Central Illinois Natural Health Clinic Registration & History Questionnaire

1. PATIENT INFORMATION

Last Name _____ First Name _____ MI _____

What do you prefer to be called? _____

Home Address _____ City _____ State _____ Zip _____

Age _____ Birth Date _____ (Circle one) Gender: **M F** Marital Status: **S M W D O**

* Would you like to receive our e-mail newsletter? ☐ Yes ☐ No **E-mail Address**: _____

* Would you like to receive our e-mail reminder appointments? ☐ Yes ☐ No

2. PATIENT PHONE NUMBERS

Patient Home Phone: _____

Patient Work Phone: _____

Patient Other Phone: _____

In event of emergency

Name: _____ Relationship: _____

Home Phone _____ Work Phone: _____

Who is your Medical Dr.? _____ Phone: _____

3. PATIENT EMPLOYER / SCHOOL INFORMATION

(Please check one) ☐ Employed ☐ Retired ☐ Student ☐ Other _____

Name of Employer or School: _____

Address: _____ City: _____ State/Zip: _____

Phone: _____ Occupation: _____

4. REFERRAL INFORMATION

How did you hear about our office? (please check one of the following)

☐ Yellow Pages ☐ Newspaper ☐ Sign ☐ Dr._____ ☐ Patient _____

☐ Family _____ ☐ Website_____ ☐ Other _____

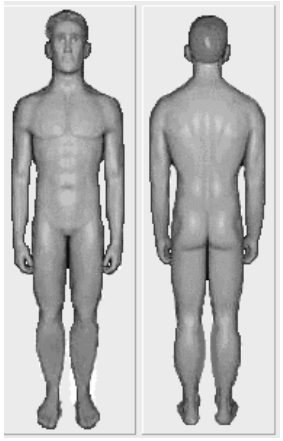
5 PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

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

Mark an X on the picture where you have pain, numbness, tingling, or other symptoms
IF YOU HAVE PAIN, please complete the following:



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

Type of Pain:

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

How often do you have this pain? _____

Is it constant or does it come and go? _____

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

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

Please complete page two on back

6. HEALTH HISTORY

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

Name and address of Doctor(s) who have treated your condition _____

Place a mark on "Current" or "Past" to indicate if you have now, or have ever had any of the following:

	CURRENT	PAST		CURRENT	PAST		CURRENT	PAST		CURRENT	PAST
Abuse(physical/emotional)	☐	☐	Diabetes	☐	☐	Liver Disease	☐	☐	Tumors, Growths	☐	☐
AIDS/HIV	☐	☐	Diarrhea	☐	☐	Menopause	☐	☐	Ulcers	☐	☐
Anemia	☐	☐	Dizziness	☐	☐	Menstrual Problems	☐	☐	Sexually Transmitted	☐	☐
Arthritis	☐	☐	Fibromyalgia	☐	☐	Migraine Headaches	☐	☐	Disease	☐	☐
Asthma	☐	☐	Heart Disease	☐	☐	Osteoporosis	☐	☐			
Breast Lump	☐	☐	Herniated Disc	☐	☐	Prostate Problem	☐	☐	Other:_____		
Cancer	☐	☐	High Blood Pressure	☐	☐	Shortness of Breath	☐	☐	_____		
Chemical Dependency	☐	☐	High Cholesterol	☐	☐	Sinusitis	☐	☐	_____		
Chest Pain	☐	☐	Impotence	☐	☐	Sleep Problem	☐	☐	Bowel Movements:	#_____per	
Constipation	☐	☐	Indigestion	☐	☐	Stroke	☐	☐		day/week	
Depression/Anxiety	☐	☐	Kidney Disease	☐	☐	Thyroid Problem	☐	☐			

7. ACCIDENT	WORK ACTIVITY	HABITS	
Is Condition due to an accident? ☐ Yes ☐ No Date:_____	☐ Sitting	☐ Smoking	Packs/Day___
Type of Accident ☐ Auto ☐ Work ☐ Home ☐ Other	☐ Standing	☐ Alcohol	Drinks/Week ____
To whom have you made a report of your accident? ☐ Auto Insurance	☐ Light Labor	☐ Coffee/Caffeine Drinks	Cups/Day ____
☐ Employer ☐ Worker Comp. ☐ Other	☐ Heavy Labor	☐ High Stress Level	Reason
Attorney Name (if applicable)			_____

