circumstances:

If we provide services to you in an emergency treatment situation.
If we are required by law to provide services to you and we are unable to obtain your consent after attempting to do so.
If there are substantial barriers to communication and we determine, in the exercise of our professional judgment, that you intend for us to treat you.
If we need to notify, or assist in the notification of, a family member, personal representative or another person responsible for your care of your location, general condition or death.
If we are required by law to disclose your health information to a public health authority that is authorized to receive information for the purposes of preventing or controlling disease, injury or disability.
If we are required by law to disclose your health information to a public health or other government authority that is authorized to receive reports of child abuse or neglect.
If we are required to disclose your health information to the Food and Drug Administration.
If we are required to disclose your health information to your employer to evaluate whether you have a work-related injury or illness.
If we are required by law to disclose your health information to a government authority authorized to receive reports of abuse, neglect or domestic violence.
If we are required to disclose your health information to a health oversight agency or oversight activities required by law.
If we are required to disclose your health information in response to a court order or subpoena.
If we are required to disclose your health information to law enforcement officials.
If we are required to disclose your health information to a coroner, medical examiner or funeral director.
For research purposes.
If we, in good faith, believe that the use of disclosure of your health information is necessary to prevent a serious threat to the health and safety of others.
If we are authorized by law to disclose your health information to comply with laws established to provide benefits for work-related injuries or illnesses.
If we provide services to you while you are an inmate.

SPECIFIC AUTHORIZATIONS

I give permission to Concept Care to use my address and clinical records to contact me by phone, in writing or by email with appointment reminders, missed appointment notification, birthday cards, holiday related cards, information about upcoming workshops and other promotions, newsletters, information about treatment alternatives or other health related information. If Concept Care contacts me by phone or email, I give them permission to leave a message. Unless you object, we will also share relevant information about your care with your family or friends who are helping you.

The following unique conditions apply at Concept Care: Open rooms for adjusting, rehab and physical therapy. _____

(initial)

WITH THE EXCEPTION OF THE ABOVE CIRCUMSTANCES, ANY USE OR DISCLOSURE OF YOUR HEALTH INFORMATION WILL BE MADE ONLY WITH YOUR WRITTEN AUTHORIZATION. YOUR WRITTEN AUTHORIZATION MAY BE REVOKED, IN WRITING, AT ANY TIME EXCEPT TO THE EXTENT THAT WE HAVE PROVIDED SERVICES OR TAKEN ACTION IN RELIANCE ON YOUR AUTHORIZATION.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of your health information. However, we are not required to agree to the requested restrictions, but if we agree, we must honor the restrictions you want. Your request to limit the use and/or disclosure of your health information must be made in writing to our privacy official.

Right to Receive Confidential Communications. You have the right to receive confidential communications concerning your health information. Your request to receive confidential communications must be made in writing to our privacy official. We will accommodate all reasonable requests by you to receive your health information at a place other than your home address or by means other than regular mail.

Right to Inspect and/or Copy. You have the right to inspect and/or copy certain health information for as long as that information remains in your record. Your request to inspect and/or copy your health information must be made in writing to our privacy official.

Right to Amend. You have the right to request that we amend certain health information for as long as that information remains in your record. Your request to amend your health information must be made in writing to our privacy official and you must provide a reason to support the requested amendment.

Right to Receive an Accounting. You have the right to receive an accounting of our disclosures of your health information made six (6) years prior to the date of request. We will provide you with the first (1 st) accounting in any twelve- (12) month period at no charge. There will be a fee charged for any subsequent request. Your request to receive an accounting must be made in writing to our privacy official. The accounting will not include the following disclosures:

Disclosures made to carry out treatment, payment and health care operations (TPO);
Disclosures made to you;
Disclosures made to individuals involved with your care;
Disclosures made for national security or intelligence purposes;
Disclosures made to correctional institutions or law enforcement officials: and
Disclosures made prior to the compliance date of the HIPAA Privacy Rule.

Right to Receive Notice. You have the right to receive a paper copy of this notice, upon request.

OUR DUTIES

We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of this notice and to make the new notice provisions effective for all of the protected health information that we maintain. If we make a change in the terms of this notice, we will notify you in writing and provide you with a paper copy of the new notice, upon request.

COMPLAINTS

You may complain to us and to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by writing to our privacy official at the address shown at the beginning of this Notice. We will not take any action against you for filing a complaint.

BY SIGNING THIS FORM YOU ARE GIVING CONCEPT CARE CHIROPRACTIC AND WELLNESS CENTER PERMISSION TO USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE DIRECTIVES LISTED ABOVE.

HOW TO CONTACT US

If you would like further information about our privacy practices, please contact J. Daniel Kirk, DC at the address or phone number shown at the beginning of this Notice.

ACKKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Concept Care Chiropractic and Wellness Center's Privacy Practices.

Patient's Name: _____ Signature: _____

(please print)

Date: _____

conceptcare
Chiropractic+Wellness

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Our Financial Policy

If you do not have insurance coverage of any kind, you will be expected to pay for your services in full at each visit. We accept checks, Visa, Mastercard, Discover, and even cash. If you are going to be on a regular treatment plan of one or more months, it's possible a payment plan can be worked out for you. Just ask to go over this with our Financial Department, if desired.

For those patients who are covered by insurance, we will accept assignment of benefits. This means that you must sign the portion of your insurance form that assigns the benefits to our office. Most policies do not cover 100% of the cost of your treatment. Because of this, and the extreme delay in receiving payment from the insurance company, you will be asked to pay your deductible and your portion of the charges for the day or week the service was rendered. We will call your insurance company to verify your coverage and inform you of your responsibility. We will estimate as closely as possible your coverage, but until the payment is actually received from your insurance company, it is an ESTIMATE AND MAY NOT BE ENOUGH. If that is the case, you will be required to pay the amount not covered by your insurance company. If your insurance company pays MORE than we estimated, you will be given the option of crediting your account for future services/products, or receiving a check from us on the 15th day of the following month.

We will ASSIST YOU IN DEALING WITH YOUR INSURANCE COMPANY BUT YOU ARE RESPONSIBLE FOR ANY PAYMENTS THAT YOUR INSURANCE COMPANY DOESN'T COVER, NO MATTER WHAT REASON. If we have not received payment from your insurance company within 60 days of service, you will be responsible for payment in full. Unpaid balances will be charged interest at the rate of 18% a year.

If you are here due to an AUTO ACCIDENT, or WORKERS COMPENSATION, please see our insurance representative for full details of your coverage. In addition, if you have any questions that remain unanswered before or after treatment, feel free to ask our insurance representative. We value you as a patient and want to do everything we can to keep you healthy.

CANCELLATION/NO SHOW POLICY: If you need to cancel or reschedule your appointment, please give us notice at least twelve hours before your scheduled appointment. Failure to do so may subject you to a $40 cancellation fee, which is not covered by insurance.

Sincerely,

J. Daniel Kirk, D.C.
President

I, _____, understand the policy above.

_____
Signature