York Chiropractic Clinic Registration and History

PATIENT INFORMATION

Date _____

First Name_____

Last Name _____

Address _____

City_____

State _____ Zip Code _____

Sex ☐ Male ☐ Female

Date of Birth: _____

Home Phone (_____) _____

Cell Phone (_____) _____

Best place to reach you and time _____

Email _____

Do you wish to receive e-mails with health tips and promotional deals? ☐ Yes ☐ No

Patient Employer/ School _____

Employer/ School Phone (_____) _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Home Phone (_____) _____

Relationship _____

Spouse's Name _____

Birthdate_____

Whom may we thank for your referral? _____

INSURANCE INFORMATION

Who is responsible for this account _____

Relationship to patient _____

Insurance Co._____

Is patient covered by additional insurance

☐ Yes ☐ No

Subscribers name_____

Birthdate_____

PATIENT CONDTION

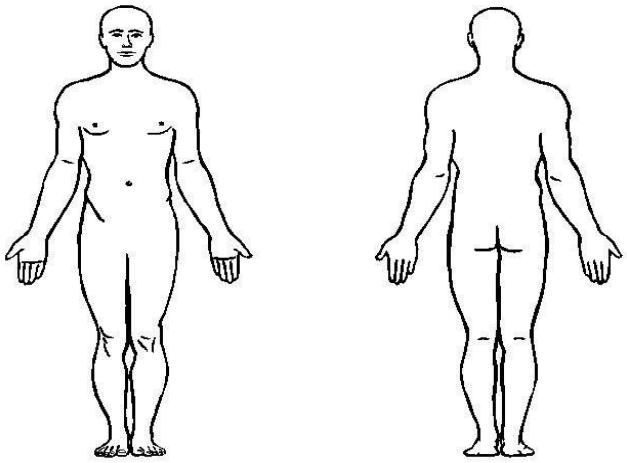
Reason for Visit?_____

When did your symptoms appear?_____

Is this condition getting progressively worse?

☐ Yes ☐ No

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



Rate the severity of the pain on a scale from 1(least pain) to 10 (serve 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 movement that are painful to perform

☐ Sitting ☐ Standing ☐ Walking ☐ Bending

☐ Lying Down

Health History

What Treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other_____

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

Exercise	**Work Activity**	**Habits**	
☐ None	☐ Siting	☐ Smoking	Packs/ Day _____
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week _____
☐ Daily	☐ Light Labor	☐ Coffee/ Caffeine Drinks	Cups/Day_____
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	Reason_____

Are you Pregnant ☐ Yes ☐ No Due Date_____

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

Medications	**Allergies**	**Vitamins/ Herbs/ Mineral**

YORK
CHIROPRACTIC CLINIC
ENHANCING THE HEALTH OF YOUR FAMILY

Dr. Noelle O`Connor D.C 486 Spring Road Elmhurst, IL 60126 | 630-834-8536 Fax: 630-834-8544 | info@yorkchiropractic.net

Office & Financial Policies

1. **Know your own Insurance Plan Benefits**
   a. As **a courtesy to you**, our office verifies information prior to your visit whenever possible
   b. Be aware the insurance company states the **"the quote of benefits given is not a guarantee of payment."**
   c. **We cannot be held responsible** for any misinformation we are given by your insurance.
   d. It is ultimately your responsibility to know your own benefits and to pay the balances as indicated by your insurance company.
2. **Insurance Claim Filing and Payment**
   a. **Our office files your insurance claims as a courtesy.**
   b. If payment from an insurance company is withheld for **any reason**, payment in full will be expected from the insured within 21 days of the first statement and/or 60 days of the service date.
   c. **Assignment is accepted on Medicare Part B Claims.**
   This means that Medicare participants are responsible for:
   - Your $200 deductible.
   - The balance of the 20% co-insurance after Medicare pays 80% of their allowed amount.
   - Any non-covered services (Medicare doesn`t cover any exams, therapy or massage in a chiropractic office)
3. **Account Balances**
   a. **Co-payments, previously determined non-covered services or services rendered to a non-insured patient are expected at the time services are rendered**.
   b. We accept Visa, MasterCard, Cash or local check. **A fee of $35.00 will be assessed for any returned checks.**
   c. **For those patients with deductibles of $200 or more,** and for our massage therapy clients, we require a credit card on file.
   d. **Statements are generally mailed from our office on a monthly basis and payment is expected upon receipt**. Your account will be considered PAST DUE after 21 days of the first statement and/or 45 days of the service date and DELINQUENT after 60 days.
   e. **Patient account balances that are 90 days past due from the date of service will automatically** be forwarded to our collections agency.

