Patient information

First Name:______________________ Last Name:______________________________ Date:____________________

Email:_____________________________________ Address: (street)____

Home phone number:_________________________ (city, state, zip)_________________________________

Cell phone number:___________________________ Best number to reach you: (H) (W) (C)

Date of Birth:_______________________ Sex: ❑Male ❑Female SS#:____

Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed ❑Separated ❑Minor

Race: ❑Caucasian ❑African American ❑Asian ❑Native American ❑Latin American ❑Other ________________________

Occupation: ______________________________ Employer:____

Employer Address:____ Phone:________________________________

How did you hear about our practice?____

Emergency Contact:________________________________Phone:______________________ Relation:______________

Accident Information

Is this visit due to an accident or injury? ❑Yes ❑No If yes, what type? ❑Auto ❑Work ❑Other Injury

If Auto or Work, has it been reported? ❑Yes ❑No If yes, to whom?_______________________________________

Insurance Information

Do you have health insurance? ❑Yes ❑No Name of Carrier:____

Do you have secondary insurance? ❑Yes ❑No Name of Carrier:____

Policy Holder Name: ____ Date Of Birth:________________________

Relationship to you (if not yourself):____________________________ Phone:___________________________________

*****PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)***

Assignment and Release (insured patients):

I certify that I (or my dependent) have insurance coverage with_______________________________ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE:____ DATE:______________________

Patient's Name: ____ DOB: ___________________________

Health History

Primary doctor & location: ____ Last Physical: __________________

Please check if you are currently experiencing any of the following conditions:

❑Neck Pain/Stiff	❑Headaches	❑Chest Pain	❑Fatigue	❑Sleeping Difficulties
❑Back Pain/Stiff	❑Tension	❑Short of Breath	❑Rapid Weight Change	❑Bowel/Bladder Changes
❑Arm/Hand Pain	❑Fainting	❑Easily Exerted	❑Fever	❑Stomach Problems
❑Leg/Knee Pain	❑Dizziness	❑Asthma	❑Night Sweats	❑Anxiety
❑Pins/Needles-Arms	❑Loss of Smell	❑Constipation	❑Night Pain	❑Depression
❑Pins/Needles-Legs	❑Allergies	❑Diarrhea	❑Nausea	❑Loss of Memory
❑Light Bothers Eyes	❑Blurry Vision	❑Cold Feet	❑Loss of Taste	❑Loss of Smell

Please check to indicate if you have ever had any of the following:

❑Hypertension	❑Hepatitis	❑Fractures	❑Rheumatoid Arthritis	❑Pneumonia
❑Heart Disease	❑Kidney Disease	❑Arthritis	❑Menstrual Problem	❑Scarlet Fever
❑Stroke	❑Liver Disease	❑Herniated Disc	❑Miscarriage	❑Mononucleosis
❑Diabetes	❑Thyroid Disease	❑Pinched Nerve	❑Vaginal Infection	❑Polio
❑High Cholesterol	❑Lung Disease	❑Migraines	❑Breast Lump	❑Tonsillitis
❑Emphysema	❑Bowel Disease	❑Prosthesis	❑Prostate Problems	❑Tuberculosis
❑Asthma	❑Bladder Disease	❑Osteoporosis	❑Aids/HIV	❑Typhoid Fever
❑Bronchitis	❑Parkinson's	❑Glaucoma	❑Sexually Transmitted	❑Rheumatic Fever
❑Cancer	❑Multiple Sclerosis	❑Cataracts	❑Gonorrhea	❑Psychiatric Condition
❑Allergies	❑Hernia	❑Chicken Pox	❑Anemia	❑Alcoholism
❑Ulcers	❑Appendicitis	❑Measles	❑Blood Disorder	❑Drug Dependency
❑Gout	❑Pacemaker	❑Mumps	❑Epilepsy	❑Suicide Attempt

Other:____

Are you currently under any medical care? ❑Yes ❑No If yes, for what condition: ______________________________

List any medications you are currently taking (Include dosage and frequency):

____

List all surgeries and/or hospitalizations (include types & dates):

____

List any allergies: ____

List any supplements you currently take: ____

Is there a family history of any of the following conditions? (Indicate which family member)

❑Heart Disease ❑Diabetes ❑Cancer ❑Arthritis ❑Other_____________________________________

Do you exercise: ❑Never ❑Daily ❑Weekly ❑Walk ❑Run Other Activities: ___________________________

At work, are you mostly: ❑Sitting ❑Standing ❑Light Labor ❑Heavy Labor

Daily/weekly intake of the following: Caffeine__________ Alcohol__________ Cigarettes__________

