

CASE HISTORY

Name _____ Date _____
Address _____ City _____ State _____ Zip _____
Telephone _____ Social Security# _____ / _____ / _____ Driver Lic# _____
Age _____ Birthdate _____ Sex _____ Status M S W D No Children _____
Occupation _____ Employer _____ Years Employed _____
Employer's Address _____ City _____ State _____ Zip _____
Spouse's Name _____ Occupation _____ Employer _____
Person responsible for this account _____ Referred by _____
What is your major complaint? _____

Other complaints _____
How long have you had this condition? _____ Have you had this or similar conditions in the past? _____
What activities aggravate your condition? _____
Is this condition getting progressively worse? YES NO CONSTANT COMES AND GOES
Is this condition interfering with your work: WORK SLEEP DAILY ROUTINE OTHER _____
How long has it been since you really felt good? _____
List surgical operations _____

Are you taking any medications? _____ What kind? _____
Any non-prescription drugs? _____ What kind? _____
OTHER DOCTORS SEEN FOR THIS CONDITION: MD DC DO DDS
Doctor's Name _____ Diagnosis _____
X-rays _____ Urinalysis _____ Blood Tests _____ Other _____
Treatment: Medication _____ Physical Therapy _____
Results _____ Length of time under care _____
Were you off work? _____ If so, how long? _____ Have you returned to your same job? _____ If not, why? _____

INSURANCE INFORMATION:

Are you covered by Medicare? YES NO Medicare # _____ State Insurance Aid? YES NO
Do you have any group, union or personal health and accident insurance? YES NO
Name of Insurance Company _____ Claim # _____ Group # _____
Address _____ Phone _____ Agent _____
Additional Insurance Company _____ Claim# _____ Group# _____
Address _____ Phone _____ Agent _____
Is your condition due to an accident? Illness Other _____

ACCIDENT INFORMATION

Did your accident occur while at work? Yes No Were you involved in an automobile accident? Yes No
Date _____ Time _____ Injury reported to employer Yes No Name of Supervisor _____
Description of accident _____
Were you injured? _____ How? _____
Location _____
Were you unconscious? _____ Fractures _____ Cuts _____ Abrasions _____ Bruises _____
Patient taken to _____ Hospital for _____ Treatment _____
Confined to hospital for _____ Days _____ Hours. Name of hospital doctor _____
Have you had any other personal injury or accident? Past year Past 5 years Over 5 years None
Describe _____
Do you have an attorney? Yes No Name & Address _____

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature _____ Date _____



SIMPLE
SPINAL HEALTH & MEDICAL CENTER

____ **MAJOR MEDICAL INSURANCE:** If your deductible has been met, you may pay the percentage of your responsibility as services are rendered. We will make every attempt at the beginning of your health care to receive verification of your policy and what it covers.

____ **WORKER’S COMPENSATION:** Our office will contact your employer to verify coverage and filing procedures.

____ **AUTOMOBILE ACCIDENT:** Our office will make every attempt to contact insurance companies and/or your attorney to verify filing procedures.

____ **CASH:** Due on the day of services, unless other arrangements have been made.

____ **MEDICARE:** X-rays are required annually by Medicare, but they will not pay for these. We will file your Medicare claim. Any co-payments or deductibles are due at the time of service.

____ **SIU STUDENT HEALTH:** A signed referral must be obtained from the Health Service. Any deductible is due at the time of service. Once the deductible has been satisfied you will be responsible for a 50% co-payment.

____ **FLEX / MEDICAL SAVING or REIMBURSEMENT ACCOUNTS:** We are not responsible for aiding these accounts, and we require payment upfront, instead of being reimbursed by the account. If diagnostic codes are required we must charge the full insurance price. We can print you a copy of the total amount you paid.

AUTHORIZATION

1. I authorize SIMPLE Spinal Health and Medical Center to release information regarding this patient.
2. I authorize payment to SIMPLE Spinal Health and Medical Center for services rendered. In lieu of over payment a refund will be forwarded immediately.
3. I realize I am responsible for all fees charged by this clinic. If an account is not paid within 90 days of the date of service and no financial arrangements have been made, I will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting the account.

Patient Signature

Date

I authorize SIMPLE Spinal Health and Medical Center to administer care as they deem necessary to my son, daughter or ward (upon approval of parent or guardian).

Parent Signature

Date



This notice describes how SIMPLE Spinal Health and Medical Center may use or disclose your protected health information (PHI). PHI is individual identifiable health information, including actual medical information, your name, address, phone number, identification number, insurance information or other identifiers. Please review this notice carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandates that patients be provided with advance written notice of the practice's policies regarding the use/and or disclosure of protected health information. This notice takes effect **April 14, 2003.**

A patient's information may be used and/or disclosed for the following reasons:

Treatment-We may use PHI to provide you with medical treatment or services. This includes communications between other healthcare professionals, and other healthcare facilities, and other providers for administering treatment.

Payment-We may use and/or disclose your PHI so the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party. This includes typical payment activities, such as verification of coverage, pre-certifications, referrals, and claims processing.

Administrative or Healthcare Operation Activities-We may use and/or disclose medical information about you for certain administrative, healthcare and management activities, such as compliance monitoring, quality improvement, and business planning. These uses and/or disclosures are necessary to run the practice and to ensure that our patients receive quality care and services.

For Communicable Diseases/Public Health Safety-We may disclose your PHI, if authorized by law, if the public may have been exposed to a communicable disease.

For Legal Proceedings-We may disclose PHI in response to a court order.

The patient reserves the right to request restrictions on the policies listed in this notice, and receive a copy of all information used and/or disclosed. Requests for the patient's own PHI will be provided only with a photo proof of identification from the patient. **You have the right to designate a personal representative to authorize the disclosure of protected health information.**

SIMPLE Spinal Health and Medical Center reserves the right to contact patients regarding appointments. Also, please be advised we have open adjusting areas. If you wish any discussion to be confidential please request a private room. If you believe your privacy rights have been violated with respect to our protection of your PHI please contact us in writing.

I hereby verify that I have read and understand this notice of privacy practices.

Name _____

Date _____

Welcome to our Integrated Health Center



SIMPLE
SPINAL HEALTH & MEDICAL CENTER

We offer Chiropractic Care, Family Practice MD, Physical Therapy, and more...

Family Practice Services

Routine Family Health Care

Pain Management

Trigger Point injections

Physicals

Testing Services

Digital x-rays

Foot scans

Pulse wave

Thermography

Algometry

Blood work

SEMG

Range of Motion

Nerve Conduction

Chiropractic Adjustments

Gonstead technique

Pettibon technique

Palmer techniques

Acute pain care

Wellness care

Durable Medical Equipment

Custom-made Orthotics

Cervical pillows

Cervical traction units

Body balls

Foam wedges

Wobble chairs

Headweighting harness

Physical Therapy

Spinal Decompression

Cervical traction

Postural weighting exercises

Clinical massage

Trigger point therapy

Home therapy programs

Spinal Rehab

Therapeutic massage

Swedish massage

Deep tissue

Myo-facial release

Sports massage

Pre-natal massage

Exams

Orthopedic

Chiropractic

Independent Medical

Neurological

Signature: _____ Date: _____

Next Appointment Date: _____ Time: _____