Southern Illinois Spine & Joint Center — Confidential Patient Information

202 W. Jackson Square, Suite A, Sparta, IL 62286 Phone (618) 443-2026 Fax (618) 443-2028 Website: www.sisjc.com

Date:_____/_____/_____ Patient's Full Name _____

Home Phone: _____ Cell Phone: _____ E-Mail: _____

☐ Male ☐ Female Age:_____ Date of Birth:_____/____/_____ Social Security # _____ - _____ - _____ Race:_____

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

☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Preferred Language:_____ Ethnicity:_____

Occupation:_____ Hours/Week_____ Employer:_____ Business Phone_____

Spouse's Name:_____Employer:_____ Business Phone_____

Emergency Contact:_____ Relationship:_____ Phone: _____

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

Family Physician: _____ City: _____ State:_____ Phone_____

May our office inform your family physician of presenting condition/s, exam findings, diagnosis, and treatment plan? ☐ Yes ☐ No

Do You Have Health Insurance? □ Yes □ No If yes, Please present insurance card to Front Desk Staff.

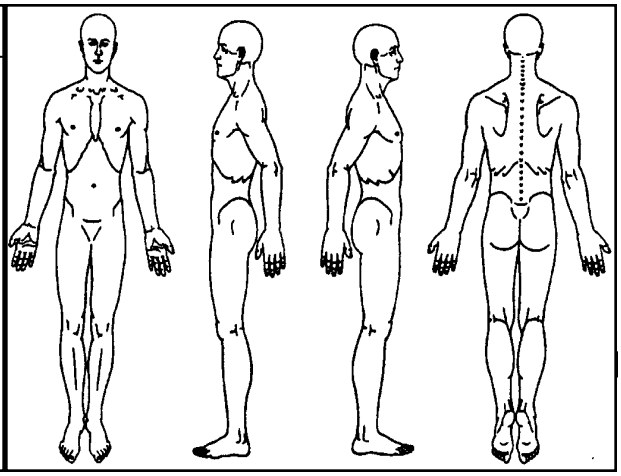
Previous Chiropractic Care: ☐ Yes ☐ No If Yes, for what Problem: _____

Doctor's Name _____ City: _____ State: _____

Where did you hear about us? Or Referred By (Friend, Relative, or Physician) :_____
(**If yes to either question below, please check with receptionist, additional information is needed**)

Is Today's Visit Due To A Work Related Injury: ☐ Yes ☐ No
Is Today's Visit Due To A Personal Injury or Auto Accident: ☐ Yes ☐ No **Date Of Injury:**_____

******Mark Your Area of Pain on the Picture******



SEVERITY OF PAIN

Chief Complaint:_____ Onset Date:_____

0 1 2 3 4 5 6 7 8 9 10
no pain unbearable

#2 Complaint:_____ Onset Date:_____

0 1 2 3 4 5 6 7 8 9 10
no pain unbearable

How did your chief complaint start? (ex. Fell on ice)_____

What makes your pain worse? □ bending □ standing □ sitting □ walking Other:_____

What makes your pain better? □ laying down □ sitting □ standing □ walking Other:_____

What is the quality of your pain? □ sharp □ dull/ache □ throbbing □ tingling/numbness/burning Other:_____

What is the worst time for your pain? □ morning □ during day □ evening □ lying in bed Other:_____

How much of the day do you experience your chief complaint? □ 0—25% □ 26—50% □ 51—75% □ 76—100%

Has your current complaint caused any of the following? □ muscle weakness □ bowel/bladder problems □ cardiac/respiratory problems

Have you tried any self-treatment (ice, heat, stretching) or taken any medication (over the counter or prescription)? □ Yes □ No

If yes, explain:_____ Results:_____

What is your goal from treatment (ex. Play a round of golf without pain)?_____

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Overall your **General Health** is (check one): ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Have you ever experienced your present problem before?: ☐ Yes ☐ No If yes, When:_____

Was treatment provided: ☐ Yes ☐ No If yes, By whom:_____ Outcome:_____

Have you **ever** had a **stroke** or issues with **blood clotting**? ☐ Yes ☐ No If yes, when: _____

Have you recently experienced **dizziness**, unexplained **fatigue**, **weight loss**, or **blood loss**? □ Yes □ No If yes, explain:_____

Have you **ever** had any **major illnesses, injuries, broken bones, hospitalizations, accidents, or surgeries?** ☐ Yes ☐ No

