ChiroSolutions, PC

630-784-8500 www.ChiroSolutions.org

124 S. County Farm Road, Suite B, Wheaton, IL 60187

PATIENT REGISTRATION FORM

Last Name:	First Name:		Middle:	
Address:	City:		State:	Zip:
* Social Security Number:	DOB: (mm/dd/yyyy)	Age:	Sex: ◯M ◯F	Marital Status: ◯S ◯M ◯W ◯D
Home Phone:	Cell Phone:		Work Phone:	
e-Mail Address:	Preferred Method of Contact: ◯Home ◯Work ◯Cell ◯E-Mail			
Reason for Appointment:			Which Side of the Body? ☐Left ☐Right	Date Symptoms Began:

PHYSICIAN INFORMATION

Primary Care Physician:	Primary Care Physician Phone:		
Address:	City:	State:	Zip:
* Other Healthcare Provider:	* Other Healthcare Provider Phone:		
* Address:	* City:	* State:	* Zip:

HOW DID YOU FIND OUT ABOUT CHIROSOLUTIONS?

☐ I am a Former Patient
☐ Website: _____
☐ Insurance Co. Recommendation
☐ Google
☐ Clinic Sign
☐ Family/Friend Recommendation
Name _____
☐ Workers' Comp./ Case Manager
☐ Yelp
☐ Doctor Recommendation
☐ Other: _____

Photo ID, insurance card, and co-pay are required on day of visit. If you did not bring insurance cards with you, all charges will be your responsibility and payable at time of service. Obtaining required referral forms and treatment precertification is the patient's responsibility. ALL UNPAID BALANCES AND/OR DENIED CLAIMS ARE YOUR RESPONSIBILITY.

Patient/Parent or Guardian Signature:	Date:

Fields marked with an (*) are optional.

PRINT ➤

FILL OUT ➤

FAX to (630) 784-0885
& bring to your appointment.

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* WORKERS' COMPENSATION INFORMATION

Work-related Injury? ◯ Yes ◯ No	Date of Accident: (mm/dd/yyyy)
Name of Workers' Compensation Carrier:	Claim Number:
What part of the body was injured?	

Address:	City:	State:	Zip:
Phone Number:	Last Date Worked?		
Adjuster's Name:	Phone Number:		

* ACCIDENT INFORMATION

Motor Vehicle/Personal Related Injury? ◯ Yes ◯ No	Accident Date:
Motor Vehicle Compensation Carrier:	Claim Number:

Address:	City:	State:	Zip:
Phone Number:	Last Work Date:	State Accident Occurred:	

* ATTORNEY INFORMATION

Attorney's Name (if lawsuit is involved):	Phone Number:

Address:	City:	State:	Zip:

I, the undersigned, hereby certify that I have answered the questions listed above accurately and to the best of my knowledge.

Patient/ Parent or Guardian Signature:	Date:

Fields marked with an (*) are optional.


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FINANCIAL POLICY

ALL PAYMENTS ARE EXPECTED AT THE TIME OF SERVICE Initials _____ (for the information below)

Please note, all Patient Responsibility Payments are due at time of service unless other arrangement were made prior to initial appointment. This includes all deductible, co-insurance, and co-payment amounts.

Also, please note that payments made at time of service are for an estimated amount based on benefit information provided by your insurance company, and not the exact amount you will owe for any given date of service. Final amount due for services will be determined after your insurance processes your claim.

The clinic accepts cash, personal checks (in-state only), VISA, MasterCard, American Express, and Discover. There is a $25.00 service charge for returned checks. All patients are required to supply the clinic with a valid credit or debit card prior to their first visit to ensure timely payment of insurance non-payment and owed amounts.

Patients with an outstanding balance 60 days or older authorize the clinic to charge their credit or debit card on file for the balance due. If we are unable to collect payment from your debit or credit card on file, we may forward your account to a third-party collection agency. Please note we will not book any additional appointments until your balance has been paid in full. Any third-party collection fees will be charged in addition to the original balance due.

