

PERSONAL HISTORY

Date: _____

Name: _____ Social Security #: _____

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

Phone #'s: Home _____ Work _____ Cell _____

E-Mail Address: _____ Your Appointment Reminder: Home Work Cell

Birthdate: _____ Age: _____ Sex: M F Height: _____ Weight: _____

Business/Employer: _____ Type of Work: _____

Check One: Married Single Widowed Divorced Separated No. of Children: _____

Name of Emergency Contact: _____ Phone #: _____

Who is responsible for your bill: Self Spouse Parent Workman's Comp. Medicare Auto Insurance

Personal Health Insurance Company: _____ ID #: _____ Group #: _____

Other _____

CURRENT HEALTH CONDITION

Purpose of this appointment: _____

Other Doctors seen for this condition: _____

When did this condition begin: _____

If disabled from work please give dates: _____ Job related Auto related

Drugs you take: Nerve pills Pain Killers/Muscle Relaxers Blood Pressure Medicine Insulin Other _____

PAST HEALTH HISTORY

Please Check or Describe: _____

Major Surgery/Operations: Broken Bones _____ Appendectomy Tonsillectomy Gall Bladder

Hernia Other _____

Major Accidents or Falls: _____

Hospitalization (other than above): _____

If Yes, Medical Doctor's Name & Approx. Date of Last Visit _____

Previous Chiropractic Care: No Yes, Provide Drs. Name & Approx. Date of Last Visit _____

Do you have Allergies: No Yes If Yes, explain: _____

Have you been treated for any health condition in the last year? No Yes, please explain: _____

How did you hear about us? Phone Book Internet Referral (please provide name) _____

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However these questions must be answered carefully as these problems can effect your overall diagnosis, treatment plan and possibly of being accepted for care.

CHECK THE FOLLOWING DISEASES YOU HAVE HAD

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Malaria | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Venereal Infection |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Typhoid Fever | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Measles | <input type="checkbox"/> Goiter | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Eczema |

CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD THE PAST 6 MONTHS

MUSCULO SKELETAL CODE

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain/Stiffness
- Walking Problems
- Sciatic Pain
- Difficult Chewing/Clicking Jaw
- Scar from Surgical Procedure

NERVOUS SYSTEM CODE

- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities

GENERAL CODE

- Allergies
- Loss of Sleep
- Fever
- Headaches

GASTRO INTESTINAL CODE

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Trouble
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps
- Gas/Bloating After Meals
- Heartburn
- Black/Bloody Stool
- Colitis

GENITO-URINARY CODE

- Bladder Trouble
- Painful/Excessive Urination
- Discolored Urine

CPT CODE

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling

EENT CODE

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose

MALE/FEMALE CODE

- Menstrual Irregularity
- Menstrual Cramping
- Vaginal Pain/Infections
- Breast Pain/Lumps
- Prostate/Sexual Dysfunction
- Genital Herpes

FEMALES ONLY

When was your last period? _____

Are you pregnant? Yes No Maybe

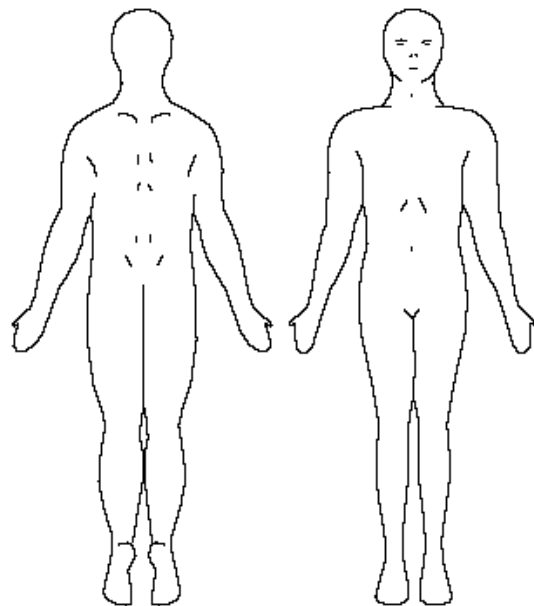
If Yes or Maybe please check any of the following you are experiencing:

- Vaginal Bleeding
- Morning sickness (nausea or vomiting)
- Sciatic Pain
- Headaches
- Edema (swelling hands/feet)
- Pain or Discomfort

If yes, where and what kind? _____

Have you had Multiple Miscarriages? Yes No

Other Concerns: _____



Back

Front

Please outline on the diagram above the area of your discomfort.

