File # _____

Date: _____

Patient Health History

Lundgren
FAMILY CHIROPRACTIC
2965 13th Avenue
Rock Island, IL 61201

In order to provide you the best possible chiropractic care, please complete this form as accurately as possible. All information is strictly CONFIDENTIAL.

Patient Data

First Name _____ M.I. _____ Last _____ Email _____

Address _____ City _____ State _____ Zip Code _____

Telephone (home) _____ (cell) _____ (work) _____

Age _____ Birth Date _____ SSN _____ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Widowed ☐ Other Spouse's Name _____ # Children _____

Emergency Contact _____ Phone # _____ Relationship _____

Occupation _____ Employer/School _____

Referred By _____ or How did you hear about us? _____

Medical Doctor _____ City _____

Previous Chiropractic Care? ☐ Yes ☐ No Doctor's Name _____ Date of Last Adjustment _____

Financial Information

☐ I will be paying for the services myself ☐ Health Insurance ☐ Auto Insurance ☐ Worker's Compensation ☐ Other

Insurance Company Name _____

Policy # _____ Subscriber's SSN _____

Subcriber's Name _____ Subscriber's DOB _____ Relationship to Subscriber _____

Purpose of this Visit

Reason for this visit: _____

When did your symptoms start? _____

How did you injure yourself? _____

Please select all that apply:

☐ Achy	☐ Radiating	☐ Stabbing	☐ Constant (75-100% of the day)
☐ Burning	☐ Sharp	☐ Stiffness	☐ Frequent (50-75% of the day)
☐ Dull	☐ Shooting	☐ Tingling	☐ Intermittent (25-50% of the day)
☐ Numbness	☐ Soreness	☐ Other	☐ Occasional (0-25% of the day)

Intensity of your symptoms: (no pain) 1 2 3 4 5 6 7 8 9 10 (unbearable)

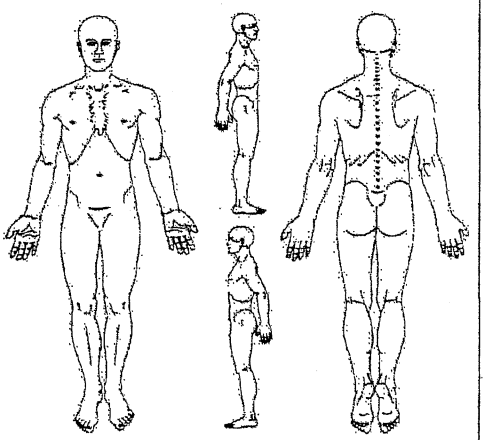
The symptoms improve when I... _____

The symptoms worsen when I... _____

This prevents me from... _____

Who have you seen for your symptoms? ☐ No One ☐ Chiropractor ☐ Surgeon ☐ MD ☐ Physical Therapist ☐ Other

Please indicate where you have pain or other symptoms:



Comments: _____

What treatments/tests were performed: (X-rays, MRI's) _____

Past History

Have you ever experienced this problem before? ☐ Yes ☐ No Please State: _____

Have you ever had any surgery? ☐ Yes ☐ No Please State: _____

Have you ever had any car accidents? ☐ Yes ☐ No Please State: _____

Sports injuries, falls, broken bones? ☐ Yes ☐ No Please State: _____

Do you take any medication? ☐ Yes ☐ No Please List: _____

Do you smoke? ☐ Yes ☐ No # Packs per day: _____

Do you consume alcohol? ☐ Yes ☐ No # Drinks per week: _____

Do you exercise? ☐ No ☐ Infrequently ☐ Occasionally ☐ Frequently ☐ Regularly

Average hours worked per week: _____ hours.

