SCHNEIDER CHIROPRACTIC, LLC

523 North Elm Street-Lincoln, IL
217.732.2140

WELCOME

The doctors and staff of Schneider Chiropractic welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient but refer you to another health care provider, if appropriate.

PATIENT INFORMATION

Name (First, Middle, Last) ____ Date of Birth___________/_____________/_______________

Address____ City, State, Zip_________________, ___________ ___________

Sex: _____Male _____Female Marital Status: _____Single _____Married _____Widowed _____Divorced

Race: ______________ Language: ______________ Name you preferred to be called in this office (nickname):________________________________

Home Phone: ( ) ____________________ Cell Phone: ( ) __________________ Work Phone: ( ) ____________________ Ext: ________

Would you like to receive appointment reminders? (You may choose both options)

_____By Email (please provide your email address):____

_____By Text Message-Cell phone number to receive the text: ( ) ___________________________ Carrier: ________________________________

EMPLOYMENT INFORMATION

Employment Status: _______Employed _______Unemployed _______Retired _______Part-time Student _____Full-Time Student _______Other

Employer: ____Occupation:____

RESPONSIBLE PARTY INFORMATION

Name (if other than self):____Relationship to the Patient: _________________________________

Address: ____City, State, Zip: _______________________, ______________ ____________

Responsible Party's Phone Number: ( ) __________________________

EMERGENCY CONTACT

Name: ____Relationship to Patient: ____________________________________

Phone Number for Emergency Contact: ( ) ______________________

IS YOUR ILLNESS RELATED TO ANY OF THE FOLLOWING?

_____Employment (Has your employer been notified? _________) _____Accident _____Auto Accident (State of Auto Accident_____)

Date of accident or injury: ______/______/______ Date symptoms appeared: ______/______/______ Have you ever had same condition? _____Yes _____No

List other practitioners you have seen for this injury/condition: ____

Have you ever been under chiropractic care? _______if yes, who did you see? ____

Please describe your injury: ____

HOW WERE YOU REFERRED TO OUR OFFICE?

_____By a Patient _____By a Doctor _____By an Attorney ____Radio Station _____Website or Internet _____Phone Book _____Location _____Other

Please print the name of your source: ____

ACCEPTANCE AS A PATIENT

I understand and agree that the doctors of Schneider Chiropractic, LLC have the right to refuse to accept me as a patient at any time before treatment begins, The taking of a history and conducting a physical examination are not considered treatment, but are part of the process on information gathering so that the doctor can determine whether to accept me as a patient.

Date: ________/________/________ Signature: ____

Please fill in the following information if you would like us to submit your charges to your insurance company. We will also ask for a copy of your insurance card to keep on file. Please note that it is the patient's responsibility to make sure that we have all necessary information on file in order to submit the claim to insurance. If you have a co-payment, co-insurance, deductible has not been met or insurance does not cover chiropractic treatments, payment is due at the time services are rendered. Patients are held responsible for the balance due on their accounts. In such cases as worker's compensation and automobile accidents, arrangements may be made with this office.

Insurance Information

Patient's Name: ____

Relationship to the insured (Policy Holder): _____Self ____Spouse _____Child _____Other (explain)______________________________ ________

INSURED INFORMATION (POLICY HOLDER):

Name of the Insured: ____ Date of Birth of the insured: ________/____________/__________

Does the insured have the same information as the patient? ______Yes ______No *if no, fill in the following:*

Address of the insured: ____ City, State, Zip____________________ _____________________

Phone # of the insured: ( ) _____________________________ Work phone #: ( ) ____

Insured's Employer: ____

INSURANCE COMPANY INFORMATION:

Name of Insurance Company: ____ ID Number: __________________________________

Group Name (if available):____ Group Number: __________________________________

Do you have a supplemental or secondary insurance? _________ *if yes, fill out the following:*

INSURED INFORMATION FOR SECONDARY INSURANCE (POLICY HOLDER):

Name of the Insured: ____ Date of Birth of the insured: ______/_________/________

Does the insured have the same information as the patient? ______Yes ______No if no, fill in the following:

Address of the insured: ____ City, State, Zip_____________________________________

Phone # of the insured: ( ) _________________________________ Work phone #: ( ) ___________________________________

Insured's Employer: ____

INSURANCE COMPANY INFORMATION FOR SECONDARY INSURANCE:

Name of Insurance Company: ____ ID Number: ________________________________

Group Name (if available):____ Group Number: ________________________________

I understand that it is a courtesy for Schneider Chiropractic to submit my treatment charges to my insurance company. I also understand that I am financially responsible for all charges whether or not they are paid by my insurance. I give consent for Dr. Alyssa J. Schneider or Dr. Juliann M. Papesch of Schneider Chiropractic LLC to verify my insurance benefits and to submit claims to my insurance company or Medicare. I authorize the release of any medical or other information necessary to process my claims. I also authorize the use of my signature on all insurance submissions and request payment of government or private benefits to Schneider Chiropractic, LLC.

