Patient #:_____ **Today's Date**:_____

ST. CHARLES PAIN & WELLNESS CENTER

Please allow our staff to photocopy your driver's license and insurance details.

All information you supply is confidential. We comply with all federal privacy standards.

Please print clearly.

Name:_____ **Date of Birth**:_____ **Gender**:_____

Address:_____ **City**:_____ **State**:_____ **Zip Code**:_____

Email:_____ **Home Phone**:_____ **Cell Phone**:_____

Cell Carrier: _____ **Would you like text message reminders regarding your appointments?**: YES NO

Work Number:_____ **Occupation**:_____ **Employer**:_____

May we contact you at work?: YES NO **Preferred method of contact**:_____

Marital Status: Married Divorced Single Separated **Spouse's Name**:_____

How did you hear about us?:_____ **Physician's Name**:_____

Have you seen a chiropractor before?: YES NO **If yes, whom and when?**: _____

Race: O American Indian or Alaskan Native O Black or African American O Native Asian O Native Hawaiian O White O Other O Decline to Answer

Ethnicity: O British O Chinese O Irish O Hispanic or Latino O Non-Hispanic or Latino O Decline to Answer

HISTORY

List any allergies:	List any surgeries and dates:	List any current medications:	List any major injuries:

Tobacco	Alcohol	Caffeine	Drug use	Exercise
O Never Smoked	O None	O None	O Never	O Never
O Current Smoker (Daily)	O Casual Drinker	O Casual Drinker	O In the Past	O Daily
O Current Smoker (Weekly)	O Moderate Drinker	O Moderate Drinker	O Recreational Use	O Weekly
O Former Smoker	O Heavy Drinker	O Heavy Drinker	O Addiction	O Monthly

Current Condition

Primary Complaint: _____

_____

_____

Secondary Complaint: _____

_____

_____

Additional Complaint: _____

_____

_____

How does you current condition effect:

Sitting	o No Effect	o Mild Effect	o Moderate Effect	o Severe Effect
Rising out of Chair	o No Effect	o Mild Effect	o Moderate Effect	o Severe Effect
Standing	o No Effect	o Mild Effect	o Moderate Effect	o Severe Effect
Walking	o No Effect	o Mild Effect	o Moderate Effect	o Severe Effect
Lying Down	o No Effect	o Mild Effect	o Moderate Effect	o Severe Effect
Bending Over	o No Effect	o Mild Effect	o Moderate Effect	o Severe Effect
Driving Car	o No Effect	o Mild Effect	o Moderate Effect	o Severe Effect
Sleeping	o No Effect	o Mild Effect	o Moderate Effect	o Severe Effect

Is your condition a result of accident or injury?

O Work O Auto O Other _____

Onset: (When did you first notice your symptoms?)

_____

Prior interventions : (What have you done to relieve the symptoms?)

O Prescription medications
O Over-the-counter drugs
O Homeopathic remedies
O Physical therapy
O Surgery
O Other_____
O Acupuncture
O Chiropractic
O Massage
O Ice
O Heat

How does you current condition interfere with your:

Work or career:_____

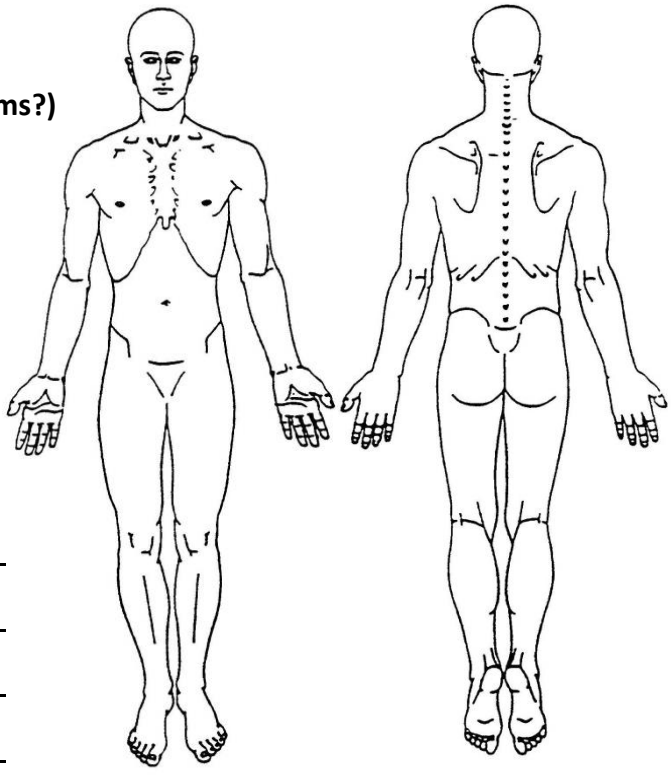
Recreational Activities:_____

Household responsibility:_____

Personal relationships:_____

Mark your areas of complaint

(Pain = X Numbness/Tingling = O)



Review of Symptoms

Chiropractic care focuses on the health of you nervous system, which controls and regulates you whole body. Please indicate whether you've had or have any of the following conditions. Leave the space blank if the condition does not apply.

Have Had	Angina	Have Had	Anorexia/Bulimia	Have Had	Anxiety	Have Had	Apnea
Have Had	Arthritis	Have Had	Asthma	Have Had	Blurred Vision	Have Had	Chronic Ear Infection
Have Had	Constipation	Have Had	Depression	Have Had	Diabetes	Have Had	Diarrhea
Have Had	Dizziness	Have Had	Eczema	Have Had	Emphysema	Have Had	Erectile Dysfunction
Have Had	Excessive Bruising	Have Had	Fainting	Have Had	Fatigue	Have Had	Food Sensitivities
Have Had	Foot/Ankle Pain	Have Had	Frequent Infections	Have Had	Hair Loss	Have Had	Hay Fever
Have Had	Headache	Have Had	Hearing Loss	Have Had	Heartburn	Have Had	High Blood Pressure
Have Had	High Cholesterol	Have Had	Hip Disorder	Have Had	Hypoglycemia	Have Had	Immune Disorders
Have Had	Infertility	Have Had	Knee Injuries	Have Had	Kidney Stones	Have Had	Loss of Smell
Have Had	Loss of Taste	Have Had	Low Blood Pressure	Have Had	Low Energy	Have Had	Low Libido
Have Had	Neck Pain	Have Had	Numbness	Have Had	Osteoporosis	Have Had	Pins and Needles
Have Had	PMS Symptoms	Have Had	Pneumonia	Have Had	Poor Appetite	Have Had	Poor Circulation
Have Had	Poor Posture	Have Had	Prostate Issues	Have Had	Psoriasis	Have Had	Ringing in Ears
Have Had	Scoliosis	Have Had	Seizures/Epilepsy	Have Had	Shortness of Breath	Have Had	Shoulder Problems
Have Had	Skin Cancer	Have Had	Stroke	Have Had	Sudden Weight Loss/Gain	Have Had	Swollen Glands
Have Had	TMJ Issues	Have Had	Thyroid Issues	Have Had	Ulcer	Have Had	Weakness

Acknowledgements (Please Initial)

_____ I instruct the chiropractor to deliver the care that, in his professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation.

_____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf of seeking reimbursement from any involved third parties.

_____ I grant permission to be called or texted to confirm or reschedule any appointment and to be checked in on occasionally to track my progress.

_____ I acknowledge that any insurance I may have is an agreement between the carrier and me, and that I am responsible for any payment of covered or non-covered services that I receive.

_____ To the best of my ability, I have provided complete and truthful information.

Signature:_____ Date_____

Consent to Treat Minor:_____ Date_____

Jacob M. Hertz, D.C.
Chiropractic Physician

302 S 14th St
St. Charles, IL 60174
(P) 630-513-7770
(F) 630-513-7778

ST. CHARLES
PAIN & WELLNESS CENTER

PAYMENTS AND STATEMENTS

Payment for office visits and x-rays are requested at the time of service.

