Center for Musculoskeletal Care

New Patient Intake Form

PATIENT INFORMATION TODAY'S DATE:

Last Name: _____ First Name: _____ Middle Name: _____

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

Home Phone: _____ Cell Phone: _____ Fax: _____

E-Mail: _____ Preferred method of contact? ◯ Home ◯ Cell ◯ Email ◯ Work

If you prefer not to receive text message appointment reminders, please check here: ☐ Opt-Out of Text Message Reminders

Gender: ◯ M ◯ F Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Separated

Birthday: _____/_____/_____ Age: _____ Cell Phone Company Used: _____

Occupation: _____ Student: ◯ Yes ◯ No Work Phone: _____

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

EMERGENCY CONTACT

Emergency Contact Name: _____ Relationship: _____

Contact's Phone: _____

INSURANCE INFORMATION

Insurance Carrier: _____ Policy Number: _____

Group Number: _____ Address: _____

City: _____ State: _____ Zip: _____

Insured Name: _____ Birth Date: _____/_____/_____

Who may we thank for referring you? _____

Have you consulted chiropractor before? ◯ Yes ◉ No

I herby certify that the information provided above for Center for Musculoskeletal Care is true and correct.

_____ _____

Patient Signature Date

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HISTORY FORM TODAY'S DATE:

Name: _____ Date of Birth:_____/_____/_____ Age:_____ Male:_____ Female:_____

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

Cell Phone#: _____ Home Phone_____ Email:_____

PLEASE DESCRIBE YOUR MAIN REASON FOR THIS APPOINTMENT

Is the reason for your visit related to: _____ Auto accident _____ Work Injury _____ Neither

Briefly describe your symptoms: _____

_____

When did your symptoms begin?_____

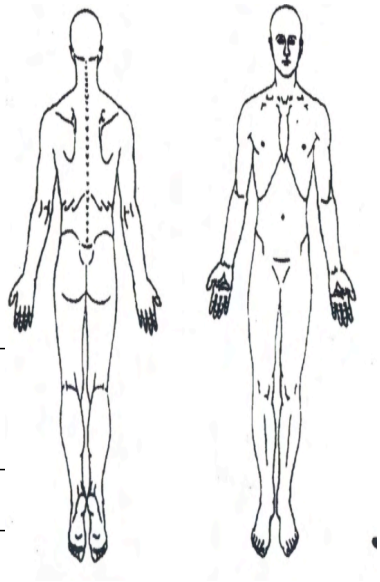
Is your condition getting worse? _____ Yes _____ No

Have you had this condition in the past? _____ Yes _____ No

Is your discomfort: ____ Constant ____ Frequent ____ Occasional ____ Intermittent

Have you seen other doctors for these conditions? ____ Yes ____ No

(If yes please list) _____



Please mark areas of pain on the figures

What helps relieve your symptoms? _____

_____

What activities aggravate your condition? _____

How much have your symptoms interfered with your daily activities (circle a number)

no effect 0 1 2 3 4 5 6 7 8 9 10 no possible activities

Rate your average pain intensity from your primary symptom.

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

Describe the nature of your symptoms: ____ Sharp ____ Dull ____ Numb ____ Burning ____ Shooting ____ Tingling ____ Stabbing ____ Throbbing ____ Radiating ____ Tightness ____ Other

Have you experienced any accident or falls in the past: ____ Year ____ 5 Years ____ Never

In general, would you say your overall health right now is : ____ Excellent ____ Very good ____ Good ____ Fair ____ Poor

How does this condition interfere with your life and ability to function? _____

_____

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PATIENT NAME: _____

MEDICAL HISTORY

Physical Exam: _____/_____ / _____ Diagnostic: _____X-rays _____ MRI _____CT Scan

ALLERGIES: _____

_____

SURGERIES/ INJURY/ HOSPITALIZATION / FRACTURES: _____

_____

_____

CURRENT MEDICATIONS DOSE

_____ _____

_____ _____

_____ _____

SUPPLEMENTS / VITAMINS DOSE

_____ _____

_____ _____

_____ _____

_____ _____

PERSONAL AND FAMILY HISTORY (check all that apply and family member who had/has any of the problems)

