Algonquin Chiropractic Center, P.C.

2210 Huntington Dr. N Algonquin, IL 60102 847-854-2000

We may use and disclose your PHI (private health information) in response to a court or administrative order if you are involved in a lawsuit or similar proceeding. We may also disclose your PHI in response to a discovery request, subpoena, or another lawful process by another party involved in the dispute.

We may use or disclose your PHI for workers' compensation and similar programs. We may use a sign-in sheet at the front desk, and we may call you in to see the doctor by name.

We may contact you by mail or phone at your residence to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may mail you a postcard reminding you to make an appointment, and we may leave a message for you on any answering device or with any person who answers the phone at your residence.

You can make a reasonable request for us to use alternative methods of communicating with you in a confidential manner. These requests must be submitted in writing in a clear and concise fashion. We are not required to agree to your request. However, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when information is necessary to treat you.

Rights that you have:
You have the right to request restrictions on some of the uses or disclosures described above. Except as stated, we are not required to agree to such restrictions.

You have the right to inspect and obtain copies of your medical Information. (A fee for the costs of copying, mailing, labor, and supplies associated with your request will be charged.)

You have the right to request amendments to your medical information. Such requests must be in writing and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosure we make of your medical information except for disclosures we make to you to carry out treatment, payment, or healthcare operations, as requested by your written authorization, as permitted or required under 45 CFR 164.502, for emergency or notification purposes, for national security or Intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law.

You have the right to receive a paper copy of this notice. To obtain a paper copy of this notice, please contact our office manager. You have the right to file a complaint if you believe your privacy rights have been violated. You may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing and addressed to this office at the above address. You will not be penalized for filing a complaint.

This privacy policy is subject to change as circumstances dictate. Any changes will be effective upon the release of a revised privacy policy, which will be made available to patients upon request.

Please sign and date below, acknowledging that you have read this policy and that you consent to the terms of our privacy policy as stated in this notice.

Signature of Patient or Legal Guardian: ______________________________ Date: ____________________

Print Name of Patient or Legal Guardian: ______________________________ Date: ____________________

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Algonquin, IL 60102
(P) 847-854-2000
www.algchiro.com

REGISTRATION

Date: ____________________ Phone: ______________________________________

Patient: ____
Last Name First Name Initial

Street Address: ____

City/State/Zip Code: ____

Sex: ☐ M ☐ F Age: ______ Birthdate: ________________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security #: ____________________ Email: ___________________________

Insurance Carrier: ____

Insured's Name: ____
Last Name First Name Initial

Primary Care Physician:
Name & Address: ____

____

Phone #: ____

Present Complaints (Please circle the appropriate ones)

Headache	__/10	Feet/Hands Cold	__/10	Unbalanced	__ Yes __ No
Mental dullness	__/10	Depression	__/10	Fainting	__ Yes __ No
Loss of memory	__/10	Rib pain	__/10	Blurred vision	__ Yes __ No
Dizzy	__/10	Nervousness	__/10	Irritability	__ Yes __ No
Neck Pain	__/10	Eye strain/pain	__/10	Double vision	__ Yes __ No
Upper back pain	__/10	Shortness of breath	__/10	Loss of smell	__ Yes __ No
Lower back pain	__/10	Chest pain	__/10	Fear	__ Yes __ No
Midback pain	__/10	Confusion	__ Yes __ No	Ears ringing/buzzing	__ Yes __ No
Pins and needles in hands right/left	__/10	Pins and needles in arms right/left	__/10	Pins and needles in legs right/left	__ Yes __ No

Medical Implants: ______________________ **Medical alerts:** ____________________

Surgical Implants: ______________________ **Pregnancy:** **yes** ____ **no** ____

PAIN SCALE: Rate the severity of your pain by filling in the pain scales above.

Patient Name: ________________________________ Date: ____________________

Doctor's Initials ________________

Medications: *(please list all medications and supplements that you currently take)*

______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________

Allergies: *(please list all medications that cause allergic reaction)*

______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________

Smoking: ___ Yes ___ No If yes, ______ Packs per Day for _____ years

Alcohol ___ Yes ___ No If yes, Number of drinks per week ________

Surgical History: Please list ALL previous surgery and the date on which it was performed:

Surgery ______________________________ Date ________________

______________________________ ________________

______________________________ ________________

______________________________ ________________

Personal Medical History & Review of Systems:

Please indicate with an "X" any medical problems that you currently have or have had in the past.