Women only: Are you pregnant? ☐ Yes ☐ No Number of weeks: _____ Anticipated Due Date: _____

Please check all that you have or have had:

☐ AIDS	☐ Cramps	☐ Irregular Cycle	☐ Sciatica
☐ Alcoholism	☐ Depression	☐ Kidney Infection	☐ Shortness of Breath
☐ Allergies	☐ Diabetes	☐ Kidney Stones	☐ Sinus Infection
☐ Anemia	☐ Digestion Problems	☐ Loss of Memory	☐ Sleep Problems/Insomnia
☐ Arteriosclerosis	☐ Dizziness	☐ Loss of Balance	☐ Spinal Curvatures
☐ Arthritis	☐ Ringing in Ears	☐ Loss of Smell	☐ Stroke
☐ Asthma	☐ Excessive Menstruation	☐ Loss of Taste	☐ Swelling of Ankles
☐ Back Pain	☐ Eye Pain/Difficulties	☐ Migraine Headache	☐ Swollen Joints
☐ Breast Lump	☐ Fatigue	☐ Neck Pain or Stiffness	☐ Thyroid Condition
☐ Bronchitis	☐ Frequent Urination	☐ Nervousness	☐ Tuberculosis
☐ Bruise Easily	☐ Headache	☐ Nosebleeds	☐ Ulcers
☐ Cancer	☐ Hemorrhoids	☐ Pacemaker	☐ Varicose Veins
☐ Chest Pain/Conditions	☐ High Blood Pressure	☐ Polio	☐ Other: _____
☐ Cold Extremities	☐ Hot Flashes	☐ Poor Posture	_____
☐ Constipation	☐ Irregular Heart Beat	☐ Prostate Trouble	_____

Family History: Please note any family history of the following conditions and inlcude relationship of relative to you:

☐ Cancer_____	☐ Arthritis_____	☐ Spine or Back Disorder_____
☐ Diabetes_____	☐ Epilepsy_____	☐ Multiple Sclerosis_____
☐ Headache_____	☐ Heart Disesase_____	☐ Psychological Problems_____
☐ High Blood Pressure_____	☐ Stroke_____	☐ Other:_____

The undersigned hereby consents to evaluation and treatment rendered according to the applicable standards of care. It is understood that options exist for treatment and that any/all treatments have risks and benefits. If the risks and benefits of proposed treatment are not clear to me, I understand that further information may be requested from the doctor. The information that I have provided above is accurate to the best of my knowledge and will be used to determine appropriate chiropractic care.

_____

Patient's Signature

Lundgren
FAMILY CHIROPRACTIC

Patient Name: _____
(please print) *Last Name* *First Name* *MI*

Lundgren Family Chiropractic, Ltd
Dr. Eric E Lundgren
2965 13th Avenue, Rock Island, IL 61201
Phone: 309.793.4858 Fax: 309.793.3596

I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as a "Spinal Manipulation" or "Spinal Adjustment". As the joints in your spine are moved, you may experience a "pop" as part of the process.

There are certain complications that can occur as a result of a spinal manipulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner"s Syndrome (also known as oculosympathethetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment

I am aware of these complications, and in order to minimize their occurrence I will take precautions. These precautions include, but are not limited to my taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell me when I take your clinical history.

_____
Patient signature (or Guardian signature if patient is a minor) Date

PREGNANCY WAIVER

I hereby acknowledge that Dr. Eric E. Lundgren of the Lundgren Chiropractic Ltd. has informed me prior to being x-rayed of the advisability of risk and the probable consequences of receiving x-rays during pregnancy.

I have stated on my own violation that I was not pregnant at the time and do hereby release and hold harmless from any legal action or responsibility caused by the use of this procedure.

_____
Patient signature (or Guardian signature if patient is a minor) Date

Lundgren
FAMILY CHIROPRACTIC

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____

Name of Patient Date

Lundgren
FAMILY CHIROPRACTIC

Financial Policy

Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans. Most of our patients that have health or accident insurance will fall under one of the plans discussed in this policy. Regardless of your coverage, we'll suggest the chiropractic care we think you need. We ask that you read and understand our policy as it applies to your particular situation.

PATIENTS WITHOUT INSURANCE

Here at Lundgren Family Chiropractic we offer to our patients that do not have insurance a "time of service discount" of approximately 20% off the standard fee if services are paid at the conclusion of each visit.