*****I certify that the above questions are accurate. I understand incorrect information can be dangerous to my health.***

SIGNATURE____ **DATE**___________________

ROS CHECKLIST: Name____Date______________

General-
□ Weight loss or gain
□ Fatigue
□ Fever or chills
□ Weakness
□ Trouble sleeping

Skin-
□ Rashes
□ Lumps
□ Itching
□ Dryness
□ Color changes
□ Hair and nail changes

Head-
□ Headache/migraine
□ Head injury
□ Neck Pain

Ears-
□ Decreased hearing
□ Ringing in ears
□ Earache
□ Drainage

Eyes-(Last Exam:_____________)
□ Vision Loss/Changes
□ Glasses or contacts
□ Pain
□ Redness
□ Blurry or double vision
□ Flashing lights
□ Specks or floaters
□ Glaucoma
□ Cataracts

Nose-
□ Stuffiness
□ Discharge-Mucous
□ Itching
□ Hay fever
□ Nosebleeds
□ Sinus pain

Throat-
□ Bleeding
□ Dentures
□ Sore tongue
□ Dry mouth
□ Sore throat
□ Hoarseness
□ Thrush
□ Non-healing sores

Neck-
□ Lumps
□ Swollen glands
□ Pain
□ Stiffness

Breasts-
□ Lumps
□ Pain
□ Discharge
□ Regular self-exams
□ Currently breast-feeding

Respiratory-
□ Cough
□ Sputum
□ Coughing Blood
□ Short of breath
□ Wheezing
□ Difficulty breathing

Cardiovascular-
□ Chest pain or discomfort
□ Tightness
□ Palpitations
□ Shortness of breath(w/ exertion)
□ Shortness of breath(lying flat)
□ Swelling
□ Sudden awakening from sleep with shortness of breath

Gastrointestinal-
□ Swallowing difficulties
□ Heartburn
□ Change in appetite
□ Nausea/Vomiting
□ Change in bowel habits
□ Rectal bleeding
□ Constipation
□ Diarrhea
□ Yellow eyes or skin

Urinary-
□ Pee too much
□ Can't make it in time
□ Burning or pain
□ Blood in urine
□ Incontinent/Accidents
□ Change in urine flow

Vascular-
□ Calf pain w/ walking
□ Leg cramping

Musculoskeletal-
□ Muscle or joint pain
□ Stiffness
□ Back pain
□ Redness of joints
□ Swelling of joints
□ Trauma

Neurologic-
□ Dizziness
□ Fainting
□ Seizures
□ Weakness
□ Numbness
□ Tingling
□ Tremor

Hematologic-
□ Easy bruising
□ Easy bleeding

Endocrine-
□ Head or cold intolerance
□ Sweating
□ Frequent urination
□ Thirst
□ Change in appetite

Psychiatric-
□ Nervousness
□ Stress
□ Depression
□ Memory loss

INITIAL ALLERGY EVALUATION

Patient Name: ____

Patient Number: ______________________________ Date: ______________________

Physician: ____

Nurse: ____

PATIENT HISTORY

	YES	NO
Do you have symptoms such as sneezing, watery nasal discharge, or nose and throat itching?	❑	❑
Do you have frequent "colds," sinus problems or chronic nasal congestion?	❑	❑
Do your eyes itch, water, get red or swell?	❑	❑
Are your symptoms seasonal only, or do they get worse in certain seasons?	❑	❑
Do your symptoms change when you go indoors or outdoors?	❑	❑
Are your symptoms worse around animals?	❑	❑
Do you have any blood relatives with allergies (e.g. parents, siblings)?	❑	❑
Do you have or did you ever have asthma, eczema or hives?	❑	❑

Yes for 3 or more questions indicates potential allergies,
and patient may be a candidate for a simple allergy test.

Notes:

Northstar Integrated Health
4513 Lincoln Ave., Suite 212
Lisle, IL 60532

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities such as surveys, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations with your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Military Activity and National Security: Workers’ Compensation: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by an alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

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.**

This notice was published and becomes effective on/or before **March 6, 2018.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to personal health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our 630-795-1889.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices"

Print Name ____ DOB____________________________

Signature____ Date____________________________

Please indicate if you would be okay receiving informative emails from Northstar: _______Yes _______No

CONSENT TO CARE

A patient coming to the doctor gives him / her permission and authority to care for them in accordance with appropriate testing, 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 agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I, ____(*print name*) have read and understand the foregoing.

