



15. What is your: Height \_\_\_\_\_ Weight \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Occupation \_\_\_\_\_

16. How would you rate your overall Health?  
 Excellent     Very Good     Good     Fair     Poor

17. What type of exercise do you do?  
 Strenuous     Moderate     Light     None

18. Indicate if you have any immediate family members with any of the following:  
 Rheumatoid Arthritis     Diabetes     Lupus  
 Heart Problems     Cancer     ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss		
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite		
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain		
<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer		
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis		
<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gall Bladder Disorder		
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> General Fatigue		
<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/> Muscular Incoordination		
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances		
<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/> Dizziness		
<input type="checkbox"/>	<input type="checkbox"/> Other: _____				

**For Females Only**

Birth Control Pills  
 Hormonal Replacement  
 Pregnancy

20. List all prescription medications you are currently taking:  
\_\_\_\_\_

21. List all of the over-the-counter medications you are currently taking:  
\_\_\_\_\_

22. List all surgical procedures you have had:  
\_\_\_\_\_

23. What activities do you do at work?

<input type="checkbox"/> Sit:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> Stand:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> Computer work:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half the day	<input type="checkbox"/> A little of the day
<input type="checkbox"/> On the phone:	<input type="checkbox"/> Most of the day	<input type="checkbox"/> Half of the day	<input type="checkbox"/> A little of the day

24. What activities do you do outside of work?  
\_\_\_\_\_

25. Have you ever been hospitalized?     No     Yes  
if yes, why \_\_\_\_\_

26. Have you had significant past trauma?     No     Yes

27. Anything else pertinent to your visit today? \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

# Preventative Healthcare

## NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**  
**THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

### **OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you the Notice about our privacy practices our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 10/5/2004, and will remain in effect until its replaced.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all the health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice available request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or the additional copies of this Notice, please contact us using the information listed at the end of this Notice.

### **USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

**Treatment:** We may or disclose your health information to a physician or other healthcare provider involved in your healthcare.

**Payment:** We may use or disclose your health information to obtain payment for the services that we provided to you.

**Healthcare Operations:** We may use or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualification of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may revoke it in writing any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only with your consent.

**Persons Involved in Care:** We may disclose health information to notify, assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on the determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with a common practice to make reasonable inferences of your best interest in allowing a person to pick up medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may use or disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim abuse, neglect, domestic violence or possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to the military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence counter

Preventive Healthcare  
NOTICE OF PRIVACY PRACTICES

intelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters)

**Patient Rights**

**Access:** You have the right to look or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make a request in writing to obtain access to your health information. You may obtain a form by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$1.00 for each page, \$25.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

**Disclosure Accounting:** You have the right to receive a list of instances in which we disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost based fee for responding to these requests.

**Restriction:** You have the right to request that we place additional restrictions on our use disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement(except in an emergency.)

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations.(You must make a request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information (Your request must be in writing, and it must explain why the information should amended.) We may deny your request under certain circumstances.)

**Electronic Notice:** If you receive this Notice on our web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

**QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices or if you have any question or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with the U.S. Department of Health and Human Services.

Contact Information:  
Telephone: 847-879-1034  
Fax: 847-879-1035  
Address: 444 East Dundee Rd.  
Palatine, IL 60074

I have read and understood the proceeding and agree to its terms

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## DISCLOSURE OF FEES/PAYMENT POLICY

99202	New Patient Evaluation and Management	\$20.00
99203	NP-Detailed History and Examination	\$115.00
99204	NP-Comprehensive History and Examination	\$125.00
99205	NP-Comprehensive History & Examination-60 min	\$175.00
99212	Established Patient Office Visit	\$50.00
99213	Est. Pt-Expanded History and Examination	\$80.00
99214	Est. Pt-Detailed History and Examination	\$100.00
99215	Est. Pt-Comprehensive History & Examination-40min	\$165.00
98940	CMT 1-2 Areas	\$50.00
98941	CMT 3-4 Areas	\$60.00
98943	CMT-Extremity	\$35.00
97124	Massage (15 Minutes)	\$25.00
97140	Manual Therapy	\$40.00
97010	Hot and Cold Packs	\$10.00
97012	Mechanical Traction	\$20.00
97014	Electrical Stimulation	\$20.00
97035	Ultrasound	\$20.00
97110	Therapeutic Procedure -per unit	\$40.00
97781	Acupuncture w/ Electrical Stimulation	\$80.00

I have read the above codes and fees and understand the cost of my care with my treating doctor. I understand that I am responsible for payment of all deductibles and co-payments related to my care. I understand if my balance is not paid per my financial agreement, I promise to pay any and all collection, court, and attorney fees in the collection of my account. I further understand that if my treatment is associated with a personal injury or accident claim, all medical bills will be paid at 100% of the above fee schedule regardless of the outcome of my case. I understand that if a check is returned for insufficient funds, I will be charged a \$25.00 service charge.

I further understand that if my insurance company declines payment, I authorize \_\_\_\_\_ to file small claims on my behalf against my insurance company as a method of collection. I further understand that I will be present at the court date if needed.

I have read and fully understand the above financial terms and prices.

Signed \_\_\_\_\_

Date \_\_\_\_\_

Diversey Health Center  
2626 N Halsted  
Chicago, IL 60614  
773-472-7484

## Confidential Patient Information

Date: \_\_\_\_\_

Were you referred to a certain doctor in this clinic? Y / N If yes, who? \_\_\_\_\_  
Did you find the doctor on the Blue Cross Website? Y / N

### Patient Data

Name \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Address \_\_\_\_\_ City/St \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Email \_\_\_\_\_ Bday \_\_\_\_\_  
Name of nearest relative \_\_\_\_\_ Phone \_\_\_\_\_

### Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for the patient in accordance with appropriate tests, diagnosis and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the physician.

I understand and agree that health and accident insurance policies are an arrangement between the insurance company and myself. Furthermore, I understand that this office will submit the forms to the insurance company to assist in collecting 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-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, and fees and professional services rendered me will be due and payable immediately.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_