DO NOT WRITE BELOW THIS LINE

Diagnosis:

Patient Accepted: Yes No

 Doctor's Signature

 Date

 Patient Name

Notice of Privacy Practices (HIPPA)

Natural Care Chiropractic, PC

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.

Dear patient: The Federal laws, HIPPA – Health Insurance Portability and Accountability Act, has been written to protect the confidentiality of your health information. Your personal health history is NEVER unnecessarily made available to others outside of my office. Protecting your confidential Health Information has always been important to me.

So what has changed? Why a privacy policy now?

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. I have reviewed how your health information is used with the internet, phone, faxes, copy machines, and charts. I have put in writing the policies and procedures I used to ensure the protection of your health information everywhere it is used.

I want you to know about these policies and procedures that I developed to make sure your health information will not be shared with anyone who does not require it. My office is subject to State and Federal laws regarding the confidentiality of your health information and in keeping with these laws, I want you to understand procedures and your rights as my valuable patient.

I will use and communicate your health information only for the purposes of providing your treatment, obtaining payment and conducting health care operation. Your health information will not be used for other purposes unless I have asked for and been voluntarily given your written permission.

How Your Health Information May Be Used

To Provide Treatment

I will use your health information within my offices to provide you with the best care possible. This may include administrative and clinical office procedures. I may share your health information with referring physicians, clinical and pathology laboratories or other health care personnel providing your treatment.

To Obtain Payment

I may include your health information with an invoice used to collect payment for treatment you receive in my office. I may do this with insurance forms filed for you in the mail or sent electronically. I will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

It is possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process of certification, licensing or credential activities.

Patient Communication

I may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications include postcards, letters, telephone calls, voice mail, bulletins or e-mail.

Abuse or Neglect

I will notify government authorities if I believe a patient is the victim of abuse, neglect or domestic violence. I will make this disclosure only when I am compelled by my ethical judgement, when I believe that I am specifically required or authorized by law or with the patient's agreement.

Public Health and National Security

I may be required to disclose to Federal official or military authorities health information necessary to complete and investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of a new medical device.

For Law Enforcement

As permitted or required by State or Federal Law, I may disclose your health information to a law enforcement official for certain law enforcement purposes, included (under certain limited circumstances) if you are a victim of a crime or in order to report a crime.

Family, Friends, and Caregivers

I may share your health information with those you tell me will be helping you with your treatment or payment. I will be sure to ask your permission first. In the case of an emergency, I will use my best judgement when sharing your health information.

Notice of Privacy Practices, continued

Medical Research

Advancing medical knowledge often involved learning from the careful study of the medical histories of prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements and approval of an Institutional Review Board.

Authorization to Use or Disclose Health Information

Other than what is stated about or where Federal, State or Local law requires me, I will not disclose your health information without or written authorization. You may revoke that authorization in writing at any time.

Patients Rights

This law is careful to describe that you have the following rights related to your health information.

Restrictions

You have the right to request restrictions on certain uses and disclosures of your health information. I will make every effort to honor reasonable restriction preferences from my patients.

Confidential Communications

You have the right to request that I communicate with you in a certain way. You may request that I only communicate your health information privately with our other family members present or through mailed communications that are sealed. I will make every effort to honor reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays, and billing records. If you would like a copy of your health information, please let me know. You will be charged, according to the State regulations, for duplicate costs.

Amend Your Health Information

You have the right to ask me to update or modify your records if you believe your health information records are incorrect or incomplete. I will be happy to accommodate you as long as my office maintains this information. In order to standardize the process, requests must be made in writing along with a description of the reason for the change.

Your request may be denied if the health information record in question was not created by my office, is not part of my records, or if the records containing your health information are determined to be complete and accurate.