____ __________/_________/________

Signature Date

____

FOR OFFICE USE ONLY

[ ] In network [ ] Out of network
[ ] Preauthorization required
Authorization #____________
From________to __________
Approved_______________

Deductible amount $_________
[ ] Co-pay [ ] No Co-pay
Co-pay amount $__________
Deductible begins______________
Exclusions? ____________________

Max Chiro Benefits?
[ ] Met [ ] Not Met
Number allowed____________
Number remaining tx________
ETN__________________________

SCHNEIDER CHIROPRACTIC, LLC
523 North Elm Street-Lincoln, IL
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FINANCIAL POLICY

The following is an explanation of our office policy. We believe that a clear definition of our policy will allow us both to concentrate on the big issue—reestablishing, retaining, and maintaining your health. We will be happy to answer any questions you have regarding our policy, your account and your insurance coverage.

PAYMENTS

At Schneider Chiropractic, LLC your health care is our primary concern. We do not want finances to get in the way of you getting the health care that you need. Policies are in place in an attempt to assist you in meeting your financial obligations without increasing stress in your life.

- If you do not have insurance, **ALL** payments are expected at the time of service. Prepayments are also allowed.
- If you have insurance, **ALL COPAYS & CO-INSURANCE** are due at the time of service. By taking care of this while you are in the office, the need for an invoice is minimized.
- A finance charge of 1.5% may be applied to delinquent accounts. It is imperative that you keep your account balance current in order to avoid finance charges.
- There will be a $25.00 charge on all returned checks.
- If for any reason your account is turned over to a collection agency, you will be responsible for any legal or contingency fees that are applied to your account balance.

INSURANCE COVERAGE

Insurance claims will be filed with your insurance company at your request. It is the patient's responsibility to make sure that we have all necessary information on file in order to submit the claim to insurance. When the deductible has not been met or your insurance does not cover chiropractic services, payment is due at the time treatment is rendered. If your insurance has not paid the claim within 60 days of submission, you agree to take an active part in the recovery of your claim. If your insurance has not paid within 90 days of submission, you accept responsibility for payment in full of any outstanding balance. If you would like to keep a credit card on file at our office, we can apply any outstanding balance after 90 days directly to your credit card. In such cases as worker's compensation and automobile accidents, arrangements may be made with this office.

MEDICAL RECORDS & X-RAYS

We will release your medical records or X-rays to another doctor only after you sign a release/transfer form and your account has been paid in full, unless you have been referred for a consultation. We will need a 48 hour notice to enable us to mail the records or x-rays in time for your appointment.

TIME OF SERVICE FEE/ STUDENT FEE (THE DISCOUNT EXCLUDES ACUPUNCTURE, MASSAGES & PRODUCTS)

Because of the continued costs to our office for submission of insurance claims, Schneider Chiropractic, LLC offers a discounted fee to those who elect to pay their bill at the time of service. A 15% discount off the total charges for the day will be applied when the patient pays at the time of service. All discounts are rounded to the nearest whole dollar amount. This discounted fee does not apply when this office sends claims to insurance. If the fee is not paid at the time of service, the patient will not receive the time of service discount.

Schneider Chiropractic, LLC offers a discount to those patients that can provide proof of full time enrollment in school (elementary, junior high, high school, or college). Students will receive 40% off total services. All discounts are rounded to the nearest whole dollar amount. In order to charge this discounted price, we will not submit this charge to insurance of any kind. If the fee is not paid at the time of service, the account will be taken off the student discount and the patient will be responsible for our normal charges.

****If at any time the charges are submitted to an insurance company (including a personal injury, AFLAC, etc.), the discount will be removed and you will be responsible for the difference.**

CANCELLATION & NO-SHOW POLICY

When you schedule an appointment with Schneider Chiropractic, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and <u>no later than 2 hours prior to your scheduled appointment</u>. This gives us time to schedule other patients who may be waiting for an appointment. Any patient, who fails to show for their appointment or cancels less than 2 hours prior to their treatment time, will be charged a $35.00 fee. Acupuncture appointments will be $50.00 and new patient appointments will have a $60 fee applied. This fee will not be billed to or covered by your insurance company. Also, if you arrive for your appointment 7 minutes past the scheduled time, you will be considered a no show. You will be asked to reschedule and you will be charged for the cancellation/no show fee.

