Central Illinois Natural Health Clinic Registration & History Questionnaire

1. PATIENT INFORMATION

First Name _____ MI _____ Last Name _____

What do you prefer to be called? _____

Home Address _____ City _____ State/Zip _____

Birth Date _____ Sex on original birth certificate: **M F** Marital Status: **S M W D O**

Gender: **M F Other:** _____ Preferred pronouns**:** _____

Would you like to receive electronic appointment reminders? ☐ Yes ☐ No

E-mail Address: _____

2. PATIENT PHONE NUMBERS

Cell Phone: _____

Work Phone: _____

Home/Other Phone: _____

In event of emergency

Name: _____ Relationship: _____

Cell Phone _____ Alternate 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)

☐ Patient _____ ☐ Dr._____ ☐ Website_____

☐ Sign ☐ Newspaper ☐ Other _____

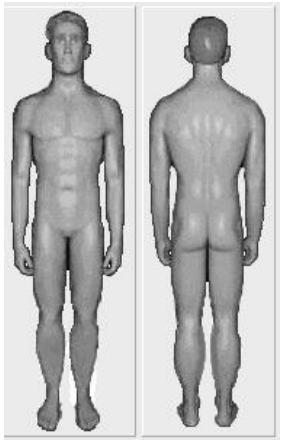
5 PATIENT CONDITION

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

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

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 (optional)				
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

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

Please read this entire section prior to signing. It is important that you understand the information contained in this section. If anything is unclear, please ask questions before you sign.
DO NOT SIGN THIS CONSENT TO BE TREATED UNTIL YOU HAVE READ, UNDERSTOOD AND ASKED ANY QUESTIONS YOU MAY HAVE!

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 procedures as necessary to facilitate my diagnosis and treatment, including:

Common diagnostic procedures: physical examination, venipuncture, laboratory testing.
Naturopathic Therapies: therapeutic nutrition; botanical (herbal) medicine; lifestyle counseling.
Chiropractic Therapies: chiropractic joint manipulation, soft tissue manipulation (Neurostructural Integration Technique), stretching, therapeutic exercise

Potential risks of naturopathic therapies include, but are not limited to: allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, bruising from venipuncture.
Potential risks of chiropractic therapies include, but are not limited to: fracture, disc injury, dislocation, sprain/strain. These complications are generally described as rare.

- Manipulation of the neck has been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. The incidences of stroke are exceedingly rare and are estimated to occur in less than one in a million neck adjustments.

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 am free to withdraw my consent and to discontinue participation in these procedures at any time.

_____ _____
Patient/Guardian Name Printed Date

_____ _____
Patient/Guardian Signature Relationship to Patient

I have addressed any questions regarding consent to treat: _____
Doctor Signature

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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. 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. 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.**

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. 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. Electronic copies are free of charge, per the 21st Century Cures Act. The fee for a paper copy is a $28.44 handling charge, plus $1.07/page for the first 25 pages, plus $0.71/page for pages 26-50, plus $0.36/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.

Dr. Andrew R. Peters, DC, ND
1012 W. Fairchild Street Danville, IL 61832
302 W. Elm St., 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.