new health
CHIROPRACTIC

Date _____

Name _____ Preferred Name _____

Address _____

City _____ State _____ Zip _____

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

Email Address _____

Social Security Number _____ Date of Birth _____

Occupation _____ Employer _____

Marital Status Minor Single Married Separated Divorced Widowed

Spouse's Name _____

Emergency Contact: Name _____ Relationship _____

Phone number _____

Have you ever had chiropractic care before? No Yes

If yes, please tell us who _____

How did you hear about our office? _____

CURRENT HEALTH

What are your pressing health concerns? _____

_____

_____

For how long? _____

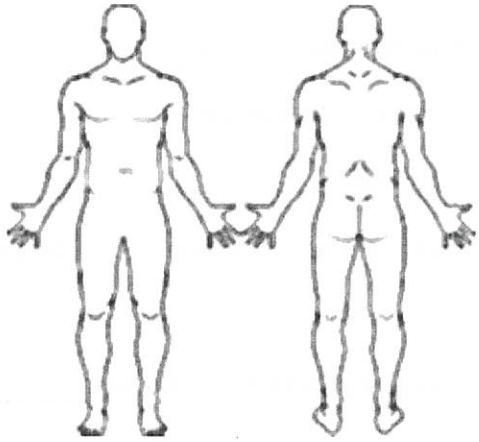
Is the pain...

- o Getting worse
- o Improving
- o Intermittent
- o Constant
- o Can't say
- o Sharp
- o Dull

Are your symptoms affected by...

- o Sitting
- o Standing
- o Walking
- o Bending
- o Lying down
- o Weather
- o Other

Please indicate on the illustration where the problem is located...



On a scale of 1-10 (1 least, 10 most), please rate:

The severity of your symptoms 1 2 3 4 5 6 7 8 9 10

Have you ever suffered from (please check all that apply)

- o Neck Pain
- o Low Back Pain
- o Headache
- o Migraines
- o Arm Pain/Tingling
- o Shoulder Pain
- o Hand Pain/Tingling
- o Leg Pain/Tingling
- o Jaw Pain
- o Chest Pain
- o Lung Problems
- o Heart Problems
- o Abnormal Blood Pressure
- o Irregular Heartbeat
- o Ankle Swelling
- o Cold Extremities
- o Blurred Vision
- o Vision Problems
- o Difficulty Breathing
- o Stuffy Nose
- o Fainting
- o Weight Loss
- o Poor Appetite
- o Excessive Appetite
- o Nervousness
- o Confusion
- o Depression
- o Dental Problems
- o Excessive Thirst
- o Frequent Nausea
- o Prostate Problem
- o Breast Pain/Lump
- o Cramps
- o Painful Urination
- o Bladder Trouble
- o Excessive Urination
- o Discolored Urine
- o Gas/Bloating After Meals
- o Heartburn
- o Irritable Bowel
- o Black or Bloody Stools
- o Constipation
- o Hemorrhoids
- o Liver Problems
- o Paralysis
- o Numbness
- o Fatigue
- o Dizziness
- o Loss of Sleep
- o Difficulty Hearing
- o Ear Pain
- o Other _____

_____

_____

If applicable, date of last menstrual period _____

Past injuries can affect present health (please check all that apply)

- o Falls/Accidents
- o Sports Injuries
- o Spinal Tap
- o Use(d) a Cane or Walker
- o Head Injuries
- o Broken Bones
- o Knocked Unconscious
- o Extensive Dental Work
- o Fights
- o Dislocations
- o Traction
- o Dental Applications
- o Surgery

If yes to any of the above, please describe _____

_____

_____

_____

Are you on any medications? _____

_____

The above is accurate to the best of my knowledge.

_____ _____

(Signature) Date

I, parent /guardian, give permission for minor's care.

_____ _____

(Signature) Date

CONSENT TO CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me or on _____ by Dr. _____ in New Health Chiropractic Clinic.

Since Chiropractic is a health care profession distinct and separate from medicine, it is important that you understand some fundamental distinctions concerning Chiropractic care. Experience shows that informed patients make better choices concerning their health care.