INSURANCE Initials _____ (for the information below)

Our office will check your benefits as a courtesy to you and provide this information on or before your first appointment. The benefit information we will provide for you is only a quote of benefits, so it is not a guarantee that we will receive payment from your insurance company for services rendered. The actual benefit for services provided will be determined by your insurance once they receive your claim.

We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible, co-insurance, and/or co-payment at the time of service. If we have not received payment from your insurance company within 60 days of the date of service, you may be expected to pay the balance in full. Please note, even though we will bill your insurance carrier, you are still responsible for payment of all services rendered whether by you or your insurance company.
We do not bill secondary insurance companies. However, we will provide any and all necessary receipts for you to be able to submit your claim to your secondary insurance.

SELF-PAY Initials _____ (for the information below)

Payment for all self-pay appointments is due at time of service. Costs for self-pay appointments will be provided upon your request.

REFUNDS Initials _____ (for the information below)

Patient/guarantor credits will be retained on account to be credited toward future balances unless a request for refund is received.

I have read and understand the Clinic's Financial Policy. I agree to assign insurance benefits to the Clinic's Practice whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I may also be responsible for the fee charged by the collection agency for cost of collections.

Signature _____ Date _____


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CONFIDENTIAL HEALTH HISTORY

Patient Name: _____ Date: _____

The items below may relate to your current health condition. In the space in front of each item, place a letter next to the item that relates to you based on your typical health profile.

Key: C = Have the condition Currently P = Have had the condition in the Past

GENERAL

___ Frequent illness: *Describe*:

_____

___ Loss of sleep
___ Fatigue
___ Weight loss or gain
___ Bleeding problems
___ Anemia
___ Diabetes
___ Night sweats
___ Cancer, *Describe*:

_____

___ Chicken pox
___ HIV positive

GENITOURINARY

___ Frequent urination
___ Painful urination
___ Blood in urine
___ Kidney disease
___ Urinary tract infection
___ Difficulty starting urine flow
___ Breast lump or pain
___ Venereal infection
___ Sexual difficulties

CARDIOVASCULAR

___ Atherosclerosis
___ High blood pressure
___ Pain over heart
___ Previous heart trouble
___ Ankle swelling or varicose veins
___ Stroke

GASTROINTESTINAL

___ Poor digestion
___ Difficulty swallowing
___ Frequent nausea or vomiting
___ Coughing up blood
___ Heartburn
___ Intestinal / stomach pain
___ Ulcer
___ Black or bloody stools
___ Hernia
___ Diarrhea or constipation

SKIN

___ Itching or psoriasis
___ Skin cancer

NEUROLOGICAL

___ Weakness, *Location*:

_____

___ Headaches
___ Migraines
___ Dizziness
___ Tremors, *Location*:

_____

___ Numbness / tingling
___ Arm / leg pain
___ Mental disorder

RESPIRATORY

___ Chronic cough
___ Shortness of breath
___ Asthma

HABITS

___ Smoking ___ packs / day
___ Drinking ___ drinks / daily

EYE, EAR, NOSE, MOUTH/THROAT

___ Poor vision
___ Pain in eye(s)
___ Deafness / difficulty hearing
___ Sinus troubles


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CONFIDENTIAL HEALTH HISTORY *(CONTINUED)*

Key: C = Have the condition Currently P = Have had the condition in the Past

ACCIDENTS / TRAUMA

___ Motor vehicle accidents
___ Other trauma / accidents

MIND

___ Poor memory / concentration
___ Poor physical coordination
___ Learning disability
___ Anxiety / fear / nervousness
___ Anger / irritability / aggressiveness
___ Depression

MUSCULOSKELETAL

___ Neck stiffness / pain
___ Pain between shoulders
___ Low back pain
___ Swollen or painful joints
___ Arthritis. *Location*:

_____

___ Muscle aches / soreness
___ Abnormal spinal curvature
___ Other diseases / disorders:
Describe:

_____

___ Broken bones / fractures:
Location and dates:

_____

_____

SURGERIES

___ List dates and reasons:

_____

_____

MEDICATIONS

___ Prescriptions, list:

_____

_____

___ Nutritional supplements, list:

_____

_____

EXERCISE

___ None
___ Times per week:___

RADIOLOGY / ADVANCED IMAGING

___ X-rays; area(s) x-rayed and dates:

_____

_____

_____

___ MRI / CT scan;
area(s) imaged and dates:

_____

_____

_____

HOSPITALIZATIONS

___ List Dates and reasons:

_____

_____

FAMILY HISTORY

___ Diabetes
___ High blood pressure
___ Heart disease
___ Cancer
___ Muscle, bone, or nerve disease
___ Other / describe:

