IRVING PARK CHIROPRACTIC CENTER

Thank you for choosing Irving Park Chiropractic Center. To help us complete our records and submit accurate bills to your insurance company, please assist us by providing the following information. If you have any questions about these forms the receptionist will gladly help you.

Today's Date:______________________ Patient's Social Security # ______________________________
First Name: ______________________ M.I. _____ Last Name: ______________________________
Date of Birth: ______________________ Sex: ❑M ❑F
Address: ____
City:______________________________ State:______________ Zip Code: ____________________
Home Phone: (______)________________ Work Phone: (______)________________
Cell Phone: (______)_________________ Pager: (______)_____________________
Email Address:____
Occupation: _________________________ Employer: _________________________

How did you find us?: ❑Friend / Family Member (Name)____
❑Yellow Pages ❑Website ❑Insurance Provider Directory ❑Clinic Location
❑Presentation (Where & When)____
❑Other (Please Describe)____
Payment for Services will be: ❑Cash ❑Health Insurance ❑Auto Accident ❑Worker's Compensation

Health Insurance Patients:

- Insurance Carrier Name:____
- Insurance Carrier Address: ____
- Group Number: __________________ Policy Number: _______________________
- Is the Insurance Policy in your name? ❑Yes ❑No (**If no**, fill out the following for the insured)

Insured's First Name: __________________ M.I. _____ Last Name: ___________________________
Insured's Date of Birth: _______________ Sex: ❑M ❑F Insured's Social Security #:_______________
Insured's Address: ____
City:______________________________ State:______________ Zip Code: ____________________
Insured's Home Phone: (______)______________
Your Relation to the Insured ❑Spouse ❑Child ❑Other (Describe Relation)________________________

Auto Accident & Worker's Comp Patients:

- Type: ❑Auto Accident ❑Worker's Comp
- Insurance Carrier Name:____
- Insurance Carrier Address: ____
- Insurance Carrier City, State, Zip: ____
- Date of Injury: _______________________ Claim Number:_______________________________
- Adjuster's Name: _____________________ Adjuster's Telephone: (______)_________________

I, the undersigned, hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). Further, I authorize assignment of my Insurance rights and benefits directly to this provider and also release of such information as is needed to process Insurance claims by provider or agent. I understand that I am responsible for all charges which may include legal fees, collection fees or other expenses incurred by the provider in collecting my account. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.

☞**Patient Signature:** ____ **Date:** __________________

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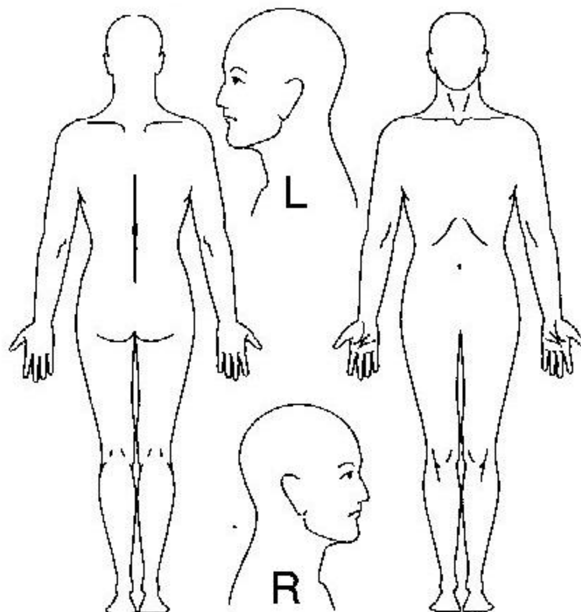
Patient's Name:___________________________ Date:______________________

Case Number:_______________

Please **Mark** your painful spots on the chart. Use the following symbols to describe the pain.

Burning: ********** Sharp/Stabbing: //////////// Aching: ooooooooo Dull: ~~~~~~~~



1. Pain right now 1 --10

2. Average pain 1 --10

3. Pain at its best 1 --10

4. Pain at its worst 1 --10

Percentage of time pain is at its worst _____%

Percentage of time pain is at its best _____%

Patient Signature:__________________________________

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PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

WHAT ARE YOUR PRESENT COMPLAINTS? ____________________

WHEN DID THEY START? ____________________

WHAT HAPPENED TO CAUSE THESE SYMPTOMS? ____________________

SYMPTOMS ARE WORSE IN: ❑MORNING ❑NIGHT ❑AFTERNOON ❑CONSTANT ❑COME & GO

HAVE YOU EVER HAD THIS BEFORE: ❑NO ❑YES WHEN? ____________________

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S): ____________________

•PLEASE CHECK THE FOLLOWING ACTIVITIES THAT **AGGRAVATE YOUR CONDITION**:
❑BENDING ❑REACHING ❑COUGHING ❑SITTING ❑LYING DOWN ❑TURNING HEAD
❑LIFTING ❑SNEEZING ❑WALKING ❑STANDING ❑STRAINING AT STOOL
❑OTHER____________________

•PLEASE CHECK THE FOLLOWING ACTIVITIES THAT **RELIEVE YOUR CONDITION**:
❑BENDING ❑SITTING ❑LIFTING ❑STANDING ❑LYING DOWN ❑TURNING HEAD ❑REACHING ❑WALKING
❑OTHER____________________