Documentation of Health Information

You have the right to ask me for a description of how and where your health information was used by me for any reason other than for treatment, payment or healthcare operations. Please let me know in writing the time period for which your are interested. Thank you for limiting your request to no more than six years at a time. I will charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from me at any time.

I am required by law to maintain the privacy of your health information and to provide you and your representative this Notice of Privacy Practices. I am required to practice the policies and procedure described in this notice but I do reserve the right to change the terms of the Notice. If I change my privacy practices, all patients will receive a copy of the revised Notice.

You have the right to express complains to me, or the Secretary of Health and Human Services if you believe your privacy rights have been compromised. I encourage you to express any concerns you may have regarding the privacy of your information. Please let me know of your concerns or complaints in writing, so I may undertake the proper procedures to remedy the situation as quickly as possible.

Thank you very much for taking time to review how I am carefully using your health information. If you have any questions, please ask.

Dr. Mark J. Freund, DC, B CAO, ND, DACBN, CTN, FIAMA, DCBCN, Dipl. Med. Acu.

Patient Acknowledgement

Patient Name _____

Date _____

Patient Signature _____

Doctor-Patient Relationship to Chiropractic — Informed Consent

Natural Care Chiropractic, PC

Chiropractic

It is important to acknowledge the difference between the health care specialties of Chiropractic, Osteopathy and Medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the Chiropractic Doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

Acupuncture

Acupuncture seeks to restore health through the insertion of needles at specific points that lie just below the skin surface. The ear staple for weight loss is applied to the ear. In certain instances inflammation and irritation and even infection may occur in this location. When this reaction occurs, the staple must be removed immediately. Consult Dr. Freund immediately if you have any questions with regard to this procedure.

Analysis

A Doctor of Chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, Chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the Chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

Diagnosis

Although Doctors of Chiropractic are experts in Chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every Chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your Doctor of Chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

Informed Consent for Chiropractic Care

A patient, in coming to the Doctor of Chiropractic, gives the Doctor permission and authority to care for the patient in accordance with the Chiropractic tests, diagnosis and analysis. The Chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a Chiropractic adjustment, or health care, if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the Doctor of Chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Doctor of Chiropractic provides a specialized, non-duplicating health service. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

Results

The purpose of Chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the Chiropractic procedures. Sometimes the response is phenomenal.

In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same Chiropractic care. Many medical failures find quick relief through Chiropractic. In turn, we must admit that conditions which do not respond to Chiropractic care may come under the control or be helped through medical science. The fact is that the science of Chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have great strides in alleviating pain and controlling disease.

To the Patient

Please discuss any questions or problems with the Doctor before signing this statement of policy.

I have read, and understand the foregoing.

Patient's Signature

Date

Financial Agreement

The undersigned agree that **FULL PAYMENT** of the patient's portion of charges is **DUE AT THE TIME OF SERVICE**. Natural Care Chiropractic is required to collect co-pays and deductibles.

With respect to the remainder of the fee, we both acknowledge that YOUR INSURANCE POLICY is a contract between you and your insurance company. We are **NOT** a party to that contract unless we are a participating provider. We file claims as a courtesy for our patients.

IT IS TOO DISRUPTIVE TO OUR DELIVERY OF HEALTHCARE to be involved in disputes between you and your insurance company i.e., involving deductibles, co-payments, whether our services are covered charges, secondary insurance or your insurance company's definition of "usual and customary charges." Of course, we will provide all factual information as you have authorized us to do. You will need to do your part in pursuing your rights under your insurance contract.

NORMALLY, after this office receives insurance benefits and appropriate managed care or Medicare reductions have been applied, you will be asked to forward payment of any remaining balance due **WITHIN THIRTY (30) DAYS**. Reductions do not apply to co-pays and/or portions of balance applied to deductibles.

Insurance Companies make questionable, unexplained determinations of what are usual and customary fees. These are methods of cost containment. Rest assured, Natural Care Chiropractic's charges are well within the norm of usual and customary fee schedules.