_____

MEN ONLY

___ Testicular pain / swelling
___ Prostate problems
___ Erectile dysfunction (ED)

WOMEN ONLY

___ Currently pregnant
___ Think you might be pregnant
___ Live birth / total: ___
___ Miscarriage / episodes : ___
___ Painful periods
___ Irregular cycles
___ Hot flashes
___ Date last period began:

_____

___ Date of last PAP test:

_____

___ Date of last mammogram:

_____


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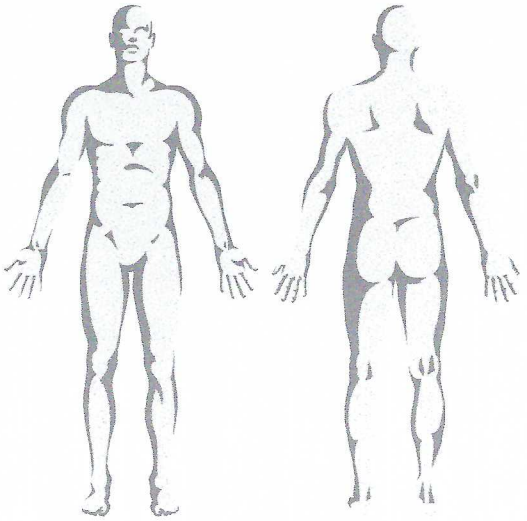
PATIENT ASSESSMENT FORM & VISUAL ANALOG SCALE

Patient Name: _____ Date: _____

This drawing allows you to visually describe your pain. Mark the areas of your body where you feel the sensations described below, including pain radiation, using the appropriate symbols.

KEY

Aching:	XXX
Numbness:	000
Pins & Needles:	= = =
Burning:	***
Stabbing:	/ / /



The line below represents the intensity of **low back pain**.

Please mark an "X" at the position on the scale that indicates how much pain you feel in your low back at this time.

No Pain _____ Worst Pain Imaginable

The line below represents the intensity of pain **other than low back pain.**

Please mark an "X" at the position on the scale that indicates how much pain you feel at this time.

No Pain _____ Worst Pain Imaginable

Check each of the activities which you have difficulty performing and/or can perform only with pain:

GENERAL
- ☐ Walking
- ☐ Standing
- ☐ Running
- ☐ Sitting
- ☐ Lifting children
- ☐ Bending
- ☐ Climbing stairs
- ☐ Reading
- ☐ Lying in bed
- ☐ Playing Instruments
- ☐ Chewing
- ☐ Swimming
- ☐ Getting up from seated
- ☐ Using computer
- ☐ Kneeling
- ☐ Sexual intercourse
- ☐ Exercising
- ☐ Sleeping
- ☐ Using telephone
- ☐ Working
- ☐ Concentration
- ☐ Sports:

List:_____

HOUSEWORK
- ☐ Doing laundry
- ☐ Making beds
- ☐ Vacuuming
- ☐ Washing dishes
- ☐ Ironing
- ☐ Carrying groceries
- ☐ Caring for pets
- ☐ Cooking
- ☐ Shoveling
- ☐ Mowing Lawn

PERSONAL GROOMING
- ☐ Combing Hair
- ☐ Shaving
- ☐ Getting in or out of bathtub
- ☐ Brushing teeth

TRAVEL
- ☐ Driving
- ☐ Riding (passenger)
- ☐ Getting in and out of car

OTHER: Please list any other difficulties you are experiencing with activities you have engaged in since your condition arose:

_____

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CONSENT FOR TREATMENT

I, the undersigned, do hereby agree and give my consent for ChiroSolutions, PC to furnish medical care and treatment to myself or _____, considered necessary and proper in diagnosing or treating my physical condition.

