FOX CHIROPRACTIC CENTER
(630) 232-6321

Patient Name: _____ Birthdate: _____ Sex: M/F Today's Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Home #: _____ Email Address: _____ Cell #: _____
Would you like appointment reminders sent via: Email Text Cell Carrier (for text reminders): _____
Employer/ Occupation: _____ Full Time Part Time Retired
Work #: _____
Social Security #: _____ Referred By: Patient Insurance Relative Other, _____
Person to contact in case of emergency: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____
Regular Medical Doctor: _____

Billing Method: (Circle One)

Major Medical Insurance *Personal Injury* *Workers Compensation* *Cash*
Primary insurance goes through: Employer Spouse Self

Family History:	Back	Heart	Stroke	Cancer	Diabetes	High BP	Arthritis	Thyroid	Osteoporosis	High Cholesterol	Good Health	Unknown	Other
Mother:													
Father:													
No. of Sisters													
No. of Brothers													
No. of Children													

Social History:	Daily	3X/Week	2X/Week	1X/Week	2X/Month	1X/Month	Never
Standing:							
Sit at a Desk:							
Work on a Computer:							
Work on a Phone:							
Moderate/Heavy Labor:							
Stay at Home:							
Deliver Packages:							
Tobacco/Smoke:							
Alcoholic Beverages:							
Caffeine:							
Exercise:							

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Surgical History: _____ Date Performed: _____
_____ Date Performed: _____
_____ Date Performed: _____

Smoking Status: (Please Circle) *Daily* *Occasionally* *Never* *Former* *Exposed to Second Hand*

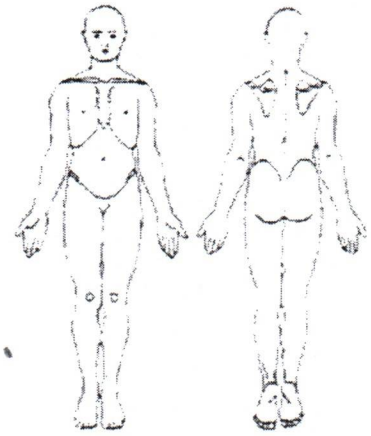
Height: _____ Weight: _____BP: _____HR: _____
Allergies: _____
Medications & Supplements: _____
_____

Health History: Please check all that apply to you:

__ADHD
__Alcohol/Drug Addiction
__Anemia
__Aortic aneurysm
__Arrhythmia
__Arthritis
__Asthma
__Back Pain/Joint Pain
__Bleeding Disorder
__Blood Clots
__Blood Transfusion
__Blurred Vision
__Bowel Problems
__Broken Bones
__Cancer
__Carpal Tunnel
__Cataracts
__Chickenpox
__Colitis
__Collagen Vascular Disease
__Constipation
__Depression/Anxiety
__Diabetes
__Digestive Disorders
__Dizziness/Fainting
__Eating Disorder
__Emphysema
__Epilepsy/Seizures
__Fatigue
__Female Health Challenges
__Fibromyalgia
__Gallbladder Disease
__Glaucoma
__Gluten Intolerance
__Gout
__Headaches/Migraines
__Hearing Loss
__Heart disease/ Attacks
__Heart Murmur
__Hemorrhoids
__Hepatitis
__High blood pressure
__High Cholesterol
__HIV/AIDS
__ Kidney Infections/ Stones
__Liver Disease/ Problems
__Lung Disease
__Menstrual Cramps
__Mental Disorder
__Neck pain
__Nervousness
__Night Sweats
__Osteoporosis
__Pneumonia
__Polio
__Paralysis
__Prostate problems
__Rheumatic Fever
__Scoliosis
__Sexual Dysfunction
__Sickle Cell
__Sinus Trouble
__Stress/Tension
__Stroke
__Suicidal Tendencies
__Thyroid Disease/ Problems
__Tuberculosis
__Tumor/growth
__Ulcer/Reflux
__ Urine Discoloration
__ Vertigo

Are you currently pregnant? (Please Circle): *Yes* or *No*

Please Mark with an "X" on the picture below where your pain/discomfort is currently



Type of Pain:

___Aching ___Burning ___Sharp ___Dull ___Radiating
___Stiff ___Stabbing ___Sore ___Tight ___Sharp
___Numbness ___Cramping ___Throbbing ___ Pounding
___Constricting ___Shooting ___Tingling

Is your pain/discomfort primarily on one side?

