

CHIROPRACTIC HEALTH QUESTIONNAIRE

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

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 _____

PLEASE LIST YOUR HEALTH COMPLAINT(S)/ SYMPTOMS

A _____
B _____
C _____

DR'S COMMENTS:

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.
- Other _____

IF THE DOCTOR(S) FEEL 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.
- I am not interested in receiving any care.



Essential Family Chiropractic
1020 104th street
www.Naperville-chiro.com

Your health potential lies within.... Our Purpose is to set it in motion.....

Pediatric History form (13 and under)

It is our pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help serve you better, please complete the following information. We look forward to working with you! Thank you!

Date: _____ Referred By: _____

Patient Name: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Birth Date: _____ Sex: _____ Weight: _____ Height: _____ S.S.#: _____

Names of Parents/ Guardians: _____

Purpose for contacting us? _____

Other doctors seen for this condition: N/Y If yes, list doctor's name and prior treatments: _____

Other health problems? _____

Research shows that spinal misalignments occur in **8 out of every 10 children** due to the birth process (C-section, Forceps, Vacuum extraction, Vaginal delivery) These misalignments often cause allergies, ear infections, breathing problems and difficulty in concentration.

Check any of the following conditions your child has suffered from during the past six months:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Digestive problems | <input type="checkbox"/> ADHD | <input type="checkbox"/> Temper tantrums |
| <input type="checkbox"/> Asthma/ Allergies | <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Auto accident | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Seizures | <input type="checkbox"/> Chronic colds | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Scoliosis | | <input type="checkbox"/> Recurring fevers | |

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

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

Family History: _____

Previous chiropractor: _____ Date of last visit: _____ Reason: _____

Were you satisfied: _____ Why? _____

Name of pediatrician: _____ Date of last visit: _____ Reason: _____

Number of doses of antibiotics your child has taken:

a) During the past six months: _____

b) Total during his/ her life: _____

Number of doses of other prescription medications your child has taken:

a) During the past six months: _____

b) Total during his/ her life: _____

Vaccination history: _____

Feeding History:

Breast Fed: N/Y If yes, how long? _____ Formula: N/Y If yes, how long? _____

Introduced to solids at _____ months. Cows' milk at _____ months.

Prenatal History:

Complications during pregnancy? N/Y If yes, please list them: _____

Ultrasounds during pregnancy? N/Y If yes, how many: _____

Medications during pregnancy/ Delivery? N/Y If yes, please list them: _____

Cigarette/ alcohol use during pregnancy? N/Y

Location of birth: Hospital: _____ Home: _____ Other: _____

Birth intervention: Forceps: ___ Vacuum Extraction: ___ Caesarian Section: ___

Complications during delivery? N Y If yes, please list them: _____

Birth Weight: _____ Birth Length: _____ APGAR Scores: _____

Childhood diseases:

Chicken Pox: N/Y age: ___ Rubeola: N/Y age: ___ Whooping Cough: N/Y age: ___

Rubella: N/Y age: ___ Mumps: N/Y age: ___ Other: _____ N/Y age: ___

Developmental History:

. At what age was your child able to:

Respond to sound: _____

Respond to visual stimuli: _____

Hold head up: _____

Sit up: _____

Cross Crawl: _____

Stand Alone: _____

Walk Alone: _____

Has your child ever been involved in a car accident? N/Y If yes, please list: _____

Has your child fallen from a high place? N/Y If yes, please list: _____

Prior surgery? N/Y If yes, please list: _____

I hereby authorize (Your Office) to administer care to my son/ daughter. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signed: _____ Relationship to patient: _____

Terms of Acceptance

Understanding the Purpose of Chiropractic Care

When we accept you or your family as a patient it is important that you understand the objectives of our care. Chiropractors provide a unique service that other healthcare providers do not offer. Chiropractors specialize in the location and correction of vertebral subluxations for the purpose of improving the health and function of your spine and nervous system.

A vertebral subluxation is a misalignment or distortion of your spinal column and related structures that can affect your health and overall body functioning. Chiropractors spend years studying how to locate and correct this destructive condition. The correction is performed using specialized techniques called "chiropractic or spinal adjustments" over a period of time. When your spine is free of the nerve and musculoskeletal stress caused by subluxations your body can function more efficiently and your body's natural ability to heal can work more optimally.

It is not our objective to prescribe medication, medically diagnosis or treat disease. If you desire diagnosis or treatment for a disease or condition or advice on taking or stopping medications, we recommend that you consult a medical physician who specializes in that area.

If we discover unusual findings during the course of our chiropractic examination(s) we will discuss them with you. You may then decide whether you wish to investigate further and discuss your healthcare options with other health professionals. We are happy to communicate our concerns with any other health professional.

The purpose of chiropractic care is not to treat disease, suppress symptoms, perform surgery or prescribe medications but rather to improve the health and function of your spine and nerve system to help your body function at its optimum health and healing potential. Our primary objective is to improve and maintain the health and normal function of your spine and nerve system to the maximum degree possible for you.

I understand the purpose of chiropractic care as explained above.

Patient Signature

Date

Staff Signature

Date

Essential Family Chiropractic Financial Policy and Privacy 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. Your initial visit will cost approximately \$200. 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.

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. Copies can be made for a charge of \$75. All requests for X-rays must be received in writing. Once this request has been submitted a copy will be available within 24-48 hours.

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 Hagmeyer D.C. or Dr. Ryan Betz, D.C. (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 Hagmeyer or Dr Ryan Betz, D.C., 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:
