Spinal Rehab Wellness Center
Inspiring Health and Well Being

Ph: 630-236-8600, 630-708-2225
Fax: 630-236-8612
www.spinalrehabcenter.com

In order to provide you the best care possible please complete this form & bring it to your first appointment.
All information is strictly confidential.

Intake - Chiropractic Registration and History

Patient Information

Patient First & Last Name
Patient Name

Date of Birth
MM DD YYYY

Gender
◯ Male ◯ Female

Address Line 1
Address Lin 1

Address Line 2
Address Lin 2

City
City

State
State

Zip Code
Zip Code

Occupation
Occupation

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

Employer
Employer

Employer Address
Employer Address

Employer Phone
Phone

Spouse's Name
Spouse's Name

Spouse's Birthday
MM DD YYYY

Spouse's Occupation
Spouse's Occupation

Spouse's Employer
Spouse's Employer

Whom may we thank for referring you?
Referring

Insurance and Financing

Who is responsible for the account?

Relationship to Patient
Relationship

Insurance Company Name
Company Name

Group#
Group#

Date of Birth
MM DD YYYY

Phone #
Phone #

ID#
ID#

Is patient covered by additional insurance?

Company Name
Company Name

Phone #
Phone #

Group#
Group#

ID#
ID#

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Spinal Rehab & Wellness Center and/or Specialists 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 my insurance company. In the event the payment is not made and this account is referred for collection, I will pay the cost of collection. If suit or action by an attorney is instituted, I will pay reasonable attorney fees in said suit or action. Invoice payments will be due upon receipt and are considered past due thirty (30) days from date of invoice, including acceptable lien cases. Interest at the rate of 1.5% monthly will apply to past due amounts. Additionally, 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 & acknowledge receipt of Privacy Notice given to me (Federal HIPPA Privacy Practices).

Responsible Party Signature

Relationship
Relationship

Date
MM DD YYYY

Phone Numbers

Home
Home

Work
Work

Cell
Cell

Chiropractic Registration and History

IN CASE OF EMERGENCY CONTACT

Name
Name

Relationship
Relationship

Email Address
Email Address

Home
Home

Work
Work

Cell
Cell

Accident Information

In condition due to an accident?
◯ Yes ◯ No

Date of the accident
MM DD YYYY

Type of accident
☐ Auto ☐ Work ☐ Home ☐ Other

Insurance Company Responsible
Insurance Company Responsible

Auto Insurance
Auto Insurance

Insurance Company Name
Insurance Company Name

Insurance Company Phone No.
Phone Number

Employer Name
Employer Name

Employer Phone #
Phone #

Workers' Compensation
Workers' Compensation

Other
Other

Attorney Name
Attorney Name

Attorney Phone No.
Phone Number

Attorney Address
Attorney Address

Patient Condition

Reason for Visit
Reason for Visit

When did your symptoms appear?
Symptoms

Is this condition getting progressively worse?
☐ Yes ☐ No ☐ Unknown

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)

Type of pain

☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling
Other

How often do you have this pain?
Please explain frequency of pain

Does it interfere with your
☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movement that are painful to perform
☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Health History

What treatment have you already received for your condition?
☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None