□ **NO MEDICAL PROBLEMS** - no prior history of any significant medical problems

Lungs / Pulmonary – breathing disorders

□ asthma □ pulmonary embolism □ respiratory arrest
□ COPD □ pneumonia □ sleep apnea
□ emphysema □ tuberculosis □ other: ________________

Cardiac / Heart and peripheral vascular disease

□ chest pain / angina □ irregular heartbeat, arrhythmia □ high blood pressure
□ heart attack □ heart murmur, valve disorder □ peripheral vascular disease
□ congestive heart failure □ mitral valve prolapse □ deep vein thrombosis
□ other: ________________ □ bleeding problems

Neurologic Disorders

□ stroke or TIA □ Parkinson's □ cerebral palsy
□ peripheral neuropathy □ MS □ polio
□ other: ________________

Bone & Joint Disorders

□ osteoarthritis □ gout □ osteomyelitis
□ rheumatoid arthritis □ lupus □ ankylosing spondylitis
□ other: ________________

Patient Name: ______________________________ Date: ________________

Algonquin Chiropractic Center

Doctor's Initials ________________

Gastrointestinal Disorders

□ peptic ulcer or stomach ulcer
□ acid reflux, GERD
□ GI bleed
□ other: ____________________
□ diverticulitis
□ irritable bowel
□ inflammatory bowel disease
□ hepatitis - Type ______
□ liver disease

Genitourinary Disorders

□ urinary tract infection
□ bladder problems
□ kidney problems
□ kidney stones
□ dialysis, kidney failure
□ other: ____________________

Metabolic & Other Disorders

□ Diabetes x ________ years
□ thyroid problems
□ sickle cell disease
□ high cholesterol or lipids
□ skin disorder _____________
□ psoriasis
□ any skin ulcer
□ tooth abscess, gingivitis
□ depression
□ anxiety
□ alcohol or drug dependency
□ other: _________________

Cancer: any type -- please specify ____

Other medical problems NOT included above (explain)

____

____

Family History:

Please indicate with an "X" any significant family medical history or problems:

□ asthma
□ COPD or Emphysema
□ heart attack, myocardial infarction
□ irregular heartbeat, arrhythmia
□ MS or Parkinson's
□ osteoarthritis
□ rheumatoid arthritis
□ acid reflux, GERD
□ liver disease
□ kidney problems
□ diabetes
□ thyroid problems
□ Malignant hyperthermia
□ tuberculosis
□ other lung :________________________
□ other neuro :__________________
□ Lupus
□ Other bone & joint: ____________________
□ hepatitis - Type _____
□ other GI :______________________
□ dialysis, kidney failure
□ psoriasis
□ sickle cell disease
□ sleep apnea
□ congestive heart failure
□ bleeding problems
□ gout
□ inflammatory bowel disease
□ high cholesterol or lipids
□ any skin ulcer
□ Peripheral neuropathy

Cancer: any type -- please specify

____

Other medical problems NOT included above (explain)

____

____

Patient Name: ______________________________________ Date: ____________________

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Doctor's Initials ____________________

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Major Problem Index

Patient Name: ___________________________________ Date: ________________

List the number **ONE** issue you want Dr. Galante to evaluate you on:

____

Approximate date this problem started ____

Approximate date this problem got worse ____

Was this due to trauma? ____

Have you had treatment in the past for it? _______________________________________

List Doctors seen and procedures: ____

How did this start and what was the cause?

