

ADULT CHIROPRACTIC HEALTH QUESTIONNAIRE



WELCOME TO ESSENTIAL CHIROPRACTIC

DATE _____ PATIENT # _____
NAME _____ DATE OF BIRTH _____ AGE _____ SEX: M F
ADDRESS _____ CITY _____ STATE _____ ZIP _____
PHONE (H) _____ (W) _____ (C) _____
BEST TIME TO CALL _____ AM _____ PM EMAIL _____
YOUR OCCUPATION _____ EMPLOYER _____
SS# _____ MARITAL STATUS M S W D # OF CHILDREN _____
SPOUSES NAME _____ EMPLOYER _____
NAME OF EMERGENCY CONTACT _____ RELATIONSHIP _____ PHONE _____
DO YOU HAVE HEALTH INSURANCE? YES _____ NO _____ NAME OF COMPANY _____
NAME OF INSURED _____ DOB _____ SOCIAL SECURITY # _____ RELATIONSHIP _____
MEDICAID YES _____ NO _____ MEDICARE YES _____ NO _____

IT IS OUR PLEASURE TO SERVE YOU TODAY. PLEASE ANSWER THE FOLLOWING QUESTIONS

PLEASE LIST YOUR HEALTH COMPLAINT(S)/ SYMPTOMS

- A _____
B _____
C _____

MY PURPOSE FOR TODAY'S APPOINTMENT IS:

(Please check all that apply to you)

- I'm here for an evaluation. I'm a healthy person and I'm interested in maximizing my health and preventing future problems.
- I'm here for an evaluation because I'm having health challenges and am looking for a natural health solution.
- I'm here for an evaluation. I am curious to know if my spine is healthy and to see if I have any problems that I don't know about.
- I am here for an evaluation because I'm curious to learn more about Chiropractic Care.

IF THE DOCTOR(S) FEELS THAT THEY CAN HELP YOU:

(Please check the one that best applies to you)

- I am willing to follow the doctor's recommendations because I strongly value my health.
- I am willing to receive care if payment plans are available.
- I am willing to receive care but only if my insurance pays for all of it.



PLEASE ANSWER THE FOLLOWING QUESTIONS VERY CAREFULLY.

1. Many patients are referred to our office by a caring family member or friend. What made you decide to visit our office? Family Member or Friend's Name _____

- Telephone Call Yellow Pages Sign Website Presentation E-mail

2. Research shows that your spine should be **checked regularly**. How many times have you visited a chiropractor in your lifetime? _____ NEVER

3. When was your **last complete spinal examination** including x-rays? _____ NEVER

4. Have you ever been told that you have a spinal curvature, flat feet, spinal arthritis, or inherited spinal problem?

- YES _____ NO

5. Spinal misalignments cause **decay and degeneration**, which may result in grinding or cracking noises. Do you ever hear noises or feel grinding when you move your head or neck? YES

NO

6. Spinal misalignments can make you feel like you need to twist, stretch or crack your neck or back. Do you ever feel the need to crack or pop your neck or lower spine? YES NO

7. **Poor posture** leads to **poor health** and often indicates a spinal problem. How would you rate your posture?

Poor - 1 2 3 4 5 6 7 8 9 10 - Excellent

8. **Stress** can cause or **accelerate spinal damage**. Rate your stress level over the last 90 days.

Low - 1 2 3 4 5 6 7 8 9 10 - High

9. Prescription medications may cause various side effects, hide the severity of health problems and hinder the body's ability to heal. Please list any and **ALL** medications you are currently taking and why you are taking them. (Ex. Aspirin, Tylenol, Vicodin for Back Pain, Birth control pills to regulate cycle)

10. **Auto** and work-related injuries can cause **serious** spinal problems. Is this visit related to an accident or injury? YES NO Date of Incident _____

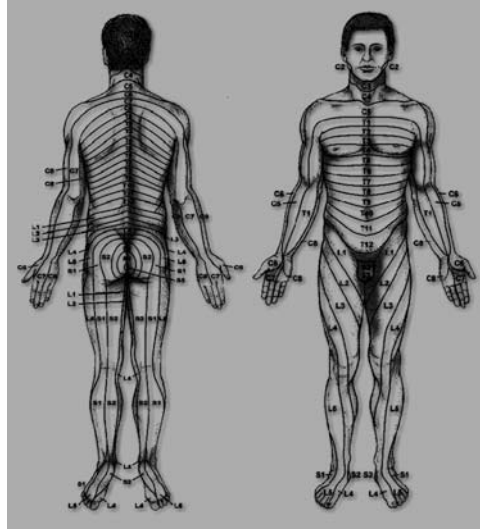
11. Research shows that spinal misalignments occur in **8 out of every 10 children** due to the birth process. These misalignments often cause allergies, ear infections, breathing problems and difficulty in concentration. As a child, did you experience any of these problems? YES _____ NO

The above information is true and accurate to the best of my knowledge.