Are you pregnant? ☐ Yes ☐ No Due Date _____

8. List any accidents, injuries, and surgeries you have had (please indicate date).

9. MEDICATIONS	ALLERGIES	VITAMINS / HERBS / SUPPLEMENTS

10. Family History – Please list any diseases or major health conditions for your blood relatives.	
Mother:	Siblings:
Father:	Grandparents:

11. Social and Lifestyle				
Sleep	Hours per night:	Quality of sleep:		
Exercise	Type:	How often:	How long each session:	
Support system (family & friends)	☐ Good	☐ Moderate	☐ Poor	Comments:
Spirituality(Optional) Please describe any important religious, spiritual, or philosophical beliefs:				
My goals for treatment are:	☐ Symptom relief (palliative care)	☐ Correction of the cause of my condition	☐ Enhance my overall level of wellness and vitality	☐ Other:_____
Is there anything in your life that you would like to:	☐ Stop doing:_____	☐ Start doing:_____	☐ Do better: _____	☐ Do differently:_____

- **I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.**

Patient Signature **Date**

☐ Adult Patient ☐ Parent or Guardian ☐ Spouse

Central Illinois Natural Health Clinic, Ltd.
1012 W. Fairchild Street, Danville, IL 61832 ▪ 302 W. Elm Street, Urbana, IL 61801
(217) 443-4372

CHIROPRACTIC AND NATUROPATHIC MEDICINE
INFORMED CONSENT FOR TREATMENT

I, _____, hereby authorize Andrew R. Peters, DC, ND and/or other licensed Doctors of Chiropractic, Physicians, or qualified support staff of Central Illinois Natural Health Clinic, Ltd., to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Common diagnostic procedures: e.g., physical examination, venipuncture, Pap smears, radiography, laboratory, x-ray.
Physical Medicine: e.g., chiropractic manipulative therapy, soft tissue manipulation (massage, myofascial release), stretching, therapeutic exercise, physiotherapy (electrical stimulation, ultrasound, heat, ice, mechanical traction), hydrotherapy (therapeutic use of water)
Minor office procedures: e.g., dressing a wound, ear cleansing.
Medicinal use of nutrition: therapeutic nutrition, nutritional supplementation.
Botanical medicine: botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, plasters, or suppositories.
Homeopathic medicine: the use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.
Lifestyle counseling and hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.

I recognize the potential risks and benefits of these procedures as described below:

Potential risks include, but are not limited to: allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from injections, venipuncture or procedures. Potential risks of physical medicine include, but are not limited to: fracture, disc injury, stroke, dislocation, sprain/strain, increased pain.

Potential benefits: restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Central Illinois Natural Health Clinic, Ltd., or any of its personnel regarding cure or improvement of my condition. I understand that I have the right to an explanation of: my suspected diagnosis; the nature, purpose, and potential benefit of the proposed care; the inherent risks, complications, potential hazards, or side effects of the treatment or procedure; the probability of success; reasonable available alternatives to the proposed treatment/procedure; the possible consequences if treatment or advice is not followed and/or nothing is done. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by my practitioner to the best of his/her ability.

_____ _____
Date Signature of Patient

Original to: Chart
Copy to: Patient *(if requested)*

_____
Signature of Patient Representative or Guardian

_____
Signature of CINHC Representative

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Financial Policy

Thank you for choosing us as your health care provider. We are committed to the success of your treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to treatment. If at any time you have questions regarding any treatment, fee, or service, please discuss them with us promptly and frankly. We will make every effort to avoid a misunderstanding or rectify an injustice.

INSURANCE

As a courtesy to you, we will bill your insurance carrier for you. All co-payments, deductibles, and payments for supplements, supports, and other "non-covered" services are due at time of service unless prior arrangements have been made. Payments may be made by cash, check, Visa, MasterCard, or Discover. Any unpaid balances 90 days and over will be charged interest of 1.0% per month. Returned checks will be charged a $25 fee (in accordance with 810 ILCS 5/3-806). If you are unable to pay in full, it is your responsibility to contact our billing department to set up an agreeable payment plan. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

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**. **Payment will be due by you at the time of service for any non-covered services, deductibles or co-pays.**

UCR (USUAL AND CUSTOMARY RATES)

Our practice is committed to providing the best treatment possible for our patients, and we charge what is usual and customary for our area. You are responsible for payment in full, regardless of any insurance company's arbitrary determination of usual and customary rates.