____

____

My Pain Increases when I cough:
Yes________ No________

I have lost control of my bowel or bladder:
Yes________ No________

The Pain wakes me up at night:
Yes________ No________

I have pain or numbness in my:
Arms, Hands: Yes________ No________
Legs, Feet: Yes________ No________

I have weakness in my:
Arms, Hands: Yes________ No________
Legs, Feet: Yes________ No________

Pain (0-10): Average pain ______/10
Worst pain ______/10

Pain quality **(circle all that apply)**:

Achy Numbness/Tingling
Sharp Throbbing
Stiff Burning

Pain frequency: **Circle one**
Constant (76-100% of the time)
Frequent (51-75% of the time)
Occasional (25-50% of the time)
Infrequent (0-25% of the time)

My pain is: ________worse in the morning
________worse as the day goes on
________time of day does not matter

Symptoms made worse by:____

Symptoms decreased by:____

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Please initial after reading each paragraph

Chiropractic Care: I instruct the chiropractor to deliver the care that, in his or her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Initial: ________

X-Ray Verification: I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Initial: ________
Date of last menstrual period. _______________ N/A if Male ______________

Permission to Contact: I grant permission to be called/texted to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office. Initial: ________

Payment Verification: I acknowledge that any insurance I may have is an agreement between the carrier and me. I am responsible for the payment of any services I receive. Initial: ________

Testimonial Consent: I authorize Algonquin Chiropractic to use my chiropractic story, and my photograph for marketing purposes, in print and otherwise, for a period of five (5) years.
Decline: ________ Accept: ________

General Verification: To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern. Initial: ________

Signature ______________________________ Date _______________

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*Complete if the patient is a minor

Print child's name: ____

I, ____ being the parent or legal guardian of the aforementioned child have read and understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Signature ______________________________ Date _______________

Witness Signature _______________________ Date _______________

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Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for H.I.P.P.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Algonquin Chiropractic to release my records and any information to the following individuals.

1.______________________________ **Relation to Patient:**________________

2.______________________________ **Relation to Patient:**________________

3.______________________________ **Relation to Patient:**________________

Initial here if you do not give consent to anyone: __________

______________________________ __________________________

Patient Name (PLEASE PRINT) Date

____

Patient Signature

REFERRING PHYSICIAN: **ALGONQUIN CHIROPRACTIC**

TYPE OF CASE: ____GRP. HEALTH ____MEDICARE ____WORK COMP ____PI ____PI WITH MEDPAY

____BILL PATIENT ____BILL DOCTOR Date Of Accident: ____________ (Work Comp and PI)

PATIENT INFORMATION:

LAST NAME: ____________ FIRST NAME: ____________ MI: ______

ADDRESS: ____________ CITY: ____________ STATE: ______ ZIP: ______

TELEPHONE: ( ) ____________ DOB: ____/____/____ SS# ______-______-______

SEX: M OR F RELATION OF INSURED: SELF SPOUSE CHILD OTHER: ____________

EMPLOYER: ____________ TELEPHONE: ____________

ADDRESS: ____________

SEND BILLS TO: (*CIRCLE ONE*) ATTORNEY INSURANCE PARENT PATIENT GUARDIAN

NAME: ____________

ADDRESS: ____________

INSURANCE INFORMATION:	PRIMARY	SECONDARY
NAME:		
ADDRESS:		
CITY / STATE / ZIP:		
POLICY OR CLAIM NUMBER:		
GROUP:		
ADJUSTOR:		
INSURED IF DIFF. FROM PT:		
ADDRESS:		
INSURED SOC. SEC. #:	( ) / / (BC/BS PREFIX)	( ) / / (BC/BS PREFIX)

I, ____________ consent to Specialized Radiology Consultants ("SRC") use and disclosure of my Protected Health Information for the purpose of providing radiology readings on me, for purposes relating to the payment of services rendered to me, and for SRC's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management, and other general operation activities, I understand that the SRC's diagnosis of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, **"Protected Health Information"** means any information, including my demographic information, created or received by SRC, that relates to my past, present, or future physical or mental health or condition: the provision of health care to me; or the past, present, or future payment for the provision of health care services to me: and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of SRC, but SRC is not required to agree to these restrictions. However, if SRC agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have a right to review the SRC's Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information. I understand that if I desire a copy, I may call the above number and one will be copied and mailed to me.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or SRC has acted in reliance on this consent.

I understand that there will be a *separate bill* for SRC's radiology interpretation and written report. I also authorize all claims to be sent directly to the insurance company and I authorize payment to be made directly to SRC and accept responsibility for any remaining balance billed.

____________ DATE: ____________

Signature of Patient or Personal Representative

SPECIALIZED RADIOLOGY CONSULTANTS
WHEATON, IL (630) 462-9772