Physicians Plus
1700 W. Diversey Pkwy 2W, Chicago, IL 60614
Phone: 773-348-0033 Fax: 773-348-0553

OFFICE USE ONLY ☐ INS ☐ MC ☐ WC ☐ PI ☐ AA ☐ SP ☐ IO PPN # _____

PATIENT INFORMATION

Last Name:_____ First Name:_____
Middle Initial:_____ Nickname:_____ Today's Date:_____
Address:_____
Apt. #:_____ City/State:_____ Zip Code:_____
Home Phone:(____)_____ Work Phone:(____)_____ Cell Phone:(____)_____
E-mail:_____ ☐ Do not send me "Physicians Plus" newsletter.
Date of Birth:_____ Age:_____ S.S.N:___-___-_____ Gender: ☐ Male ☐ Female
Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed
Employer/Occupation:_____
Emergency Contact:_____ Relationship:_____ Phone:(____)_____
Primary Care Physician (PCP):_____ Phone:(____)_____

HOW DID YOU HEAR ABOUT US?

☐ Patient:_____ ☐ Internet Site:_____ ☐ Other:_____

INSURANCE

RELATION TO INSURED:	☐ SELF ☐ SPOUSE ☐ PARTNER ☐ CHILD ☐ OTHER
INSURED NAME:	
INSURED BIRTHDAY:	
MALE OR FEMALE	
ADDRESS:	

PATIENT CONDITION / HISTORY

Give a brief description of the condition that brought you in today:_____
_____
_____
When did the problem start?_____
What caused the problem?_____
Did your condition/pain come on: ☐ Gradually ☐ Suddenly
Is the condition/pain: ☐ Getting better ☐Getting worse ☐ Staying the same
Have you ever had this or a similar condition before? ☐ Yes ☐ No If **Yes** give a brief description:_____
_____
What makes the condition/pain better?_____
What makes the condition/pain worse?_____
Are the injuries/conditions you are seeking treatment for related to an **auto accident**, **personal injury** or **worker's compensation** claim? ☐ Yes ☐No *If yes, please inform the front desk before treatment is initiated.*

☐ Smoking _____packs(s) a day for ___year(s) ☐ Alcohol _____drinks per week
☐ Caffeine _____ cups per day ☐ Water _____ounces per day

What is your exercise level? ☐ None ☐ Moderate ☐ Daily ☐ Heavy Type:_____ Height:_____
How would you rate your current health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor Weight:_____

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Please number and mark the severity of pain you are currently experiencing on a scale from 0 (no pain) to 10 (severe pain).

Area 1 (0-10)_____

Area 2 (0-10)_____

Area 3 (0-10)_____

Please describe the type of pain or sensation you are currently experiencing. (Check all that apply) and MARK them on the diagram to the RIGHT:

□ Aching □ Shooting

□ Burning □ Stabbing

□ Cramps □ Stiffness

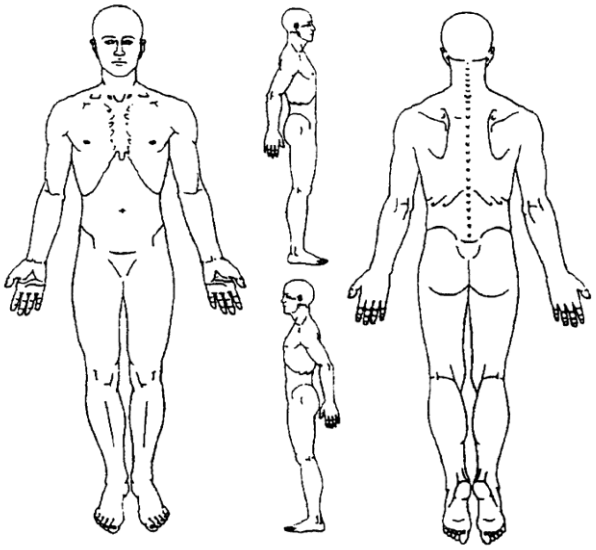
□ Dull □ Swelling

□ Numbness □ Throbbing

□ Sharp □ Tingling

□ Other, describe it: _____

Please mark on the diagram the location of the pain.



