ARLINGTON CHIROPRACTIC CLINIC, PC
www.ArlingtonChiroClinic.com

UPDATED CONTACT INFORMATION

Please fill in your name and other demographic information that may need to be changed or updated in our files.

Arlington Chiropractic Clinic, PC
Totalcare®
1702 W. Campbell Street
Arlington Heights, IL 60005
(847) 259-4493
◯ Christa S. Andreoli, D.C., DACO, MCS-P
◯ Peter J. Horn, D.C., CCSP

Today's Date (MM/DD/YYYY) _____ Patient Number (office use only) _____

Your Last Name _____ Your Social Security Number _____ Birth Date (MM/DD/YYYY) _____ Age _____

Your First Name _____ Your Middle Name (or Initial) _____ Gender ◯ Male ◯ Female Race _____

Address _____ Marital Status ◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Separated Ethnicity _____

City _____ State/Province _____ ZIP/Postal Code _____ Preferred Language _____

Home Phone _____ Cell Phone _____ Spouse's Name _____

Email Address _____ Child's Name and Age _____

Emergency Contact _____ Emergency Contact's Phone _____ Child's Name and Age _____

Your Occupation _____ Child's Name and Age _____

Your Employer _____ Work Phone _____

Address _____ May we contact you at work? ◯ Yes ◯ No

City _____ State/Province _____ ZIP/Postal Code _____ Preferred method of contact? ◯ Home Phone ◯ Cell Phone ◯ Work Phone ◯ Email

Primary Care Provider's Name _____

Insurance Carrier _____ Policy Number _____

Insured's Last Name _____ Birth Date (MM/DD/YYYY) _____ Who carries this policy? ◯ Self ◯ Spouse ◯ Parent

Insured's First Name _____ Insured's Middle Name (or Initial) _____

Insured's Employer _____

Address _____

City _____ State/Province _____ ZIP/Postal Code _____ Employer's Phone _____

I certify that any changes to my personal information have been updated above for your records. _____ Signature

UPDATED CONTACT INFORMATION

Version No. 191093585
© 2013 Paperwork Project. All rights reserved.

ARLINGTON CHIROPRACTIC CLINIC, PC
www.ArlingtonChiroClinic.com

Arlington Chiropractic Clinic, PC
Totalcare®
1702 W. Campbell Street
Arlington Heights, IL 60005
(847) 259-4493
◯ Christa S. Andreoli, D.C., DACO, MCS-P
◯ Peter J. Horn, D.C., CCSP

UPDATED PATIENT HISTORY

Today's Date (MM/DD/YYYY) _____

Patient Number (office use only) _____

Your Last Name _____ **Your First Name** _____ **Your Middle Name (or Initial)** _____

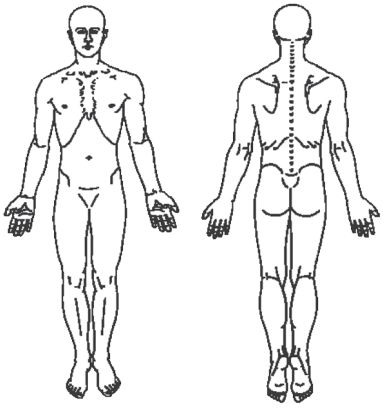
◯ **I have new contact information**

Please select one:

◯ **Progress evaluation** – I've been under active care and this is a periodic reevaluation.
◯ **New condition** – I've been under care and a new or returning condition has emerged.
◯ **Maintenance patient** – I'm under maintenance care with a new or returning health issue.
◯ **Returning patient** – After a period of inactivity, I've had a relapse or an all-new health issue.

Current symptoms: _____

1. Location (Where does it hurt?)
Circle the area (s) on the illustration.



2. Quality of symptoms (What does it feel like?)

◯ Numbness
◯ Tingling
◯ Stiffness
◯ Dull
◯ Aching
◯ Cramps
◯ Nagging
◯ Sharp
◯ Burning
◯ Shooting
◯ Throbbing
◯ Stabbing
◯ Other

3. Intensity (How extreme are your current symptoms?)

0 ◯—◯—◯—◯—◯—◯—◯—◯—◯—◯ 10
Absent Uncomfortable Agonizing

4. Duration and Timing (When did it start and how often do you feel it?)

◯ Constant ◯ Come and goes.