Date	Injury/Fracture/Illness/Surgeries	Treatment	Results

Please list current **medications and supplements** you may be taking:

_____

_____

Systems Review Questions:

1. _____ Eyes
2. _____ Ears, Nose, Mouth, Throat
3. _____ Heart
4. _____ Lungs/ Breathing
5. _____ Intestines/Bowels
6. _____ Urinary
7. _____ Muscles
8. _____ Nerves
9. _____ Joints/Bones
10. _____ Skin
11. _____ Internal Organs
12. _____ Blood
13. _____ Allergy
14. _____ Psychological/Emotional

Females only:

15. _____ Gynecological/Menstrual/Breast

Males Only:

16. _____ Prostate/Testicular/Penile

Please explain check marks: _____

_____

Recreational Activities/Hobbies:_____

Your Education Level: □ Highschool □ Some College □ College Graduate □ Post Graduate □ Other:_____

Yes	No		
☐	☐	Do you exercise? _____	times per week?_____
☐	☐	Do you smoke? _____	packs per day (If you have quit smoking, when did you quit?)_____
☐	☐	Do you use other forms of tobacco?	What/How much per day? _____
☐	☐	Do you consume alcohol?	How many drinks per week? _____
☐	☐	Do you eat a balanced low fat diet?	If no, explain: _____
☐	☐	Do you get adequate sleep?	If no, explain: _____
☐	☐	Is work stressful to you?	If yes, explain: _____
☐	☐	Is family life stressful to you?	If yes, explain: _____
☐	☐	Do you use recreational drugs?	If yes, explain: _____

Family History and Health Status: list any diseases or major illnesses which affect your family (mother/father/sister/brother):

_____

How do you sleep? □ Back □ Side □ Stomach Do you use a pillow? □ Yes □ No

Do you wear orthotics or arch supports? □ Yes □ No

Females: Date of last gynecological and breast exam:_____

For X-Ray Purposes: Possible pregnancy? □ Yes □ No Date of last menstrual cycle?_____

I herby state that all the information I have provided is complete and truthful and that I have fully disclosed my health history.

Patient/Guardian Signature:_____ **Date:**_____

INFORMED CONSENT

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I_____, Do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used.

Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware the there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasionally bruising in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor.

Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including, rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Patient/Guardian Signature:_____ Date:_____

Southern Illinois Spine & Joint Center

AUTHORIZATION AND ASSIGNMENT

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release **any information** you deem appropriate concerning my physical or emotional condition and/or health history to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the **direct payment to you** of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated make payment to me or you based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services **refuses to make such payment** upon demand by you , I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. However, it is understood that all reasonable efforts have been made to collect the sums due from the insurance company, or companies, contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what was due, I personally owe you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this state of Illinois
5. I further agree that this Authorization and Assignment is irrevocable until all moneys owed Southern Illinois Spine & Joint Center are paid in full.

Patient Signature_____ Date_____/_____/_____

Financial/Privacy Policy and Disclaimer

Insurance Verification

- **Insurance verification is not a guarantee of payment.** Verification is only a quote of patient benefits. Insurance companies review charges individually and make payment accordingly. **Charges not covered by insurance are the patient's responsibility and due within 30 days of billing.**

Deductible Payments

- **It is our policy to collect at time of service.** Once we receive an "Explanation of Benefits" report form the patient's insurance company, we will bill or credit the account for the remaining balance. Reimbursement checks can be issued upon request.

Collection of Patient Balance

- Co-payments and Co-insurance is the patient's responsibility and will be collected at the time of service.
- If the "Explanation of Benefits" report shows the patient has an outstanding balance from services not covered by the individual insurance company, patients will receive a bill outlining these outstanding charges. **Upon receipt, payment is due within 30 days. After 30 day, it is the clinic's policy to turn unpaid accounts over to a collections agency.**

Returned Checks

- It is our policy to collect $25.00 for checks that are returned to us. This is to cover any fees that apply from the transaction

Appointments

- If unable to keep an appointment, as a courtesy to our staff and other patients please give 24-hour notice. If it is a continual problem there will be a **$20 charge** added towards your account each visit that is missed. The patient will be responsible for payment.

Financial Policy Questions

- We are happy to address questions regarding you account at any time. Please direct accounting questions to our billing administrator.

HIPPA Privacy Policy

- Notice of Privacy Practice is available at the front desk. Please take a moment to read over the information and sign the acknowledgement given to you upon arrival.