Sikorsky Chiropractic & Fitness

Confidential Patient Information

Today's Date____/____/____

Name _____ Nickname _____

Address

_____

City _____ State _____ Zip

_____

Phone (_____)_____

Work Phone _____

E-Mail Address _____

S.S.# _____

D.O.B. _____/_____/_____

Marital Status: M S D W

Spouse Name _____

How Many Children? _____

Nearest Relative _____

Phone # _____

Referred by:

_____

Occupation _____ Company Name _____

Company Address _____ City _____ State _____ Zip_____

ABOUT YOUR INSURANCE (Please complete all—X out if none)

Group Health:

Insured Name: _____ Policy # _____ Group # _____

D.O.B. _____/_____/_____ Soc. Sec. # _____

Insurance Co. _____ Phone _____

Address _____

Secondary Health Insurance:

Insured Name: _____ Policy # _____ Group # _____

D.O.B. _____/_____/_____ S.S.# _____

Insurance Co. _____ Phone _____

Address _____

Tertiary Health Insurance:

Insured Name: _____ Policy # _____ Group # _____

D.O.B _____/_____/_____ S.S.# _____

Insurance Co. _____ Phone _____

Address _____

Pain Relief today, Health for a lifetime!

About Your Condition

Date symptoms appeared or accident happened _____/____/_____
What are your PRESENT symptoms and complaints? _____
Have you ever had the same or similar condition ( )Yes ( ) No. If yes, please describe: _____
_____
What activities aggravate your condition? _____
Is condition due to your employment: ( )Yes ( ) No
Have you lost time from work as a result? ( ) Yes ( )No
Have you been treated by another doctor for this condition? ( )Yes ( )No If yes, please list doctor's name and address:
_____
What type of treatment did you receive? _____
Date of last Physical Exam _____/_____/_____ Female: are you pregnant? ( )Yes ( )No
What operations or serious illnesses have you had? _____
What medications or drugs are you taking? _____
Have you ever been under Chiropractic care? ( )Yes ( )No Doctor's Name _____
Is this condition getting progressively worse: ( ) Yes ( )No ( ) Constant ( ) Comes and goes
Is this condition interfering with: ( )Work ( )Sleep ( )Daily Routine ( )Other
Do you notice any activity restrictions as a result? ( )Yes ( )No. Describe _____
Please include any other concerns you have regarding your visit today? _____
_____
_____

CHECK THE SYPTOMS YOU HAVE NOTICED SINCE THE CONDITION STARTED

___Headache
___Neck Pain
___Stiff Neck
___Sleeping Problems
___Back Pain
___Nervousness
___Tension

___Irritability
___Chest Pain
___Dizziness
___Heads Seems Heavy
___Pins & Needles in Arm
___Pins & Needles in Legs
___Numbness in Fingers

___Numbness in Toes
___Shortness of Breath
___Fatigue
___Depression
___Light Bothers Eyes
___Loss of Memory
____Ears Ring

___Face Flushed
___Buzzing in Ears
___Loss of Balance
___Fainting
___Loss of Smell
___Loss of taste
___Diarrhea

___Feet Cold
___Hands Cold
___Stomach Upset
___Constipation
___Cold Sweats
___ Fever
_____

HAVE YOU *EVER* SUFFERED FROM THE FOLLOWING

___Headache
___Cancer
___Significant Weight Gain/Loss
___Spinal Curvature
___Tuberculosis
___Enlarged Thyroid
___Heart Problems

___Stroke
___ Chest Pain
___ Dizziness
___High Blood Pressure
___Persistent Cough
___Asthma
___Stomach Problems

___Colon Problems
___Urinary Abnormalities
___Kidney Infection or Stones
___Prostate Trouble
___Menstrual Problems
___Lumps in Breast

TINGLING OR NUMBNESS
___Shoulder ___Hips
___Arms ___Legs
___Elbows ___Knees
___Hands ___Feet

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. I acknowledge full responsibility for payment of services to Sikorsky Chiropractic Clinic, S.C. and Dr. Sikorsky and agree to pay them in full AT THE TIME OF SRVICE, unless other arrangements are made in advance. Furthermore, I understand that this chiropractic office will prepare necessary reports and forms to assist me in making collections from the insurance companies and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. I also give this office power of attorney to endorse checks made out to me, to be credited to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. All fees are due and payable within 60 days of being released from care. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable, in either case I will pay a monthly rebilling fee of 2% of the outstanding balance for any late payments. I further understand and agree I will pay court costs, filing fees, court appearance fees, in addition to collection agency and/ or attorney's fees of 1/3 of the outstanding balance, if my account is ever referred to same.

Patient Signature _____Date_____
Guardian's or Spouse's signature authorizing care_____
Comments _____

CONSENT TO CHIROPRACTIC CARE

I hereby request and consent to the consent to the performance of chiropractic adjustments and other chiropractic procedures on me or on _____ by Stephen Sikorsky D.C., and/ or other licensed doctors of chiropractic who may be employed by or engaged in practice in the Sikorsky Chiropractic Clinic.

I have had an opportunity to discuss with Stephen Sikorsky, D.C., or other clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that the practice of neither chiropractic nor medicine is an exact science and that my care may involve the making judgments based upon the facts known to the doctor at the time; that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications; that an undesirable results does not necessarily indicate an error in judgment; that no guarantee as to results has been made to nor relied upon by me, and I wish to rely on the doctor to exercise judgment during the course of the procedure which he/she feels at the time, based upon the facts then know, is in my best interest.

I have also been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should know of possible complications, which have been alleged. These include, but are not limited to, fractures, disk injures, strokes, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetectable by the doctors.

I have read or have had read to me the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, acknowledge my understanding of its contents.

_____
Date

_____
Patient

_____
Patient Signature

_____
Relationship/authority if not signed by patient

Doctor's Notes
Patient Counseled by the use of the following

_____Discussion

_____Other (please specify) _____

X_____
Signature of Doctor or other

SIKORSKY
CHIROPRACTIC
1425 N. McLean Blvd. Suite 700 Elgin, IL 60123
Phone (847) 695-0464 Fax (847) 695-0461 elginchiropractor.com

Right to Request Confidential Communications: You have the right to request that we communicate with you about the medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by e-mail. To request confidential communications, you must make your request in writing to our privacy officer. We will accommodate all reasonable requests.
Right to Receive Notice of a Breach: We are required to notify you by first class mail or by e-mail (if you have indicated a preference to receive information by e-mail); of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Protected Health Information unusable; unreadable, and undecipherable to unauthorized users.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint. To file a complaint with us, contact our privacy officer at the address listed above. All complaints must be submitted in writing and should be submitted within 180 days of when you knew or should have known that the alleged violation occurred.

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 protect health information. We are also to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

By signing this Agreement, you are acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

Sikorsky Chiropractic Clinic, S.C.
1425 N McLean
Unit 700
Elgin, IL 60123

Date _____

Patient: _____
Employer: _____
Claim// Group #: _____
SS# / ID#: _____

I herby instruct and direct _____ Insurance Company / Fund to pay by check made out and mailed to:

Sikorsky Chiropractic Clinic, S.C., 1425 N McLean, Elgin, IL. 60123, 847-695-0464

Or

If my current policy prohibits direct payments to the doctor, I herby also instruct and direct you to make out the check to me, and mail as follows:

Sikorsky Chiropractic Clinic, S.C., 1425 N McLean, Elgin, IL. 60123, 847-695-0464

For the professional or medical benefits allowable, and otherwise payable to me under my current insurance / health benefits policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I hereby also instruct and direct you to recognize Sikorsky Chiropractic Clinic, S.C. and its employees as my designated authorized representative. If this is not in accordance with plan procedures, please forward an explanation of such procedures and any necessary forms by facsimile addressed to me at 847-695-0461. I herby also instruct and direct you to send any forms necessary to the processing of a claim to me at the above address or fax number.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize the doctor to initiate a compliant to the Insurance Commissioner or U.S. Department of Employment Security, for any reason on my behalf.