The pain: □ is constant □ comes and goes. If it comes and goes, how often does the pain exist? _____

And for how long? _____

Does it interfere with your: □Work □Sleep □Daily Routine □Recreation □Other_____

Have you seen another healthcare practitioner for the pain/condition? □Yes □No

If yes, who? _____

PLEASE INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING CONDITIONS

Asthma	□	Gall Stones	□	Multiple Sclerosis	□
Atherosclerosis	□	Gastric Reflux	□	Measles/Mumps	□
Appendicitis	□	Gout	□	Migraines	□
ADD/ADHD	□	Glasses/Contacts	□	Osteoporosis	□
Angina	□	Heart Disease	□	Rheumatic Fever	□
Blood Pressure (High/Low)	□	Hypertension	□	Seizures	□
Cancer – Type_____	□	Hepatitis – Type_____	□	Syphilis	□
Cholesterol (high)	□	Hemorrhoids	□	Stroke	□
Diabetes – Type_____	□	Hyperthyroidism	□	STD's – Type_____	□
Drug Addiction – Type_____	□	Hypothyroidism	□	Other:_____	□
Epilepsy	□	Lupus	□	Other_____	□
Fibromyalgia	□	Liver Disease_____	□	Other_____	□

FAMILY MEDICAL HISTORY

Relative	Medical Conditions	Relative	Medical Conditions
Mother		Maternal Grandmother	
Father		Maternal Grandfather	
Paternal Grandmother		Sibling	
Paternal Grandfather		Sibling	

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PLEASE INDICATE PAST OR PRESENT SYMPTOMS

Symptoms	Past	Present	Symptoms	Past	Present
Vision Changes	☐	☐	Hip/Knee Pain/Stiffness	☐	☐
Dizziness/light headed	☐	☐	Arm/hand numbness/tingling	☐	☐
Headaches	☐	☐	Arm/hand fatigue/weakness	☐	☐
Nausea/Vomiting	☐	☐	Leg/foot numbness/tingling	☐	☐
Night Sweats	☐	☐	Leg/foot fatigue/weakness	☐	☐
Sensitive to light/sound	☐	☐	Leg pain/cramps with walking	☐	☐
Fainting/Convulsions	☐	☐	Joint pain/swelling	☐	☐
Balance/Coordination	☐	☐	Pain with exertion (stairs/sports)	☐	☐
Hearing Changes	☐	☐	Abdominal Pain	☐	☐
Pain/difficulty swallowing	☐	☐	Diarrhea/constipation	☐	☐
Pain/difficulty breathing	☐	☐	Blood in urine/stool	☐	☐
Chest Pain	☐	☐	Difficulty/Pain with urination	☐	☐
Coughing/phlegm	☐	☐	Difficulty with sexual function	☐	☐
Jaw Pain/clicking/locking	☐	☐	Abnormal menstrual cycles	☐	☐
Neck Pain/stiffness	☐	☐	Anxiety/depression	☐	☐
Shoulder pain/stiffness	☐	☐	Memory problems/loss	☐	☐
Mid back pain/stiffness	☐	☐	Sleep disturbances	☐	☐
Low back pain/Stiffness	☐	☐	Rashes/Skin Conditions	☐	☐

Please indicate any surgeries, traumas, fractures, hospitalizations or motor vehicle accidents below:

_____

_____

_____

_____

Allergies, Sensitivities or Reactions:

