Plainfield Spine And Rehab
Registration Form
PLEASE PRINT ALL INFORMATION CLEARLY

Patient's Legal Name: _____ DOB: _____ Age: _____

Address: _____ Home phone: _____

City/State/Zip: _____ Cell phone: _____

E-mail address: _____ SSN: _____ (required for claims)

☐ I authorize your office to contact me via e-mail and cell phone

Marital status: Single Married Divorced Widow/widower Separated

Gender listed under insurance Policy: _____

If married, spouse's name: _____ # of children: _____

Occupation: _____ Work phone: _____

Employer name: _____ Ethnicity/Race: _____

2 EMERGENCY CONTACTS

Contact Name#1: _____ Phone: _____

Relationship to patient: _____

Contact Name#2: _____ Phone: _____

Relationship to patient: _____

Primary Care Physician: _____

How did you hear about our office? _____

Relationship to patient: _____

Have you ever received professional chiropractic treatments before? Yes No

If yes, have you been treated by another chiropractor during your current insurance benefit period? Yes No

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PERMISSION AGREEMENT & INFORMED CONSENT

I hereby give permission to the doctor to release any information requested by my insurance company acquired in the course of my treatment.

I hereby authorize and direct my insurance benefits to be paid directly to the doctor. I am financially responsible for non-covered services.

I hereby give permission to the doctor to administer treatment and perform such general procedures as deemed necessary in the diagnosis and/or treatment of my condition. I understand that results of treatment are not guaranteed. I further understand and am informed that, as with any healthcare procedure, in the practice of chiropractic there may be risks associated with treatment, although rare, possible. I understand it is my responsibility to fill out my case history completely and to the best of my knowledge, and to inform the doctor of any information that is not listed on my case history. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, and is in my best interest.

If treating a minor child of mine, under the terms and conditions of my divorce, separation, or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

I attest that I wanted this examination, consultation, and/or treatment(s). I was not paid or solicited by a 3rd party to have this examination and/or consultation, I was not personally targeted due to my insurance carrier, or financial situation, and am here on my own free will.

Signature: _____ Date: _____

Plainfield Spine and Rehab

Health Status

Patient name: _____ **Date:** _____

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

☐ Headache ☐ Neck pain ☐ Mid-back pain ☐ Low back pain

☐ Other: _____

Is this? ☐ Work related ☐ Auto related ☐ N/A

Date problem began: _____

How problem began: _____

How would you describe your pain? (ie: achy, burning, sharp)_____

What makes your pain worse?_____

What makes your pain feel better?_____

How often are your symptoms present? **Daily** **Weekly** **Monthly** **Yearly**

☐ ☐ ☐ ☐

(Occasional) 0-25% 26-50% 51-75% 76-100% (Constant)

In the past week, how much has your pain when its at its worse interfered with your daily activities (e.g. work, social activities, etc.)?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

In the past week, how intense has your pain been at its worse on a scale of 1-10 (10 being the worst and 1 being minimal)?

Normal 0 1 2 3 4 5 6 7 8 9 10 Unbearable

Have you missed work or school due to your pain?

☐ Yes ☐ No

In general, how would you describe your overall health right now?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Have seen another physician(s) for this condition? (*If so please list names and dates)*

_____

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered, and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient signature: _____ **Date:** _____

Patient Health History

Name: _____ Date: _____

DOB: _____ Height: _____ Weight: _____ M or F

Please indicate if you have or have had any of the following conditions. This is a confidential health report.

- ☐ Neck pain/stiffness
- ☐ Back pain/stiffness
- ☐ Arm/elbow/hand pain
- ☐ Hip/knee/leg pain
- ☐ Ankle/foot pain
- ☐ Headaches
- ☐ Arthritis
- ☐ Dizziness
- ☐ Asthma
- ☐ Tingling in arms
- ☐ Tingling in legs
- ☐ Sciatica
- ☐ Joint swelling
- ☐ Fatigue
- ☐ Sleeping difficulties
- ☐ Allergies
- ☐ Blurred vision
- ☐ Depression
- ☐ Nervousness
- ☐ Tension
- ☐ Cold sweats
- ☐ Night pain
- ☐ Sudden weight loss
- ☐ Jaw/TMJ problems
- ☐ Constipation
- ☐ Diarrhea
- ☐ Acid Reflux
- ☐ Nausea
- ☐ Shortness of breath
- ☐ Chest pain
- ☐ Wheezing
- ☐ Gallbladder problems
- ☐ Liver problems
- ☐ Kidney infections
- ☐ Kidney stones
- ☐ Fever
- ☐ Fainting
- ☐ Sinus infections
- ☐ Bowel/bladder changes
- ☐ Hemorrhoids
- ☐ Arteriosclerosis
- ☐ Heart disease
- ☐ Hypertension
- ☐ Hypotension
- ☐ Swelling of ankles
- ☐ Thyroid problems
- ☐ Goiter
- ☐ Eczema
- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Autoimmune Disease
- ☐ Loss of Appetite
- ☐ Bleeding disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Gout
- ☐ Hernia
- ☐ Herniated disc
- ☐ Measles
- ☐ Mumps
- ☐ Malaria
- ☐ Migraines
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate problems
- ☐ Prosthesis/Crutch
- ☐ Rheumatoid arthritis
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors/Growths
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Venereal disease/STD
- ☐ Whooping cough

Women only:

- ☐ Intense monthly cramps
- ☐ Intense monthly headaches
- ☐ Hot flashes
- ☐ Currently Pregnant

Family History: (Please indicate any conditions in family)

- ☐ Inflammatory Arthritis (Rheumatoid, Psoriatic)
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Neurologic Disorders (Parkinson's, Multiple Sclerosis, Lou Gehrig's, etc.)
- ☐ Autoimmune Diseases (Lupus, Scleroderma, etc.)

Other: _____

Patient Health History

Name: _____ Date: _____

Date of last physical examination (within the last year): _____

Date of last blood work (within the last year): _____

List any medications you are currently taking:

_____

_____

List any vitamins/supplements/herbs you are currently taking:

_____

_____

List any surgeries/hospitalizations you have had:

_____

_____

List any known allergies:

_____

_____

List any broken bones/fractures you have had:

_____

_____

Do your work activities mostly involve:

__ Sitting __ Standing __ Light labor __ Heavy labor

What is your daily/weekly intake of the following:

Coffee: ____cups/day Soft drinks: ____cups/day Alcohol: __drinks/week

Cigarettes: ____packs/day Smokeless tobacco: ____ x/day

What is the intensity of your exercise? ___Heavy ___Moderate ___Light ___None

After reading and filling out the health history, your signature will verify that all the information you have given us is accurate and you have read all the history questions.

Signature: _____ Date: _____

HIPAA Notice of Privacy Practices

Plainfield Chiropractic & Rehabilitation LTD
Plainfield Spine and Rehab
13520 S. Route 59
Plainfield, IL 60544
(815)-439-9800

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, 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, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: 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 with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to 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 or health care operations. 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 physician is not required to agree to a restriction that you may request. If physician 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. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. 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 alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. 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.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

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.**

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.
11. I understand that this office treats in an open adjusting area, where privacy is limited. I understand that I can meet with the doctor privately in a closed room upon my request. Unless a request is made, it is understood that I will be treated in the open adjusting room.
12. I understand that at some point in the future that if I refer someone to this office, that my name and image may appear on a thank you board or other notation(s) throughout this office, that is in plain view of other individuals that are in this office.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Name of Patient:_____
(Please print)

Signature:_____ Date:_____