___ Right
___ Left
___ Bilateral

On a scale of 1-10, 10 being most intense, what would you rate your pain?

___ /10

Is your discomfort/ pain?

Mild Moderate Severe

DESCRIBE YOUR CURRENT PROBLEM:

_____

_____

DATE PROBLEM BEGAN: _____

HOW PROBLEM BEGAN: (please explain)

Gradually Sudden Overtime Other

_____

_____

Have you seen anyone else for this condition? If yes, describe:

_____

_____

Have you had spinal X-Rays, MRI, CT scan? _____ Approximate date: _____

How often are your symptoms present?

_____0-25% _____26-50% _____51-75% _____76-100%

Can you perform your daily activities? If No, describe:

_____

_____

Treatment Policy/Annual HIPAA Notification

Chiropractic treatment almost always includes the chiropractic adjustment which is a specific type of joint manipulation. Like most healthcare procedures, the chiropractic adjustment can carry some risk. These risk factors are rare but can be as follows:

Temporary or increased soreness. It is not uncommon for patients to experience temporary soreness or increased pain/discomfort following the first a few treatments.

* **Dizziness, nausea, flushing.** These symptoms are relatively rare. It is important to notify us if you experience any adverse reactions.
* **Disc herniation or prolapse.** Spinal disc conditions like bulges or herniations may worsen even with chiropractic care.
* **Fractures**. Fractures can occur in patients with underlying conditions such as osteoporosis which may weaken bones. It is important to notify your Chiropractor regarding a diagnosis of a bone weakening disease/condition.
* **Stroke**. A very rare type of stroke has been associated with chiropractic care. The increased occurrence of this type of stroke is likely explained by patients with neck pain and associated headache which should be brought to your Chiropractor and Primary Care Physicians attention.
* **Bruising**. Soft tissue manipulation may result in temporary bruising.

Please review the above information prior to signing this document. I hereby give my consent to receive chiropractic treatment, diagnostic testing, and procedures to be directed/administered by Dr. David Di Iorio, DC, and office staff at Fox Chiropractic Center. I acknowledge that no guarantee has been made as to the effect or outcome of such treatment. I have read or had read to me the above Informed Consent Document. I have discussed or have been given the opportunity to discuss any concerns with my chiropractor and to my satisfaction have had my concerns answered. I have made my decision voluntarily.

Patient's/Guardian's Signature_____ Date_____

Notice of Privacy Practices Acknowledgement and Hippa

The HIPAA Privacy Rule (45 CFR 164.506) establishes Federal Privacy Protection of personal health information. This rule generally prohibits disclosure of your protected health information unless authorized by patients, except where this prohibition would interfere with quality health care. Fox Chiropractic is committed to patient privacy and the confidentiality of your personal health information. You have the right to restrict how your protected health information is used and (in writing) can revoke potential usage of this information. However, such a revocation does not apply to the use of your protected health information being released for the purpose of treatment, payment, or healthcare operations. We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with the respect to Person Healthcare Information Our intention to abide by the terms of the Notice of Privacy Practices and HIPPA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provisions effective for all Personal Healthcare Information.You have recourse if you feel that your protection has been violated by our office. I understand as part of Fox Chiropractic Center treatment, payment or healthcare operations, it may become necessary to disclose my protected health care information to another entity, and I consent to such disclosure for these permitted uses. I consent to treatment by Fox Chiropractic Center staff and Doctor. We may contact you, by phone, email or text, to provide appointment reminders or information about treatment alternatives or other health -related benefits and services. I have read, understand, and agree to all the above policies, terms conditions and authorizations described above and understand its purpose and content.