_____

_____

_____

_____

_____

PLEASE LIST MEDICATIONS/SUPPLEMENTS YOU ARE TAKING

MEDICATION:_____ DOSAGE:_____ TIMES/DAY:_____

MEDICATION:_____ DOSAGE:_____ TIMES/DAY:_____

MEDICATION:_____ DOSAGE:_____ TIMES/DAY:_____

SUPPLEMENT:_____ DOSAGE:_____ TIMES/DAY:_____

SUPPLEMENT:_____ DOSAGE:_____ TIMES/DAY:_____

SUPPLEMENT:_____ DOSAGE:_____ TIMES/DAY:_____

I, the undersigned, hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). Further I authorize assignment of my Insurance rights and benefits directly to this provider and also authorize the release of such information as needed to process Insurance claims by provider or agent I designate this provider, practice, and agent as Authorized Representative with Durable Power of Attorney in insurance related matters. I understand that I am responsible for all charges which may include legal fee, collection fees or other expenses incurred by the provider in collecting my account. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing, I designate provider and agent (here after referred to as my doctor), to the full extent permissible under the Employee Retirement Income Security Act of 1974 ("ERISA") and as provided in 29 CFR 2560-503-1 (b)4 to act on my behalf to pursue claims and exercise alt rights connected with my employee health care benefit plan, with respect to any medical or other health care expense(s) incurred as a result of the services I received from my doctor. These rights include the light to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, insurance or health care reimbursement and to pursue any other applicable remedies, all in connection expenses as the result of doctor services.

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Cancellation and No-Show Policy

We require a 24 hour notice for appointment cancellations, at which time you may reschedule your appointment. This 24 hour notice gives courtesy to patients waiting to fill that time. Cancellations without a 24 hour notice and no-show appointments will be charged $70 (not covered by insurance). After the third discrepancy, it will be at the physician's discretion as to whether a discharge letter will be sent out disengaging you from the practice and give you 30 days to enroll with a new physician.

Medical record policy

Written medical records will not be released without your written consent, unless required so by law. Copies of your medical records will be released by you or transferred to another physicians upon written consent. There may be a $25 copying fee for this service.

SPECIALIZED RADIOLOGY CONSULTANTS

1039 College Ave, Suite A – Wheaton, IL 60187 – (630) 462-9772

In an effort to provide you with the highest quality health care, it is the policy of your doctor's office to have the x-rays taken in his/her office read by a board-certified radiologist. This is a separate charge from any clinic charges for examination and taking of the x-rays. You will receive a separate billing for this service directly from our office. If you have insurance it will be billed first before asking you for payment.

PLEASE SIGN BELOW AFTER YOU HAVE READ AND UNDERSTOOD THIS POLICY

I understand that there will be a separate bill for the radiologist's interpretations and written report on my x-rays. I authorize the release of any medical information to insurance carriers or their agents. I authorize all claims to be sent directly to the insurance company and I authorize payment to be made directly to the Specialized Radiology Consultants. I accept personal responsibility for any remaining balance.

Physicians Plus Financial Policy

Physicians Plus considers payment of your accounts as part of your treatment. Services will not be rendered to "you" the patient if outstanding financial statements are left unpaid. This policy is set in effect to avoid financial misinterpretation concerning your care.
Physicians Plus works with both "In-Network" and "Out-Of-Network" insurance plans. Physicians Plus will verify your insurance for you if provided prior to treatment and will discuss the coverage breakdown for your understanding. Physicians Plus will not be held responsible, nor guarantee that insurance companies will pay for your care, even if pre-authorized. We will provide a **quote** of benefits, not a **guarantee** of coverage when verified. We encourage you to contact the insurance company to verify your benefits; sometimes incorrect information is provided to us.

All time of service and co-pay fees are due at the time of care. Illinois Law and your insurance company require us to collect the co-payment on the day of service. Co-insurance and deductibles will be billed to you at the first of the next month. Physicians Plus' policy is to have the financial statements paid 30 days after the invoice has been mailed. After 30 days a 1.5% finance charge will be applied to your invoice; after 60 days another 1.5% finance charge will be applied to your invoice. You will be sent statements at each 30 and 60 days after your first bill. After 90 days have passed the first invoice date, your account will be forwarded to a collections agency and finance charge will continue to accrue on each unpaid invoice. Once your account is sent to collections, a 30-50% collections fee will be added to your total balance.

