PATIENT INFORMATION

Name (*Last, First, Middle Initial*) ____

Gender: *M* *F* **Social Security #**: ____________________________________

Marital Status: *S* *M* *D* *W* **Date of Birth**: __________________________

Address: _______________________ **City**:________________ **State**: _____ **Zip**__________

Phone: ***Cell*** (_____)________________ ***Work/Home*** (_____)________________

Preferred #: *H* ☐ *W* ☐ *C* ☐ **Where may we leave messages for you?** *H* ☐ *W* ☐ *C* ☐

E-mail: ____

Emergency Contact: ***Name*** _________________________ ***Phone*** *(*_____)_______________

Is this appointment related to a recent accident? Y☐ N☐ What type of accident? Work ☐ Auto ☐ Other ☐

Occupation: ______________________ **Employer:** ________________________________

Spouse/Parent/Guardian Name: ____

Spouse/Parent/Guardian Date of Birth: ________**Spouse/Parent/Guardian SS#:** _____________

Spouse/ Parent/ Guardian Employer: ____

Are you currently taking any medications? *Y*☐ *N* ☐ *If yes, please list*: ____________________

____

____

Are you allergic to any medications? *Y* ☐ *N* ☐ *If yes, please list*: ________________________

Are you currently taking any supplements? *Y* ☐ *N* ☐ *If yes, please list*: __________________

____

____

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 is needed to process insurance claims by provider or agent. 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.

Patient Signature:____________________________________ Date: _________________

Blackman Family Chiropractic

Healthier people, Healthier planet.

Case History

Name:____ Date:__________

Were you referred, if so by who?_________________________________

Have you ever received chiropractic care? ☐ YES ☐ NO

If so, where? _________________ Reason for visit? _________________

Approx. Date of last visit? ___________

About your health

The human body is designed to be healthy. Throughout life, events occur which damage your health. Following your exam, your chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

Are you aware that: Doctors of Chiropractic work with the nervous system? The nervous system controls all bodily functions and systems? Chiropractic is the largest natural healing profession in the world? And, If Chiropractic care starts at birth, you can achieve a higher level of health throughout your life? ☐ **YES** ☐ **NO**

Loss of Wellness

Let's begin at birth when you first damaged your nerve system, lost your wellness and began your journey to ill health.

Birth Process

	Yes	No		Yes	No
Did your mother experience any falls, injuries, or abuse during pregnancy?	☐	☐	Breach?	☐	☐
Was the delivery long?	☐	☐	Home birth?	☐	☐
Was the delivery difficult?	☐	☐	Hospital birth?	☐	☐
Forceps?	☐	☐	Mother given drugs during delivery?	☐	☐
Cesarean?	☐	☐	Was labor induced?	☐	☐

GROWTH AND DEVELOPMENT (BIRTH THROUGH TEENAGE YEARS)

	Yes	No		Yes	No
Were you taught how to care for your spine?	☐	☐	Did you have surgery?	☐	☐
Did you fall out of bed?	☐	☐	Did you take medication/drugs?	☐	☐
Did you fall while learning to walk?	☐	☐	Were you picked on by siblings?	☐	☐
Did you have childhood sickness?	☐	☐	Did you have any child abuse?	☐	☐
Did you fall down stairs?	☐	☐	Did you have a severe spanking?	☐	☐
Chair pulled out when sat down?	☐	☐	Did you have your ear/chin pulled?	☐	☐
Did you have accidents?	☐	☐	Were you yanked by your arm?	☐	☐

Loss of whole body health

As layers of damage due to physical, chemical, and mental stresses increased, you probably began to experience symptoms and random bouts of sickness.

HEALTH HABITS AND STRESSES	Yes	No	If yes, tell us more
Did/ do you smoke?	☐	☐	________________
Did/ do you drink any alcohol?	☐	☐	________________
Diet (Do you eat healthy foods?)	☐	☐	________________
Have you been in accidents?	☐	☐	________________
Have you had surgery & organs removed/ replaced?	☐	☐	________________
Did/ do you take drugs prescription?	☐	☐	________________
Did/ do you have occupational stress?	☐	☐	________________
Did/ do you have physical stress?	☐	☐	________________
Did/ do you have mental stress?	☐	☐	________________
Did/ do you have sports injuries?	☐	☐	________________

Primary Reason for Consulting this Office

Present complaint________________________ When did this start? ______________

What were you doing?________________ Is it? ☐ Sharp ☐ Dull ☐ Constant ☐ Intermittent

Is this condition getting worse? ☐ Yes ☐ No How often? ☐ Daily ☐ 2-3 X/week ☐ Occasionally

Is this condition worse at certain times of the day? ☐ Morning ☐ Afternoon ☐ Evening ☐ Sleeping

Does this condition interfere with? ☐ Work ☐ Sleep ☐ Routine ☐ Other______________

Have you seen other doctors for this?________________ Are you using home remedies?______________

OTHER SYMPTOMS Please check each of symptoms if you have them now or have had them in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis and care plan.