Patient/Guardian Signature _____ Date _____

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, the undersigned, hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance, and third-party payers to ChiroSolutions, PC. A photocopy of these assignments is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

Patient/Guardian Signature _____ Date _____

CANCELLATION POLICY

Together, you and your therapist will set your treatment goals and time frames to complete these goals. It is important that you attend all scheduled treatment sessions in order to achieve the best results. If you must cancel or change an appointment, we request that you give us 24-hour notice prior to your scheduled appointment time by calling 630-784-8500 or emailing info@chirosolutions.org.

There will be a $25.00 cancellation fee for any scheduled treatment services without a prior 24-hour notice provided. After three cancellations without 24-hour notice, or no-shows, we reserve the right to charge $50.00 per cancellation or no-show, per scheduled appointment. If you are a worker's compensation patient, please be advised that your employer, physician, and rehabilitation nurse/adjustor may be notified of each missed appointment. Please note that cancellation fees are not billable to insurance companies, Medicare, workman's comp, or personal injury cases

I acknowledge that I have read and understand this cancellation policy.

Patient/Guardian Signature _____ Date _____


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MEDICAL RECORD PRIVACY INFORMATION

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Policy on Medical Record Privacy

This notice describes the way our practice will treat medical records we keep regarding your medical care. We are required to keep a record of your care, including your diagnosis, treatment, services you receive, and other information. We are required by law to protect your personal medical records by keeping them private and following certain rules that dictate whether and when we can use or disclose your information. This notice will inform you of these rules. It will also notify you of your rights and our obligations in our use and disclosure of your health information. We are also required to give you notice, and to follow the terms of the notice that are currently in effect. We reserve the right to change this notice and apply those changes to the health information we currently have, as well as any information we may receive in the future. If we change this notice, you will receive a new copy of this notice the next time you receive services from our practice.

Understanding Your Health Records

Each time you visit ChiroSolutions, PC, a record of your visit is made. Typically, this record contains your symptoms, examinations, test results, diagnoses, treatment, and a plan for future care of treatment. This information, often referred to as your health or medical record, may serve as a:

- Basis for planning your care and treatment.
- Means of communication among the many health professionals who contribute to your care.
- Legal document describing the care you received.
- Means by which you or a third-party payer (such as your insurance company) can verify that services billed were actually provided.
- Source of data for medical research.
- Source of information for public health officials charged with improving the health of Illinois and the nation.
- Source of data for planning and marketing.
- Tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Your Rights Regarding Your Health Information

You have the right to:

- Request that we restrict the use or disclosure of your health information for treatment, payment, or healthcare operations (as described in this notice).
- Request that we restrict from disclosing information to family or friends.
- Request how you would like us to communicate with you.
- Inspect and copy certain health information, including most of your medical and billing records. This request must be made in writing to the Privacy Officer. A reasonable fee may be applied for copying, postage, or other expenses related to your request. We may deny your request to inspect and or copy your health information. If we do, another licensed health care professional will review your request and we will comply with the outcome of the review.
- Amend your health record as provided in 45 CFR 164,528.
- Obtain an accounting of disclosure of your health information as provided in 45 CFR 164,528.
- Obtain a paper copy of this notice upon request.

NOTE:

We are not required to agree to your requests. To request restrictions or limitations, you must make a written request to the Privacy Officer. The request must tell us (1) what information you want to limit; (2) whether you want to limit the use of the information and/or disclosure of the information; (3) to whom the limitations or restrictions will apply.

Our Responsibilities

ChiroSolutions, PC is required to:

- Maintain the privacy of your health information.
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the practice's Privacy Officer at 630-784-8500. If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office of Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office of Civil Rights. The address for the OCR is listed below:

Office of Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

How We May Use and Disclose Your Health Information

We may use and disclose your health information for several purposes in connection with your medical care and in running our practice. The following lists a few of the typical uses and disclosure within our practice. We will use your health information for the following:


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Treatment
We may use your health information to diagnose your illness or injury, provide you with services, or refer you to another physician. We may disclose your health information to doctors, nurses, technicians, medical students, or other personnel who are involved with your care. We also may disclose your health information to people outside of our medical practice who may be involved in medical care, such as family members, clergy or others.

