HealthSource®
Chiropractic & Progressive Rehab™

ENTRANCE APPLICATION

WELCOME!... WE ARE HONORED YOU CHOSE US TO EVALUATE YOUR CONDITION.
SO WE MAY FILE YOUR INSURANCE FORMS FOR YOU, WOULD YOU PLEASE FILL OUT THE PERSONAL INFORMATION BELOW?
IF YOU NEED ASSISTANCE PLEASE INFORM THE FRONT DESK PERSON. THANK YOU!

First Name ______________ Middle ______________ Last ______________

Gender ❑ Male ❑ Female Home Phone ______________ Cell Phone ______________

Address ______________

City ______________ State ______________ ZIP ______________

Social Security Number ____ - ____ - ____ E-mail Address ______________

Birthdate ______________ Age ______ **Marital Status** S M W D

Employer Name ______________

Job Title ______________ Work Phone ______________

Spouse's Name ______________ Spouse's Birthdate ______________

Social Security Number ____ - ____ - ____

Person responsible for this account ______________

Name of person on your health insurance card ______________

Name of their employer ______________ City ______________

Employer Phone ______________

Children–Names & Ages ______________

In case of emergency, whom should we contact? ______________

Phone ______________

FAMILY PHYSICIAN: ______________

What is your primary complaint? ______________

____

____

IS THIS WORKMAN'S COMPENSATION? ______ **IS THIS PERSONAL INJURY?** ______

Patient Informed Consent

I, ______________, the undersigned patient, consent to the treatment(s) provided by this clinic. I understand that my condition may necessitate modifications from time to time of the type of treatment(s) rendered and the portions of my body that may need to be examined. I understand and consent to clinic staff providing me with verbal descriptions, when there are changes to my exam(s) and treatment(s), consent to the clinic staff providing said treatment(s) and exam(s) and hereby consent to any similar subsequent treatment(s) or exam(s). If I do not consent, I will immediately inform clinic staff. There are times when individuals other than staff may see me receive treatment at the clinic or overhear discussions of my condition or insurance. I consent to others perceiving these interactions at the clinic. If additional privacy is required, I will inform the clinic staff.

Patient Signature ______________

(Office use only)	**Account Number**	**Date**

Assignment of Benefits and Financial Responsibilities

Payment is due at the time of service unless other arrangements are made. **Balances unpaid 90 days after services are rendered become the patient's responsibility and will be considered delinquent.**

I authorize payment for services rendered to me or my dependents to HealthSource of Lombard from my insurance company, my attorney, or any other party who may be obligated to pay me any sums. I further authorize the endorsement of my name to any draft containing my name to which you are legally entitled. I understand that all charges incurred are the personal responsibility of the patient/guarantor. Commercial insurance is filed as a courtesy to the patient, and managed care insurance is filed with contracted carriers. The patient/guarantor is responsible for all residual balances including but not limited to co-pays, deductibles,, co-insurance and services or charges not paid by insurance for any reason, after consideration of contractual adjustments.

In the event any insurance company, attorney, or other person obligated by contractual agreement to make payment to me for your service charges refuses 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, attorney, or person and authorize you to prosecute said action either in my name or your name and for you to resolve said claim as you see fit. I understand that I shall continue to remain responsible for any uncollected or unpaid balance on my account.

I hereby direct my attorney not to interfere with or claim any lien upon any medical payment benefits to which I may be entitled from either my health insurance or medical payment sources. And if any said medical payment checks include my attorney's name, I direct my attorney to sign his name to these checks for the benefit of the medical provider herein.

A late payment charge will be added to an account if payment is not made within 90 days. The late payment charge is 1 ½% per month on charges not paid within 90 days. The late payment charge will be billed each month until those charges are paid (at the rate of 18 percent per year) and will appear separately on your regular statement.

In the event that this account goes into default and our office turns it over to our outside collections agency/attorney for collections, it is accepted and agreed that thirty percent (30%) of the principal amount of the balance due will be added as collection/attorney fees.

It is also agreed and accepted that in the event that a lawsuit is filed, you, the patient will be liable for any and all court costs expended whether judgment has been entered or not.

