CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Cell Phone (_____) _____ Home Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

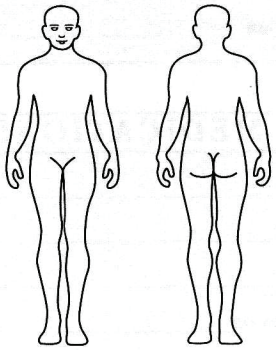
5 PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

6 HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Other _____	
Chemical Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No		
Chicken Pox	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
				Rheumatoid Arthritis	☐ Yes ☐ No		

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

7 MEDICATIONS

_____
_____
_____

Pharmacy Name _____

Pharmacy Phone (____) _____

ALLERGIES

VITAMINS/HERBS/MINERALS

Post Rehabilitative Solutions

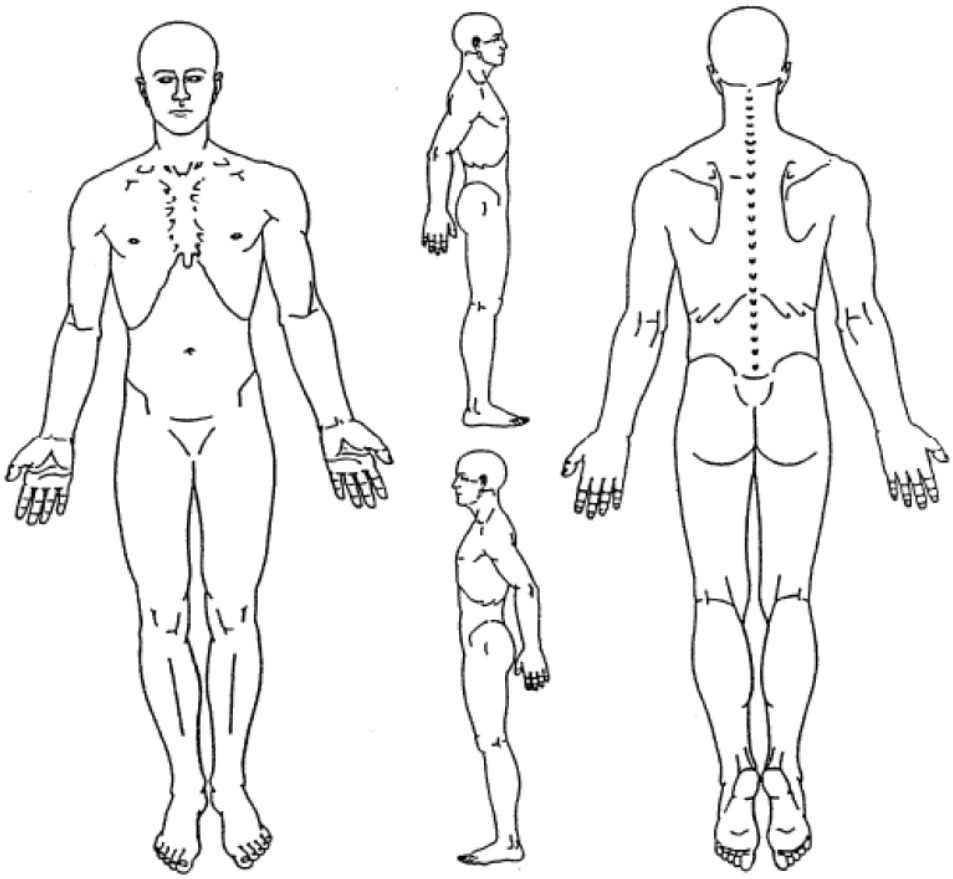
PAIN DRAWING

Patient Name: _____ **Patient ID#:** _____

Date: _____

KEY

USE LETTERS BELOW TO INDICATE TYPE AND LOCATION OF DISCOMFORT		
A = ACHE	B = BURNING	C = STABBING
N = NUMBING	P = PINS & NEEDLES	O = OTHER



Consent to Examine/Treat/Insurance Authorization

I, _____, give consent to be examined and treated by the team of specialists at Post Rehabilitative Solutions (PRS). I understand the risks and benefits of chiropractic care and allow treatment. I give authorization to PRS to contact my insurance company for treatment received at PRS. Insurance information provided by the patient is solely used for the purpose of repayment of treatment being rendered. I understand that my insurance may not cover the cost of treatment fully. I am liable for the treatment cost not covered by my insurance company (copays, deductibles and other services not covered by insurance). All information provided by the patient is confidential and will not be misused. PRS is HIPPA compliant and abides by its regulations.