I have read and understand Schneider Chiropractic's office policies and I will honor them. I also give consent for Schneider Chiropractic, LLC to submit claims to my insurance company or Medicare. I authorize the release of any information necessary to process my claims. I authorize the use of my signature on all insurance submissions and request the payment of government or private benefits to Schneider Chiropractic, LLC. I understand that I am financially responsible for all charges whether or not they are paid by my insurance.

____ __________/__________/__________

Signature Date

SCHNEIDER CHIROPRACTIC, LLC
523 North Elm Street-Lincoln, IL
217.732.2140

MY PRIVACY

By the way of my signature, I am confirming that I have received a copy of the **Notice of Privacy Practices** from Schneider Chiropractic, LLC. I understand that I have certain rights to privacy regarding my protected health information. By my signature, I provide my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment and health care operations described in this privacy notice.

____ ______/_______/__________

Patient's Signature Date

____

Patient's Printed Name

By my signature, I give Schneider Chiropractic, LLC permission to discuss my treatment information and/or billing information with the following:

________________________________ ________________________________

Name Relationship to the patient

________________________________ ________________________________

Name Relationship to the patient

________________________________ ________________________________

Name Relationship to the patient

________________________________ ________________________________

Patient's Signature Date

(This authorizes information to be given to the above names)

SCHNEIDER CHIROPRACTIC, LLC
523 NORTH ELM ST- LINCOLN, IL

Patient Name______________________
DOB____________ Date____________

MEDICAL HISTORY

Primary Care Physician:
____

Please review the following CAREFULLY and check any conditions that apply to you as these are important to know for your care.

____

- □ Persistent fever
- □ Night sweats
- □ Loss of sleep
- □ Fatigue
- □ Nervousness
- □ Anemia
- □ Bleeding problem
- □ Type I diabetes
- □ Type II diabetes
- □ Cancer
- □ Thyroid disease/ Goiter
- □ Loss of balance
- □ Unexplained weight loss/ gain
- □ Intentional weight loss/gain
- □ Indoor/ outdoor allergies

____

- □ Poor vision
- □ Eye pain
- □ Hearing problems
- □ Nosebleeds
- □ Nose problems
- □ Sinus trouble
- □ Dental problems
- □ Hoarseness
- □ Tonsillectomy
- □ Loss of smell

____

- □ Difficulty breathing
- □ Shortness of breath
- □ Chronic cough
- □ Spitting phlegm
- □ Bronchitis
- □ Spitting blood
- □ Wheezing/ asthma
- □ Pneumonia
- □ Tuberculosis
- □ Lung disease

____

- □ Irregular heart beat
- □ Chest pain
- □ Heart disease
- □ High blood pressure
- □ Pacemaker
- □ Ankle swelling
- □ Varicose veins
- □ Rheumatic fever
- □ Stroke
- □ Arteriosclerosis

____

- □ Itching
- □ Change in mole(s)
- □ Skin cancer
- □ Hair/ nail changes
- □ Cold extremities
- □ Bruise easily

____

- □ Poor appetite
- □ Poor digestion
- □ Difficulty swallowing
- □ Belching or gas
- □ Vomiting blood
- □ Pain over abdomen
- □ Stomach ulcer
- □ Black or bloody stool
- □ Liver problems
- □ Jaundice
- □ Diarrhea
- □ Constipation
- □ Gall bladder problems
- □ Bloating
- □Hemorrhoids
- □ Appendicitis
- □ Hernia
- □ Frequent nausea/ vomiting

____

- □ Car accident
- □ Major fall
- □ Head injury
- □ Broken bone

____

- □ Frequent urination
- □ Painful urination
- □ Blood in urine
- □ Urinary Tract Infection
- □ Kidney disease
- □ Kidney stones
- □ Inability to control urination
- □ Difficulty starting urination
- □ Getting up at night to urinate
- □ Sexually transmitted disease
- □ Sexual difficulty

____

- □ Testicular Problems
- □ Prostate problems
- □ Painful periods
- □ Irregular cycles
- □ Vaginal burning/ itching
- □ Severe cramps
- □ PCOS
- □ PMS
- □ Hot flashes
- □ Date of last menstrual period:

____

- □ Date of last Pap smear:

____

Are you currently experiencing pre or post menopause?
□ YES □ NO
Is there a possibility you are currently pregnant?
□ YES □ NO

