REVERMANN
chiropractic
& spinal rehabilitation

Welcome and thank you for coming in today. In order to serve you properly, we need the following information. All information is strictly confindential. If you need assistance, our front desk personnel will be happy to help.

GENERAL

Patient's name _____ Preferred Name to be called

if minor, name of responsible party _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ **Sex**: Male/Female **Marital Status**: Married/Single/Divorced/Widowed

SSN: _____ Mobile Phone # _____

Home Phone # _____ Mobile Carrier _____

Work Phone # _____ ext: E-mail Address _____

Would you like to receive text or email appointment reminders? (choose only one) Text Email

EMPLOYMENT

Employment Status : Employed / Full-time Student / Part-time Student / Retired / Other

Occupation: _____

Employer: _____

Employer's Address _____

City _____ State _____ Zip _____

PRIMARY PHYSICIAN

Primary Care Physician _____ Phone # _____

Address: _____

City _____ State _____ Zip _____

Would you like us to contact your Primary Care Physician regarding your care?

- ☐ Yes, I would prefer that you do , you have my permission
- ☐ Yes, if you feel the need to
- ☐ No, please discuss with me if you feel my Primary Doctor needs to know something regarding my treatment

REFERRAL

Who can we thank for referring you to us today? (name) _____

Self / Friend / Insurance / Primary Physician / Other Physician

In case of emergency who would you like us to contact?

Name: _____

Phone # : _____

Patient Name _____ Date: _____

INSURANCE	Insurance Company: _____ Address _____ City _____ State _____ Zip _____ Policy # _____ Group # _____ Insured's Name _____ Your relationship to insured _____ Insured's Date of Birth _____ Insured's Social Security # _____ Employer of Insured _____ Address _____ City _____ State _____ Zip _____
	Do you have additional insurance? YES / NO **If you do, please complete the following:**
SECONDARY INSURANCE	Insurance Company: _____ Address _____ City _____ State _____ Zip _____ Policy # _____ Group # _____ Insured's Name _____ Your relationship to insured _____ Insured's Date of Birth _____ Insured's Social Security # _____ Employer of Insured _____ Address _____ City _____ State _____ Zip _____
	Do you have one of the following: HSA Account / Flex-comp / Cafeteria Plan

I the undersigned hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my condition(s). Further, I authorized assignment of my insurance rights and benefits directly to this provider and also authorize the release of such information as is needed to process insurance claims. I understand that I am responsible for all charges which may include legal fees, collection fees or other expenses incurred by the provider in collecting my account. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.

Signature _____ Date: _____
Patient, or Parent/Guardian if Minor

OFFICE USE ONLY

All paperwork completed and signed by patient	____	staff initials
Demographics entered	____	staff initials
Insurance information entered	____	staff initials
Insurance verified	____	staff initials
Insurance benefits discussed with patient	____	staff initials

Patient Name _____ Date: _____

Please give us a brief description of what brings you in to see us today? _____

_____

_____

_____

If you were injured was it? ☐ at work ☐ at home ☐ due to auto accident

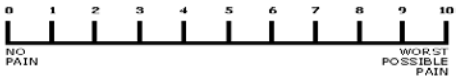
☐ other injury ☐ not related to an injury

Primary Complaint

please mark on the figures on the right the area of pain or discomfort

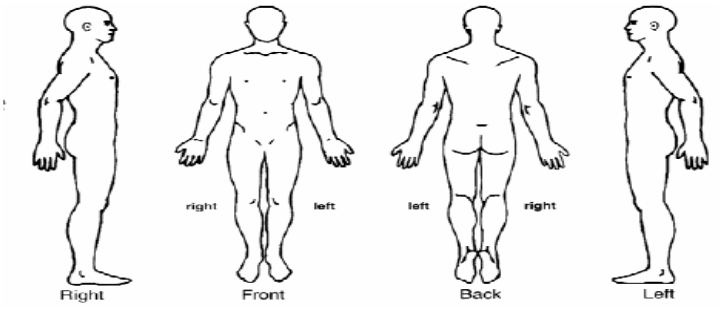
*** please fill out one (1) sheet for each area of complaint.**

My pain in this area is a _____ on a scale of 1 thru 10.



