Confidential Patient Information

Is your visit due to an accident? Yes No **Accident Date:**..

Type of Accident: Work Auto/Traffic Other **Was accident reported?** Yes No

Today's Date: ..../......../..........

Patient Title: Mr. Mrs. Ms. Miss Dr. Prof. Rev

First Name: .... **Middle Name:** ....

Last Name:... **Preferred Name:**...

Address: ....

City:.. **State:**.................................. **Zip Code:**..

Home Phone:... **Work Phone:**..

Cell Phone:... **Email:**..

Date of Birth: ..../........../........... **Age:** .... **Social Security #:**..

Gender: Male Female Unspecified

Marital Status: Single Married Other

How did you hear about us?: Google Yelp Friend/Colleague ZocDoc Facebook Newspaper Mailer

Emergency Contact - Name:.. **Phone:**...

Employment Status: Employed FT Student PT Student Other Retired Self Employed

Employer/Company Name:..

Address:.. **City:**...

State:.. **Zip Code:**..................... **Occupation:**..

Insurance Data: Major Medical Ins. Work Comp Personal injury Other

Name of Insurance:...

ID#:... **Policy#:**... **Group:**..

Policy Holders Name:.. **Date of Birth:**..

For accident related: Claim#:.. **Phone #**:..

Adjustor Name:...

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issue remittances for the conveyance of credit to my account. However, 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. I assign to you, the medical provider, and grant the right of lien against any and all claims against any third party, whose negligence may have caused my injury, Including their insurance, up to the amount of the bill for treatment.

Patient's Signature:... **Date:**..

Legal Guardian Signature:.. **Date:**...

Have you been treated by any other physician for this condition? Yes No

Physician Name:...

Do you currently smoke tobacco of any kind? Yes Former smoker Never been a smoker

If yes, how often do you smoke: Current, every day smoker Current, sometimes smoker

Social History:

Caffeine Used:	Daily	Occasionally	Never
Drink Alcohol Used:	Daily	Occasionally	Never
Exercise:	Daily	Occasionally	Never

Other:..

Medical Conditions:

Arthritis	Hypertension	Diabetes	Heart Disease
Cancer	Psychiatric Illness	Skin Disorder	Stroke

Briefly list any other health problems:...

....

Surgical History

Appendectomy Hysterectomy Joint Replacement Disc Procedure

Cardiovascular Procedure Prostate Surgery Other:...

Current medications, including dosage if known. If there are no current medications, circle here: None

1) ....
3) ....

2) ....
4) ....

List any known allergies you have had to any medications. If no allergies are known, circle here: None

1) ....
3) ....

2) ....
4) ....

Briefly describe the reason you are here today:...

....

Describe your symptoms and how they started:...

....

How often do you experience your symptoms?:

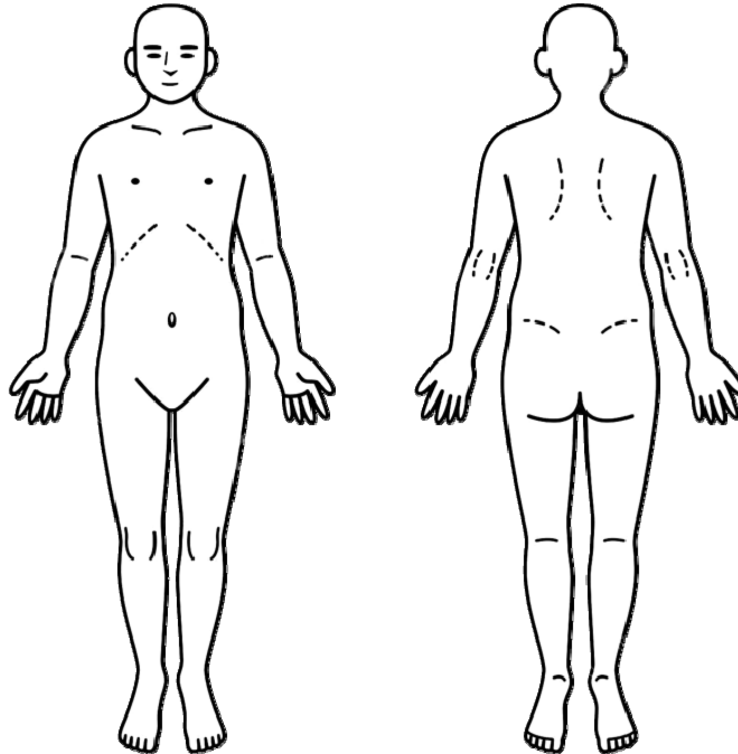
Constantly Frequently Occasionally Intermittently

Describe the nature of your symptoms:

Sharp Dull Ache Numb Shooting Burning Tingling

Stabbing Other ....

Indicate on the body diagram where you are experiencing your symptoms:



During the past 4 weeks, indicated the average intensity of your symptoms

(0 = none to 10 = unbearable)

0 1 2 3 4 5 6 7 8 9 10

During the past 4 weeks, how much has the pain interfered with your work and social activities?

Not at all A little bit Quite a bit Extremely

In general, would you say your overall heath right now is:

Excellent Very good Good Fair Poor

Have you had an X-ray or CT scan or MRI of your spine in the past 28 days? Yes No

Are your currently taking vitamin and/or mineral supplements? Yes No

If yes, list what you take?..

AMERICAN
BACK CENTER

Functional Rating Index

Patient Name:.. **Date:**..