When did it start and how often? _____

5. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)

_____

6. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem? _____

What tends to lessen the problem? _____

7. Prior interventions (What have you done to relieve the symptoms?)

◯ Prescription medication ◯ Surgery ◯ Ice
◯ Over-the-counter drugs ◯ Acupuncture ◯ Heat
◯ Homeopathic remedies ◯ Chiropractic Other _____
◯ Physical therapy ◯ Massage _____

8. What else should Arlington Chiropractic Clinic know about your current condition? _____

_____

_____

9. Review of systems (Identify any changes since your most recent evaluation with us):

	Worse	No Change	Improved
a. Musculoskeletal System – Such as osteoporosis, arthritis, neck pain, back problems, poor posture, etc.	◯	◯	◯
b. Neurological System – Such as anxiety, depression, headache, dizziness, pins and needles, numbness, etc.	◯	◯	◯
c. Cardiovascular System – Such as high blood pressure, low blood pressure, high cholesterol, angina, etc.	◯	◯	◯
d. Respiratory System – Such as asthma, apnea, emphysema, hay fever, shortness of breath, pneumonia, etc.	◯	◯	◯
e. Digestive System – Such as anorexia/bulimia, ulcer, food sensitivities, heartburn, constipation, diarrhea, etc.	◯	◯	◯
f. Sensory System – Such as blurred vision, ringing in ears, hearing loss, chronic ear infection, etc.	◯	◯	◯
g. Skin System – Such as skin cancer, psoriasis, eczema, acne, hair loss, rash, etc.	◯	◯	◯
h. Endocrine System– Such as thyroid issues, immune disorders, hypoglycemia, frequent infection, etc.	◯	◯	◯
i. Genitourinary System – Such as kidney stones, infertility, bedwetting, prostate issues, PMS symptoms, etc.	◯	◯	◯
j. Constitutional System – Such as fainting, low libido, poor appetite, fatigue, sudden weight, weakness, etc.	◯	◯	◯

10. Illnesses, operations, injuries or treatments since your most recent evaluation with us: _____

_____

_____

This updated patient history is for:

◯ Current Patient
Periodic Re-evaluation

◯ Current Patient
Additional Complaint/
Exacerbation

◯ Maintenance Patient (circle one)
Exacerbation
Re-Occurrence
New Episode

◯ Inactive Patient (circle one)
Exacerbation
Re-Occurrence
New Episode

Consultation Notes

Doctor's Initials _____

UPDATED PATIENT HISTORY

Version No. 191093585
© 2013 Paperwork Project. All rights reserved.

11.Medications (please list all prescription and over-the-counter): _____

_____

12. Social History (Tell Arlington Chiropractic Clinic about your health habits and stress levels.)

Alcohol use	◯ Daily	◯ Weekly	How much?_____	Prayer or meditation?	◯ Yes	◯ No
Coffee use	◯ Daily	◯ Weekly	How much?_____	Job pressure/stress?	◯ Yes	◯ No
Tobacco use	◯ Daily	◯ Weekly	How much?_____	Financial peace?	◯ Yes	◯ No
Exercising	◯ Daily	◯ Weekly	How much?_____	Vaccinated?	◯ Yes	◯ No
Pain relievers	◯ Daily	◯ Weekly	How much?_____	Mercury fillings?	◯ Yes	◯ No
Soft drinks	◯ Daily	◯ Weekly	How much?_____	Recreational drugs?	◯ Yes	◯ No
Water intake	◯ Daily	◯ Weekly	How much?_____			

Hobbies: _____

13. Activities of Daily Living (How does this condition currently interfere with your life and ability to function?)

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	◯	◯	◯	◯
Rising out of chair	◯	◯	◯	◯
Standing	◯	◯	◯	◯
Walking	◯	◯	◯	◯
Lying down	◯	◯	◯	◯
Bending over	◯	◯	◯	◯
Climbing stairs	◯	◯	◯	◯
Using a computer	◯	◯	◯	◯
Getting in/out of car	◯	◯	◯	◯
Driving a car	◯	◯	◯	◯
Looking over shoulder	◯	◯	◯	◯
Caring for family	◯	◯	◯	◯

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	◯	◯	◯	◯
Household chores	◯	◯	◯	◯
Lifting objects	◯	◯	◯	◯
Reaching overhead	◯	◯	◯	◯
Showering or bathing	◯	◯	◯	◯
Dressing myself	◯	◯	◯	◯
Love life	◯	◯	◯	◯
Getting to sleep	◯	◯	◯	◯
Staying asleep	◯	◯	◯	◯
Concentrating	◯	◯	◯	◯
Exercising	◯	◯	◯	◯
Yard work	◯	◯	◯	◯

14. Is there anything else Arlington Chiropractic Clinic should know about your current condition, your progress or ways your current condition is affecting your life?