Even though you have insurance coverage, **YOU ARE RESPONSIBLE FOR THE TIMELY AND FULL PAYMENT OF YOUR ACCOUNT**. Payment plans may be established for balances over \$500.00. Natural Care Chiropractic accepts cash, checks, Visa, MasterCard and Discover.

You may get an Explanation of Benefits Form (EOB) from your insurance carrier which indicates that our healthcare services are "Maintenance" "Not Medically Necessary" or "Not Covered" under your insurance policy. **YOU HEREBY ACKNOWLEDGE THAT YOU ARE STILL RESPONSIBLE FOR PAYMENT OF THESE SERVICES.**

IF WE RECEIVE A CHECK MADE PAYABLE TO YOU, for payment of our healthcare services rendered, you hereby authorize us to deposit said check when received.

Further, **IN THE EVENT THAT YOUR INSURANCE COMPANY PAYS YOU DIRECTLY** for our healthcare services, you hereby agree to immediately pay this office for same.

Natural Care Chiropractic, P.C., will charge a **\$30.00** fee for all returned checks due to "NON-SUFFICIENT FUNDS" or "CLOSED ACCOUNT" status.

Natural Care Chiropractic, P.C., reserves the right to turn all delinquent accounts over to a collection agency and /or pursue all legal avenues to collect its fees for healthcare services. You agree to pay all legal fees and other costs associated with our collection activity.

Finally, our professionals and the management of Natural Care Chiropractic believe that appointments are a mutual benefit to and a mutual obligation of both Natural Care Chiropractic and its patients. Appointments allow our professionals to provide individual, quality care to each and every patient and to provide adequate time to perform scheduled procedures. You are provided the reserved time and attention of the doctor, therapists and support staff, generally at a time that you have previously selected. Our office will call and verify your therapy appointment as a courtesy to you. You are responsible for arriving to your appointment on time. Notice must be given for any cancellation of therapy appointments at least 24 hours in advance. **SHORT NOTICE CANCELLATIONS** will be charged payable by you.

THANK YOU FOR YOUR COOPERATION, NATURAL CARE CHIROPRACTIC, P.C.

By: _____

Mark J. Freund, D.C.-Its President

I have read and BEEN GIVEN A COPY of this Natural Care Chiropractic, P.C., Financial Agreement. I hereby acknowledge that I have been given an opportunity to discuss the Financial Agreement with Dr. Freund. I understand that my signature on this Financial Agreement acknowledges my duties to pay as stated above and I hereby agree to the same. Natural Care Chiropractic, P.C., reserves the right to change its financial policy if it is deemed necessary.

____ **PRIVATE PAY** I will pay for all services, as they are rendered, and submit my own insurance claims.

____ **INSURANCE** I would like to assign my benefits to your office and have you submit my insurance claims for me, either in-network or out-of-network participation. I will pay for initial services rendered and any co-payment for subsequent services. If my deductible has not been met, I will pay the full amount until it is met. I understand that if my insurance company does not pay the balance within 45 days of submission, I am responsible for the entire balance overdue.

____ **AUTO ACCIDENT/ PERSONAL INJURY** I was involved in an automobile accident/personal injury and would like to assign benefits to your office and have you submit all charges to my insurance company for me. I will sign all liens necessary to protect your office. I also understand that regardless of settlement, I am personally responsible for the entire balance. If for some unforeseen reason your office is not paid within 45 days of claim submission, I will personally pay the entire overdue balance.

____ **WORKERS COMPENSATION** I was involved in an injury at work. I will see to it that all appropriate paper work is filed by my employer (i.e. accident report, etc.). I understand that it is my right as an Illinois citizen to have any bills incurred as a result of a work related accident paid for. I will read the Illinois worker's compensation pamphlet to better understand my rights. If after 60 days my claim is not paid, I will personally pay the overdue balance. I understand that if this in the case, my rights may have been violated and I have the option to seek legal counsel.

____ **MEDICARE** I am a Medicare participant and will pay for services as they are rendered. I understand that your office does not accept assignment of benefits for Medicare but will submit all charges to Medicare for me.

Print Patient Name _____ Signature _____ Date _____