WORKER COMPENSATION INFORMATION

Innate Concepts Chiropractic
668 E. Northwest Hwy, Mount Prospect, IL 60056

Patient Information

Name:_____ Birthdate:_____ Social Security #_____
Address:_____
Home Phone: (___) _____ E-mail:_____
Cell Phone: (___) _____ Occupation:_____

Employer

Employer Name:_____
Employer Address:_____
Employer Phone: (___) _____ Injury Verified by (For Office Use Only) _____
Contact Person:_____ E-mail:_____

Worker Compensation Carrier (For Office Use)

Worker Compensation Carrier:_____
Carrier Address:_____
Carrier Phone: (___) _____ Coverage Verified by:_____
Adjuster's Name:_____ Claim Number:_____

Injury Information

Date of Injury:_____ Time:_____ ❑ AM ❑ PM Place of Injury:_____
Accident reported to employer? ❑ Yes ❑ No Name of Person you reported accident to:_____
Give full description of how accident happened:_____
_____
_____
Have you lost time from work? ❑ Yes ❑ No How much?_____
Other doctors seen for this condition: Doctor's Name_____
Diagnosis:_____ Were X-Rays taken? ❑ Yes ❑ No Other tests? ❑ Yes ❑ No
If yes, by whom? Please list test(s) and result(s) _____
_____
_____
Any previous Worker Compensation injuries? ❑ Yes ❑ No Date(s) of previous injuries:_____
Describe previous Worker Compensation injuries:_____

Authorization

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for Worker Compensation benefits is denied. I understand that filing for Worker Compensation benefits does not relieve me from my responsibility for the payment of all charges.

Signature of Patient, Parent, Guardian or Personal Representative:_____ Date:_____

Please Print Name:_____ Relationship to Patient:_____

ABOUT THE PATIENT

Innate Concepts Chiropractic, 668 E. Northwest Highway, Mount Prospect, IL 60056

Name _____ Today's Date_____ Birthdate _____ Age_____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____ Gender ❑ M ❑ F

Significant Other's Name _____ Kid's Names and Ages _____

Your Employer _____ Type of Work _____

e-Mail Address _____ Have you been to a chiropractor before? ▫ No ▫ Yes

Emergency Contact _____ ph # _____

Name of Medical Doctor(s)_____ How did you hear about us? _____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Innate Concepts Chiropractic to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient?_____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.
- For my balance my preferred payment method is: ❑ Cash ❑ Check ❑ Credit Card ❑ Car/Work Ins.

_____ _____

Patient / Parent Signature (This represents a long term authorization for all occasions of service) Date

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse

❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

2. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse

❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

3. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse

❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

4. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse

❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

5. Does your condition affect: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving

_____

6. What makes it better?_____

7. What makes it worse? _____

8. What Doctor's have you seen for this?_____

_____

9. Type of treatment:_____

10. Results: _____

NOTES: _____

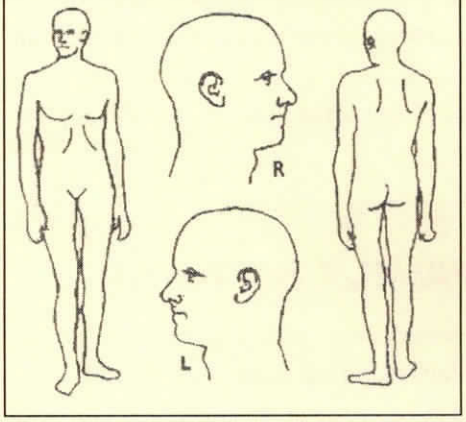
_____

_____

Are you pregnant?

❑ Yes ❑ No

Please mark all areas of concern.



GENERAL HEALTH HISTORY

Innate Concepts Chiropractic, 668 E. Northwest Hwy, Mount Prospect, IL 60056

Patient Name_____ *Mark the conditions that apply to you.*

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Urinary Problems
❑	❑	Migraines	❑	❑	Easy Bruising
❑	❑	Shortness of Breath	❑	❑	Tobacco Use
❑	❑	Allergies / Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Fibromyalgia
❑	❑	Diabetes	❑	❑	Blood Thinner use
❑	❑	Hands or Feet cold	❑	❑	HIV Positive
❑	❑	Muscle aches	❑	❑	Cancer
❑	❑	Trouble Walking	❑	❑	Depression
❑	❑	Leg / Foot Numbness	❑	❑	Alcohol Use
❑	❑	Fainting	❑	❑	___High or ___Low Blood Pressure
❑	❑	Gall Bladder Trouble	❑	❑	Stroke History
❑	❑	Ringing in Ears	❑	❑	High Cholesterol
❑	❑	Ear Problems	❑	❑	TMJ
❑	❑	Sleeping Problems	❑	❑	Digestive Problems
❑	❑	Vision Problems	❑	❑	Pain all Over
❑	❑	Thyroid Problems	❑	❑	Tension / Irritability
❑	❑	Liver Disease	❑	❑	Chest Pains
❑	❑	Kidney Problems	❑	❑	Heart Pacemaker
❑	❑	Light Bothers Eyes	❑	❑	Heart Problems
❑	❑	Other _____			

1. List any medications are you taking:_____

_____

2. Please list all doctors you are currently seeing: _____

_____

3. Has any Doctor or other professional advised you to "Go to a Chiropractor ": ❑ No ❑ Yes, Name_____

_____

_____

PAST HISTORY

4. List any past auto collisions:_____ Was any care received?_____
5. List any past work injuries: _____ Was any care received?_____
6. List any past sport, recreational, or home injuries_____
7. Please describe any past conditions and treatment received: _____

_____

8. Please list any past hospitalizations and surgeries: _____

_____

FAMILY HISTORY

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Is there any other family history you want us to know?_____

Innate Concepts Chiropractic

Paying for your care is easy here!