I hereby convey to the above name doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Dated this _____ day of, 20_____

_____ _____

Signature of policyholder of Claimant, if other than the policyholder.

Witness

Printed Patient Name:	Date information Needed:
Address:	Date of Birth:
City:_____ State:_____ Zip Code:_____	Telephone Number: (___)_____

I hereby authorize _____ to release the protected health information indicated below on the above named individual to:
(facility name)

_____
Provider Name/Organization/Individual

City:_____ State:_____ Zip Code:_____ Telephone Number: (___)_____ Fax Number: (___)_____

☐ For the following purpose: ☐ Physician of Health Care Facility ☐ Legal Purposes ☐ Personal Use ☐ At request of the individual

☐ Other _____

For treatment date(s) or service _____

Expiration Date of Expiration Event:
(If no prior notice of revocation is received, or expiration event/expiration date indicated, this authorization will expire 90 days form the date signed below)

INFORMATION TO BE DISCLOSED:

☐ Abstract Chart (includes Face Sheet, Discharge Summary, History & Physical, Consultation Reports, Operative Reports, Diagnostic tests)

☐ Entire Medical Record

☐ History and Physical ☐ Operative Report ☐ Consultation ☐ Discharge Summary

Outpatient Services:

☐ Emergency Room ☐ Pathology Report(s) ☐ Laboratory Results ☐ Radiology Results ☐ Rehabilitation Services

☐ Other: _____

I understand that:

* **The information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), of human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse.**
* I have the right of access to inspect and obtain a copy of my protected health information.
* I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing to the Health Information Management Department.
* Revocation will not apply to information that has already been released in response to this authorization.
* Once the above information is disclosed, there is the potential that it may be re-disclosed by the recipient, and therefore may not be protected by the federal privacy law regulations.
* Failure to provide all required information will not constitute a proper authorization to disclose protected health information and that, therefore, my request may not be honored.
* Authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment, payment or eligibility for benefits.

_____ _____ _____ _____
(Signature of patient or legal representative) (Date) (Witness Signature) (Date)

(If signed by a legal representative, indicate the relationship to patient of authority to act for patient. _____)
Fees and charges will comply with all laws and regulations applicable to release protected health information.

FOR FACILITY USE: Date received: _____ Date Completed: _____ MR#: _____
When applicable, the identity of the Legal Representative was verified by the following documentation and established that in his/her capacity, the above named legal representative is authorized to act on behalf of the patient: __ Drivers License __ Picture Id __ Legal guardian __ Court appointed legal guardian
__ Power of Attorney __ Executor of Estate __ Other _____

Person/Department completing the request _____

Authorization to Disclose Protected Health Information

Sikorsky Chiropractic
1425 N. McLean
Elgin, IL 60123

Consent for X-rays

Patient name: _____ Date: _____

- ❑ I understand that if I am pregnant and have X-rays taken that expose my lower torso to radiation, it is possible to injure the fetus.
- ❑ I have been advised that the 10 days following onset of a menstrual period are generally considered safe for X-ray exams (low risk of pregnancy during that time).

With those factors in mind, I am advising my doctor:

I am pregnant	___Yes ___No ___Don't know
I could be pregnant	___Yes ___No ___Don't know
My menstrual period is late	___Yes ___No ___Don't know
I am taking oral contraceptives	___Yes ___No
I have an IUD	___Yes ___No
I have had a tubal ligation	___Yes ___No
I have had a hysterectomy	___Yes ___No
I have irregular menstrual periods	___Yes ___No

My last menstrual period began _____

I have begun menopause _____yes _____no

An X-ray may be performed on me with my consent.