_____ _____

Patient's/Guardian's Signature Date

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Annual Financial Policy

Thank you for choosing Fox Chiropractic Center for your chiropractic Care. We are committed to providing you excellent care.

Group Health/Liability Insurance

* **It is the patient's responsibility to provide us with current/accurate policy** information when using a health insurance carrier. As a courtesy we will bill your insurance within 10 days of treatment.
* Patient copays or any out of pocket expenses, including account balances (if any) should be paid at the time of your visit.
* Our office will, nor cannot, guarantee your insurance will pay for your services. If your insurance claim is denied you will be responsible for your bill in full. It should be noted your benefits are a contract between you and your insurance company and this office only serves as an intermediary. We will at no time enter into a dispute with your insurance carrier over your claim. This is your responsibility and obligation.
* Workers compensation, personal injury, and/or managed care may take additional time to process and the charges may accrue over time. In some instances there may be limitations on your policy and if you elect to continue treatment, under these provisions you will be solely responsible for the balance.
* **Most Insurance do not cover acupuncture, massage and some services such as those. It is Your responsibility to know what is covered.**
If you have an **HMO** insurance it is your responsibility to verify with insurance and get **Referral** if needed before appointment or you will be responsible for payment.

I hereby authorize any payment of benefits made directly to Fox Chiropractic Center. Additionally, I authorize the release of any medical information necessary to process the claims.

Print Name: _____

Patient/Guardian Signature: _____

CASH PATIENT: SELF PAY:

* Payment for Cash claims must be made at the time of service. Once entered into a cash agreement Fox Chiropractic will not, under any circumstance bill any previous cash charges to another party or insurance company. Please review and understand our cash policy pricing with the front desk.

I hereby authorize Fox Chiropractic to bill me directly for any services received at their facility. I understand I am responsible for payment of those services at the time of my appointment.

Print Name: _____Date_____

Patient/Guardian Signature: _____

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INTAKE FORM ADDENDUM - COVID-19

NAME: _____ DATE: _____

Have you been tested for Covid-19 recently? If yes, what type of test did you have? TYPE: _____

When was your test?

_____

Have you been in places with a high infection rate within the last two (2) weeks (e.g. state designated "hotspots")? If yes, please explain:

_____

_____

Please check if you are experiencing any of the following as a NEW PATTERN within the past 14 days:

___ Fever	___ Nasal, sinus congestion	___ Fatigue	___ Sore throat
___ Chills	___ Loss of sense of smell or taste	___ Sudden onset muscle soreness (not related to a specific activity)	___ Have been around anyone with confirmed COVID within the past 14 days
___ Shortness of breath	___ Diarrhea, digestive upset	___ Cough	

Do you have any discomfort with exertion or exercise? Yes or no (if yes, please provide details)

_____

_____

ASSUMPTION OF RISKS

I understand that while Service Provider has undertaken reasonable steps to lessen the risk of transmission of COVID-19 in connection with the Services, Service Provider is not responsible in any manner for any risks related to COVID-19 in connection with the Services. BY signing this form, I acknowledge that I am aware of the risks involved and give consent to receive treatment from this practitioner. I understand that despite adhering to all precautions, there is still a possibility that I will be exposed to or contract COVID-19. Persons with underlying health conditions may be particularly susceptible to illness and death from COVID-19. Such conditions include but are not limited to heart disease, chronic lung disease, suppressed immunity system, severe obesity, diabetes, chronic kidney disease and liver disease. I have been advised and choose to visit, understanding my own health condition(s). I have read the above and understand it is not inclusive of all risks and safety measures related to COVID-19. By signing this agreement, I waive any and all liability to me.

I declare that the information provided above is true and accurate to the best of my knowledge.

_____

Print name Signature Date