- ☐ Asthma
- ☐ Alcoholism
- ☐ Arteriosclerosis
- ☐ Alzheimer's
- ☐ Anemia
- ☐ Arthritis
- ☐ Allergies
- ☐ Aids
- ☐ Glaucoma
- ☐ Headaches
- ☐ Kidney Disease
- ☐ Breast Cancer
- ☐ Cancer
- ☐ Colon Cancer
- ☐ Diabetes
- ☐ Depression
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Stroke
- ☐ Liver Disease
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Irritable Bowel Syndrome
- ☐ Multiple Sclerosis
- ☐ Mental Illness
- ☐ Neurological Problems
- ☐ Parkinson's
- ☐ Osteoporosis
- ☐ Prostate Cancer
- ☐ Ulcers

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REVIEW OF SYSTEMS - Please check any conditions you have or previously had.

GENERAL	EARS, NOSE, THROAT	CARDIOVASCULAR	MUSCULOSKELETAL	GASTROINTESTINAL
Chills _____ ☐	Allergy _____ ☐	High Blood Pressure_____ ☐	Headaches _____ ☐	Abdominal pain __ ☐
Dizziness _____ ☐	Facial Pain _____ ☐	Low Blood Pressure___ ☐	Neck Pain _____ ☐	Blood in Stool____ ☐
Fainting _____ ☐	Grinding Teeth ___ ☐	Hardening of Arteries_ ☐	Back Pain _____ ☐	Nausea _____ ☐
Fatigue _____ ☐	Jaw Pain _____ ☐	Pain over heart ____ ☐	Joint Pain _____ ☐	Vomiting _____ ☐
Fever _____ ☐	Ringing Ears _____ ☐	Swelling in ankles ____ ☐	Shoulder _____ ☐	Indigestion _____ ☐
Weight Loss ___ ☐	Sore Throat _____ ☐	Varicose Veins _____ ☐	Elbow _____ ☐	Heartburn _____ ☐
Weight Gain ___ ☐	Sinus Infection ___ ☐	Blood Clots _____ ☐	Wrist _____ ☐	Hemorrhoids ____ ☐
Sweats _____ ☐	Ear Ache _____ ☐	Anemia _____ ☐	Hips _____ ☐	Constipation_____ ☐
Sleep Loss ____ ☐	Poor Hearing ____ ☐	Easy Bruising _____ ☐	Knees _____ ☐	Diarrhea _____ ☐
Anxiety _____ ☐	Mouth Sores ____ ☐	Lightheaded _____ ☐	Ankles/Feet ☐	Liver Trouble ____ ☐
Depression ____ ☐	Other _____ ☐	Palpitations _____ ☐	Sciatica _____ ☐	Gassy Gut _____ ☐
Other _____ ☐		Other _____ ☐	Arthritis _____ ☐	Change in Appetite ☐
			Bursitis _____ ☐	Food Sensitivities _ ☐
			Muscle Weakness ___ ☐	Other _____ ☐
			Numbness _____ ☐	
			Joint Swelling _____ ☐	

RESPIRATORY	GENITOURINARY	SKIN, HAIR	SENSORY, NERVES, BRAIN	OTHER CONDITIONS
Chest pain ☐	Painful Urination ☐	Eczema ☐	Poor Balance ___ ☐	Thyroid issues _____ ☐
Shortness Of Breath ☐	Kidney stones ☐	Rash ☐	Blurred Vision __ ☐	Goiter _____ ☐
Wheezing Chronic ☐	Loss of Bladder Contro ☐	Changes in Mole ☐	Seizures _____ ☐	Diabetes _____ ☐
Cough ☐	Prostate issues ☐	Skin Cancer ☐	Poor Coordination ☐	Immune Disorders __ ☐
Asthma ☐	Other ☐	Acne ☐	Pins & Needles _ ☐	Gout _____ ☐
Other ☐		Psoriasis ☐	Anxiety ☐	Hypoglycemia _____ ☐
		Hair Loss ☐	Depression ☐	Swollen Glands _____ ☐
			Tremors _____ ☐	

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PATIENT NAME: _____

WOMEN ONLY

Are you pregnant? ____Yes ____No If Yes, how many months? _____ Date of last period: _____