- □ Breast lump or pain

____

- □ Weakness
- □ Twitching
- □ Tremor
- □ Headache
- □ Fainting
- □ Dizziness
- □ Convulsions
- □ Epilepsy/ seizures
- □ Numbing/ tingling
- □ Arm/ leg pain
- □ Mental disorder
- □ Depression
- □ Loss of memory
- □ Loss of taste

____

- □ Painful joints
- □ Spinal curvature
- □ Osteoarthritis
- □ Sprain/ strain
- □ Swollen joints
- □ Rheumatoid Arthritis

SCHNEIDER CHIROPRACTIC, LLC
523 NORTH ELM ST- LINCOLN, IL

Patient Name______________________
DOB____________ Date____________

List any **medications** that you are currently taking, including birth control and nutritional supplements

____
____

List any known **allergies**

____
____

List any other **health conditions, surgeries, or hospitalizations**

____
____

List any history of **trauma** (ie: falls, accidents, fractures, etc)

____
____

FAMILY HISTORY

Please check if your mother, father, son, daughter, brother, sister, maternal grandmother, maternal grandfather, paternal grandmother or paternal grandfather have had any of the following conditions.

□ My family history is unknown

Condition	Please list relation and living or deceased
Type I Diabetes □ NO □ YES	____
Type II Diabetes □ NO □ YES	____
Thyroid disease □ NO □ YES	____
Goiter □ NO □ YES	____
Tuberculosis □ NO □ YES	____
Kidney disease □ NO □ YES	____
High blood pressure □ NO □ YES	____
Heart disease □ NO □ YES	____
Cancer □ NO □ YES	____
Multiple sclerosis □ NO □ YES	____
Rheumatoid arthritis □ NO □ YES	____
Lung disease □ NO □ YES	____
Ulcer □ NO □ YES	____
Arthritis □ NO □ YES	____
Seizure □ NO □ YES	____
Stroke □ NO □ YES	____

SOCIAL HISTORY

Smoking status:
□ Every day smoker
Packs/day__________
□ Occasional smoker
□ Former Smoker
□ Never smoked

Do you drink alcohol?
□ YES □ NO
If yes, how much? _____________

Do you exercise?
□ YES □ NO
If yes, how much? ______________

Do you use caffeine?
□ less than 3 drinks/day
□ 3-6 drinks/day
□ more than 6 drinks/day

Do you use recreational drugs?
□ YES □ NO

SCHNEIDER CHIROPRACTIC, LLC **Patient Name**______________________

523 NORTH ELM ST- LINCOLN, IL DOB____________ Date____________

Have you seen a chiropractor before? □ NO □ YES Last Visit: ___________________

What is your main complaint? ____

When did this start? ____

Do you know what caused this problem? ____

What makes it better? ____

What makes it worse? ____

Circle the word or words that best describe it:

Sharp, Dull, Aching, Burning, Tingling, Numb, Shooting, Intense, Random, Insidious, Comes and Goes, Numbness, Pain, Discomfort, Tightness, Throbbing, Varying with activity, Increasing with movement, Mild nuisance

Does the pain start one place and travel to another? □ YES □ NO

How severe is it at its worst?* (Circle the one that applies) 0 1 2 3 4 5 6 7 8 9 10

*(0 is no pain, 1-3 is mild, 4-6 is moderate, 7-9 is severe and 10 is intolerable)

Is there a time of day associated with your pain? (Circle one) None Morning Afternoon Night Constant Intermittent

What have you done to treat this problem? ____

Have you had this type of problem in the past? ____

Does this problem interfere with: □ Work □ Activities □ Sleep □ Appetite

Have you had x-rays taken? □ NO □ YES If so, when? _______________________________

Do you have any other complaints? □ NO □ YES

If yes:

What else is bothering you?_______________________

When did it start?_______________________________

Do you know what caused this problem? ____________

What makes it better?___________________________

What makes it worse?___________________________

Describe the pain (use words from above)___________

____

Does pain start one place and travel to another?

