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: _____

Algonquin Chiropractic Center

2210 Huntington Dr. N.
Algonquin, IL 60102
(P) 847-854-2000
www.algchiro.com

REGISTRATION

Patient Name: _____ Date: _____
Address: _____
Email: _____ Birth Date: _____
Home Phone: _____ Cell Phone: _____
Occupation: _____ Employer: _____
Social Security #: _____

Marital Status: _____
Name of Wife/Husband: _____ Cell Phone: _____

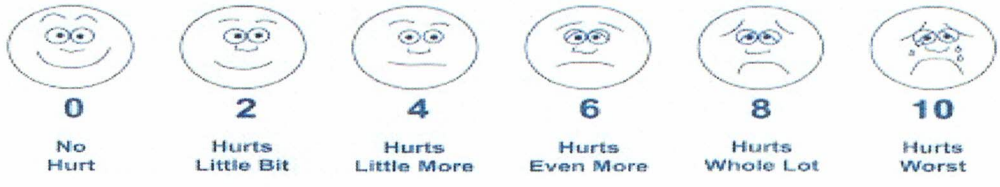
Is this condition due to injury or sickness arising out of patient's employment: YES or NO
Is this condition due to injury or sickness arising out a car accident: YES or NO
Name of Primary Care Physician: _____
Name of Specialist(s) that you see: _____
Referred to Algonquin Chiropractic by: _____

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: _____

Algonquin Chiropractic Center

Doctor's Initials _____

Please List Current If Applicable:

MEDICATIONS	VITAMINS	ALLERGIES
1)_____	1)_____	1)_____
2)_____	2)_____	2)_____
3)_____	3)_____	3)_____
4)_____	4)_____	4)_____
5)_____	5)_____	5)_____
6)_____	6)_____	6)_____

SURGERIES	YEAR	IN PATIENT PROCEDURE?
1)_____	_____	YES or NO
2)_____	_____	YES or NO
3)_____	_____	YES or NO
4)_____	_____	YES or NO

SOCIAL HISTORY. Please circle the one that applies per category: *(H) Heavy (M) Moderate (L) Light (N) None*

Alcohol	H / M / L / N	Exercise	H / M / L / N
Coffee	H / M / L / N	Sleep	H / M / L / N
Smoking	H / M / L / N / Former	Drugs	H / M / L / N

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:

Mark ALL conditions that run in your family

- ○ Cancer
- ○ Cholesterol
- ○ Anemia
- ○ Diabetes
- ○ Heart Problems / Stroke
- ○ High Blood Pressure
- ○ Genetic Disorders
- ○ Other

Relationship: (mother, father, sibling)

_____
_____
_____
_____
_____
_____
_____
_____

Cancer: any type -- please specify

_____

Other medical problems NOT included above (explain)

_____

_____

Patient Name: _____ Date: _____

Algonquin Chiropractic Center

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_____

My pain is: _____worse in the morning
_____worse as the day goes on
_____time of day does not matter

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)

Symptoms made worse by:_____

Symptoms decreased by:_____

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FINANCIAL ARRANGEMENTS-HEALTH INSURANCE

To assist our patients in determining if they have a third party responsible for their health expenses, or to aid in determining if they will be reimbursed by an insurance company, we have prepared the following checklist and policy statement. All of the following are generally subject to a deductible that is to be paid by the patient and then an additional percentage of the expenses:

1. PRIMARY GROUP HEALTH AND ACCIDENT – My insurance company is:

   _____

2. SECONDARY GROUP HEALTH – My insurance company is:

   _____

   I understand that I may be able to collect benefits from No. 2 in addition to No. 1 above.

Algonquin Chiropractic Center will call my insurance company to verify benefits. Benefits are payable per insurance company approval. Patient will contact their insurance company as well to verify benefits. **I agree to pay the balance in full until insurance benefits are known.** Patient portion of fees are due at the beginning of each week.

ASSIGNMENT AUTHORIZATION, POWER & AGREEMENT

In that the office is waiting for the payment of some or all of its fees, I agree to provide the office with information and forms regarding any potential source of fee payment, to assist in any way I can. And

1. I hereby assign to this office my rights to receive payments from negligent parties or from insurance companies. Payments should be payable and mailed to: Algonquin Chiropractic Center, 2210 Huntington Drive North, Algonquin, IL 60102. If my policy prohibits assignments, then the check should be payable to me and sent to the above address.
2. I understand that if this office receives more than their fees, the office will pay any credit balances to me, the patient.
3. I authorize the office to release any information to any insurance company, adjustor, or attorney that will assist in the payment of a claim.
4. I appoint this office as attorney-in-fact to correspond in my behalf with insurance companies, to negotiate any settlement and to cash any settlement draft or check. Counsel, insurance companies, and negligent parties be advised that no settlement can be effectuated without the agreement of this office or the office's release of this specific provision. Said negotiation to be for the payment of health expenses and will not release negligent party from other responsibilities. The office does not intend to "represent" me in any way, this appointment is strictly to prevent negligent parties, attorneys, or insurance companies from settling any financial relations with me without fulfilling my financial responsibilities to this office first.
5. I fully understand and agree that insurance policies are an arrangement between an insurance carrier and myself. I will be responsible for any expenses not paid by insurance.
6. A photo copy of this form shall be as valid as the original.

Patient Signature: _____ Date: _____

Responsible Party: _____

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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 which may include deductible and/or copays.
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