GROUP OR INDIVIDUAL INSURANCE

Your insurance is an agreement between you and your insurance company, not between your insurance company and our office. We cannot be certain if your insurance covers Chiropractic, although most policies do provide coverage. The amount they pay varies from one policy to another. When possible, we will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles or co-pays.

"ON THE JOB" INJURY (Worker's Compensation)

If you are injured on the job, your care should be paid for under your employer's Worker's Compensation insurance. You will need to inform your employer of the accident and obtain the name, address and phone number of the carrier of their insurance, along with an adjuster's name and claim number if at all possible. Since Worker's Compensation claims are between the Provider and the Worker's Compensation carrier, our office will need to be able to validate a Worker's Compensation claim before proceeding with billing. Please be aware that if your claim under Worker's Compensation is denied, we will bill your health insurance if available and you are personally responsible for payment of any non-covered services, deductibles or co-pays.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please present your auto insurance card, your health insurance card, and tell us if you have retained an attorney. There are four options available to the PI patient:

1. Pay cash for your care and we will submit reports whenever necessary.
2. We will bill (accept assignment) from the Med Pay portion of your auto insurance.
3. We will accept a Letter of Protection or Doctor's Lien from an attorney and await payment at the time of settlement as long as you remain an active patient.
4. If your auto policy limits have been exhausted and there is no pending litigation or other responsible party, we will then bill your standard health insurance plan and you will be responsible for all co-pays and deductibles as they are incurred.

Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to 6(six) months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

MEDICARE

We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover which for Chiropractors is ONLY manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20%. All other services we provide are NON-COVERED. These services include, but are not limited to, x-rays, examinations, therapies, rehabilitative services, orthotics, supports, and/or nutritional supplements. Medicare patients are fully responsible for charges of non-covered services. Secondary insurance may or may not pay for these non-covered services.

SECONDARY INSURANCE

Please inform us of any secondary insurance you may have, so that our staff can file your claims promptly upon payment from your primary insurance.

FLEX PLANS/MEDICAL SAVINGS ACCOUNTS

Please inform us if you have health savings account, sometimes known as a 'flex plan'. We will be happy to provide you with a statement of your charges for reimbursement. Or if you have a debit card for your HSA/FLEX account, we are happy to accept that at the time of service for any co-pays or co-insurance.

INSURANCE FORMS/PAYMENT

If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request of more information regarding your care, please bring it in as soon as possible. If you should receive any unexpected check in the mail, please contact us to see if it does represent payment of your bill here.

I have read and understand the payment policy of Lundgren Family Chiropractic, I understand that my insurance is an arrangement between myself and my insurance company, NOT between Lundgren Family Chiropractic and my insurance company. I request that Lundgren Family Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctors at Lundgren Family Chiropractic that fees will be due and payable immediately.

_____

Patient Signature (or guardian if patient is a minor) Date

_____

Witness

SPECIAL PAYMENT INSTRUCTIONS

Patient's Name: _____

1. We have verified your benefits and while your insurance company did not guarantee payment, they stated that you have a $_____deductible, $_____of which has been met. Additionally, your insurance will pay _____% of covered charges, leaving _____% of each visit due by you.

2. We have verified your benefits and while your insurance company did not guarantee payment, they stated that you have a $_____deductible, $_____of which has been met. Additionally, your insurance will pay _____% of covered charges, leaving $_____co-pay of each visit due by you.

Missed Appointment Policy

We want to thank you for choosing us as your chiropractic health care provider. In order to provide you and our other patients with the best optimal spinal care, we request that you follow our guidelines regarding broken and/or cancelled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. *When you cancel your appointment at the last minute, everyone loses – you, the doctor and the other patients that would like to have utilized your appointment time.*

Since our office does not charge for broken or cancelled appointments, please realize how important it is to keep your reserved time. Thank you for your consideration of our policies and for the opportunity to be your chiropractic office of choice.