Fredrick Chiropractic Plus

3930 Washington St

Gurnee IL, 60031 Suite B

(847)662-1600

Fax: 847-662-1612

Consent to Contact

I, _____, hereby give my Chiropractor, Mark Fredrick D.C, permission to contact my medical facility _____ regarding my health. My primary care provider is _____ and I approve the contact and conversation about my health.

_____ _____ _____

Print Sign Date

Our office prides itself in confidentiality and following HIPPA compliance rules. By signing this release, you are giving authority for our office to share your health information with your primary care facility.

_____

Initials

Diplomate, American Board of Chiropractic Orthopedists

Diplomate, American Board of Chiropractic Internists

Mark Fredrick, D.C, D.A.B.C.O, D.A.B.C

Patient Information

Name_____ Date of Birth_____ Male__ Female__ Preferred Language_____

Date_____ Phone #_____ Cell phone carrier:_____ Email_____

Ethnicity:_____ Drivers License Number_____

Address:_____ City:_____ Zip Code:_____

Employer:_____ Job title:_____ How long?_____

Primary Doctor_____ Dr. Phone number_____

How did you hear about us? _____ Referred by_____

Emergency Contact: Name_____ Phone#_____ Relation_____

Person Responsible For Account (If different from patient) _____ Phone#_____

Spouse Information : Single____ Married____ Divorced____ Separated____ Widow____

Name_____ Cell Phone_____ Date of Birth_____

Employer_____ Work Phone_____

Auto Accidents: Attorney_____ Phone #_____

Address_____ City_____ Zip Code_____

Patients Insurance Company_____ Adjuster/Agent_____ Phone#_____

Address_____ City_____ Zip Code_____

Policy#_____ Claim #_____

Other Person's Insurance_____ Adjuster/Agent_____ Phone#_____

Policy #_____ Claim #_____

I hereby authorize Fredrick Chiropractic Plus to release to insurance companies, government agencies, and other third party payers, information concerning medical care, advice treatment supplies, itemized bills, or other information that may be necessary for the purpose of determining eligibility and available benefits and obtaining payment on my behalf for the health care services provided to me or to the patient covered by this authorization.

I understand that the care and services at Fredrick Chiropractic Plus is subject to review, both during and after treatments covered by this authorization, health care professionals, third party payers and review agencies.

I understand that I will be financially responsible for all the charges incurred for the services provided if revocation or refusal to authorize the disclosure of my medical records results in a denial of payment for the charges incurred.

I hereby authorize payment directly to Fredrick Chiropractic Plus of the insurance benefits herein specified and otherwise payable to me for this period of treatment. I understand that I am financially responsible to pay for my care and that if my insurance plan does not pay the full amount due, I will be responsible for the balance. This may include costs of collection and/or reasonable attorney's fees.

Signature of person Responsible_____Date_____

Patient Health History

Patient Name_____ **Date**_____

What kind of regular exercise do you perform? 1.None 2. Light 3. Moderate 4. Strenuous

Patient Height _____**Ft**_____**In** **Patient Weight**_____**LB**

Past	Present		Past	Present	
O	O	Headaches	O	O	High Blood Pressure
O	O	Neck Pain	O	O	Heart Attack
O	O	Upper Back Pain	O	O	Chest Pain
O	O	Mid Back Pain	O	O	Arthritis
O	O	Low back Pain	O	O	Rheumatoid Arthritis
O	O	Shoulder Pain	O	O	General Fatigue
O	O	Elbow/Upper arm pain	O	O	Muscular Incoordination
O	O	Wrist Pain	O	O	Visual Disturbances
O	O	Hand Pain	O	O	Dizziness
O	O	Hip/Upper Leg pain	O	O	Stroke
O	O	Knee/Lower leg pain	O	O	Angina
O	O	Ankle/Foot Pain	O	O	Kidney Stones
O	O	Jaw pain	O	O	Bladder Infection
O	O	Joint Swelling/Stifness	O	O	Painful or frequent Urination
O	O	Sleeping Problems	O	O	Loss of bladder control
O	O	Prostate Problems	O	O	Abnormal Weight loss/Gain
O	O	Loss Of Appetite	O	O	Ulcers
O	O	Hepatitis	O	O	Asthma
O	O	Chronic Sinusitis	O	O	Diabetes
O	O	Tumor	O	O	Cancer
O	O	Systematic Lupus	O	O	Epilepsy
O	O	HIV AIDS	O	O	Depression
O	O	Dermatitis/Eczema			