Age Menopause _____ Number of Live Births _____ Pregnancies Lost _____

Hot Flashes ____ Pelvic Pain ____ Lumps in Breast ____ PMS Syndrome ____

PAP exam (date): _____ Mammogram (date): _____ Thermography (date): _____

LIFESTYLE (please describe your habits)

Alcohol Use Yes ____ No ____ How much? _____

Caffeine Intake Yes ____ No ____ How much? _____

Tobacco Use Yes ____ No ____ How much? _____

Recreational drugs Yes ____ No ____ How often? _____

Exercising Yes ____ No ____ How often? _____

Soft Drinks Yes ____ No ____ How much? _____

Water Intake Yes ____ No ____ How much?_____

Healthy Diet Yes ____ No ____ Not sure _____ Need Help _____

STRESS LEVEL: Please rate your stress level on a scale of 0 (no stress) to 10 (highly stressed)

0 1 2 3 4 5 6 7 8 9 10

HOW MUCH SLEEP DO YOU AVERAGE PER NIGHT? _____ hours

What is your preferred sleeping position? _____

What is the type and age of your mattress and pillow? _____

OTHER:
In addition to the main reason for your visit today, do you have any other health issues or concerns that we should be made aware of? _____

_____

PRIMARY CARE PHYSICIAN: _____ PHONE # _____

ADDRESS: _____

May we communicate with your primary physician or referring doctor?_____

____ I HAVE REVIEWED AND CONFIRMED THE INFORMATION WITH THE PATIENT

PHYSICIAN SIGNATURE : _____ DATE :_____

181 WAUKEGAN RD., SUITE 103 * NORTHFIELD, IL. 60093 * P: 847.999.0074 * F: 847.994.1533 * WWW.CENTERFORMSKCARE.COM

Center for Musculoskeletal Care

Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's right concerning those records. With patient consent, Center for Musculoskeletal (MSK) Care may use and disclose protected health information to carry out treatment, payment, and healthcare operations only. Please review the Health Information Portability and Accountability Act (HIPAA) Notice, for a more detailed account of our privacy policies that are available to you at the front desk and at our website.

1. The Center for MSK Care will do its best to protect Patient Health Information (PHI). The Center for MSK Care may use and/or disclose my PHI for the purpose of treatment, payment, health care operations and coordination of care. I agree to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment.

2. The Center for MSK Care will not release your information for any purposes without your signed consent. The patient written consent is valid for as long as the patient receives care at this office, however the patient has a right to revoke this consent in writing, at any time. A revocation of consent will not apply to any prior care or service.

3. The patient has the right to review and obtain a copy of their records at any time and make amendments to those records. Records may be obtained by submitting a written request.

4. The Center for MSK Care reserves the right to change its privacy practices that are described in Center for MSK Center Notice of Privacy Practices, in accordance with applicable laws.

5. The patient has a right to submit a written request on the use of their PHI. However, the Center for MSK Care is not required to agree to those restrictions.

6. The Center for MSK Care protects patient's PHI. Staff has been trained in the area of patient record privacy and privacy official has been designated to enforce those procedures. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. I consent to the following appointment reminders that will be used by the Center for MSK Care (please initial).

a). ☐ Call my home, or another designated number and leave a message, recorded or with a person.

b). ☐ Mail to address provided by patient

c). ☐ E-mail to my home or address provided

8. I understand that the Center for MSK Care has the right to refuse treatment if I revoke this consent at any time.

CONSENT TO PROFESSIONAL TREATMENT

The patient acknowledges request of healthcare services. The doctors and practitioners of Center for Musculoskeletal Care are authorized to perform treatment as deemed necessary. The patient certifies that all information provided is true and correct, to the best of their knowledge. The patient may refuse treatment at any time. By signing below, I have weighted the risks and benefits in undergoing treatment and have decided to initiate treatment at this time. I hereby give consent to treatment.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign all benefits for services rendered under the terms of my insurance policy to be paid to this provider. I also authorize Center for MSK Care to release any information required by my insurance company in order to process claims.

I have read and understand the Center for Musculoskeletal Care Privacy Policy and Consent to Treatment. My questions have been answered and I thoroughly acknowledge, understand, agree to and accept all of the above information.

_____

SIGNATURE

_____ _____

PRINTED NAME DATE

_____

RELATIONSHIP TO PATIENT (if minor)

Center for Musculoskeletal Care

Financial Policy

Welcome to Center for Musculoskeletal (MSK) Care and thank you for choosing us as your health care center. Please understand that your insurance policy is an agreement between you and your insurance, not between your insurer and this center. The following is provided to enhance understanding concerning payment for professional services.

INSURANCE COVERAGE

In order to help you determine your responsibility toward payment for services, please read the following:

- Center for Musculoskeletal Care do not verify your insurance benefits. You need to call the number on the back of your insurance card for all inquires. You accept full responsibility to understand the benefit and reimbursement policies of your insurance company.
- It is your responsibility to provide us with accurate and current insurance information.
- Private Pay patient pays for all services, as they are rendered, and submit their own insurance claims.
- We are In-Network provider with Blue Cross/Blue Shield PPO plans, Blue Choice PPO plan, United Health Care and Aetna plans.
- We are Out-of-Network with all other insurance plans.
- Any unpaid amount becomes your responsibility 60 days after the insurance claim submission. If payment is not received within six weeks of the first statement date, the account may be sent to a third party collection agency.
- Active monthly payments are required. If you require payment arrangements, you must contact Center for MSK Care within two weeks of the first statement date.

You accept full financial responsibility for service rendered by Center for Musculoskeletal Care, including any amounts not covered by health insurance, any fees incurred, including but not limited to collection agency, legal or and other expenses incurred in the collection of past due accounts.

Payment is required for all co-pays, deductible, co-insurance and non-covered services, according to your In-Network Insurance Plan at the time of service. You are responsible for payment of all services you insurance carrier deems a service experimental, investigational, or unproven.

For Out-of-Network Insurance Plans, you are responsible for the payment at the time of service. We will provide you with a super bill and you can submit claims for reimbursement to your Insurance Plan carrier.

NON-COVERED SERVICES

Some of our rendered services may be non-covered services and not considered "reasonable and necessary" under the Medicare Program or other medical insurance plans. Therefore, it is our policy not to bill for services like acupuncture, massage therapy or nutritional supplements.

MISSED APPOINTMENTS AND LATE CANCELLATIONS

Our policy is to charge for missed appointment a rate of $45.00, unless cancelled at least 24 hours in advance.

I have read, understand, and agree to this Financial Policy.

_____

SIGNATURE

_____ _____

PRINTED NAME DATE

_____

RELATIONSHIP TO PATIENT (if minor)

181 Waukegan Rd., Suite 103
Northfield, IL.60093
847.999.0074

Patient Name: _____ CC Exp. Date: _____

CREDIT CARD AUTHORIZATION

Our office requires you to have a credit card on file. Your credit card information will be kept confidential and secure. It is a convenient method of payment for the portion of services that your insurance does not cover, but for which you are responsible. This would include co-payments, co-insurance and annual deductibles. For all self-pay patient, the card will be charged on the date of service. This would also include late cancellations or missed appointments.

LATE CANCELLATION/MISSED APPOINTMENT: Our office requires 24 -hour cancellation notification. The fee for any cancellation within that time is $50.00. The fee for a missed appointment is $100.00.

I, _____, have authorized Center for Musculoskeletal Care to capture my credit card information and charge my credit card for payment on any balance put into the "patient responsibility" as a result of my insurance plan's deductible, co-insurance, co-payment or late cancellation/no-show fee. I understand and agree that this payment will be processed on the date of service or after the claim is finalized and when we receive a copy of the Explanation of Benefits from the insurance plan. Center for Musculoskeletal Care will also provide me with a receipt of proof of payment. I understand and agree that this form is valid until I give a 30-day written notice to cancel this authorization.

I certify that I am an authorize user of this credit card and that I will not dispute the payment with my credit card company, so long as the transaction corresponds to the terms indicated in this form.

I have read and understand this agreement. _____ Accept _____ Decline

Name (As shown on card): _____

Signature: _____ Date: _____

Card Type: _____ Visa _____ MasterCard _____ Discover

Credit Card Number: _____

Expiration Date: _____ **CVV Code:** _____ **Billing Zip Code:** _____