□ YES □ NO

How bad is it at its worst? 0 1 2 3 4 5 6 7 8 9 10

Is there a time of day associated with your pain? None

Morning Afternoon Night Constant Intermittent

What have you done to treat this

problem?_____________________________________

Have you had this type of problem in the past?_______

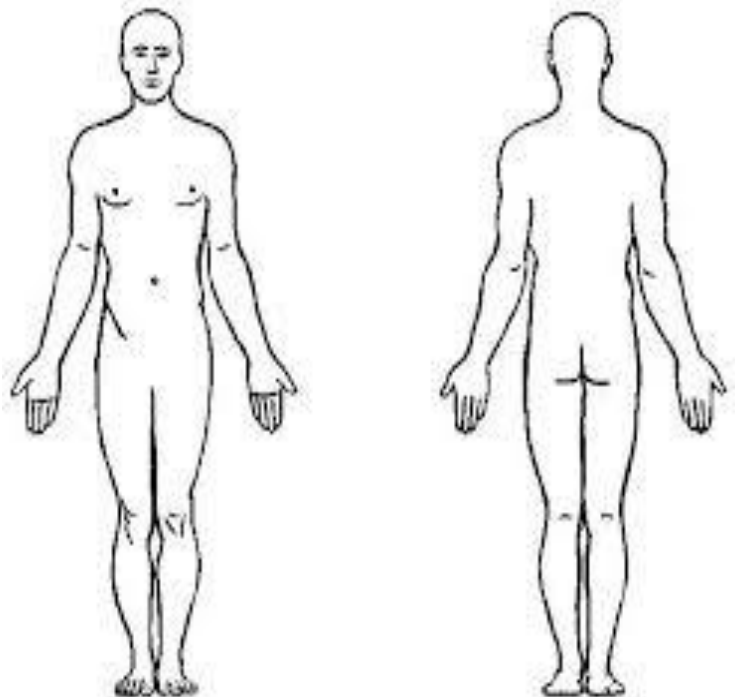
Does this problem interfere with: □ Work □ Activities

□ Sleep □ Appetite

Have you had x-rays taken? □ NO □ YES

If so, when? _______________________________

Please mark areas on the body where you experience pain or unusual sensation. Include all affected areas



To the best of my ability, the information I have supplied is complete and truthful. By signing below, I state that I want to investigate how chiropractic care can help me (*or the patient to whom I am Legal guardian*) and consent to a chiropractic examination. I intend this consent to cover any examinations for my present condition and for any future conditions for which I seek treatment at Schneider Chiropractic, LLC. (Or the condition(s) of the patient for whom I am the legal guardian)

Signature ____ Date___________________

NOTICE OF PRIVACY PRACTICES
Schneider Chiropractic, LLC
523 North Elm Street
Lincoln, IL 62656
217-732-2140

PLEASE READ CAREFULLY: This notice explains how Schneider Chiropractic, LLC can use or share the medical information that the office has about you. It also explains your rights.

Disclosure or your Health Care Information

Payment:
We may disclose your health information to your insurance/Medicare provider for the purpose of payment. An Electronic Data Interchange System may also obtain your information for billing purposes only. Our office has on file, a signed contract from this company that prohibits them from using or disclosing your information.
Worker's Compensation/Automobile Accident/Personal Injury:
We may disclose your health information as necessary to comply with the State of Illinois Laws associated with these types of claims.
Emergencies:
We may disclose your health information to notify or assist a family member or person responsible for your care in the event of an emergency or death.
Public Health and Safety:
As required by law, we may disclose your health information to public health authorities as needed.
Judicial and Administrative Proceedings:
We may disclose your health information in the course of any administrative or judicial proceeding.
Law Enforcement or Specialized Government Agencies:
We may disclose your health information to a law enforcement official complying with a court order or subpoena or other law enforcement purposes. We may also disclose your health information for military, national security, prisoner and government benefits.
Organ Donation/Deceased:
We may disclose your health information to organizations involved in organ donations. We may also disclose the information to coroners or medical examiners.

Change of ownership

In the event that the office of Schneider Chiropractic, LLC is sold or merged with another doctor or organization, your information and records will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised that our office is not required to agree with the restrictions that you request.
- You have the right to copy and inspect your health information.
- You have the right to have your health information sent to an alternative location upon your request.
- You have the right to request that our office amend your protected health information. Please be advised, our office is not required to agree to amend your protected health information. If your request is denied, you will be provided with an explanation of our denial.
- You have the right to receive an accounting of disclosures of your protected health information made by this office.
- You have the right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to the Notice of Privacy Practices

Our office reserves the right to amend this Notice of Privacy Practices at any time. Until such amendments are made, our office is required by law to comply with this notice. We are required by law to maintain the privacy of your health information. If you have any questions regarding this privacy notice, please contact the office during our regular business hours.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. You may reach our privacy compliant officer at Schneider Chiropractic, LLC at (217) 732-2140 for further information about the complaint process. You may also find more information by calling (866)627-7748 or going to www.hhs.gov/ocr/hippa