Chiropractors do not diagnose or treat specific disease conditions such as cancer, diabetes, etc. Chiropractors are trained in the detection of Vertebral Subluxation Complex (VSC). VSC concerns the integrity of the spine, the central and peripheral nervous system, and the muscular system. Extensive scientific evidence suggests that imbalances in the musculoskeletal system can affect the ability of the nervous system to accurately transmit information to and from the muscles, organs and glands of the body. This nervous system interference decreases the body's natural recuperative ability. Chiropractic treatment in the Clinic consists of various procedures aimed at decreasing or eliminating nervous system interference and to increase the overall level of body function. You will receive nutritional recommendations if our analysis shows this would enhance your overall body function and well-being. Such advice is only a recommendation and is not to be considered treatment of a specific pathology.

I have been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should know of possible complications which have been alleged. These include, but are not limited to, fractures, disk injuries, strokes, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetectable by the doctor.

I have read or have had read to me and understand the above consent. I understand my condition as the doctor has explained it to me. I understand the possible risks and complications of treatment. I also understand the alternative to the proposed treatment and the doctor's opinion concerning the consequences of not receiving treatment. The doctor has explained the probability of a satisfactory response to treatment and that he cannot guarantee a successful outcome.

_____ _____

Date Patient Name Print Name

_____ _____

Patient Signature Relationship or authority if not signed by Patient

New Health Chiropractic Billing Policy

- ✓ **I understand payment is due at the time services are rendered.**
- ✓ I understand that it is my responsibility to provide New Health Chiropractic with current, accurate billing information at the time of check in and to notify New Health Chiropractic of any changes in the information.
- ✓ I understand qualified insurance charges can be submitted to primary insurance carriers by New Health Chiropractic. I understand this is done as a **courtesy** and New Health Chiropractic will not enter into a dispute with any insurance carrier over any claim. This is ultimately my responsibility and obligation.
- ✓ I understand that New Health Chiropractic does not guarantee that my insurance will cover treatment.
- ✓ I understand that if my account becomes past due, it may be turned over to a collection agency. If my account is not paid in full and is turned over to a collection agency and/or attorney, then I agree to be responsible for all reasonable fees necessary for collection of the delinquent account including, but not limited to, collection agency fees of 50% of the balance due and costs and reasonable attorney's fees of 33% of balance.
- ✓ I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a $35 NSF fee. I further understand that to rectify my account, I will be required to pay with cash or credit card.
- ✓ **I understand that I must give 24 hour notice for canceling an appointment. If 24 hour notice is not given I understand that I may be charged a $35 fee which is my responsibility, not the responsibility of my insurance company.**

My signature below confirms that I have read these billing policies and understand my financial obligation.

Print Name _____

Signature _____ **Date** _____

Relationship to Patient _____

BLUE CROSS / BLUE SHIELD PATIENTS ONLY:

Our office does not guarantee that your insurance carrier will pay.

I hereby authorize payment directly to New Health Chiropractic for services rendered to me. I understand that services rendered to me by New Health Chiropractic will be billed to my insurance company as a courtesy to me, but that I am personally responsible and liable for any and all medical fees billed. I understand that according to the requirements of my insurance plan, that it is my responsibility to pay for any and all **deductibles, co-pay and coinsurance expenses as well as any service deemed not covered** by my insurance at the time of service. All denied fees must be paid in full upon receipt of notification. I am aware that I will be billed for amounts my insurance determines are patient responsibility on the Explanation of Benefits and will be due upon receipt of notification. Accounts will be considered late after 30 days and subject to collection and collection fees and/or interest charges. I hereby authorize New Health Chiropractic to release to any insurance company, or their representative, any information, including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical care necessary to process my insurance claims. Our office will not enter into a dispute with your insurance company over any claim. *This is ultimately your responsibility and obligation.*

SIGNATURE _____ **DATE** _____

Dr. Justin Pals, D.C.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail _____

SECTION B: TO THE PATIENT ---- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting the office manager at 217-342-3384 or fax at 217-342-3385 or mail at 401 N. Keller Dr. Suite 2, Effingham, IL 62401

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.