LAKE ZURICH WELLNESS GROUP

165 S. Rand Rd ■ Lake Zurich, IL 60047 ■ Office: 847.550.4094 ■ Fax: 847.550.4096

PATIENT INFORMATION

Name: ______________________________

Address: ______________________________

City: ____________ State: ____ Zip: ________

Date of birth : _____ / _____ / _____ Sex ☐ M ☐ F

Phone: (______)__________ ☐ Home ☐ Cell ☐ Work

Phone: (______)__________ ☐ Home ☐ Cell ☐ Work

Phone: (______)__________ ☐ Home ☐ Cell ☐ Work

E-Mail: ______________________

How did you hear about the office : ________________

____

____

EMERGENCY CONTACT INFORMATION

Name **Relationship** **Phone**

____

RESPONSIBLE PARTY (If patient is un der 18 years of age)

Name: ______________________________

Address: ______________________________

City: ____________ State: ____ Zip: ________

Phone: (_____)________ ☐ Home ☐ Cell ☐ Work

Phone: (_____)________ ☐ Home ☐ Cell ☐ Work

PATIENT EMPLOYMENT INFORMATION

☐ Employed ☐ Retired ☐ Unemployed ☐ Other

Employer: ____________________

Phone: (_____)________ Occupation: ____________

INSURANCE INFORMATION

My insurance is : ☐ PPO ☐ HMO ☐ Federal funded (i.e. Medicare/Medicaid) ☐ I do not have health insurance

Insurance Company: ____________________ ID #: ____________ Group #: ____________

Subscriber Name: ______________________________ Subscriber's Date of birth : _____ / _____ / _____

Relationship to Subscriber : ________ Subscriber's Phone: (_____)________ ☐ Home ☐ Cell ☐ Work

Is your visit a result of a motor vehicle / work accident? ☐ Yes ☐ No **(if yes, please inform the front desk)**

MEDICAL HISTORY (please check all that apply) ☐ **None apply**

☐ Heart attack	☐ Osteoporosis	☐ Gout	☐ Phlebitis
☐ Heart Failure	☐ Osteoarthritis	☐ Stomach Ulcer	☐ Blood clots in legs
☐ Heart Murmur	☐ Asthma	☐ Kidney Stones	☐ Blood clots in lungs
☐ High Blood Pressure	☐ Pneumonia	☐ Kidney failure	☐ Insomnia
☐ Low Blood Pressure	☐ Tuberculosis	☐ Pacemaker	☐ GERD
☐ High Cholesterol	☐ Emphysema	☐ HIV Positive / AIDS	☐ Loss of Memory
☐ Rheumatoid arthritis	☐ Lung Disease	☐ Hepatitis	☐ Cold Hands / Feet
☐ Peripheral neuropathy	☐ Blood vessel Disease	☐ Lupus	☐ Hand Tremors
☐ Peripheral vascular disease	☐ Mental Illness	☐ Liver Problems	☐ Epilepsy
☐ Coronary artery disease	☐ Sleep apnea	☐ Hyperthyroidism	☐ Stroke
☐ Bulging / Herniated disc	☐ ADHD / ADD	☐ Hypothyroidism	☐ Diabetes
☐ Spinal stenosis	☐ Gall Bladder Problems	☐ Hyperlipidemia	☐ Other (explain below)
☐ *Cancer (please explain below)	☐ Alcohol Dependence	☐ Transplants	

* Explanation: ____

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to the doctor and/or office and authorize the office to furnish information regarding my illness to my insurance carrier. **I understand that I am responsible for any amount not paid by my insurance company.**

Patient Signature: ____________________ Date: ________ Account# :________________

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HISTORY OF PRESENT PROBLEM

Chief complaint: (why are you seeing the doctor today): ____

How long have you had this problem: ________________________ Has the pain ever been a level 9 or 10? ☐ Yes ☐ No

When do you feel it most? ☐ AM ☐ PM ☐ All Day How long does the complaint last? _____ Mins _____ Hrs

Circle the current pain level of your complaint:

1	2	3	4	5	6	7	8	9	10

Mild Severe

Circle the percentage of day you experience the complaint:

10	20	30	40	50	60	70	80	90	100

Does anything make your chief complaint worse? ☐ Yes ☐ No

If yes, please explain : ____

Does anything make your chief complaint better? ☐ Yes ☐ No

If yes, please explain : ____

Have you been treated previously for this condition? ☐ Yes ☐ No

Prior treatments for your chief complaint include: ☐ Chiropractic ☐ Physical Therapy ☐ Medical Doctor / Orthopedic

☐ Hospitalization ☐ Anti-Inflammatory ☐ Pain Medication ☐ Injection ☐ Heat/Ice ☐ Exercise ☐ Massage