Other
Other

Name and address of other doctor(s) who have treated you for your condition

Name
Enter Doctor's Name

Address
Enter Address

Date of Last

Physical Exam
MM DD YYYY

Spinal X-Ray
MM DD YYYY

Blood Test
MM DD YYYY

Spinal Exam
MM DD YYYY

Chest X-Ray
MM DD YYYY

Urine Test
MM DD YYYY

Dental X-Ray
MM DD YYYY

MRI , CT-Scan, Bone Scan
MM DD YYYY

Place a mark on "YES" or "No" to indicate if you have had any of the following

AIDS/HIV ☐ Yes ☐ No	Emphysema ☐ Yes ☐ No	Miscarriage ☐ Yes ☐ No	Scarlet Fever ☐ Yes ☐ No	Alcoholism ☐ Yes ☐ No	Epilepsy ☐ Yes ☐ No
Mononucleosis ☐ Yes ☐ No	Stroke ☐ Yes ☐ No	Allergy Shots ☐ Yes ☐ No	Fractures ☐ Yes ☐ No	Multiple Sclerosis ☐ Yes ☐ No	Suicide Attempt ☐ Yes ☐ No
Anemia ☐ Yes ☐ No	Glaucoma ☐ Yes ☐ No	Rheumatic Fever ☐ Yes ☐ No	Tonsillitis ☐ Yes ☐ No	Anorexia ☐ Yes ☐ No	Goiter ☐ Yes ☐ No
Mumps ☐ Yes ☐ No	Thyoid Problems ☐ Yes ☐ No	Appendicitis ☐ Yes ☐ No	Gonorrhea ☐ Yes ☐ No	Osteoporosis ☐ Yes ☐ No	Arthritis ☐ Yes ☐ No
Gout ☐ Yes ☐ No	Pacemaker ☐ Yes ☐ No	Tuberculosis ☐ Yes ☐ No	Asthma ☐ Yes ☐ No	Heart Disease ☐ Yes ☐ No	Tumors, Growths ☐ Yes ☐ No
Parkinson's Disease ☐ Yes ☐ No	Bleeding Disorders ☐ Yes ☐ No	Hepatitis Disorders ☐ Yes ☐ No	Pinched Nerve ☐ Yes ☐ No	Typhoid Fever ☐ Yes ☐ No	Breast Lump ☐ Yes ☐ No
Hernia ☐ Yes ☐ No	Pneumonia ☐ Yes ☐ No	Bronchitis ☐ Yes ☐ No	Herniated Disk ☐ Yes ☐ No	Polio ☐ Yes ☐ No	Ulcers ☐ Yes ☐ No
Bulimia ☐ Yes ☐ No	High Cholesterol ☐ Yes ☐ No	Prostate Problem ☐ Yes ☐ No	Vaginal Infections ☐ Yes ☐ No	Cancer ☐ Yes ☐ No	Kidney Disease ☐ Yes ☐ No
Prosthesis ☐ Yes ☐ No	Venereal Disease ☐ Yes ☐ No	Cataracts ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Psychiatric Care ☐ Yes ☐ No	Measles ☐ Yes ☐ No
Chemical Dependency ☐ Yes ☐ No	Rheumatoid Arthritis ☐ Yes ☐ No	Whooping Cough ☐ Yes ☐ No	Liver Disease ☐ Yes ☐ No	Chicken Pox ☐ Yes ☐ No	Migraine ☐ Yes ☐ No

Other: Other

Exercise

☐ None ☐ Moderate ☐ Daily ☐ Heavy

Work Activity

☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labour

Habits

☐ Smoking ____ Packs / Day ☐ Alcohol ____ Drinks / Week ☐ Coffee/Caffeine Drinks ____ Cups / Day

☐ High Stress Level — Stress Level

Other — Other

Are you pregnant? ☐ Yes ☐ No Due Date MM DD YYYY

Injuries / Surgeries History

Falls	Enter description	MM	DD	YYYY
Head Injuries	Enter description	MM	DD	YYYY
Broken Bones	Enter description	MM	DD	YYYY
Dislocation	Enter description	MM	DD	YYYY
Surgeries	Enter description	MM	DD	YYYY