Patients who fail to show ("No Show") or cancel less than 24 hours prior to the massage appointment will be charged a $50 missed appointment fee. This fee is not billable to insurance and must be paid before your next visit with our office. People who are late for their appointment will be charged the full fee for the time they were scheduled.

Authorization to Release Information

I authorize HealthSource of Lombard and its physicians to release any information regarding medical, dental, mental, alcohol or drug abuse history treatment, including disability related information, to any third party payor (including Medicare) or their contracted agents, to validate or determine benefits payable for services rendered to myself or any dependents.

Signature:____

Print Name:____

Date:____________________________

HIPAA PATIENT CONSENT FORM

We are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to maintain the privacy of your protected health information (PHI) and to provide you with a Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your PHI, and contains a section describing your rights as a patient under the law. You have the right to review our Notice before signing this Consent and you are advised to do so.

By signing this form, you consent to our use and disclosure to third parties of your PHI for treatment, payment, and health care operations, and for certain marketing purposes, as described in our Notice of Privacy Practices. If you sign this Consent but later change your mind, you have the right to revoke this Consent by delivering to us a written, dated document signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

The patient understands that:

The Clinic has a Notice of Privacy Practices. The patient has received, and had the opportunity to review, this Notice before signing this consent. The Clinic encourages all patients to review the Notice of Privacy Practices.

The Clinic reserves the right to modify the Notice of Privacy Practices to keep up with changes in the law or office practices. We will make all modifications available for review by patients.

Protected health information may be disclosed or used for treatment, payment, or health care operations, and for certain marketing purposes.

The Clinic or its business affiliates may use your PHI to contact you with educational and promotional items in the future via email, U.S. Mail, telephone, fax and/or prerecorded messages. We **WILL NOT** ever sell or "SPAM" your personal contact information.

The patient has the right to restrict the uses of his or her information, but the Clinic does not have to agree to all such restrictions.

The patient may revoke this Consent in writing at any time and all future disclosures that require the patient's prior written consent will then cease.

The Clinic may condition receipt of treatment upon the execution of this Consent.

The Consent was signed by: ______________________________

Printed Name – Patient or Representative

____

Signature Date

Relationship to Patient
(if other than patient) ______________________________

Witness: ______________________________

Printed Name – Clinic Representative

____

Signature Date

For Internal Use:

☐ Patient Refused to Sign ☐ Patient unable to sign for the following reason:______________________________

HS HealthSource® Chiropractic & Progressive Wellness™

Patient Name: ____________________ Height: _____ Weight: _____

HISTORY OF ILLNESS / INJURY / PAIN

LOCATION

Chief complaint and its location: ____

____

TIMING & DURATION

How often do you experience this pain? _____Constant _____Frequent _____Intermittent ____Occasional

What caused the onset? ____

____

Date of onset? / / (Please list your most recent incident (minor or major) that prompted this visit.)

SEVERITY

On a scale of 0 to 10 with 0 representing no pain and 10 being the most severe pain imaginable, use the key below to rate the severity of your pain.

0 = None 1 = Minimal 2 = Very Mild 3 = Mild 4 = Mild to Moderate 5 = Moderate
6 = Moderate to Severe 7 = Mildly Severe, Restricts Some Activity 8 = Severe, Limits Most Activity
9 = Very Severe 10 = Excruciating

Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the least intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the most intense the symptom has been on a scale of 0 to 10?

_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

ASSOCIATED SIGNS & SYMPTOMS

Please check those that apply ➡ _____Inflexibility _____Stiffness _____Spasms _____Cramps

If this pain radiates or travels, please identify where to: ____

____

QUALITY

How would you best describe the sensation of the pain/symptom:

_____ Sharp _____ Stabbing _____ Aching _____ Pins & Needles _____ Pounding _____ Shooting
_____ Burning _____ Dull _____ Tingling/Numb _____ Throbbing _____ Crawling _____ Stinging

MODIFYING FACTORS

What aggravates the pain/symptom?