In order to properly assess your condition and accurately grade your response to treatment, we must understand how much your neck and/or back problem(s) have affected your ability to manage everyday activities (ADLs).

For each section below, please circle the one number which most closely describes your condition right now.

Pain intensity: **0.** No Pain **1.** Mild Pain **2.** Moderate Pain **3.** Severe Pain **4.** Worst Possible Pain	**Pain Frequency:** **0.** No Pain **1.** Occasional Pain; 25% of the Day **2.** Intermittent Pain; 50% of the Day **3.** Frequent Pain; 75% of the Day **4.** Constant Pain; 100% of the Day
Sleeping: **0.** Perfect Sleep **1.** Mildly Disturbed Sleep **2.** Moderately Disturbed Sleep **3.** Greatly Disturbed Sleep **4.** Totally Disturbed Sleep	**Recreation:** **0.** Can do all activities **1.** Can do most activities **2.** Can do some activities **3.** Can do few activities **4.** Cannot do any activities
Personal Care (washing, dressing etc.): **0.** No pain; no restrictions **1.** Mild Pain; no restrictions **2.** Moderate Pain; need to go slowly **3.** Moderate Pain; need some assistance **4.** Serve Pain; need 100% assistance	**Lifting:** **0.** No pain with heavy weight **1.** Increased pain with heavy weight **2.** Increased pain with moderate weight **3.** Increased pain with light weight **4.** Increased pain with any weight
Travel (driving, etc.): **0.** No pain on long trips **1.** Mild pain on long trips **2.** Moderate pain on long trips **3.** Moderate pain on short trips **4.** Severe pain on short trips	**Walking:** **0.** No pain; any distance **1.** Increased pain after 1 mile **2.** Increased pain after ½ mile **3.** Increased pain after 1/4 mile **4.** Increased pain with all walking
Work: **0.** Can do usual plus unlimited extra work **1.** Can do work; no extra work **2.** Can do 50% of usual work **3.** Can do 25% of usual work **4.** Cannot work	**Standing:** **0.** No pain after several hours **1.** Increased pain after several hours **2.** Increased pain after 1 hour **3.** Increased pain after ½ hour **4.** Increased pain with any standing

Patient Signature :.. **Date :**..

Raw Score :................................... **Percent Impairment :**................................ **Doctor's Initials :**..........................

PATIENT AGREEMENT & AUTHORIZATIONS

CONSENT FOR TREATMENT (please initial each) ....
I hereby consent to the treatment provided by American Back Center (''Practice'') and its employees or designees. I authorize the physical health care services deemed necessary or advisable by my caregivers to address my needs.

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION..........................
I authorize use and disclosure of my personal health information for the purposes of diagnosing and/or providing treatment to me, obtaining payment for my care and/or for the purpose of conducting the health care operation of the practice. I authorize the practice to release any personal health information required in the process of applications for financial coverage for the services rendered. This authorization provides that the practice may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent.

ASSIGNMENT OF INSURANCE BENEFITS/ PAYMENT GUARANTEE.....................
I authorize payment to be made directly to the practice for insurance benefits payable to me. I understand that I am financially responsible to the practice for any covered or non-covered services, as defined by my insurer. I understand that if my account balance becomes overdue and the overdue account is referred to collections I am responsible, including any reasonable attorney's fees.

24 HOUR APPOINTMENT CANCELLATION POLICY...................
The American Back Center has a 24-hour cancellation policy. This policy is in place out of respect for our therapists and our patients. Cancellations with less than 24 hours' notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot. By signing below, you acknowledge that you have read and understand the Cancellation Policy for the American Back Center as described. If you miss your appointment, or cancel your appointment with less than 24 hours' notice, you will be charged $25. One-hour massages missed without 24 hours' notice, incur a $35 charge.

PRIVACY......................
I acknowledge having received the practice's ''Notice of Privacy Policies''. My rights, which include the right to see and copy my record, to limit disclosure of my private health information, and to request an amendment to my record, are explained in the policy. I understand that I may revoke in writing my consent for release of my health care information, except to the extent the practice has already made disclosures with my prior consent.

CONSENT FOR TREATMENT OF A MINOR CHILD.............
I hereby authorize American Back Center to administer treatment as they so deem necessary to my son/daughter...of minor age.

Print Name:...

Patient Signature or Authorized Consent:..

Date:..

Patient unable to sign. Verbal consent given. Reason:..

HIPPA Notice of Privacy Practices

American Back Center
122 South Michigan Avenue, Suite 1265
Chicago, IL 60603

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT MAYBE USED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. ''Protected health information'' is information about you, including your demographic information, that may identify you and relates to you past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your Protected Health Information may be used and disclosed by your physician, our office staff and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's, and any other use required by law.

Treatment:

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose you.

Payment:

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical students that see patients at out office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health Issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug administration requirements: Legal proceedings: Law Enforcement: coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Security of the department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization**,** at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, civil, criminal, or administrative action or proceeding, and protected health information that is subject to law the prohibits access to protected health information.

You have the right to request a restriction of your protected health information.

This means you may ask us not use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of you protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, you protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request and receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively (i.e. electronically).

You may have the right to have your physician amend your protected health information.

If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number: (312) 939-4121

Your signature below is your acknowledgement that you have received our Notice of our Privacy Practices:

Print Name:..

Sign Name:...

Date:...