Medications, Allergies, Supplements

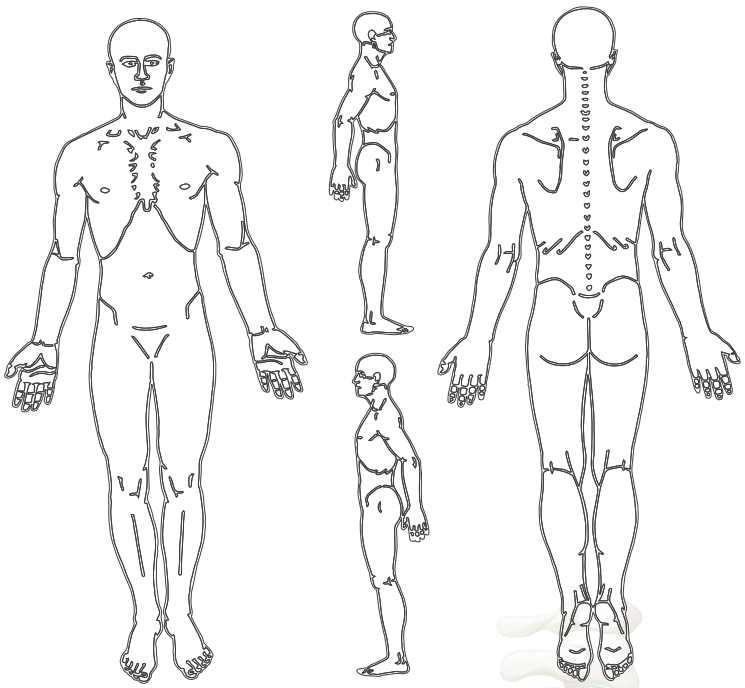
Medications	Allergies	Vitamins / Herbs / Minerals
Medications	Allergies	Vitamins / Herbs / Minerals
Medications	Allergies	Vitamins / Herbs / Minerals
Medications	Allergies	Vitamins / Herbs / Minerals
Medications	Allergies	Vitamins / Herbs / Minerals

Pain Drawing

Mark an **X** on the picture where you continue to have pain, numbness, or tingling →

Key: Use Letters below to indicate type and location of Discomfort

A = Ache	B = Burning
C = Stabbing	N = Numbing
P = Pins & Needles	O = Other



HIPPA - Consent for Use or Disclosure of Health Information

Spinal Rehab and Wellness Center has always been concerned with protecting our patients' privacy. While the law requires us to give you the HIPAA disclosure, please understand that SRWC has and always will, respect the privacy of your health information. There are several circumstances in which we may have to use or disclose your health care information.

We have a more complete notice that provides detailed descriptions of how your health information may be used or disclosed. We reserve the right to change our privacy policy as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come into the office for treatment or by mail. Please feel free to call us at any time for a copy of our privacy policy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing.

Your right to revoke your authorization

You have the right to revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have a right to receive a copy of this notice.

Printed Name

Printed Name

Date

MM DD YYYY

Signature

Personal Representative Printed Name
Effective Date: April 14, 2003

Authorized Provider Representative

Authorized

Address

Spinal Rehab and Wellness Center
3450 Montgomery Road Suite 21
Aurora, IL 60504

Personal Representative Signature

Assignment of Benefits

Name of Insured (print)

Name of Insured

Social Security Number

Social Security Number

I request that payment of authorized insurance benefits, including Medicare if I am a Medicare Beneficiary, be made either to me or on my behalf to the organization listed below for any equipment or services provided to me by that organization. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my Insurance Carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my Insurance Company or other entity, if requested. The original authorization will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for products and services received.

General Patient and Patient Family Responsibilities:
In certain circumstances, insurance company may send a check for services provided by Spinal Rehab & Wellness Center directly to the patient. In such cases, the patient agrees to endorse and send such a check to Spinal Rehab & Wellness Center. If the patient deposits such a check into a personal account, the patient agrees to send Spinal Rehab & Wellness Center a check for the equivalent amount.

If the patient receives from an insurance company an Explanation of Benefits (EOB), the patient agrees to send a copy of the EOB, by mail, or fax.

Signature of Insured or Parent/Guardian | Name of person signing below (print) | Relationship to Insured | Date

Person Name | Relationship | MM | DD | YYYY

Insurance Notice Regarding Your Coverage

NOTE: There may be services listed below that your healthcare provider may deem medically necessary for your care. Your private insurance carrier or health plan may not pay for all of the recommended services. In this event, you will be responsible for payment.

Because we strive to provide you the best care possible, we would like to offer you the following options:

A = Ache	B = Burning	CMT (1)
97012 (Traction)	97530 (Therapeutic Activities)	98940 (1-2 Areas)
97035 (Ultrasound)	97110 (Therapeutic Exercise)	98941 (3-4 Areas)
97032 (Electric Stim)	97112 (NMR)	98943 (Extremity CMT)
97140 (Manual Therapy)		

Check only one box. We cannot choose a box for you

◯ **Option 1**
If I need any services listed above,
I am willing to pay at time of service.