Patient Signature _____ **Date** _____

CONFIDENTIAL PATIENT HISTORY

Date: _____
Patient # _____



Please mark off all areas of complaint on the diagrams with the following indicators:

AAA=ache
DDD=dull
NNN = numbness
TTT= tingling
BBB= burning
SSS=sharp/stabbing
XXX = other

Please rate the intensity of your symptoms on a scale of 0-10 (0 being no symptoms, 10 being extreme)

0 ♦♦♦ 1 ♦♦♦ 2 ♦♦♦ 3 ♦♦♦ 4 ♦♦♦ 5 ♦♦♦ 6 ♦♦♦ 7 ♦♦♦ 8 ♦♦♦ 9 ♦♦♦ 10

Do you smoke? yes no If yes, how many packs per week? _____ Have you ever smoked in the past? yes no When did you quit? _____

Do you consume alcohol? yes no If yes, how many drinks per week? _____

Do you consume caffeine? yes no If yes, how many drinks per day? _____

Do you exercise? yes no If yes, how many times per week and what type? _____

Do you have a high stress level? yes no If yes, list reasons: _____

Is there any possibility that you may be pregnant? yes no Date of Last Menstrual Cycle _____

Please check if you have had any of the following:

<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/> Midback Pain
<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Disc Degeneration	<input type="checkbox"/> Arm/Leg Pain	<input type="checkbox"/> Jaw Pain/Clicking
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Asthma	<input type="checkbox"/> Numbness/Tingling
<input type="checkbox"/> Allergies	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Digestive Problems	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/> Menstrual Problems
<input type="checkbox"/> Pinched Nerve	<input type="checkbox"/> Loss of Sleep	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Cancer	<input type="checkbox"/> Nervousness	<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Heart Disease/Problems
<input type="checkbox"/> Paralysis	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> PMS/Cramps	<input type="checkbox"/> Prostate Problems
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Sciatica	<input type="checkbox"/> Sinus Pain	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Stroke
<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Tumors/Growths	<input type="checkbox"/> Urinary Problems	<input type="checkbox"/> Vascular Disease	<input type="checkbox"/> Vision Problems
<input type="checkbox"/> Other:				

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that *Essential Family Chiropractic* will prepare any necessary reports and forms to assist me in making collection from the insurance company. I authorize payment of insurance benefits directly to *Essential Family Chiropractic*. I also authorize the doctor to release all information necessary to communicate with personal physicians, other healthcare providers, and/or payors to secure the payment of benefits. However, I clearly understand that I am personally responsible for all costs of treatment rendered, regardless of insurance coverage. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable.

Patient's Signature: _____ Date: _____
Guardian's Signature: _____ Date: _____

Terms of Acceptance



When a person seeks Chiropractic care and we accept a person for such care it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent confusion.

Adjustment: A specific application of forces to facilitate the body's correction of the vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spine resulting in nerve dysfunction, resulting in the lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. Our focus in this office is the vertebral subluxation. However, if we encounter non-chiropractic or unusual findings we will advise you. If you desire advice, diagnoses or treatment for those findings we recommend that you seek another healthcare provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to locate, analyze and correct vertebral subluxation by specific adjustments.

I, _____ have read and fully understand the above statements.
(Print name)

All questions regarding the chiropractors objective to my care in his office have been answered to my complete satisfaction. I therefore accept care on this basis.

Signature: _____ **Date:** _____

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____
Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive Chiropractic care. If you agree, sign below.

Signature: _____ **Date:** _____

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his staff have my permission to perform X-ray. Date of last menstrual period: _____

Signature: _____ **Date:** _____

Essential Family Chiropractic Financial Policy



INSURANCE-Your insurance is a contract between you and your insurance company. We can offer assistance with providing information to help you in filing claims, but you are primarily responsible for any charges that you have incurred as a patient with Essential Chiropractic Center. As a benefit and courtesy to you, our office will verify and submit bills to your insurance. It is important for you to understand that these benefits are a quote of benefits not a guarantee of payment. Health insurance is designed to help you meet the cost of your health care, but ultimately the responsibility is yours. Your insurance contract is strictly between you and your insurance company. We are not a party to that contract.