_____

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.

Patient (or Guardian's) signature

Date (MM/DD/YYYY)

Patient name

Patient Number
(office use only)

Consultation Notes

Doctor's Initials

Arlington Chiropractic Clinic
Christa S. Andreoli, D.C., DACO, MCS-P
Peter J. Horn, D.C., CCSP

Version No. 191093585
© 2013 Paperwork Project. All rights reserved.

Financial Policy

Thank you for choosing Arlington Chiropractic Clinic. Our goal is to provide you and your family with optimal care. We look forward to helping you, encourage you to ask questions and want you to understand our financial policy.

Financial Agreement: Our patients who have insurance are required to pay their copay at the time of service. Deductibles and co-insurance are due after insurance claims are processed. Full payment is due at the time of service for uninsured patients, and for those patients that are receiving non-covered services, such as maintenance care. Payments may be made using cash, check, Visa, Mastercard, American Express, and Discover. We will impose a fee for returned checks. We also offer CARECREDIT, a financing option with no interest if paid in full within 6, 12, or 18 months.

Initial_____

Insurance Information: *It is the patient's responsibility to know their insurance coverage.* Our office will call your insurer to verify your benefits, however we are not responsible for your insurer's final payment and benefit determination. Treatment recommendations will be based on individual needs, NOT insurance coverage. As a patient of Arlington Chiropractic Clinic, you authorize payment of insurance benefits directly to the provider and understand you are responsible for what the insurance does not pay.

Initial_____

Automated Payments: We are requiring that you provide your credit card information to facilitate the collection of any balances that may become your responsibility throughout or after your care is complete, such as for a deductible or coinsurance. Nothing will be charged to your card until we have received an explanation of benefits from your insurance company. Once we receive the response, payment will be automatically charged to the card on file. *This authorization is valid up to the expiration date on the card.* Payment of copays, non-covered services, and products are due at the time you receive them and should be paid in the office with a payment method of your choice.

Initial_____

Appointments: Due to scheduling and staffing requirements, we ask that cancellations be made more than 24 hours prior to your appointment. Missed appointment charges may apply.

Initial_____

Minors/Parents/Guardians: Parents/Guardians are responsible for the payment of the minors account. In all cases, the Parent/Guardian that accompanies the minor assumes all financial responsibility of the minors account.

Initial_____

Medical Forms and Records: This office will fill out routine forms at no charge. Medical records will be released within 30 days of request pursuant to a valid written authorization, in accordance with the rules of HIPPA, Illinois law, or under other circumstances required by law. We will charge copy fees as permitted by law. You authorize the doctor to release any medical or other information necessary to communicate with payers to secure the payment of benefits.

Initial_____

I have read the above. I understand and agree to these policies.

_____ _____ _____

(Print Name) (Signature) (Date)

HIPAA Notice of Privacy Practices

Arlington Chiropractic Clinic • 1702 W. Campbell Street • Arlington Heights, IL. 60005 • 847/259-4493

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We do not provide patient information to other organizations.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature:_____ Date:_____

ARLINGTON CHIROPRACTIC CLINIC, PC
Dr. Christa S. Andreoli, D.C., DACO, MCS-P
Dr. Peter J. Horn, D.C., CCSP
1702 W. Campbell St. Arlington Hts., IL 60005
(847) 259-4493

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, diagnostic x-rays, physio therapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during chiropractic treatments. The incidence of complications associated with chiropractic treatment is very low and include but is not limited to: fractures, disc injuries, dislocations, muscle strain, sprain, stiffness, soreness, nerve injuries, costovertebral strains and separations, and those that relate to physical aberrations unknown or reasonably undetectable by the doctor. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

I have read (or have had read to me) the above explanation of the chiropractic treatments. I state that I have been informed and weighed the risks involved in chiropractic treatment at this health care office. I have decided that it is in my best interest to receive chiropractic treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

Sign only after you understand and agree to the above.

_____
Printed name of Patient

_____ _____
Signature of Patient *Date*

_____ _____
Signature of Representative *Date*
(if patient is a minor or is handicapped)

_____ _____
Witness to Patient's Signature *Date*