☐ Other (please list) : ____

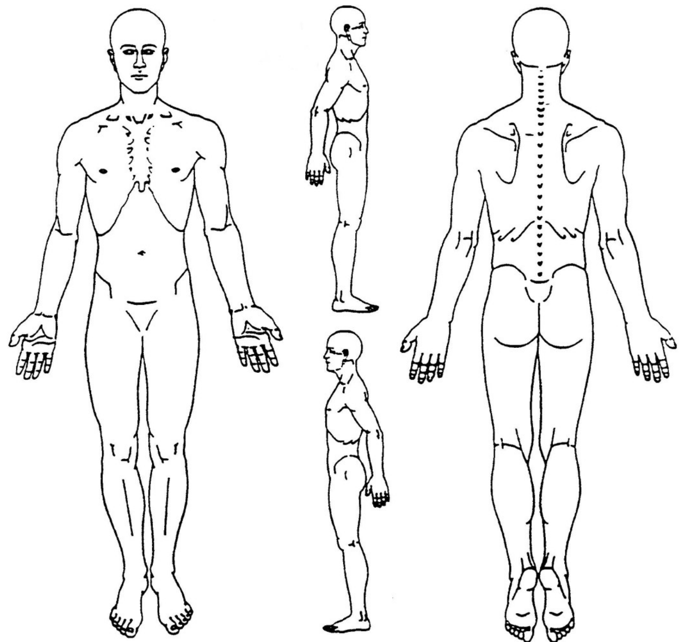
Please indicate the name of facility/physician and date of last visit: ____

____

Primary Care Physician: ______________________________ Referring Physician: ______________________________

On the diagram to the right, please indicate where you are experiencing your chief complaint by placing the letter(s) on the left on that specific area.

A: Ache **D:** Dull **R:** Throbbing **T:** Tingling
B: Burning **F:** Stiffness **S:** Soreness **Z:** Stabbing
C: Cramping **N:** Numbness **X:** Sharp



Mark all activities affected by your chief complaint.

☐ Standing ☐ Sitting ☐ Walking ☐ Running

☐ Bending ☐ Twisting ☐ Sleeping ☐ Driving

☐ Carrying objects ☐ Lifting objects ☐ Lifting children

☐ Kneeling ☐ Exercising ☐ Housework

☐ Personal Grooming

☐ Other : ______________________________

Patient Name (please print): ____ Account # ________________

Patient Signature __________________________________ Date: __________

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Social History

Marital Status? ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Do you have children? ☐ Yes ☐ No If yes, what are their ages: ____________________

Are you, or could you be, pregnant? ☐ Yes ☐ No

What was the first day of your last menstrual cycle? ___________________________

Risk Factors

Do you smoke or use tobacco? ☐ Daily ☐ Occasionally ☐ Former ☐ Never smoked

Do you drink alcohol? ☐ Yes ☐ No If yes, indicate quantity: _____ drink per ☐ Day ☐ Week ☐ Month

Do you Exercise? ☐ Yes ☐ No What type?: ________________________ How many days per week? _________

Family History (check all that apply) ☐ None apply

Condition	Family Member (s)	Condition	Family Member(s)
☐ Heart disease		☐ Scoliosis	
☐ Stroke		☐ Spine problems	
☐ High Blood Pressure		☐ Kidney failure	
☐ Diabetes		☐ Mental illness	
☐ Osteoporosis		☐ Bleeding disorders	
☐ Rheumatoid Arthritis		☐ Anemia	
☐ Osteo Arthritis		☐ Alcohol dependence	
☐ Lupus		☐ Cancer	
☐ Sickle Cell		☐ Other: __________	

Medications / Supplements you take ☐ None apply

Name	Dosage & Frequency	Who prescribed	Reason for taking

Patient Name (please print): ____________________________________ Account # ______________

Patient Signature ______________________________ Date: __________

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INFORMED CONSENT FOR CHIROPRACTIC CARE

Before you, the Patient, receive chiropractic care, it is important that you read this Consent and understand the nature and risks of chiropractic medicine. The "practice of chiropractic medicine" (or chiropractic care) involves the adjustment, manipulation, and treatment of your body in which vertebral subluxations and other malpositioned articulations and structures may be interfering with the normal generation, transmission, and expression of nerve impulse between the brain, organs, and tissue cells, thereby causing disease. Chiropractic adjustments, manipulations, and treatments are intended to restore the normal flow of nerve impulse which produces normal function and consequent health. I hereby request and consent to chiropractic treatment (or on the patient named below, for whom I am legally responsible) by the doctors of chiropractic who now or in the future work at this office listed above. I understand that results are not guaranteed if I consent to treatment.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to ataxia, bruising, thermal injuries, dislocations, dizziness, "drop attacks," fracture(s), disc injuries, paralysis, quadriplegia, spinal injury, stroke/disruption of blood flow to brain, vision problems, and death. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I will have an opportunity to ask questions about its content, and by signing below I am agreeing to the treatment recommendations that the doctor will lay out for me with the exception of the procedures I decline to undergo. By declining any of the procedures, I understand that the doctor may be working from limited information and that I understand and take full responsibility for the fact that this may affect the overall outcome of my care and possibly not reveal any potential abnormal findings that would be viewed or exposed with the use of further diagnostic investigation.

I intend for this consent to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment for at this office. We encourage you to ask questions. Although we are not affiliated with and cannot confirm the content of internet sites, resources such as WebMD, Chiro.org, AmerChiro.org, and others may be helpful. I, the undersigned Patient, understand the risks and limitations associated with the practice of chiropractic medicine, including the use of chiropractic care, evaluation, diagnosis, adjustments, manipulations, and treatments by this office.