Payment
We may give your health plan information regarding your diagnosis and treatment in order to be paid for your office visits, procedures, x-rays, or laboratory work. We may also provide information to determine whether your health plan pays for the treatment you need, and whether we need to get authorization from the health plan before treating you.

Health Care Operations
We may use or disclose your information if we conduct quality assessment and improvement activities to ensure that our patients receive quality medical care. We may also use or disclose your information in the training and evaluation of our physicians and other staff, or as part of a medical review, audit, or legal activities.

Appointment Reminders
We may use or disclose your information to contact you as a reminder that you have an appointment with our practice.

Individuals Involved in Your Care or Payment for Your Care
We may disclose your health information to a family member or friend who is involved in your medical care or who helps pay for your care. We may also tell your family or friends about your condition, for example, if you are admitted to the hospital or in the event of a disaster relief effort.

Public Health Risk
We may disclose your health information to report disease, injury, disability, births, deaths, child abuse or neglect, defects, recalls or problems with drugs, medical devices, or other products to prevent or conditions. We may also notify authorities if we believe you have been the victim of abuse, neglect or domestic violence.

Health Oversight Activities
We may also disclose your health information to agencies authorized by law for audits, investigations, inspections, and licensure.

Law Enforcement
We may disclose your health information when the following circumstances apply:
- If you have incurred certain injuries or wounds that are legally required to be reported.
- In response to a court order, subpoena, warrant, summons, investigative demands, or similar processes.
- To identify or locate a suspect, fugitive, material witness, or missing person.
- About the victim of a crime if under certain limited circumstances.
- About a suspicious death that we believe may be the result of criminal conduct.
- About criminal conduct on our premises.
- In emergency circumstances to report a crime, its location, or information about the person who may have committed the crime.
- Coroners, Medical Examiners, and Funeral Directors as necessary to carry out their duties.

Specialized Government Functions
We may disclose your health information to release information to military command authorities, upon your separation or discharge from military service to authorized officials. We may also disclose your health information to the appropriate government officials when it is necessary to conduct intelligence or other national security activities authorized by federal law. In addition, we may release your health information if it relates to the protection of the Presidents of the United States or foreign heads of state. Finally, we may disclose certain information related to members of the armed services and foreign military services to the appropriate personnel

Inmates
If you are an inmate of a correctional facility, or under the custody of a law enforcement official, we may disclose your health information to the correctional institution or law enforcement official in order to provide you with medical services, protect you or others, or to ensure safety of the correctional facility.

Workers' Compensation for Work Related Illness or Injuries
We may disclose your health information in relation to workers' compensation or similar programs established by law that provide benefits for work-related illness or injuries.

Other Uses of Your Health Information
We may disclose your health information, when required by federal, state or local law, for treatment alternatives or health related benefits/services, organ and tissue donations, or to avert a serious threat to health or safety.

Contact Information:
Dr. Robert Sierszulski
124 S. County Farm Road, Ste B
Wheaton, IL 60187
Email: Dr.Robert@chirosolutions.org
Phone: 630-784-8500
Fax: 630-784-0885

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I received the Notice of Privacy Practices of ChiroSolutions.

_____ _____
Patient / Parent or Guardian Signature Date

_____
Patient / Parent or Guardian Printed Name

Office Use Only:

_____ _____
Witness Date


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CREDIT CARD AUTHORIZATION FORM

I, _____ , hereby authorize ChiroSolutions, PC to charge my credit/debit/HSA card for the portion of services that are my responsibility. This includes any patient responsibility for services rendered (deductibles, co-payments, and co-insurances) and/or fees incurred (cancellations within 24 hours or no-show appointments). I understand my card will be charged at time of service. I also understand that in the event my card declines, I will be required to provide a different method of payment. I will also be expected to pay for any previously unpaid charges resulting from the decline, in addition to the current charges due.

I authorize my card to be charged for:

_____ patient responsibility and fees incurred.

_____ fees incurred only.

Credit Card Number: _____

Exp. Date: _____ CVV code _____

Billing Address for the Debit/Credit Card listed above:

_____

_____

Patient Name: _____ Date: _____

Patient / Parent or Guardian Signature: _____

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