

# 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) \_\_\_\_\_

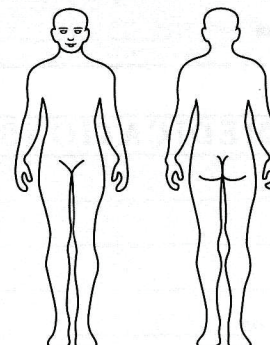
Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
 Burning  Tingling  Cramps  Stiffness  Swelling  Other

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

## ALLERGIES

## VITAMINS/HERBS/MINERALS

_____	_____	_____
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone (____) _____	_____	_____



**PAIN DRAWING**

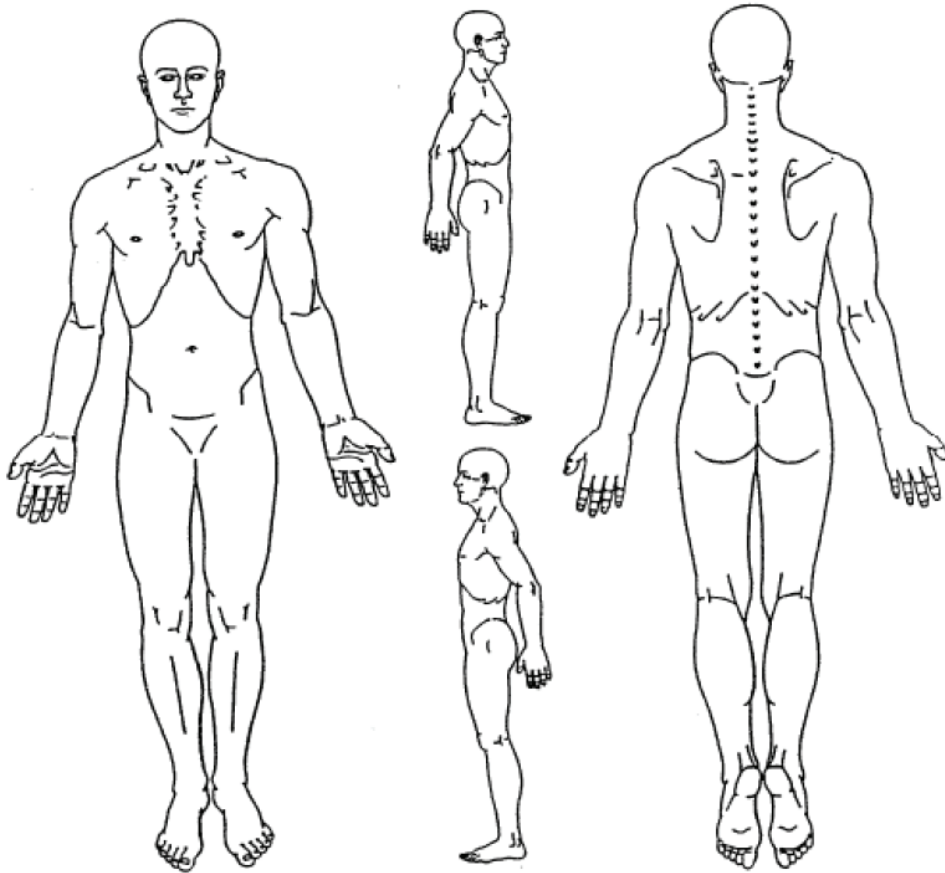
Patient Name: \_\_\_\_\_

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)

\_\_\_\_\_  
Authorized Provider

\_\_\_\_\_  
Signature

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

\_\_\_\_\_  
Date



### **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](http://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:** \_\_\_\_\_

Patient name: \_\_\_\_\_

Post Rehab Solutions  
12624 S. Route 59, Unit 2  
Plainfield, IL 60585  
815-254-1234

### Advance Beneficiary Notice of Non-coverage (ABN)

Medicare doesn't pay for everything, even some care you or your health care provider think you need. **We expect Medicare to not pay for the item, test, service or care listed below.** If Medicare doesn't pay, you may have to pay.

Item, test, service or care	Reason Medicare may not pay	Estimated cost
97112- Neuromuscular Re-Education 97530 – Therapeutic Activities 97110 – Therapeutic Exercises	<b>MEDICARE DOES NOT COVER THE FOLLOWING PROCEDURES WHEN PERFORMED BY A CHIROPRACTOR</b>	<b>PHYSICAL THERAPY COPAYS: \$40 COPAY for Medicare \$55 COPAY for Medicare Advantage Plans</b>
<b>ALL MASSAGE THERAPY</b>		<b>Massage Therapy Price ranges: \$45-\$85</b>

#### What to do now

- Read this notice to make an informed decision about your care.
- Ask any questions you have.
- Choose one option below to let us know if you still want to get the item, test, service or care.

#### Choose ONE option below. We can't choose for you.

If you choose Option 1 or 2, we may help you use any other insurance you might have, but Medicare can't require us to do this.

- Option 1: I want the item, test, service or care listed above, and I want Medicare to be billed for an official decision on payment, which I'll get on a Medicare Summary Notice (MSN).** You can ask to be paid now. I understand that if Medicare doesn't pay, I'm responsible to pay, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you'll refund any payments I made to you, minus co-pays or deductibles.
- Option 2: I want the item, test, service or care listed above, but don't bill Medicare.** You can ask to be paid now and I'm responsible to pay. I understand that I can't appeal, since Medicare isn't billed.
- Option 3: I don't want the item, test, service or care listed above.** I understand I'm not responsible for payment and I can't appeal to see if Medicare would pay.

#### Additional information:

This notice gives our opinion, not an official Medicare decision. For other questions about this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. Signing below means you received and understand this notice. You can ask to get a copy.

<b>Signature</b>	<b>Date (mm/dd/yyyy)</b>
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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](http://Medicare.gov/about-us/accessibility-nondiscrimination-notice).

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. This information collection is for providers, suppliers, Hospice and Religious Non-medical HealthCare Institutes and Home Health Agencies to notify original Medicare beneficiaries of their potential financial liability under specific conditions. The time required to complete this information collection is estimated to average less than 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. This information collection is mandatory under Section 1879 of the Social Security Act, 42 CFR 411.404(b) and (c) and 411.408(d)(2) and (f). If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

Tel: 815-254-1234  
Fax: 815-254-2020  
Email: postrehabolutions@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: \_\_\_\_/\_\_\_\_/\_\_\_\_

# Patient Reminders

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

\* Required

1. Name \*

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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

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4. Preferred Email

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