_____
Signature of Patient

_____
Date

We would like to keep you updated on the progress of your treatment along with sending you tailored exercise and stretches for your treatment. Your email is solely confidential to PRS.

Email Address: _____

Consent for Use or Disclosure of Health Information

Post Rehabilitative Solutions (PRS) has always been concerned with protecting our patient's privacy. While the law requires us to give you the HIPPA disclosure, please understand that PRS has and always will respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information:

- We may have to disclose your health information to another healthcare provider or hospital if it is necessary to refer you to them for diagnosis, assessment and/or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your service.
- We may need to disclose your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides detailed descriptions of how your health information may be used or disclosed. We reserve the right to change our privacy policy as described in that notice. If we make a change to our policy practices, we will notify you in writing when you come into the office for treatment or by mail. Please feel free to call us at any time for a copy of our privacy policy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. However, please note that we are not required to adhere to those restrictions unless agreed upon, then they are binding.

Your right to revoke your authorization

You have the right to revoke your consent to us at any time; however this revocation must be given in writing. We will not be able to honor your request if we have already released your health information before it was given. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I also acknowledge that I have the right to a copy of this notice.

_____
Patient Name (Print)

_____
Signature

_____
Date

_____
Authorized Provider

Provider Address:
12624 S. Rt. 59 Unit 2
Plainfield, IL 60585

Office Policies

In order to better serve our patients, we have established the following office policies:

Late Appointments

When Appointments are scheduled, it is time that we have set aside specifically for you and the needs of your treatment plan. We ask that patients to arrive on time to ensure that the best quality of care can be provided during your session. It is preferred that you reschedule appointments to which arrival time is delayed by 10 minutes for 30 minute appointments or delayed by 5 minutes for 20 minute appointments. We do our best to accommodate late arrivals into the schedule for the same day if there is a later appointment available, but there may be an extended wait time.

Cancelled Appointments

We realize that certain cancellations happen last minute and cannot be helped. However, we do ask that you give us the courtesy of contacting us prior to 12:00pm (noon) the day before your appointment if you are unable to make your scheduled appointment. This way, we are able to allow other patients who would like to come in to be treated. It is at the discretion of PRS to charge a fee for frequently cancelled appointments or last minute cancellations.

Missed Appointments

When a scheduled appointment is missed, there is another patient that could be receiving the services they need. Out of respect for our providers and other patients, failure to show up for any appointments could result in a fee of $50 for each appointment missed.

Payment and Account Balances

Copays, payments toward your deductible, and past due balances are due at the time of and are to be paid prior to receiving any services unless otherwise arranged with PRS.

Insurance

If you have health insurance, we bill it as a courtesy to you. If you have a copayment, co-insurance or a deductible that needs to be met, it is your responsibility to make payments at the time of service.

If you have health insurance and are unable to provide us with a card, we are unable to bill your insurance therefore we will require payment in full at time of service.

If you do not have health insurance, we require that you either pay in full for services at the time of service or the payment plan amount that was agreed upon. All outstanding account balances greater than 90 days will be turned over to collections. If your account ends up in collections, all reasonable attorney's fees, and/or court costs incurred by PRS to enforce terms, covenants or defend upon the same and/or collect any balances owed past 90 days shall be awarded to PRS by any court of competent jurisdiction.

For your convenience we accept cash, personal check, Apple Pay, Android Pay, Visa, MasterCard and Discover.

Sign here: _____ *Date:* _____

Building a bridge to a pain-free life
12624 S. Rt. 59 unit 2, Plainfield, IL 60585
Phone: 815-254-1234/Fax: 815-254-2020
www.postrehabsolutions.com

Effective: June 2019

Permission to Use Medical AI Transcriber/Recorder Patient Consent Form

Purpose of the AI Transcriber/Recorder

To enhance the accuracy and efficiency of medical documentation, this practice utilizes a secure, HIPAA-compliant Artificial Intelligence (AI) transcription tool that records and transcribes patient-provider interactions. This tool is used strictly for medical documentation and is intended to support high-quality care.