Responsibility for all bills remains with the patient. If you have a financial problem, please ask to speak with the insurance administrator.

INSURANCE AND MEDICARE

Our office will bill your insurance company for all services. Our insurance administrator will confirm your insurance benefits with your insurance carrier/payer. If we are unable to confirm your benefits, you will be asked to pay for services until we can confirm those benefits.

If you have Medicare, we will bill the charges directly to Medicare for you. We accept Medicare assignment*. If you have supplementary insurance it is customary for Medicare to forward the claim automatically. If you have any further questions about Medicare or Medicare coverage please ask to speak with our insurance administrator.

*Medicare assignment is a form of payment agreement where your doctor accepts the allowed amount as full payment for his/her services. Medicare pays 80% of the allowed rate and the patient is liable for 20%.

Credit Policy

Health insurance is designed to help you meet the cost of medical care. However, the responsibility of payment is yours. Your insurance contract defines the extent to which the company will reimburse you or us for your care. It is your obligation to notify our insurance administrator of any insurance changes.

Please indicate below that you understand it is your responsibility to pay your account. If your insurance does not pay, you are responsible for the amount due.

Patients Name:_____

Signature:_____ Date:_____

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Consent for Purposes of Treatment, Payment and Healthcare Operations

I, _____ [Patient's Name] consent to St. Charles Pain and Wellness Center, LLC ("the Practice's") to use and disclose my Protected Health information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purpose. Healthcare operations purpose shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health information for the purposes of treatment, payment or healthcare operations of the practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician of the Practice has acted in reliance on this consent.

Patients Name:_____

Signature:_____Date:_____

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ACKNOWLEDEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

I, _____, [Patient's Name] acknowledge that I have received, reviewed, understand, and agree to the Notice of Privacy Practices of St. Charles Pain and Wellness Center, LLC, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protective health Information created, received, or maintained by the Practice.

_____
Print Name

_____ _____
Signature Date

FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO PATIENT

The Practice has made a good-faith effort to obtain an acknowledgement of _____ [Patient's Name]'s receipt of our Notice of Privacy Practices. In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

- ☐ Patient Unavailable
- ☐ Patient Physically Unable
- ☐ Patient Unwilling

In an effort to obtain the patient's acknowledgement, the Practice has attempted to provide patient with a Notice of Privacy Practices in the following manner (check all that apply):

- ☐ Personally
- ☐ Mail
- ☐ Phone Follow Up
- ☐ Other _____

_____ St. Charles Pain and Wellness Center, LLC
Print Name of Physician Name of Practice

_____ _____
Signature Date

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Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with the information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some ricks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase of symptoms, lack of improvement of symptoms, burns and/or scarring from electric stimulation and from hot or cold therapies (including but not limited to hot packs and ice), fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With the respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissection have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, incidence of hospital admission attributed to aspirin use from major GI events for the entire (upper and lower) GI tract was 1219 events/per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care for all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patients Name:_____

Signature:_____ Date:_____

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth ____ / ____ / ____

Release of Information

( ) I authorize the release of information including the diagnosis, records; examination rendered to me, claims information and appointment information. This information may be released to:

( ) Spouse _____

( ) Child(ren) _____

( ) Other _____

( ) Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call ( ) my home ( ) my work ( ) my cell number

If unable to reach me:

( ) you may leave a detailed message

( ) please leave a message asking me to return your call

( ) _____

Signed: _____ Date: ___ / ___ / ___

Witness: _____ Date: ___ / ___ / ___

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Cancellation/No Show Policy for Doctor Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a twenty dollar ($20) fee, this will not be covered by your insurance company.

If you do not show up for your appointment and do not call you will be charged a thirty dollar ($30) fee, this will not be covered by your insurance company.

Patients Name:_____

Signature:_____Date:_____