INJURIES/ACCIDENTS INVOLVING LITIGATION

We will make every effort to recover our fees from all available sources, including your health insurance and any med-pay benefits that are available on your auto insurance policy. We will then wait to collect any unpaid balances until after a settlement is reached. **It must be understood, however, that the payment of the balance is ultimately your responsibility.**

WORKER'S COMPENSATION

Our office will file worker's compensation claims. It is your responsibility to contact your employer to establish a worker's compensation claim. If the claim is denied, we will bill your personal health insurance carrier. If the claim is unsettled or unpaid within 90 days, you will receive a statement from our office.

SPECIALTY LABS

Certain lab tests that we may order for you are not usually covered by insurance; therefore, we do not bill these tests to insurance, and ask that you pay for them either directly to the lab, or through our office. These include, but are not limited to, tests through these laboratories: **U.S. Biotek, Diagnos-Techs, Genova Labs, Doctor's Data, Metametrix, Labrix.** We will be happy to provide you with a receipt for any such tests that you may submit to your insurance company on your own.

PATIENTS WITHOUT INSURANCE

We request that 100% of the first visit be paid at the time of the visit. On other visits, payment may be made at the end of the week if you sign a credit guarantee form. We are happy to accept your check, Master Card, Visa, or Discover.

MINOR PATIENTS

An adult must accompany the minor at the time of the first visit. The adult accompanying the minor is responsible for payment of the account.

MEDICARE PARTICIPANTS

We 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%, as well as any non-covered services (exams, labs, supplies, etc.). Our office completes and files the forms for Medicare at no charge.

SECONDARY INSURANCE

Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

MEDICAL RECORDS

You have the right to a copy of your medical records. The fee for copy is a $24.44 handling charge, plus $0.92/page for the first 25 pages, plus $0.61/page for pages 26-50, plus $0.31/page thereafter (735 ILCS 5/8-2006).

MISSED APPOINTMENTS

We require 24 hours notice for cancellation of all appointments. There will be a $10 charge to the patient for all appointments that are missed and not canceled.

Notice of Privacy Practices: Acknowledgement of Receipt

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the privacy officer. Our ***Notice of Privacy Practices*** describes in more detail how your health information may be used and disclosed, and how you can access your information.

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with, _____ and assign directly to Central Illinois Natural Health Clinic, Ltd. all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I also authorize Central Illinois Natural Health Clinic, Ltd. or insurance company to release any information required in order to process my claims.

I have read and understand the Financial Policy of the Central Illinois Natural Health Clinic, Ltd. I understand that I am ultimately responsible for the payment of any services or products received at this office. I also understand that I will be responsible for any fees related to collecting my unpaid balance, including a 40% collection agency fee, and/or reasonable attorney fees. By my signature below I also acknowledge receipt of the Notice of Privacy Practices.

Signed_____ Date_____

(Parent or Guardian if patient is under 18 years of age)Patient's Name (printed) _____

CINHC Representative Signature: _____ Date: _____

Patient has or will receive a copy of Notice of Privacy Practice in their Patient Binder.

This form will be retained in your medical record.

Central Illinois Natural Health Clinic, Ltd.

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302 W. Elm Street, Urbana, IL 61801
Phone: 217-443-4372
Fax: 217-443-0452

Authorization for the Release of Medical Records

This authorization will be effective for six months after the date signed, unless canceled in writing. I understand that the cancellation will have no effect on information released prior to receiving the cancellation. A copy of this authorization is as valid as the original.

Patient Name (please print) _____

Patient Date of Birth _____

Patient Address _____

City/State/Zip _____

_____ _____

Signature of Patient or Legal Representative/Relationship **Date:**

If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law.

Notice to recipient of information: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without the specific written consent of the patient or legal representative.

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CHIROPRACTIC AND NATUROPATHIC MEDICINE
INFORMED CONSENT FOR TREATMENT OF MINOR CHILD

CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize Andrew R. Peters, DC, ND, and whomever he may designate as his assistants, to administer treatment as he/she so deems necessary to my_____, _____.

Dated on this day: _____, 20___

Signed: _____

Witnessed: _____