What You Should Know:

- **Recording:** Your visit may be recorded (audio only) for transcription purposes.
- **Transcription:** The recording will be transcribed by a secure AI tool and used to update your medical records.
- **Confidentiality:** All data is encrypted, stored securely, and handled according to HIPAA regulations.
- **Access:** Only authorized medical personnel will have access to the transcription and recording.
- **Voluntary:** You may refuse or withdraw consent at any time without affecting your care.

Consent

I, the undersigned patient (or authorized representative), acknowledge that:

- I have been informed that my visit may be recorded and transcribed using an AI tool.
- I understand the purpose of this tool and how the information will be used and protected.
- I have had the opportunity to ask questions and receive answers regarding the use of the AI transcriber/recorder.
- I understand that I may decline or revoke this permission at any time.

☐ **I give my permission** for the use of an AI transcriber/recorder during my medical consultation.

☐ **I do NOT give my permission** for the use of an AI transcriber/recorder.

Patient Name (Printed): _____
Patient Signature: _____
Date: _____

If signed by authorized representative:
Name: _____
Relationship to Patient: _____
Signature: _____
Date: _____

Post Rehab Solutions
12624 S. Rt. 59 unit 2
Plainfield, IL 60585

Tel: 815-254-1234
Fax: 815-254-2020
Email: postrehabsolutions@gmail.com

Assignment of Benefits

Name of Insured (print) _____

I request that payment of authorized insurance benefits, including Medicare if I am a Medicare Beneficiary, be made either to me or on my behalf to the organization listed below for any equipment or services provided to me by that organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my Insurance Carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my Insurance Company or other entity, if requested. The original authorization will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for products and services received.

General Patient and Patient Family Responsibilities:
In certain circumstances, insurance company may send a check for services provided by Post Rehab Solutions directly to the patient. In such cases, the patient agrees to endorse and send such a check to Post Rehab Solutions. If the patient deposits such a check into a personal account, the patient agrees to send Post Rehab Solutions a check for the equivalent amount.
If the patient receives from an insurance company an Explanation of Benefits (EOB), the patient agrees to send a copy of the EOB, by mail, or fax directly to:

Post Rehab Solutions
12624 S. Rt. 59 unit 2
Plainfield, IL 60585
Fax: 815-254-2020

By signing this document, I also acknowledge that I have received a copy of the organization's Notice of Privacy Practices. This acknowledgement is required by the HIPPA (Health Insurance Portability and Accountability Act) to ensure that you have been made aware of you privacy rights.

Organization

Post Rehab Solutions
12624 S. Rt. 59 unit 2
Plainfield, IL 60585

Name of person signing below (print): _____

Relationship to Insured: _____

Signature of Insured or Parent/Guardian: _____

Date: _____/_____/_____

A. Notifier: POST REHABILITATIVE SOLUTIONS
B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D. Physical Therapy below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D. Physical Therapy** below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
97112- Neuromuscular Re-Education 97530 – Therapeutic Activities 97110 – Therapeutic Exercises ALL MASSAGE THERAPY	MEDICARE DOES NOT COVER THE PROCEDURES IN COLUMN D. WHEN PERFORMED BY A CHIROPRACTOR	$40 COPAY will be applied to your visit to cover 97112, 97530 and 97110 Massage Therapy: Price ranges: $45-$85

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D. Physical Therapy** listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D. Physical Therapy** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D. Physical Therapy** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D. Physical Therapy** listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You may ask to receive a copy.

I. Signature:	J. Date:

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

Patient Reminders

Please select your preferences for appointment reminders and notifications. You may select multiple.

* Required

1. Name *

_____

2. Preferred Reminder/Notification *

Check all that apply.

- [ ] Call Reminder
- [ ] Text Reminder
- [ ] Email notification when appointments are scheduled or changed
- [ ] No reminder

3. Preferred Phone Number

_____

4. Preferred Email

_____