Missed Appointment Policy

We value your time and we want your chiropractic experience to be positive and helpful in all ways. Chiropractic and massage are most effective when kept consistently. It is our pledge to meet with you for your appointment in as timely a manner as is possible and we expect for you to make all reasonable efforts to attend your appointment and to be on time.

Cancellation of an Appointment:

When you schedule your appointment, you have reserved this time in our schedule and we have placed it aside to meet with you. If you must cancel or change your appointment, we require that you contact our office at 1-630-834-8536 **at least an hour in advance.**

Late Cancellations and No show Policy:

York Chiropractic Clinic will charge for each appointment that is missed without adequate notice ("no show".) A no show is an appointment that is:

- Missed without notice
- Missed with less than an hour notice
- Missed due to arriving 15 minutes or more beyond the scheduled appointment time.

If you do not keep your appointment and have not called to cancel or reschedule within the allotted time limits, you will be charge a fee of $35 dollars. The only exception to this policy are appointments missed due to the last minute illness or emergencies.

You will be billed directly for missed appointments. Payment for missed appointments is due on or before your next scheduled appointment. If you have not paid in advance, you should be prepared to pay the outstanding balance at the time you check in for your next appointment.

Thank you for taking time to review our missed appointment policies. We hope making these policies clear will eliminate any possible misunderstanding. By signing below, you are indicating that you have read, understood and agree to these conditions.

Patient Signature: _____ Date: _____

INFORMED CONSENT

I consent to treatments and other procedures associated with York Chiropractic and Oriental Medicine by Dr. O'Connor or a licensed therapist. I have discussed the nature and purpose of my treatment with Dr. O'Connor. I understand that methods of treatment may include, but are not limited to acupuncture, moxibustion, cupping, electrical stimulation, and Tui Na (Chinese Massage).

I have been informed that chiro and acupuncture are safe methods of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although Dr. O'Connor uses sterile, disposable needles and maintains a clean and safe environment. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

I do not expect Dr. O'Connor to be able to anticipate and explain all possible risks and complications of treatment and I wish to rely on her to exercise judgment during the course of treatment which she thinks, at the time and based upon facts known to her, is in my best interests.

By voluntarily signing below I show that I have read, or have read to me, this consent to treatment, that I have been told about the risks and benefits of acupuncture and other procedures, and that I have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by patient (or patient's representative if the patient is a minor or is physically or legally incapacitated).

Date Consent Completed: _____

Signature of Patient or Representative: _____

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NOTICE OF PRIVACY PRACTICES

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** is providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a consultation or physical examination.
- **Payment** is such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health Care Operations** include the business aspects such as an internal review.

We may contact you to provide appointment reminders, information about treatment alternatives or results of test taken.

Any other users and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, expect to the extent that we have already taken actions relying on your authorizations.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or locations. An example such as a different mailing address for statements or a different telephone number for communication.
- The right to inspect and copy your protected health information. The practice charges reasonable fees based on Illinois laws. If the requestor agrees to pay the fee in advance, the records will be provided.
- The right to amend your protected health information. The practice documents all requests, responds to all requests in a timely fashion, and informs requestor of denial in whole or in part.
- The right to receive an accounting of disclosures of protected health information. The practice allows an individual to request one accounting within a 12- month period free of charge. The practice charges a reasonable fee for more frequent account requests. The charge will be determined at the time of the request.
- The right to obtain a paper copy of this notice from us upon request.

The practice never requires an individual to waive any of his or hers individual rights as a condition for the provision of treatment, except under very limited circumstances allowed under law.

You have the right to file a written complaint with our office, Attn: Privacy Officer, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of this office. We will not retaliate against you in filing the complaint.

_____ _____

Signature of Patient or Legal Guardian Date