I have read and certify that I understand the cancellation/no show policy, Radiology policy, financial policy and financial obligations concerning my and dependent's accounts.

Print Name:_____

Signature:_____ Date:_____ Witness:_____

Non-Pregnancy Radiology Consent – Women Only

By my signature on this form, I_____ do herby state that, to the best of my knowledge, I am not pregnancy, nor is pregnancy suspected or confirmed at this particular time.

Date of last menstrual cycle:_____

Signature:_____ Date:_____ Witness:_____

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CHIROPRACTIC INFORMED CONSENT TO TREATMENT AT PHYSICIANS PLUS

I hereby give my consent to the performance of conservative treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/mobilizations involving movement of the joints and soft tissues. Physical therapy/modalities, acupuncture, stretching, exercises, and diagnostic tests including but not limited to: EMGs, NCVs, EKGs, Spirometry, X-RAYS, and blood draws also may be used.
Although spinal manipulation/mobilizations are considered to be one of the safest, most effective forms of therapy for musculo-skeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:
Soreness: I am aware that, like exercise, it is common to experience muscle soreness following the treatments.
Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.
Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities, or pathologies like weak bones from osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.
Stroke: Although strokes happen with some frequency in our world, strokes from adjustments/mobilizations are rare. I am aware that nerve or brain damage, including stroke, is reported to occur once in one million to once in ten million treatments. Once in one million is about the same chances as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.
Physical Therapy Burns: Some of the therapies used at Physicians Plus, LTD generate heat and may rarely cause a burn or skin irritation. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor.
Falls: I understand that the rehabilitation process, by very nature, involves certain inherent and unavoidable risks, including falls and other similar injuries, and that the only alternative to entirely avoiding these risks would be to forgo the rehabilitation process.
Tests and other procedures have been performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREAMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate that there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic and physical therapy, is not an exact science and I acknowledge that not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.
I agree to the performance of these procedures by my doctor, and such other persons of the doctor's choosing.

ALTERNATE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.
Medications: Medications can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.
Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy including exercise programs and/or stretching. Prolonged bed-rest contributes to weakened bones and joint stiffness. Exercises are of limited value, but are not corrective of injured nerve and joint tissues.
Surgery: Surgery may be necessary for joint instability or serious rupture. Surgical risks may include unsuccessful outcomes, complications, pain or reaction to anesthesia, and prolonged recovery.
Non-Treatment: I understand the potential risks of refusing, discontinuing, and/or neglecting care against the doctor's advice may include: increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.
I release Physicians Plus, LTD from any responsibility for valuables, money, and other personal possessions lost or stole while on the premises.
I consent to the administration upon me of such routine care, medications and treatments, including diagnostic procedures, as may be considered necessary or advisable. I understand that I am free to obtain information concerning any such care by asking clinic personnel.
I have read or have had read to me the above explanation of Physicians Plus – LTD, consent to treatment. Any questions I have regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision, with careful thought, voluntarily, and freely. I understand that I can withdraw my consent at any time in writing.
To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

Print Name:_____ Signature of Patient_____

Signature of Witness_____ Date_____/_____/_____

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information is information about you, including demographics information, that my identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physicians, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay you health care bills, to support the operation of the physician's practice.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information as necessary to home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed to obtain payment for you health care services. For example, obtaining approval for hospital say may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to conduct you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donations: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required uses and Disclosures WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY to Object unless required by law.
You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information: Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that nay part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

You physician is not required to agree to a restriction that you may request. If physician believes have it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend you protected health information. If we deny your request for amendment you have the right to file a statement of disagreement with us and we may prepare a rebuttal your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosure we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of nay changes. You then have the right to object or with draw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain this privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name:_____ Signature:_____ Date:_____

OFFICE USE ONLY	NAME:	ID:	DATE: