# CELAR CHIROPRACTIC

4413 W. Roosevelt Rd, Suite 100, Hillside, IL 60162 (708) 449-5900

## Patient Information

Patient Name: _____SS#: _____-_____-_____
Last First Middle

Address_____
Number & Street City State Zip Code

Home Phone: (_____)_____ Cell:(_____)_____Best # to Reach You: Home/Cell

E-Mail: _____ Driver's License #: _____

Age: ____ Date of Birth: _____/_____/_____ Sex: M / F Marital Status: M S W D Number of Kids: ___

Referred by: _____ Where did you get our phone number? _____

Employer: _____ Occupation _____

Address _____ Work phone: (____)_____
Street City State Zip Code

Spouse: _____ Phone: (_____)_____ Employer: _____

Person responsible for this account: _____

Payment method: ☐ Cash ☐ Check ☐ Credit Card ☐ Insurance ☐ Other

ASSIGNMENT AND RELEASE:
I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Celar Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature: X_____ Date: X_____

## Insurance

Check appropriate box: ☐ Auto Accident ☐ Workers' Compensation ☐ Group Health Insurance
☐ Medicare ☐ Private Health Insurance ☐ Other _____

Insurance Company: _____Insured's Name: _____

Address: _____ Phone Number: (___)_____
Street City State Zip Code

Insured's ID/SS#: _____ Insured's D/O/B: ____/____/____

Group #: _____ Policy #: _____ Claim #: _____

# OFFICE POLICY / FINANCIAL AGREEMENT

## I. OFFICE POLICY

A. Since you are under our care, we need to know of any changes or problems in your health. We are more than happy to provide you with information you need, and no question is unimportant or "silly". We are here to help.

B. In order to expedite your visit, patients are expected to pay their payments (co-pays, deductibles, or other) upon checking into the office. For your convenience we accept cash, checks, Visa, and MasterCard. A $30.00 fee is charged for all returned checks.

C. Our patients must keep their appointments. We have a specific course of treatment for you which requires a certain number of appointments. Keeping your appointments is your part in the correction of your health. We **expect** you to contact the office 24 hours in advance to re-schedule an appointment if a problem arises. Otherwise, we will contact you to re-schedule your appointment one time only. A missed appointment charge will be applied to your account if your appointment is canceled without a twenty-four hour notice.

D. New patients are encouraged to attend our Spinal Care Class. The class is designed to teach you more about health and how you can achieve the best results from your care. Please inform the Chiropractic Assistant how many guests will accompany you.

E. It is the policy of this office that if you should choose to voluntarily suspend or terminate your care and treatment, any outstanding fees for professional services rendered to you will be immediately due and payable.

## II. YOUR PAYMENT IN EXCHANGE FOR YOUR CARE

A. **Cash:** Payment is due on a daily basis for services rendered. A pre-payment program may be arranged, at your request, after the doctor establishes your treatment schedule.

B. **Private Insurance:** If you have health insurance, you are fortunate to have the benefit of an insurance company assist you in the payment of your care. At your request, we will file your insurance claim directly as a **free** service. You must sign the forms authorizing the insurance company to pay us directly—then we do the rest. Your responsibility during this period is to pay your deductible, co-payments, or any amounts your insurance company does not cover. If you choose to file claims yourself, full payment is due at time of service.

C. **Personal Injury:** We will accept cases on an approved Attorney/Patient Lien basis. We will directly bill all charges when your policy provides for direct payment to the doctor. Any outstanding balance **must** be paid "in full" at the time you are awarded your judgement. You will be responsible for any amount not covered by your insurance or judgement, at that time.

D. **Workers' Compensation:** You will be responsible for providing insurance information and authorization from your employer by your second visit. Please advise us of your work telephone numbers and supervisors names.

E. **Medicare:** We hold the right to accept assignment using Medicare's currant rates, in addition to any supplemental insurance paperwork for you. All copayments and deductibles are expected to be paid by the patient if supplemental insurance does not cover.

I hereby authorize the Doctor to treat my condition as he/she deems appropriate through the use of manipulation throughout my spine. It is understood and agreed the amount paid to Celar Chiropractic for x-rays, is for examination only and the x-ray negatives will remain the property of this office where they may be reviewed by appointment only. I also agree that I am responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Print Full Name: _____

X_____ X_____

Patients signature (if minor, parents signature) Date

**Celar Chiropractic, Ltd**
**PATIENT CONSENT**
**FOR USE AND/OR DISCLOSURE OF**
**PROTECTED HEALTH INFORMATION**
**TO CARRY OUT TREATMEANT, PAYMENT**
**AND HEALTHCARE OPERATIONS**

I, _____, hereby state that by signing this Consent, I acknowledge and agree as follows:

1. Celar Chiropractic Privacy has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for Celar Chiropractic and to provide treatment to me, and also necessary for the Celar Chiropractic to obtain payment for that treatment and to carry out its health care operations. Celar Chiropractic explained to me that the Privacy Notice will be available to me in the future at my request. The Celar Chiropractic has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. Celar Chiropractic reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by Celar Chiropractic: a) a postcard mailed to me at the address provided to me; b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. Celar Chiropractic may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for Celar Chiropractic to treat me and obtain payment for that treatment, and as necessary for Celar Chiropractic to conduct its specific health care operations.
5. I understand that I have the right to request that Celar Chiropractic restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, Celar Chiropractic is not required to agree to any restrictions that I have requested. If Celar Chiropractic agrees to a requested restriction, then the restriction is binding on us.
6. I understand that this consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that Celar Chiropractic has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, Celar Chiropractic has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then Celar Chiropractic will NOT treat me.

I have read and understand that foregoing notice and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____
Name of Individual (Printed) Signature of Individual

_____ _____
Signature of Legal Representative Relationship
(e.g., Attorney-In-Fact, Guardian, Parent if minor)

Date signed ___/___/___ Witness:_____

_

# CELAR CHIROPRACTIC

**4413 W. Roosevelt Road, Suite 100, Hillside, IL 60162 (708) 449-5900**

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

**The nature of the chiropractic adjustment.**

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands of mechanical instrument upon your body is such a way as to move joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

**Analysis / Examination / Treatment**

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

- spinal manipulative
- palpation
- vital signs
- range of motion testing
- orthopedic testing
- basic neurological testing
- muscle strength testing
- postural analysis
- ultrasound
- hot/cold therapy
- electrical stimulation
- radiological studies
- massage

**The material risks inherent in chiropractic adjustment.**

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulations and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

**The probability of those risks occurring.**

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject tremendous disagreement. The incidences of the stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

**The ability and nature of other treatment options.**

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest relaxants and pain killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

**The risks and dangers attendant to remaining untreated.**

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read ___ or have had read to me ___ the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Dana or Dr. Mike and have had any questions answered to my satisfaction. By signing below I stated that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

_____ _____

Patients Name Doctor's Name

_____ _____

Signature Signature

_____

Signature of Parent Guardian
(if a minor)

***Problem- Focused History***

***(PLEASE PRINT)***

Briefly Describe Your Pain/Problems in Order of Severity

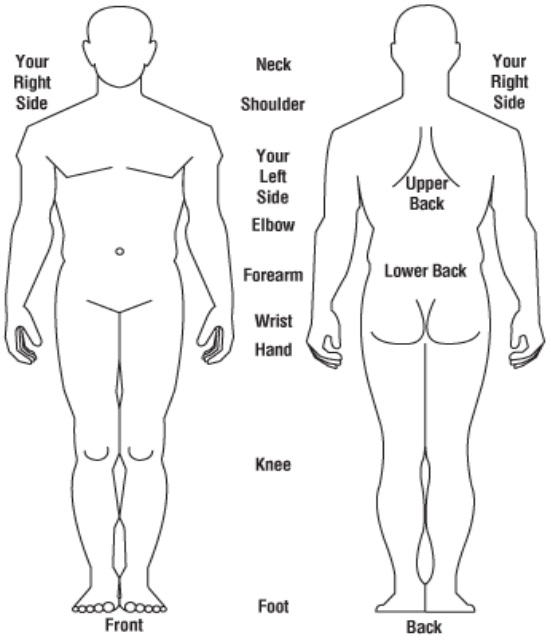
1._____

2._____

3._____

4._____

Using The Following, Indicate the Areas of You Problem: **Mark The Areas of Pain with:**




**////// -Sharp/Stabbing**

**OOO- Dull/Achy**

**XXX- Deep/Burning**

*****- Pins and Needles**

**NNN- Numbness**

**SSS- Throbbing**

**TTT- Tightness**

**Please Check All That Apply:**

___ Constant (75-100% of the time)

___ Frequent (50-70% of time)

___ Occasional (25-50% of time)

___ Rarely (0-25% of time)

On a Scale of 0-10, **0 being no pain** and **10 being the worst possible pain**:

What is your Pain Right Now? 0_____10

What is your Pain at its Worst? 0 _____10

What is your Pain at its Best? 0_____10

**Write your response:**

When did it start? _____

Why did it start? _____

How did it start? **Sudden Onset** **Gradual Onset** **Not Sure**

Since Onset, Has it: **Gotten Worse** **Gotten Better** **Stayed the Same** **Been Erratic**

Does the pain Radiate or Refer? **Yes** or **No** Where? _____

Have You Had Similar Pain/Problems In The Past? **Yes** or **No** How Long Ago? _____

**Since The Initial Onset, Have You Had Any Changes In The Following Bodily Functions? Check If Yes**

___Balance ___Bowel Habits ___Breathing ___Breathing ___Coordination ___Coughing

___Gait ___Grip ___Hearing ___Menstrual ___Sexual ___Sleep ___Sneezing

___Urination ___Visual ___Weakness ___Weight

**Do You Have Difficulty Doing Any Of The Following Daily Activities: Please Circle**

| | | |
|---|---|---|
| Getting in and out of your car | Yes | No |
| Climbing stairs | Yes | No |
| Sitting comfortably | Yes | No |
| Dressing yourself | Yes | No |
| Hygiene (brushing teeth, combining hair, etc.) | Yes | No |
| Bending and/or Lifting | Yes | No |
| Concentrating and/or Reading | Yes | No |

Are There Any Other Daily Activities That Have Been Affected? **Yes No What Activities?_____**

What Makes The Pain Worse? **Sitting Standing Walking Laying Changing Positions**

What Else Makes The Pain Worse? _____

When Is The Pain Worse? **Morning Daytime At Work Evening Nighttime Doesn't Matter**

What Makes The Pain Better? _____

Have You Seen Any Other Doctor For Your Current Complaint(s)? **Yes No**

**Name of treating Dr? _____ Test Preformed_____**

**Diagnosis_____**

Names of over the counter/Prescription Meds using for your complaint _____

What Other Treatments Have You Tried? _____

Work Status? **Full-Time Part-Time Retired Unemployed Student Disabled**

Have You Missed Any Work Due To Your Pain/Problem? **Yes No How Much? _____**

## ADDITIONAL QUESTIONS

**Do you have recurring headaches? Yes No**

**Are you losing weight without trying? Yes No**

**Does the pain wake you up at night? Yes N o**

**Do you have constant pain regardless of what position you are in? Yes No**

**Do you have sores that never heel? Yes No**

**Do you have change in your bowel or bowel habits? Yes No**

**Do you recently have any unusual bleeding or discharge? Yes No**

**Do you have a thickening or lump in the breast or somewhere else? Yes No**

**Do you have frequent indigestion or difficulty swallowing? Yes No**

**Do you have a nagging couch or hoarseness? Yes No**

**Do you have a pacemaker or any other implant devices, including artificial joints? Yes No**

*******SOCIAL HISTORY*******

**Race: Caucasian African American Hispanic Asian Other: _____**

**Do you exercise outside of your work activities? Yes No**

**What type of exercise do you do and how often? _____**

**Describe your work habits: _____**

**Are your physical demands at work: HEAVY MODERATE MILD SEDENTARY**

**Is your stress level at work…… HIGH MEDIUM LOW**

**Describe any recreational activities, including how often: _____**

**Do you drink alcoholic beverages? Yes No If yes what and how often_____**

**Do you use tobacco? Yes No If yes what and how often? _____**

**Do you use and recreational drugs? Yes No If yes what and how often _____**

**Do you drink caffeinated beverages? Yes No If yes what and how often_____**

**If your diet…BALANCED FAIR POOR EXCESSIV RESTRICTED OTHER_____**

**Females: Is there any chance you may be pregnant? Yes No**

**Females: Are you taking birth control? Yes No**

**Females: Are you nursing? Yes No**

# *****CONFIDENTAL HEALTH HISTORY*****

**___AID/HIV**
**___ALCOHOLISM**
**___ALLERGIES**
**___ANEMIA**
**___ANOREXIA**
**___APPENDICITIS**
**___ARTHRITIS**
**___ASTHMA**
**___BLEEDING DISORDER**

**___BRONCHITIS**
**___BULEMIA**

**___CANCER**
**___CATARACTS**

**___CHEMICAL DEPENDENCY**
**___CHICKEN POX**

**___DEPRESSION**
**___GOITER**

**___DIABETES: TYPE 1**
**___DIABETES: TYPE 2**

**___DIGESTIVE PROBLEMS:**
**_____**
**___PNEUMONIA**

**___EMPHYSEMA**
**___EPILEPSY**

**___GOUT**
**___FRACTURES:_____**
**GLAUCOMA**
**___GONORRHEA**
**___HEART DISEASE**
**___HEPATITIS**
**___HERNIATED DISC**
**___HERPES**

**___ HIGH BLOOD PRESSURE**

**___HIGH CHOLESTEROL**

**___KIDNEY DISEASE**
**___LIVER DISEASE**

**___MISCARRIAGE**
**___MONONUCLEOSIS**

**___MULTIPLE SCLEROSIS**

**__MUMPS**

**___OSTEOPOROSIS**
**___PACEMAKER**
**___PARKINSONS**

**___PINCHED NERVE**

**___POLIO**

**___PROSTATE PROBLEMS**
**___PROSTHESIS**
**___PSYCHIATRIC CARE**
**___RHEUMATIOD ARTHRITIS**
**___RHEMATIC FEVER**
**___SCARLET FEVER**
**___STROKE**

**___SUICIDE ATTEMPT**
**___STD: _____**
**___THYROID CONDITION**
**___TONSILLITIS**

**___TUBERCULOSIS**
**___ULCER: _____**
**___TUMOR:_____**
**_____**
**___THYPHOID FEVER**

**___VAGINAL INFECTIONS**
**___WHOPPING COUGH**

**Other Disease(s) not listed above: _____**

**List of surgeries you've had and when: _____**

**_____**

**Have you been hospitalized for any other reasons besides surgery? YES NO when?_____**

**Name of Primary Care Physician & phone number: _____**

**Last physical exam:_____**

**Medications you are currently taking:_____**

**Name of any other doctors you see: _____**

## FAMILY HISTORY

**List any diseases or conditions that are common among your family members (i.e. Cancer)**

**Mother:_____Father:_____**

**Brother:_____Sister:_____**

**Grandma(s):_____Grandpa(s)_____**