



KOEHLER SPINAL AND SPORTS REHAB LTD.
232 MAIN STREET N.W. BOURBONNAIS, IL 60914
Phone: (815) 939-4900 • Fax: (815) 939-4951



CONFIDENTIAL PATIENT INFORMATION

Name _____ Date _____
 Home Phone _____
 Address _____ City _____ Zip Code _____
 Sex: M F Age _____ Birth Date _____ Marital Status M S W D # of Children _____
 Occupation _____ Employer _____
 Work Address _____ Office Phone _____
 Name of Spouse _____ Spouse's Occupation _____
 Spouse's Employer _____ Spouse's Work Phone _____
 Patient's Nearest Relative _____ Phone _____
 Referred by: _____

DATE SYMPTOMS APPEARED OR ACCIDENT HAPPENED _____

Is condition due to injury or sickness arising out of patient's employment? _____
 List any serious illnesses or accidents and dates _____

HAVE YOU OR ANY MEMBER OF YOUR FAMILY SUFFERED FROM ANY OF THE FOLLOWING:

_____ HEART DISEASE/ATTACKS	_____ CANCER	_____ HIGH BLOOD PRESSURE
_____ LOW BACK PAIN/SURGERY	_____ STROKE	_____ OTHER
_____ NECK PAIN/SURGERY	_____ DIABETES	

Have you been treated by any other doctor or health practitioner in the last five (5) years? _____ Yes _____ No
 Please describe _____

PAYMENT IS EXPECTED AT TIME OF VISIT!

I hereby request and consent to the performance of chiropractic adjustments and any other additional health care procedures on me by the Chiropractic Physicians/supervised staff/physical therapists/other chiropractic personnel of Koehler Spinal and Sports Rehab Ltd. I have had the opportunity to discuss with the doctor the nature and purpose of the above. I understand that the practice of chiropractic/medicine is not an exact science and that my care may involve decisions based upon facts known to the doctor at the time. I further understand that it is not reasonable to expect the doctor to be able to anticipate all risks or complications; that an undesirable result does not indicate an error in judgement, and that no guarantee to results has been made. I rely on the doctor to exercise clinical judgement during the course of my care based upon the facts then known and in my best interest. I also understand that the doctor will refer me to the appropriate health care provider should my condition not be "chiropractic" in nature:

I have also been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should know of possible complications. These include, but are not limited to, fractures, disk injuries, strokes, dislocations, sprains, and those which relate to physical aberrations unknown or reasonably undetectable by the doctor. I have read or have had read to me the above Consent. I have also had an opportunity to ask questions about its contents, and by signing below, acknowledge my understanding of its contents.

I understand and agree that health and accident insurance are an arrangement between my insurance company and myself NOT between the insurance company and this office. I understand that this office will prepare to the best of our ability any necessary reports and forms to assist me in collecting from my insurance company. I further agree to pay a percentage of services such as my deductible, co-pays, co-insurance as rendered. I fully understand and accept that I am ultimately responsible for payment in full for all services rendered.

I also understand that if I suspend, terminate or are released from my relationship with this office, any fees for all services will be **IMMEDIATELY DUE AND PAYABLE** and give my permission to bill my credit card for all unpaid services.

MAJOR CREDIT CARD # (REQUIRED) _____ Exp. Date _____

PATIENT SIGNATURE: _____ S.S. # _____ DATE _____

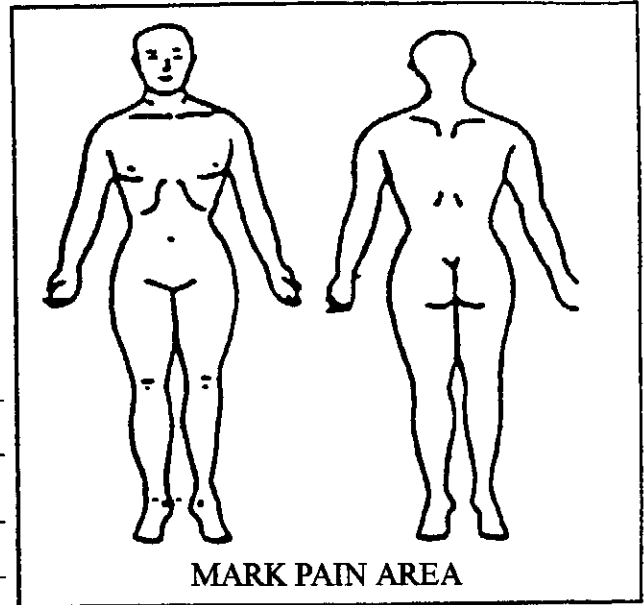
GUARDIAN/SPOUSE SIGNATURE _____

AUTHORIZING CARE: _____ DATE _____

MARK THE AREAS ON THE BODY WITH THE FOLLOWING DESCRIBED SENSATIONS USING THE FOLLOWING KEY:

PAIN CHART

- NUMBNESS - - - - BURNING X X X X
 - - - - X X X X
 PINS/NEEDLES ○ ○ ○ ○ ACHING * * * * STABBING // // // //
 ○ ○ ○ ○ * * * * // // // //



1. Major Complaints/Symptoms _____

2. Have you ever had these or similar symptoms before? _____

A. When? _____

3. What makes your pain worse? _____

Better? _____

4. When was the very first time you ever noticed this pain/problem? _____

5. Over the past _____ days _____ weeks, my health problems have been:
 _____ months, _____ years _____ getting worse _____ about the same
 _____ getting better _____ rapidly getting worse

6. Describe your pain: _____ constant _____ frequent _____ intermittent _____ occasional
 _____ very severe _____ severe _____ moderate _____ mild

7. List any other doctors/other treatments you have tried to help this problem. _____

8. List all prescriptions, other drugs or nutritional supplements you are taking. _____

8A. List all allergies _____

9. Please check all other symptoms/problems you are having:

- | | | | | |
|--|--|---|------------------------------------|---|
| <input type="checkbox"/> chest pains | <input type="checkbox"/> hoarseness | <input type="checkbox"/> fainting | <input type="checkbox"/> headaches | <input type="checkbox"/> losing weight |
| <input type="checkbox"/> trouble breathing | <input type="checkbox"/> dizzy | <input type="checkbox"/> blurred vision | <input type="checkbox"/> nausea | <input type="checkbox"/> cough up blood |
| <input type="checkbox"/> night sweats | <input type="checkbox"/> double vision | <input type="checkbox"/> constipation | <input type="checkbox"/> vomit | <input type="checkbox"/> weak/fatigue |
| <input type="checkbox"/> cough | <input type="checkbox"/> ears ring | <input type="checkbox"/> diarrhea | <input type="checkbox"/> heartburn | <input type="checkbox"/> other |

10. Smoking History: NO YES How many yrs _____ How many packs/day _____

FOR FEMALES ONLY: ARE YOU PREGNANT? YES NO NOT SURE

Check all that you currently are experiencing:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> irregular menses | <input type="checkbox"/> cystic breasts | <input type="checkbox"/> hair loss | <input type="checkbox"/> chronic yeast/urinary tract infections |
| <input type="checkbox"/> heavy menses | <input type="checkbox"/> PMS | <input type="checkbox"/> thyroid problems | <input type="checkbox"/> hot flashes |
| <input type="checkbox"/> no menses | <input type="checkbox"/> low sex drive | <input type="checkbox"/> fibroids | <input type="checkbox"/> Other (describe) _____ |
| <input type="checkbox"/> breasts tender | <input type="checkbox"/> depression | <input type="checkbox"/> birth control pills | _____ |

KOEHLER CHIROPRACTIC OFFICES

232 Main NW • Bourbonnais, IL 60914 • (815) 939-4900

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTH CARE OPTIONS

I, _____, hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care options.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care options. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven (7) years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this Consent.
7. I understand that if I revoke this Consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (Printed)

Signature of Individual

Signature of Legal Representative
(e.g., Attorney-In-Fact, Guardian, parent if minor)

Relationship

Date Signed _____ / _____ / _____

Witness: _____

DIRECT ASSIGNMENT OF BENEFITS

TO: Koehler Chiropractic Offices

FROM: _____

In consideration of your undertaking to render care, I agree to the following:

1. **RELEASE OF INFORMATION:** You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me at your treatment facility.
2. **RIGHT TO RECEIVE INFORMATION:** I authorize my chiropractic provider the authority to affix my signature as noted below to obtain medical information from any hospital, medical provider, etc.. as necessary as it relates to the care being provided by my chiropractic physician.
3. **RIGHT TO RECEIVE PAYMENT:** I authorize and assign to you, the chiropractic provider, the right to receive direct payment from my attorney or any insurance company which may become obligated to pay me any sums. I further authorize the endorsement of my name to any draft containing my name to which you are legally entitled.
4. **ASSIGNMENT OF RIGHT TO SUE:** In the event any insurance company or attorney, obligated by contractual agreement to make payment to me for your service charges, refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company or attorney and authorize you to prosecute said action either in my name or your name as you otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from said insurance proceeds (whether it be all or part of what is due) shall be paid by me.
5. I also assign to you, the chiropractic provider, and grant the right of lien against any and all claims against any third party whose negligence may have caused my injury, including their insurance, up to the amount of the bill for treatment.
6. I waive the Statute of Limitations regarding my doctor's right to recover from me directly.
7. **MEDICARE:** This office accepts Medicare assignment. This means that the provider bills Medicare for all services and waits for payment of Medicare's portion and will collect from the patient only the difference between what Medicare approves and what Medicare pays. Medicare pays for manual spinal adjustments up to 12 visits per year. If your particular case requires more than the allotted 12, we will request an extension of benefits from Medicare but cannot guarantee they will honor our request. Any service provided for Medicare patients, other than spinal adjustment, is not reimbursable by Medicare. Therefore, payment in full from the patient is expected at time of service. (Some secondary insurance policies may cover these services; if so, the patient will be reimbursed.) Medicare requires that x-rays or an examination be performed annually to establish medical necessity
8. I hereby acknowledge that I am receiving (or about to receive) health care services from Koehler Chiropractic Offices and am advised that they are willing to wait for payment for these services, provided there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim. I understand that if it is determined either (a) there is no insurance company obligated to pay for the services, or if the insurance company involved refuses to acknowledge an assignment to the Doctor(s) or make other provisions for the protection of the interest of the Doctor(s); or (b) if a liability claim exists, and my attorney refuses to agree to protect the interest of the Doctor(s), or if I have not engaged the services of an attorney, payment for services rendered by the above-named Doctor(s) will be made on a current basis and my account paid in full immediately. In any event, I hereby promise to pay my bill in full within ten (10) days from the date my liability claim is settled or after the passage of three (3) months from the date of my last treatment, whichever comes first.

Dated this _____ day of _____, 20 _____

Patient's Signature

Sign Up For The "Wellness Minute"

Feeling Better... One Byte At A Time

Koehler Chiropractic Sports And Spinal Rehab has partnered with Biotics Research and Metabolic Management to bring you:



Each week we e-mail you FREE of charge a short video on timely nutrition and health topics.

Sample Wellness Minute Topics

- The New "Flat Belly Diet" ...Why It Really Works!
- Weight Loss and Chronic Fatigue
- Natural Relief For Allergies / Sinusitis.
- How To KNOW Which Nutritional Supplements Are Right For You.
- Men... A Simple Way To Increase Testosterone.
- How To Relive Breast Tenderness... In 5 Minutes.
- Natural Hormone Replacement!
- Arthritis and Pain Relief
- Natural Relief For Anxiety/ Stress.
- Managing Blood Sugar.
- Why Take A Multi Vitamin?

To register Just fill in your name and email address below and return to us by fax at (815) 939-4951 or call at (815) 939-4900 to get started today.

Please Start emailing me the weekly "Wellness Minute"

Clinic or Doctor name: Koehler Chiropractic Sports and Spinal Rehab

My email address is _____

Signature Required _____

* Please Print Clearly*

Fax this form to (815) 939-4951

Voice Your Support
Join the American Chiropractic Association's
Chiropractic Advocacy Network

www.ChiroVoice.org

Unite with patients across the country to protect your access to essential healthcare services provided by doctors of chiropractic. Together, we can educate policymakers about the value of chiropractic and influence the outcome of any legislative efforts to reform the current national healthcare system. Through the Chiropractic Advocacy Network, you can stay informed about these important issues and help ensure that:

- Congress does not restrict your ability to access essential chiropractic services.
- Congress does not limit – but instead expands – coverage for services provided by doctors of chiropractic within Medicare.
- Insurance and managed care companies do not deny patients' access to essential chiropractic services.

It's easy to help!

There is no cost to sign up, and as a program participant, you'll enjoy benefits such as legislative updates and a monthly e-newsletter containing health information and tips on how best to correspond with your elected officials.

✓ Yes! I want to Voice My Support.

1. Sign up at ChiroVoice.org or
2. Fill out the form below and return to your Doctor of Chiropractic.

(Bolded items required)

Name _____

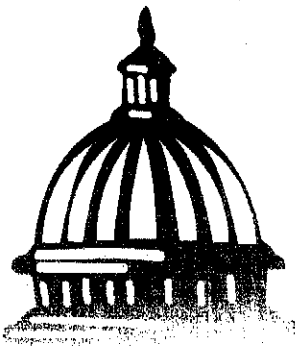
Email* _____

Address _____

City _____ **State** _____ **Zip** _____

Phone _____

Doctor of Chiropractic _____



**All e-mail addresses will be kept CONFIDENTIAL and are intended for the sole purpose of educating patients regarding important chiropractic and wellness information and for generating grassroots action under the direction of ACA. E-mail addresses will not be sold or exchanged with any third party.*