Mark which one works best for you:

_____ **No Insurance:** Easy! Our Care Plans and simple payment arrangements have helped over 5,000 people and will work great for you too!
_____ **Health Insurance:** These days, insurance pays very little for natural, drugless care to get you healthy. So we make it easy! • We will verify any benefits you may have and send your claims in to your insurance for you. • If they pay anything after your deductible is met, we will accept payments directly from them. • You are responsible for any deductible, co-insurance, co-pays and unpaid visits. • Of course you can use your HSA, HRA, and Flex dollars here! • For your convenience, all payment arrangements are made in advance. We will never surprise you with a bill in the mail.
_____ **Auto Injury:** Auto related injuries are typically covered at 100% in our state. Even if you were at fault or were a passenger. In the event the claims are denied, we will bill your medical insurance. All we need is your: • Claim number • Insurance Information • Attorney Information
_____ **Work Injury:** Work injuries are covered 100% for up to 12 weeks of care. All we need is your: • Claim number • Insurance Information • Attorney Information
_____ **Medicare:** Regardless of your condition, Medicare pays for up to a maximum of 12 weeks of care. They have very strict rules and limitations. After this, you will receive a significant Medicare discount ($35/visit). • We simply need a copy of your Medicare card. • Medicare supplements normally don't pay anything. • If you do not have a secondary insurance, you will be responsible for your 20%.

For Your Convenience:

We like to make things as easy as possible for our patients – including paying for care! Prior to beginning treatment, we will go over all costs anticipated with your customized plan. Feel comfortable knowing we use a secure portal to hold your credit card information and only process payments if:

- You give us **authorization.**

  OR

- **Your balance goes unpaid for 30 days.** At that time, we will run the card on file for the outstanding balance on your account.

Print Name _____ **Date** _____

Sign Name _____

OFFICE POLICY

Innate Concepts Chiropractic, 668 E. Northwest Highway, Mount Prospect, IL 60056

SPINAL CHECK-UP:

We recommend **everyone have their spine checked** early for spinal problems. Especially **children** to see if their spine is developing abnormally. Prevention is the best medicine. A spinal check–up is easy and fun for kids.

AGREEMENTS FOR TOP RESULTS:

- Remember it takes time and effort to improve your health. *No time + No effort = No results*
- Please keep your appointments and make-up any missed or rescheduled visits within a day whenever possible.
- Please call if you are going to be late or need to reschedule.
- Feel welcome to refer your family and friends in for care. We are here to help them too.
- If you're paid ahead, understand you will get any unused money back if care ends early.
- **I agree to allow my/family name, photo, video, or testimonial to be used during the normal course of business.**
- I understand that adjusting time is for adjustments and I can always talk to the Doctor by special appointment or phone call. He is here to help you any way he can. We want you to do great! ☺

OFFICE VISITS MAY INCLUDE:

- **Specific Chiropractic Adjustments** to promote mobility, stimulate tissue, enhance alignment. This is when the Doctor works directly on your neck or back, sometimes making a popping sound. $45-65
- **Extremity Adjustments** to promote mobility, stimulate tissue, enhance alignment of extremity joints. $35
- **Intersegmental / Mechanical traction** to tense / relax soft tissues, aid healing and mobility. This is the black table with the rollers that effectively extend, stretch, and traction the spine. $30
- **Heat** for sub-acute or chronic conditions. The digital heat pack used on the area of concern. $10
- **Cold** to reduce swelling, this is the ice pack used on the area of concern. $10
- **Electric Muscle Stim**. To control swelling, modulate pain, tone muscles. $30
- **Manual Therapy / Manual Traction** to modulate pain, increase flexibility, reduce swelling, mobilize soft tissues. This is hands-on work to your spine or other joints, performed by the Doctor. $35
- **Therapeutic Exercises** to improve spinal flexibility, strength and motion. These are stretches or exercises that you perform or the Doctor administers to you. Excellent for the neck, mid, and lower back. $35 per unit
- **Neuro Muscular Re-Education** to develop and improve coordination and balance, as well as promote flexibility and strength. An example is the Wobble chair the Doctor has you exercise with. $35 per unit
- **Myofascial release (Massage)**, muscle work to reduce muscular adhesions and aid healing. This is commonly called 'Massage' or "Trigger point Therapy" and can be performed in sessions of 15 to 90 minutes. $22.50 per unit
- **Supports/Pillow/Braces** if needed and as priced.

Massage Therapy Policy:

- Please arrive 5-10 minutes before your scheduled time. **(You are not guaranteed the full amount of time if you show up late).**
- We request a 2-hour cancellation notice. **If you no call/no show you will be responsible to pay in full for the massage.**
- **A card must be provided over the phone when booking your appointment to hold your spot. Payment is due at time of service. If you have a gift certificate or massage promotion it must be presented before your massage to accept validation.**
- We shall not be held liable for any conditions that arise after the massage. Patients agree to this for the initial and future massages by signing the informed consent form. Consent may be withdrawn at any time by either party and patients are encouraged to continuously communicate boundary requirements with us. The patient agrees to state all information on the health history form accurately and completely, and will inform the therapist of any new conditions or changes in health.

***We will maintain patient confidentiality of all patient information except in the event the patient agrees to disclosure in writing or by court order.**

Print Name: _____ Date: _____

Patient/Legal Guardian Signature: _____ Staff Initial: _____