_____Sneezing _____Lifting _____Exercising _____Looking up/down _____Walking
_____Coughing _____Sitting _____Stooping _____Looking side/side _____Standing
_____Stress _____Driving _____Getting out of bed _____Pushing _____Pulling
_____Repetitive movement _____Carrying _____Straining at BM _____Climbing stairs _____Getting in/out of car

Other:____

What relieves this pain/symptom?

_____Resting _____Sleeping _____Lifting _____Exercising _____Looking up/down
_____Shower _____Advil _____Stooping _____Looking side/side _____Mineral Ice
_____Other: ____

Over the past weeks/months this complaint is: _____Improving _____Getting worse _____About the same

Have you seen anyone for this condition? _____YES _____NO WHOM?______________________________

How did you hear about us? ____

Doctor Signature: ____

Patient Signature: ____

NAME: **DATE:** / / **Account#:**

SECONDARY COMPLAINT & LOCATION

Location ____________________ Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?
_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the least intense the symptom has been on a scale of 0 to 10?
_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the most intense the symptom has been on a scale of 0 to 10?
_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

ASSOCIATED SIGNS & SYMPTOMS Please check those that apply ➡ _____Inflexibility _____Stiffness _____Spasms _____Cramps

If the pain radiates or travels, please identify where to: ____________________

QUALITY

How would you best describe the sensation of the pain/symptom:

_____ Sharp _____ Stabbing _____ Aching _____ Pins & Needles _____ Pounding _____ Shooting
_____ Burning _____ Dull _____ Tingling/Numb _____ Throbbing _____ Crawling _____ Stinging

Over the past weeks/months this complaint is: _____Improving _____Getting worse _____About the same

THIRD COMPLAINT & LOCATION

Location ____________________ Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10?
_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the least intense the symptom has been on a scale of 0 to 10?
_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

What is the most intense the symptom has been on a scale of 0 to 10?
_____0 _____1 _____2 _____3 _____4 _____5 _____6 _____7 _____8 _____9 _____10

ASSOCIATED SIGNS & SYMPTOMS Please check those that apply ➡ _____Inflexibility _____Stiffness _____Spasms _____Cramps

If the pain radiates or travels, please identify where to: ____________________

QUALITY

How would you best describe the sensation of the pain/symptom:

_____ Sharp _____ Stabbing _____ Aching _____ Pins & Needles _____ Pounding _____ Shooting
_____ Burning _____ Dull _____ Tingling/Numb _____ Throbbing _____ Crawling _____ Stinging

Over the past weeks/months this complaint is: _____Improving _____Getting worse _____About the same

KEY VALUE QUESTIONS

1. What is your pain keeping you from doing that is most important in your life?

____

____

2. What do you enjoy doing most in your life?

____

____

NOTES / COMMENTS:

____

____

____

Doctor Signature: ____________________

Patient Signature: ____________________

NAME: DATE: / / Account#:

Please place a checkmark by the condition that applies to you: **P** = Present • **N** = Not Present • **PP** = If it has ever been present in the past

P	N	PP	
			Fatigue
			Fever
			Chills
			Night Sweats
			Fainting
			Nervousness
			Concentration Loss

P	N	PP	
			Irritability
			Depression
			Memory Loss
			Headache
			Muscle Pain
			Muscle Weakness
			Muscle Cramps

P	N	PP	
			Joint Stiffness
			Spinal Curvature
			Back Pain
			Hot Joints
			Joint Swelling
			Stiff Neck
			Lumps / Masses

P	N	PP	
			Seizures
			Dizziness
			Tremors
			Loss of Sensation
			Loss of Coordination
			Paralysis
			Difficulty of Speech

P = Present • **N** = Not Present • **PP** = If it has ever been present in the past • Do the same for your family

Family History Key: F = Father • **M** = Mother • **B** = Brother • **S** = Sister • **GF** = Grandfather • **GM** = Grandmother

Family History

P	N	PP	Past Problem	When and Explanation of Condition (use back if needed)	F	M	B	S	GF	GM
			Cancer							
			Stroke							
			Thyroid Problems							
			Asthma							
			Heart Attack							
			HIV							
			Angina/Chest Pain							
			Diabetes							
			Arthritis							
			Other							