Allergies: What & Severity (Mild, Moderate, Severe) _____

_____

Tobacco use: Never____ **Occasionally**___ **Moderate**___ **Heavy**___

Alcohol use: Never____ **Occasionally**___ **Moderate**___ **Heavy**___

List all prescriptions, over the counter medication, and any nutritional supplements you are taking:

_____

_____

List any surgical procedures you have had as well as any hospitalizations:

_____

_____

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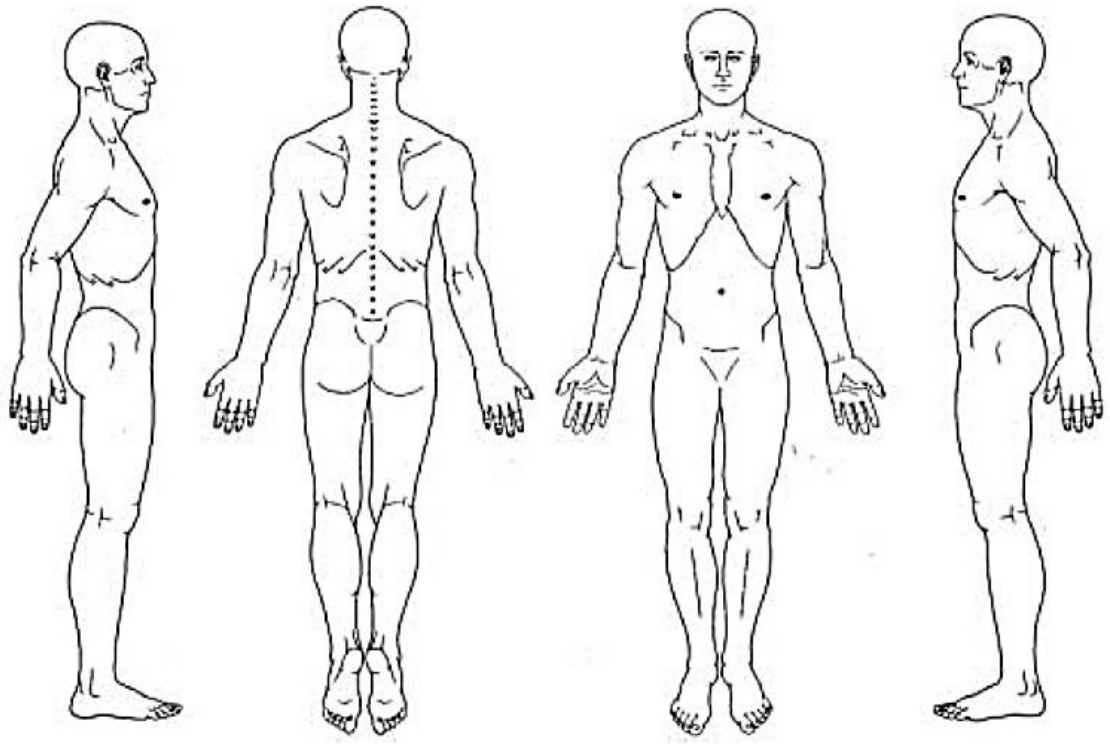
Name_____ Date_____

Using the follow symbols, mark the location and type of pain you are experiencing on the body outlines below. Then rate your pain from 1-10. 10 being the worst.

Ache	Burning	Numbness	Pins & Needles	Stabbing	Other
VVVVVV	**- - - - - - -**	**000000000**	**. . . . . .**	**/////////**	**xxxxxxx**



1	2	3	4	5	6	7	8	9	10

No Pain **Worst Possible Pain**

Sign_____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare. operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Sign Date