•PLEASE CHECK ANY **ADDITIONAL SYMPTOMS** YOU MAY BE EXPERIENCING:
❑blurred vision ❑cold hands ❑stomach upset ❑face flushed ❑fever
❑buzzing in ears ❑cold sweats ❑dizziness ❑fainting ❑headaches
❑cold feet ❑constipation ❑diarrhea ❑fatigue ❑insomnia
❑light bothers eyes ❑loss of balance ❑loss of smell ❑loss of taste ❑muscle jerking
❑numbness in fingers ❑numbness in toes ❑ringing in ears ❑shortness of breath ❑stiff neck
❑pins and needles in arms ❑pins and needles in legs ❑concentration loss/confusion
❑depression /weeping spells ❑head seems too heavy ❑low resistance to colds

•DO YOU HAVE ANY ALLERGIES? ❑NO ❑YES WHAT KIND? ____________________
•ARE YOU TAKING ANY MEDICATIONS? ❑NO ❑YES WHAT KIND: ____________________

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•ARE YOU, OR MIGHT YOU BE, PREGNANT ❑NO ❑YES DATE OF LAST MENSTRUAL PERIOD___________

MEDICAL/FAMILY HISTORY **S = Self M = Mother F = Father**

(Please indicate which PAST or PRESENT conditions have been experienced prior to present complaint by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
❑	❑	❑	AIDS	❑	❑	❑	dislocated joints	❑	❑	❑	neck pain
❑	❑	❑	anemia	❑	❑	❑	epilepsy	❑	❑	❑	nervousness
❑	❑	❑	arthritis	❑	❑	❑	German measles	❑	❑	❑	numbness
❑	❑	❑	asthma	❑	❑	❑	headaches	❑	❑	❑	polio
❑	❑	❑	back pain	❑	❑	❑	heart trouble	❑	❑	❑	poor circulation
❑	❑	❑	bladder trouble	❑	❑	❑	reproductive disorders	❑	❑	❑	hepatitis
❑	❑	❑	bone fracture	❑	❑	❑	high blood pressure	❑	❑	❑	rheumatic fever
❑	❑	❑	cancer	❑	❑	❑	HIV/ARC	❑	❑	❑	rheumatism
❑	❑	❑	chest pain	❑	❑	❑	kidney disorder	❑	❑	❑	scarlet fever
❑	❑	❑	concussion	❑	❑	❑	bowel control loss	❑	❑	❑	serious injury
❑	❑	❑	convulsions	❑	❑	❑	menstrual cramps	❑	❑	❑	sinus trouble
❑	❑	❑	diabetes	❑	❑	❑	multiple sclerosis	❑	❑	❑	Stroke
❑	❑	❑	indigestion	❑	❑	❑	muscular dystrophy	❑	❑	❑	tuberculosis
								❑	❑	❑	venereal (V.D.)

Have you been treated by a physician for any health condition in the last year? ❑Yes ❑No

Describe Condition___________________________________
Describe Condition___________________________________
Describe Condition___________________________________

Date of Last Physical Exam__________

SURGICAL HISTORY:

1.____ Date:______________________
2.____ Date:______________________
3.____ Date:______________________

Have you ever had a metal implant? ❑Yes ❑No

List Accidents you have been involved in:

❑Job ❑Auto ❑Other Type 1. __________________________Date:________________
❑Job ❑Auto ❑Other Type 2. __________________________Date:________________
❑Job ❑Auto ❑Other Type 3. __________________________Date:________________

OTHER COMMENTS:____
____
____

Patient's Signature:_____________________________________ Date:______________________

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Patient Consent Authorization

CONSENT FOR TREATMENT: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to the physician(s) accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges. I understand that I am financially responsible for charges not covered by this assignment or for any and all charges that the insurance carrier declines to pay. It is further agreed that any credit or balance resulting from payment of insurance or other sources may be applied to any other accounts owed to said physician by the insured or his/her family.

RELEASE OF INFORMATION: The physician(s) may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physician(s) or to the patient or to a family member or employer of the patient for all part or part of the physician(s) charges, including but not limited to, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

MEDICARE AND PATIENT CERTIFICATION – PATIENTS CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act, is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services.

I understand that I am responsible for my health insurance deductibles and coinsurance.

By my signature on this form I do hereby state that to the best of my knowledge I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.

Patient Name (Print)____

Patient Signature____

Date___________________

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FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This reduces your out-of-pocket expense and allows you to place your family under care.

If you do not have insurance: All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $100 at any time or care may be terminated. Our payments plans make care an affordable part of your family budget.

If you have insurance: All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed $100 or care may be terminated. Our payments plans make care an affordable part of your family budget.

You are considered a cash patient until you bring in your complete insurance forms, and we qualify and accept your insurance coverage. We do not accept assignment for secondary insurance claims, but we will be happy to provide you with a claim form for your secondary carrier.

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard and care in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

Patient's Printed Name:______________________________

Signature:____ Date:___________

Finance Counselor:_________________________________ Date:___________

Front Desk:_______________________________________ Date:___________

For your Convenience you may retain your credit card number on file with us.

Card #:________________________________ Expiration Date:_____________

Name as it appears on card:____

Signature to authorize monthly usage:_____________________________________

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Dear Claims Department:

I, ____, state that my illness is NOT due to either accident or injury. My condition is a result of gradual onset. Furthermore, there is no third party responsibility, attorney, or other primary insurance coverage involved.

Please do not send "Accident Details / Other Insurance / Accident Information" questionnaires, this statement should suffice.

Please process any claims submitted on my behalf immediately.

Thank you,

______________________________ ______________________

Patient Name Date

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