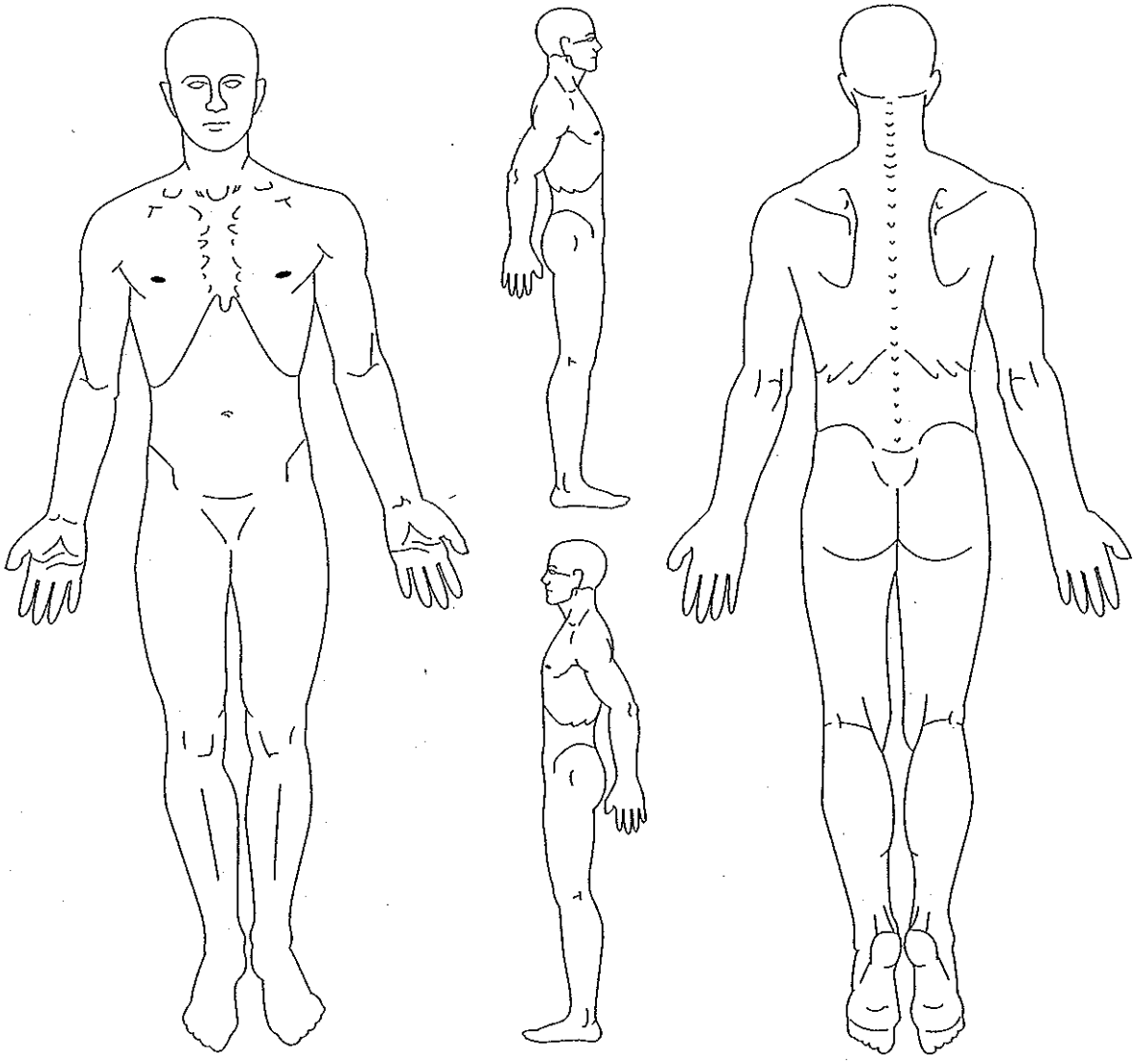
Signature: _____ Date: _____

Patient Name(Print)_____ Date_____

Patient ID #_____

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

D = Dull
B = Burning
N = Numb
S = Stabbing/Cutting
T = Tingling (Pins & Needles)
C = Cramping



On the scales below, please draw a vertical line representing your pain or discomfort:

Rate the pain you have right **now:**

No Pain — Unbearable Pain

Rate your pain at its **best** in the past week:

No Pain — Unbearable Pain

Rate your **average** pain in the past week:

No Pain — Unbearable Pain

Rate your **worst** pain in the past week:

No Pain — Unbearable Pain