◯ **Option 2**
I am not interested in any additional care. I understand with this choice
I am not responsible for any extra payments, besides my co-pay or co-insurance.

****Additional Information:**
You insurance may not cover other services and deems them unnecessary for you progress in care. I am responsible for the extra charges. I understand it is part of a wellness and maintenance program.

Signing below means that you have received and understand this notice.

Printed Name | Date | Signature

Print Name | MM | DD | YYYY

Office Policies

In order to better serve our patients, we have established these office policies. Please let us know if you have questions on any of our current policies.

Late Appointments: If a patient is greater than 10 minutes late we will do our best to accommodate them into our schedule. There may be a long wait as our patients who do arrive at their scheduled time will be seen first. If a patient is more than 20 minutes late, we kindly ask you to reschedule.

Missed Appointments: Failure to show-up for appointments could result in a $50.00 fee.

Cancelled Appointments: We realize that sometimes cancellations cannot be helped, but we kindly ask for a 24 hour notice of any cancellations.

Co-Pays: Co-pays are due at the time of service.

Past Due Balances: Past due balances are due at the time of check-out.

Insurance:

If you have health insurance, we bill it as a courtesy for you. If you have a co-pay it is your responsibility to pay at the time of service.
If you have a health insurance and are unable to provide us with a card, we are unable to bill your insurance. We will require you to pay in full at the time of service.

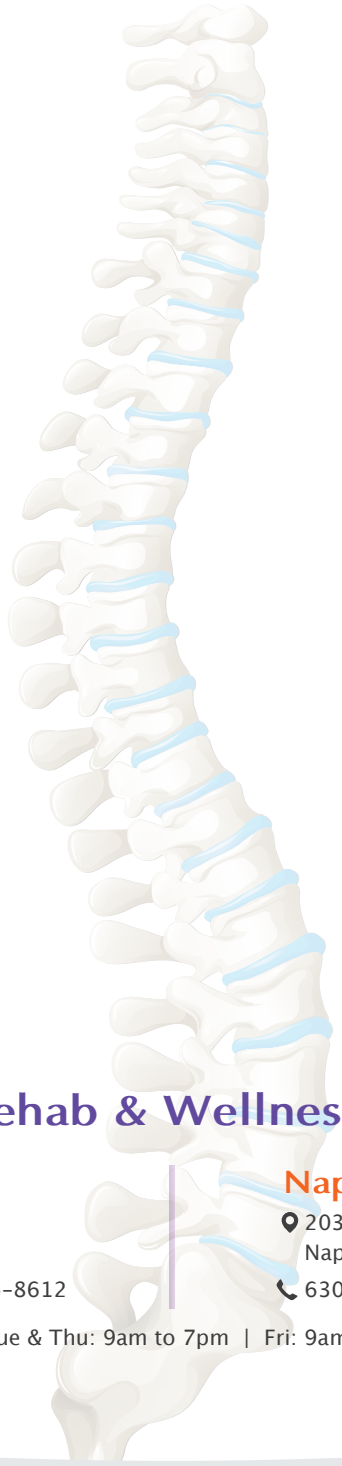
If you do not have health insurance, we require you to pay in full at time of service. If you are unable to pay for the day's charges in full, we kindly ask you to reschedule your appointment or work out a payment plan. All outstanding balances (greater then 60 days) will be turned into collections. If your account ends up in collections all reasonable attorney's fees, and/or court costs incurred by SRWC to enforce terms, covenants, or defend upon the same and/or to collect any balances owed past sixty (60) days shall be awarded to SRWC by any court of competent jurisdiction.

For your convenience we accept cash, personal check, Visa, MasterCard & Discover.

Signature

Date

MM DD YYYY



Spinal Rehab & Wellness Center

Aurora Location

3450 Montgomery Rd, #21
Aurora IL, 60504

630-236-8600 630-236-8612

Naperville Location

2035 S. Washington Ave, #147
Naperville, IL 60565

630-708-2225 630-236-8612

Mon & Wed: 9am to 6pm | Tue & Thu: 9am to 7pm | Fri: 9am to 1pm | Sat - by Appointment