Do you have a pacemaker? _____YES _____NO

Are you Pregnant? _____YES _____NO

Do you think you may be pregnant? _____YES _____NO

FOR DOCTOR'S USE ONLY – PATIENT PLEASE PROCEED TO PAGE 4

REVIEW OF SYSTEMS

SYSTEM REVIEWED

❏ Allergic / Immunologic
❏ Constitutional
❏ Endocrine
❏ Gastrointestinal
❏ Genitourinary
❏ Integumentary
❏ Neurological
❏ Respiratory
❏ Cardiovascular
❏ Ears / Nose / Mouth
❏ Eyes
❏ All other system reviews negative
❏ Hematological / Lymphatic
❏ Musculoskeletal
❏ Psychiatric

Notes / Comments: ____________________

Doctor Signature: ____________________

Patient Signature: ____________________

NAME: ______________________ **DATE:** _____/_____/_____ **Account#:** ______________________

PLEASE LIST PAST SURGERIES:

1. ______________________ Year______ 2. ______________________ Year______
3. ______________________ Year______ 4. ______________________ Year______
5. ______________________ Year______ 6. ______________________ Year______

List any other key slips, falls or accidents you've had from childhood to present:	Date
1)	
2)	
3)	
4)	
5)	

What medications are you currently taking? (Include Date)	
1)	4)
2)	5)
3)	6)

Have you ever taken:	YES	NO	YEAR
Insulin			
Cortisone			
Thyroid Medicine			
Male/Female Hormones			
Blood Pressure			
Tranquilizers/Sedatives			
Birth Control			

Hospitalizations:

Marital Status: ____Married ____Divorced ____Single ____Separated ____Widowed

Number of Children: ____ Children's Name(s): ______________________

Frequency of Exercise: ____Never ____Rarely ____Occasionally ____Moderately ____Regularly

Intensity of Exercise: ____Low Level ____Medium Level ____High Level ____Competition Level

Sufficient Rest: ____Never ____Rarely ____Occasionally ____Moderately

Hours of Sleep: ____6 ____8 ____10 ____More than 10

Well balanced diet: ____Never ____Rarely ____Occasionally ____Moderately

Do you smoke? ____No ____Occasionally ____1 to 2 ____2 to 3 ____4 to 5 ____More than 5 packs/day

Do you drink caffeinated beverages? ____No ____Occasionally ____1 to 2 ____2 to 3 ____4 to 5 ____More than 5 drinks/day

Do you drink alcoholic beverages? ____No ____Occasionally ____1 to 2 ____2 to 3 ____4 to 5 ____More than 5 drinks/day

Have you ever used street drugs? ____Yes ____No

Hobbies: ______________________

____

Patient history was obtained from: _____Patient _____Father _____Mother _____Son _____Daughter

Notes / Comments: ______________________

____

____

____

____

____

____

____

Doctor Signature: ______________________

Patient Signature: ______________________

Pregnancy Release and Consent Form

Date:___________________

Patient Name:____ ACCT#:__________________

Patient DOB:____________________________

Please answer the following questions:

Are you pregnant or any chance you may be? YES OR NO

Date of the start of your last period:____________________________________

What type of birth control do you use:

___________	Birth Control	___________	Depo Provera	__________	Other
___________	IUD	___________	Patch	__________	None

Are you trying to get pregnant? YES NO

Any surgeries? List types:
____

Please initial the line and check the box for the following that apply.

_______ I acknowledge that HealthSource Chiropractic may require that I have a urine and/or blood pregnancy test before I have any imaging procedures since I am 50 years of age or younger and have not had a Tubal Ligation or a Hysterectomy.

_______ I do not feel it is necessary for me to take a pregnancy test before I have any imaging procedures. I am aware of the potential medical risks due to exposure of radiation to myself and if I were pregnant, my unborn child.

_______ I will not hold HealthSource Chiropractic or any of the doctors or staff liable if I have an imaging procedures and find out that I am pregnant afterwards.

Your signature indicates that you have read and understand the above and accept all responsibility associated with exposure to yourself or your unborn child and have accurately answered the above statements.

Signature: ____ Date:_____________________

Witness Signature: ____ Date:_____________________