My pain is: (please circle all that apply)

Constant	Numbness
Intermittent	Stiff
Frequently	Sore
Ocassionally	Sharp
Worse in Morning	Stabbing
Worse at Night	Dull
Worse after Exertion	Achy
Only when Sitting	Throbbing
Only when Standing	Burning
With sitting & standing	Tingling



Please describe the pain in your own words

_____

_____

Other _____

Please check boxes that best describes the following :

Problem came on: ☐ Suddenly ☐ Built up over several days ☐ Gradually worse over time

How has this condition changed with time? ☐ Worse ☐ Better ☐ No change

Who else have you seen for this problem? _____ When? _____

When did this problem(s) start? _____

How do you think this problem began? (i.e. slip/ fall / sleeping wrong) _____

Do you consider this problem to be severe? ☐ Yes ☐ Yes, at times ☐ No

What have you done that aggravates your pain? _____

_____

What have you done that alleviates your pain? _____

_____

What concerns you the most about this problem? _____

_____

Have you had any X-rays, CT, MRI, NCV, EMG or other Diagnostic testing for this problem? YES / NO

If yes, where and when? _____

Treatment Expectations Please tell us what you are expecting from your treatment

☐ Quick Fix ☐ I know this will take time but once pain is gone treatment will end

☐ I am looking for REHAB - I have had similar problems in the past and would like to prevent further injuries

Patient Name _____ Date: _____

Family Medical History -

Has an blood relative had any of the following? By any blood relative, we mean Father, Mother, Grandmother (maternal and paternal), Grandfather (maternal and Paternal), Siblings, and Children (living or deceased).

			Relationship				Relationship
Arthritis	No	Yes		High Blood Pressure	No	Yes	
Cancer	No	Yes		Kidney Disease	No	Yes	
Diabetes	No	Yes		Lupus	No	Yes	
Heart Disease	No	Yes		Thyroid Disease	No	Yes	
				Other	No	Yes	

Personal History

For each of the conditions listed below, place a check in the "PRESENT" column if you presently have the condition. If you have experience the condition in the past, please check the "PAST" column. If you have never experience this condition, please check the "NEVER" column

PRESENT	PAST	NEVER		PRESENT	PAST	NEVER		PRESENT	PAST	NEVER	
☐	☐	☐	Headaches	☐	☐	☐	Chronic Sinusitis	☐	☐	☐	Visual disturbances
☐	☐	☐	Neck Pain	☐	☐	☐	High Blood Pressure	☐	☐	☐	Dizziness
☐	☐	☐	Upper Back Pain	☐	☐	☐	Heart Attack	☐	☐	☐	Diabetes
☐	☐	☐	Mid Back Pain	☐	☐	☐	Chest Pain	☐	☐	☐	Excessive Thirst
☐	☐	☐	Low Back Pain	☐	☐	☐	Stroke	☐	☐	☐	Frequent Urination
☐	☐	☐	Shoulder Pain	☐	☐	☐	Angina	☐	☐	☐	Smoking/Tobacco Use
☐	☐	☐	Elbow/Upper Arm pain	☐	☐	☐	Kidney Stones	☐	☐	☐	Drug/Alcohol Use
☐	☐	☐	Wrist Pain	☐	☐	☐	Kidney Disorders	☐	☐	☐	Allergies
☐	☐	☐	Hand Pain	☐	☐	☐	Bladder Infection	☐	☐	☐	Depression
☐	☐	☐	Hip Pain	☐	☐	☐	Painful urination	☐	☐	☐	SLE - Lupus
☐	☐	☐	Upper Leg Pain	☐	☐	☐	Loss of Bladder Control	☐	☐	☐	Epilepsy
☐	☐	☐	Knee Pain	☐	☐	☐	Unusual Weight Gain/Loss	☐	☐	☐	Dermatits/Eczema/Rash
☐	☐	☐	Ankle/Foot Pain	☐	☐	☐	Loss of Appetite	☐	☐	☐	HIV/AIDS
☐	☐	☐	Jaw Pain	☐	☐	☐	Abdominal pain	☐	☐	☐	Birth Control Pills
☐	☐	☐	Joint Pain / Stiffness	☐	☐	☐	Ulcer	☐	☐	☐	Hormonal replacement
☐	☐	☐	Arthritis	☐	☐	☐	Hepatitus	☐	☐	☐	Pregnancy
☐	☐	☐	Rheumatoid Arthritis	☐	☐	☐	Liver/Gall Bladder Disorder	☐	☐	☐	Prostate Problems
☐	☐	☐	Cancer	☐	☐	☐	General Fatigue	☐	☐	☐	Emphysema
☐	☐	☐	Tumor	☐	☐	☐	Muscular incoordination	☐	☐	☐	Seizures
☐	☐	☐	Asthma	☐	☐	☐	Migraines	☐	☐	☐	Thyroid/ Other Glands

Patient Name:_____Date: _____

Are you currently taking any medications? YES / NO

If so, please list them? _____

_____

_____

Are you currently taking any supplements? YES / NO

If so, please list them? _____

_____

_____

Have you had any surgical procedures? YES / NO

If so, please list them and when they were performed? _____

_____

_____

Can you please describe what your day consist of at work? (standing, sitting, computer work, manual labor, etc)

_____

_____

Can you please describe what activities you do outside of work?

_____

_____

Please list any Hospitalization that you have had (when, where, and what for)

_____

_____

_____

Have you ever been seen by a Chiropractor before? YES / NO

If so, were you happy with the results? And please list any problems that you had with treatment.