COPAYMENTS AND DEDUCTIBLES- Please be prepared to pay all charges at the time of your visit. Until your Insurance coverage has been verified, it is our office policy for you to pay for services rendered in their entirety. Once insurance has been verified we will apply your payment towards your deductible, co-payments or future care. If a promotional gift card was given to you, it must be presented at time of service, According to IL stature, insurers (insurance companies) are required to pay properly submitted claims within 30 days. You have the responsibility to provide information to our office so a claim can be properly submitted. If your insurance company had not paid a claim on your behalf after 90 days because of information that you have not provided, the balance will be transferred to your account and you will be responsible for payment. If we receive payment at a later date, you will be reimbursed by Essential Chiropractic Center. The patient, parent, or guardian by the acceptance of the services provided by the Doctor, agree to the Late Billing Charge of 1.5% per month added to the account that the balance remains open over 30 days from the date of service.

MISSED APPOINTMENTS- Unless cancelled within 24 hours, our policy is to charge for missed appointments. The fee for a missed routine appointment is \$35 and a fee of \$75 for a missed exam, X-ray, neurological evaluation, posture study, orthotic evaluation. This fee is not covered by your insurance plan and is your responsibility. Please respect our time and the time of others.

FEDERALY FUNDED PROGRAMS- Medicare, Medicaid, Public Aid, **WILL NOT** cover Exams, Progress exams, X-rays, spinal corrective exercises, rehabilitation, extremity adjustments nor any other services other than spinal adjustments.

X-RAYS- is the property of Essential Chiropractic Center. Once films are used they cannot be released. All X-rays are read by a radiologist. You can request a copy of this report. All requests for X-rays reports must be received in writing. Once this request has been submitted, you will be notified when your report is available.

I have read the financial policy and agree to its terms. Our office policy is to maintain an active credit card on file.

Patient Signature _____ Date Signed _____

Credit card number _____ Exp Date _____ V-C _____ MC VISA DISC

NOTICE OF PRIVACY PRACTICES

Richard Hagemeyer, D.C.
Essential Family Chiropractic Center

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

**PLEASE REVIEW IT CAREFULLY AND SIGN.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted by law.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time.

Uses And Disclosures Of Protected Health Information Based Upon Your Written Consent

You will be asked by your chiropractor to sign this consent/acknowledgment form. By signing the consent/acknowledgment form, your chiropractor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you may also use and disclose your protected health information to pay your health care bills and to support the operation of the chiropractor's office.

Following are examples of the types of uses and disclosures of your protected health care information that the chiropractor's office is permitted to make once you have signed this consent/acknowledgment form:

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your chiropractic care and any related services. This includes the coordination or management of your chiropractic care with a third party that has already obtained your permission to have access to your protected health information.

Payment: Your protected chiropractic information will be used, as needed, for your chiropractic services. This may include certain activities that your chiropractic insurance plan may undertake before it approves or pays for the chiropractic services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your chiropractor's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of chiropractic students, substitute chiropractors, doctors who observe our practice, licensing, marketing, fundraising activities, and conducting or arranging for other business activities.

In addition we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting or adjusting room. We may use your health information to call you to remind you of, cancel or re-schedule an appointment. We may leave a message on your answering machine or voice mail. To promote a less stressful, family friendly and time efficient environment, most office visits are performed in an open area where complete privacy of your name and health information will be respected but cannot be guaranteed. Special appointment times are available by request for discussion of private or confidential matters. We may mail appointment reminders, announcement or greeting cards to your home. Your name or picture may be used on a "Thank You for Referring", "Welcome to Our Office" or office bulletin board unless you specifically request us not to do so. Your private information will be used when we bill insurance claims for you or need to collect an outstanding balance using an outside collection agency.

We may share your protected health information with third party "business associates" that perform various activities (e.g., billing transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your chiropractor or the chiropractic practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health care information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your chiropractor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

NOTICE OF PRIVACY PRACTICES

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your chiropractic care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your chiropractor shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your chiropractor or another chiropractor in the practice is required by law to treat you, and the chiropractor has attempted to obtain your consent, but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your chiropractor or staff member in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the chiropractor or staff member determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

We may use or disclose your protected health information in the following situations without your consent or authorization:
When required By Law, Public Health, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration, Legal Proceedings, Law Enforcement, Funeral Directors, and Organ Donation, Criminal Activity, Military Activity, Inmates and National Security:

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance.