Patient Name (please print): ______________________________________ Account # _______________

By signing below, you are indicating that you have read and understand and agree to the above conditions of this office:

Patient Signature: _______________________________ Date: __________

Witness Name (please print): ______________________________________

Witness Signature: _______________________________ Date: __________

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
PLEASE REVIEW IT CAREFULLY.

Lake Zurich Wellness Group is committed to maintaining the privacy of your Protected Health Information known as PHI, which 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 the care and treatment you receive from our practice. In addition, the Notice describes your rights to access and control your PHI. This Notice describes how medical information about you may be used and disclosed and how you can obtain access to this information.

We are required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment : We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

Payment : We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

Workers' Compensation : We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Public Health : As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Agministration problems with products and reactions to medications, and reporting disease or infection exposure.

Additional Uses and Disclosures
Law Enforcement, National Security, Funeral Director, Organ Donation, Research, Public Safety.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation-of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Lake Zurich Wellness Group.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices
We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice. We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact Dr. Matt Weintraub, compliance officer, by calling this office at (847) 550-4094

Complaints
Complaints about your Privacy rights, or how Lake Zurich Wellness Group has handled your health information should be directed to Dr. Matt Weintraub, compliance officer, by calling this office at (847) 550-4094. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to the appropriate Civil Rights office of Illinois.

This notice is effective as of January 1st, 2018. I have read the Privacy Notice and understand my rights contained in the notice. By way of my signature, I provide with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patient Name (please print): ____

Patient Signature: ________________________________ Date: ___________

Note: This is a confidential record and will be kept in this office. Information contained here will not be released to anyone without authorization to do so.

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WELCOME TO OUR OFFICE

We are committed to providing you with the best care possible and are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask any questions you may have regarding our fees or your responsibility in complying with our financial policy and/or procedures. We gladly accept Visa, Master Card, Discover, American Express, check and cash.

- **Limited Release of Medical Information:** I authorize Lake Zurich Wellness Group to make inquiries and to release any pertinent information to any insurance company, adjuster, attorney, or government agency to facilitate collections/reimbursements under these assignments.

- **Insurance Patients:** I understand that my health insurance is a contract between myself, the insurance carrier and the provider. I understand that I am ultimately responsible for any fees for services rendered to me that does not get covered by my insurance company. I understand that this office accepts billing for Individual or Group policies, Personal Injury Claims, authorized Worker's Compensation, and Medicare.

- **Authorized to Process Drafts:** I agree that Lake Zurich Wellness Group shall be appointed as my agent to endorse drafts on any checks for payment of my bill for medical services rendered.

- **Assignment of Cause of Action:** In the event that any insurance company or third party obligated to make payment to me or to Lake Zurich Wellness Group for the charges made for services rendered, refuses to make such payment upon demand, I hereby assign, transfer, and convey to Lake Zurich Wellness Group any and all cause of action that might exist is my favor against any such company or person. I authorize Lake Zurich Wellness Group to prosecute said action in my name or their name to collect fees due for care rendered and legal expenses, and to resolve said claims as they see fit.

- **Collection/Attorney Fees:** I agree to pay all costs of a collection agency, if necessary, to obtain payment in the event legal action should become necessary to collect an unpaid balance due for medical services rendered. I agree to pay reasonable attorney fees or other such costs as a court might deem proper.

- **Discounts and Promotions:** I agree that any discounts or promotions given to me applies if I agree to follow the full and complete treatment plan set forth by the doctor(s) of Lake Zurich Wellness Group regardless if they are currently or formerly employed. In the event that I do not follow the treatment plan recommendations and I unilaterally remove myself from care, I agree and understand that any discount or promotion I have received will become null and void and will be responsible for the complete balance in full less any payment made by me at the time of my unilateral discharge.

Patient Name (please print): ____

By signing below, you are indicating that you have read and understand and agree to the above conditions of this office:

Patient Signature: _________________________________ Date: __________

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X-Ray Waiver Form

The physician has advised me that radiographs would help to clarify my present clinical condition and diagnosis. I understand that the doctor uses this information to better interpret my condition. I understand my diagnostic picture may be lacking as a result of forgoing this diagnostic procedure.

If you wish to waive your right to this diagnostic procedure, please check one of the following statements as it pertains to your reasoning:

____ I waive my right to have this diagnostic test performed today for my own personal reasons. If in the future I feel that I would like to have this diagnostic procedure performed then I will inquire with the doctor at that time.

____ I waive my right to have this diagnostic test due to the fact that I am or might possibly be pregnant at this time.

____ I waived my right to have this diagnostic test performed today due to my unwillingness or inability to remove any body jewelry. I understand that in doing so there is a chance that a pathological condition might not be detected, as well as hide normal anatomy seen on the film.

Patient Name (please print): ____ Account # ________________

Patient Signature: _________________________________ Date: ___________

Witness (please print): _________________________________

Witness Signature: _________________________________ Date: ___________

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