- ☐ Headaches
- ☐ Neck Pain
- ☐ Neck Stiff
- ☐ Upper Back Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Numbness or pain in arms/hands/fingers
- ☐ Numbness or pain in legs/feet/toes
- ☐ Fever
- ☐ Face flushed
- ☐ Dizziness
- ☐ Loss of Balance
- ☐ Light bothers eyes
- ☐ Sinus Problems
- ☐ Buzzing or Ringing in ears
- ☐ Cold feet/Hands
- ☐ Fainting
- ☐ Sleeping Problems
- ☐ Shortness of Breath
- ☐ Chest Pains
- ☐ Loss of Memory
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Cold Sweats
- ☐ Asthma
- ☐ Tension
- ☐ Irritability
- ☐ Fatigue
- ☐ Depression
- ☐ Anxiety
- ☐ Stomach Upset
- ☐ Diarrhea
- ☐ Constipation
- ☐ Allergies

FOR WOMEN:

- ☐ Pregnant
- ☐ Nursing
- ☐ Birth Control
- ☐ Painful Periods
- ☐ Irregular Cycle

List your medications: ________________________________

List your supplements: ________________________________

Patient Signature: ________________________ **Date:**______________

Doctor Signature: ________________________ **Date:**______________

BLACKMAN FAMILY CHIROPRACTIC FINANCIAL POLICY

FEES	Insurance Charges	Cash Charges
Examinations		
New Patient	$95.00	$95.00
Re-Examination	$75.00	$75.00
X-Rays	$165.00	$165.00
Adjustments	$60.00	$45.00
Medicare Adjustments	$39.22	$25.00
Physical Therapy		
Electric Stim	$30.00	$15.00
Ultrasound	$40.00	$20.00
Dry Needling	N/A	$50.00
Graston	N/A	$25.00
Kinesotape	N/A	$20.00

*****MONTHLY CASH PLANS AVAILABLE AS NEEDED*****

(Notice: Continued missed appointments will be subject to a $20.00 charge)

FORMS OF PAYMENT

Patients are responsible for co-payment at the time of service. We accept cash, personal check, your card on file, Visa or MasterCard. There will be a $25 service charge on all returned checks.

BILLING

Our policy is that a patient not carry a balance and at the time of the first visit a credit card is required to be put on file. Once over 30 days, an interest charges of 2% (or a minimum of a $1.00 per month) will begin to accrue; plus service fees and **any legal or collection fees**.

INSURANCE

All professional services rendered are the responsibility of the patient. We will file your insurance claims as a courtesy to you; although you (NOT the insurance company) are responsible for all charges incurred. We will do our best within our legal limits to support your covered services, however **your health insurance is an agreement between you and your insurance carrier**, **therefore it is your responsibility to handle any disputes with your insurance company that is beyond our capability.** **Payment from your insurance company is not guaranteed; you will be responsible for any unpaid charges.**

AUTHORIZATION AND AGREEMENT

I understand that my chiropractic insurance carrier may pay less than the actual billed services.
I agree that my balance is to be **paid in full** in order to receive any records or x-rays.
I agree that any and all coupons are considered null and void if patient does not return for 2nd visit within two weeks.

I authorize and request my insurance company to pay directly to the chiropractor or chiropractic group insurance benefits otherwise payable to me and also authorize the release of such information as is needed to process insurance claims by provider or agent. I agree to be responsible for payment of all services rendered on my behalf or my dependents. **I understand that I am responsible for all charges which may include legal fees, 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.

I have read, understood, agreed to, and received a copy of this form if requested.

______________________________ ____________________

Patient / Responsible Party Date

Updated January 2023

Blackman Family Chiropractic
5390 Elevator Road Roscoe, IL 61073-8878
(815) 623-5460 blackmanchiro1@gmail.com

Patient Consent

For use and/or disclosure of Protected Health Information (PHI) To carry out Treatment, Payment, and Health Operations

_____________________, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice would be available to me in the future at my request. The Practice has further explained by right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. The Practice's "Notice of Privacy Practices" is available upon request.

4. This Notice of Privacy Practices also describes my rights and duties of this office with respect to my protected health information.

5. I understand that, and consent to, the following appointment reminders that will be used by the Practice:
a) a postcard mailed to me at the address provided by me; and
b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone

6. The Practice may use and/or disclose my PHI (which includes information about my health condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

7. I understand that I have a right to request the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

8. I understand that is Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

9. I understand that if I do not sign this consent or revoke consent at any time, the Practice has the right to refuse to treat me.

10. I understand and consent to the following other types of correspondence from this office:
a.) a birthday card may be mailed to me at the address I provided; and
b.) I may receive periodic mailings of general health information in the form of a newsletter
c.) sign-in sheet

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_________________________________ Name of Individual (Printed)

_________________________________ Signature of Individual

_________________________________ Signature of Legal Representative

__________ Date Signed

_________________________________ Relationship

_________________________________ Witness

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of Chiropractic adjustments and any other Chiropractic procedures including examination tests, diagnostic x-rays and physical therapy techniques, on me (or on the patient named below which I am legally responsible) which are recommended by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic who now, or in the future, render treatment to me, while employed by, working for, or associated with, or serving as backup for the Doctor of Chiropractic named below.

I understand that, as with any health care procedures, there are certain complications which may arise during a Chiropractic adjustment. Those complications include, but are not limited to; fractures, disc injuries, dislocations, muscle strain, Homer's Syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck, leading to, or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, and are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of Chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read, or have had read to me (   ) the above explanation of chiropractic adjustment and related treatment. By signing below, I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the Chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

CONSENT TO TREATMENT OF A MINOR CHILD

I, being the parent or legal guardian, hereby authorize Dr. Trina Blackman-Morgan and whomever they may designate as assistants to administer treatment as deemed necessary to my child.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

______________________________ ______________

Printed Name of Patient

______________________________ ______________

Signature of Patient — Date

______________________________ ______________

Name of Patient's Representative (i.e. Parent/Guardian)

______________________________ ______________

Signature of Patient's Representative (i.e. Parent/Guardian) — Date

______________________________ ______________

Relationship to Patient

Blackman Family Chiropractic
5390 Elevator Road
Roscoe, IL 61073
815-623-5460

Name(s) of Doctor(s) Treating This Patient:

Dr. Trina Blackman-Morgan

Dr. Airn Houlahan

Updated January 2023