You have the right to inspect and copy your protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, health operations or additional uses listed above in paragraph 8. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your chiropractor is not required to agree to a restriction that you request. If your chiropractor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your chiropractor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for this request. Please make this request in writing to our Privacy Contact.

You may have the right to have your chiropractor amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. The terms of this Notice may change. If the terms do change you may receive a revised Notice by contacting our Privacy Contact.

Privacy Contact: Dr. Richard Hagemeyer D.C. or (630) 718-0554 Fax (630) 718-0555
1020 104th Street Ste. 100, Naperville, IL 60564

I have received a copy of this office's Notice of Privacy Practices and consent to the use and disclosure of protected health information by Dr Richard Hagemeyer., staff and business associates for treatment, payment, health care operations and additional uses listed above. I have reviewed, acknowledge, and understand the content of the Notice of Privacy Practices.

"You May Refuse To Sign This." THIS NOTICE WAS PUBLISHED AND BECOMES EFFECTIVE ON APRIL 14, 2003.

Printed Patient Name _____ Date _____

Signature _____

Printed Name of Parent/Guardian _____

Signature of Parent/Guardian _____

Chiropractic Digital Solutions

Your doctor is sending your x-rays to CDS to obtain information that will help provide you with better patient care. CDS will send reports about you to your doctor in the form of Pathology, Biomechanical, and Mensuration analyses. CDS is a laboratory with specialized equipment, which provides over 500 different mathematical calculations used to construct and display 59 different diagnostic analyses of your spine. Our Radiologist will review your x-rays and will carefully analyze all data which your doctor considers when rendering your diagnosis and recommending a treatment plan based on your individual needs for faster recovery. Radiographic Mensuration objectively documents the significance of the presence or absence of spinal injuries caused by trauma. This analysis measures the degree of spinal injury very accurately. The process produces a precise graphical representation of your spine. This will enhance your understanding of your existing spinal problems and may correlate spinal instability with some of your symptoms.

It is important for you to give your consent to the following items:

a. Release

I understand my x-rays and other pertinent information relating to my treatment will be presented to CDS for analysis. I further understand: (1) the sole purpose of this analysis is to obtain numeric measurements and graphical data pertinent to identifying Spinal injuries, Biomechanical abnormalities and Pathology analyses; (2) this information is valuable in order to assist my doctor in his/her evaluation of an initial treatment plan as well as modifications to this plan during the course of treatment.

b. Insurance Assignment

I authorize direct payment of medical benefits by all responsible insurance companies to CDS. I also authorize the release of any medical information necessary to process this claim. Should my current insurance policy prohibit direct payment to providers, I will direct my insurance company to issue a check payable jointly to CDS and myself. I grant CDS my power of attorney to endorse any checks made payable in my name, individually and/or jointly. A copy of this authorization shall be deemed valid as the original. If I have not met my deductible, it will be my responsibility to pay the amount still owed.

c. Assignment of Legal Rights

If for any reason my insurance company denies payment for the CDS procedure, I authorize the release to CDS any and all medical review documentation that led to the denial. I irrevocably assign my legal rights to CDS to act on my behalf to secure payment of this claim.

d. Attorney Lien

I, hereby, irrevocably authorize my attorney to make payment in full to CDS out of any eventual verdict or settlement. I am also notifying my attorney not to take any actions, as my representative, in any way to compromise or reduce the charges due CDS. I will direct my attorney to sign the CDS letter of protection regarding my charges. Upon issuance, I hereby agree that such letter of protection cannot be revoked or modified without the expressed written consent of this office. I have read the above and authorize the foregoing to be carried out on my behalf.

Patient's Signature: _____

Date:

AUTHORIZATION AND ASSIGNMENT



In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorized the direct payment to you of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, **and by any insurance company** obligated to make payment to me or you based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services refused to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to correctly set forth under pertinent data below) and authorize you to prosecute said action in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claims as you see fit. However, it is understood that until all reasonable efforts have been made to collect the sums due from the insurance company, or companies, contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what is due, I personally owe you.
4. A time-price differential (a late fee for professional services) of 1.5% per month may be imposed on all patient balances owing more than 30 days. By signing below you acknowledge that you understand the information above and you agree to be responsible for payment of all costs, including any collection fees.

SIGNED: _____ DATE: _____

Essential Family Chiropractic

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