_____

_____

Please list any past traumas you may have had? (Motor Vehicle Accident, tramatic falls, etc)

_____

_____

Women Only:	
Can you become pregnant: Yes / No	If not why? _____
Date of Last Period : _____	Was it normal? _____
Date of Last Mammogram : _____	Was it normal? _____
Date of Last Pap Smear : _____	Was it normal? _____
ARE YOU NOW OR COULD YOU BE PREGNANT?	**YES / NO**

Patient Name_____ Date: _____

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Authorization to Share Medical Information

Name of Patient _____ Date of Birth _____/_____/_____

Revermann Chiropractic is authorized to release protected health information about the above named patient to the entities named below.

Entity To Receive Information. *Check each person / entity that you approve to receive information*	**Description of information to be released** *Check each that can be given to person(s) / entity checked in the left column*
☐ Spouse (provide name)	☐ Any of my medical information
☐ Parent(s) (provide name)	☐ My appointment times, dates and reason for the visits
☐ Coach / Trainer (provide names)	☐ Financial
☐ Other	☐ Test results

_____ Date _____/_____/_____

Signature of Patient

HIPAA (Health Insurance Portability and Accountability Act of 1996) states if you are 18 years or older, you have the right to strict confidentiality regarding your healthcare. In order to release any information including the date or nature of your visit, Revermann Chiropractic must have your signed consent and specific directions about what information you are consenting to be released. Without written consent, Revermann Chiropractic cannot release or discuss any information relating to your visit with anyone including your parents, guardians, spouse, children, faculty, staff, coach and other medical professionals. In addition, you have the right to revoke this authorization at any time. Revocation will be effective when Revermann Chiropractic receives written notice that this authorization has terminated. A copy of this document will be kept in your health record. The information disclosed under this authorization risks re-disclosure by a recipient and, as a result, no longer protected to the same extent as required by HIPPA while solely in the possession of Revermann Chiropractic.

HIPAA Notice of Privacy Practices

Revermann Chiropractic
397 N. Plum St.
618-526-4700

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED ABD DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (PTO) 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 demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. **Uses and Disclosure of protected Health Information**

Uses and Disclosure of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your cared 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 practice, 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 or treat 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 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. For example, we any disclose your protected health information to medical school students that see patients at our 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: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement 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: Following is a statement of your rights with the 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 a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that 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 to 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 your 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 in no required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will both be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to 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 withdraws 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 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/or 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 HIPAA Compliance Officer in person or by phone at our Main Phone Number.

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I herby acknowledge receipt of the **HIPAA Notice of Privacy Practices** for Revermann Chiropractic regarding my health information. I have been informed and understand the manner in which my health information shall be maintained, utilized and disclosed by Revermann Chiropractic and my respective rights contained there in. I also understand that the Notice furnished to be is subject to change at any time. I am aware that I may obtain a current copy of this Notice at any time by contacting Dr Craig Revermann (clinic privacy officer) at (618) 526-4700 or 397 N Plum, Breese, IL 62230.

My signature herein below constitutes full acknowledgement that I have been furnished with a copy of the Notice of Privacy Practices for Revermann Chiropractic.

_____ _____
Patient Signature Date

_____ _____
Patient's Legal Representative Date
If required

If signed by a patient's legal representative, please state representative's relationship to patient:

_____

Revermann Chiropractic Office Policies

CANCELLATION / NO-SHOW POLICY:

Any patient who fails to arrive for a scheduled appointment without cancelling the appointment at least 3 hours prior to the scheduled time is considered a "no-show". A no-show patient will be charged $25, as set by the practice, for failure to show. This will be payable prior to your next visit. A patient who is a no-show four times will be dismissed from the practice.

FINANCIAL POLICY:

Any patient who has a balance that has exceeded $100.00 must pay balance in full in order to be scheduled for their next appointment. In order to avoid this please pay copays, deductibles and co-insurances at time of service.

AFTER HOURS:

If for any reason one of our Chiropractors treats you after hours, there will be a $100.00 office visit charge on top of the charges for the services rendered. This charge is a cash fee and must be paid at the time of service.

Signature:_____ Date:_____

Patient Consent Form

I _____, understand my rights as a patient and by signing this form, do give consent for Revermann Chiropractic and it's healthcare providers the right to provide medical treatment.

I understand that my healthcare provider may need to obtain or share my medical information from/with various healthcare entities for the purpose of diagnosis and treatment, and may do so without my signed consent.

I also give equal consent to any physician that Revermann Chiropractic has contracted with for coverage in my provider's absence, to ensure continuity of care for my healthcare needs at Revermann Chiropractic.

_____ _____

Signature of Patient/Guardian Date

_____ _____

Print Name Date of Birth