____ ___________________ ___________________

Patient's Signature DOB Date

X-ray Questionnaire (Women Only)

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

- ❑ There is a possibility that I may be pregnant at this time.
- ❑ Yes, I am definitely pregnant
- ❑ No, I am definitely not pregnant at this time

I request that x-ray films not be taken because:

____

____

Date of beginning of last menstrual period: ___________________

____ ______________________

Patient's Signature Date

<u>Manual Manipulation Consent</u>

A patient coming to the doctor gives their permission and authority to care for them in accordance with appropriate testing, diagnosis, and decision making. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities, or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare if he is aware that such care may be contraindicated. It is the responsibility of the patient to report any known contraindications or adverse effects from any treatment or test they have received. It is also the patient's responsibility to report any future adverse effects they may experience.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, by binding arbitration under the current malpractice terms which can be obtained by written request.

Manual Manipulation, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with manipulative care. The types of complications that have been reported secondary to manipulative care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with manipulative care, occurring at a rate between one instance per 1-2 million cervical spine (neck) adjustments. In these rare events, a vertebral artery could be injured which may lead to stroke.

Prior to receiving any manual manipulation treatment at this clinic, a health history, physical examination, and possible diagnostic tests will be completed. These are performed to assess your specific condition, your overall health and, in particular, your spine health. These activities assist us in determining if manual manipulation is needed, or if any further examinations or studies may be needed. In addition, they will help us determine if there is any reason to modify your treatment plan or provide you with a referral to another health care specialty. All relevant findings will be reported to you along with a treatment plan prior to beginning care.

I understand and accept that there are risks associated with manual manipulation and give consent to the indicated examinations and diagnostics.

Patient Name : ____

Patient Signature:____ **Date:___________**

DOB: ______________

*****This notice is effective as of this date,_____________________, and will expire seven years after patient's final date of treatment at Northstar Integrated Health & Physical Medicine, SC.***

PATIENT MISSED APPOINTMENT POLICY

It is our wish that each and every one of our patients receive the highest quality of care and service possible. Providing the best possible care gives our patients the best possible results and allows them to enjoy best quality of life. **Your Treatment Program** consists of a specific series of treatments given over a pre-planned time period. Quite simply, if you are unable to follow this plan, then you will not receive the desired results.

If we did not insist that you meet all your appointments, we would be doing you a disservice by providing less than optimal care and it would also suggest that we did not care about the outcome of your treatment. We do not want to do you a disservice and we do care about you and the success of your program here. Therefore, we have a few simple rules that we insist you follow:

1. Meet all your appointments. Arrange the activities in your life so that this can occur.

2. If you become ill, we still want you to come in. Physical Medicine Treatments will help you recover more quickly and we would be happy to provide any general medicine treatment that may be necessary as well.

3. If you are unable to make it in due to an emergency, please call us and let us know so we can reschedule your appointment.

4. Appointments cancelled with less than 24 hour notice are subject to a $20.00 service charge.

5. All cancelled or missed appointments must be rescheduled and made up within one week.

6. There is a $20.00 service charge for no call/no show appointments scheduled with Dr. Paul Rieselman.

I have read, understand, and agree to follow the above policy.

Patient's Name: ___________________________________

DOB: ____

Signature: _______________________________________

Staff Witness: ____________________________________

Financial Policy

1. All patients are on a cash basis until our staff can verify all insurance coverage(s).
2. Your insurance will be verified promptly and will be reviewed with you if applicable.
3. After coverage and deductible are verified, this office may accept assignment on most policies provided the insured/patient signs an appropriate statement of benefits and/or a lien authorizing payment to be sent to the doctor.
4. Waiting for insurance payment is a courtesy and it may be withdrawn under certain circumstances.
5. It is the patient's responsibility to pay their co-payment (usually a percent or fixed amount) and any non- covered services on a monthly basis. This office may make payment arrangements on an individual basis. Any such plan or arrangements will be discussed during your report of findings.
6. This office does not warrant or guarantee that your insurance company will pay, nor does this office promise that an insurance company will or should pay the fees charged. Insurance policies are an arrangement between the insurance carrier and the patient/insured.
7. Any service not covered or coverage reductions by your insurance carrier will be the patient's responsibility.
8. This office will submit an insurance claim for you. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly with your insurance adjuster or agent. Any denied or disputed claims will be treated as uncovered.
9. If your account should go to collections for any reason, it will be the patient's responsibility for any court costs, attorney's fees, and or collection costs incurred in collecting the account balance.
10. I authorize the release of any medical or other records or information from my health record. I authorize release of records or information necessary to process any claims.
11. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due. This means refunds are made only after your balance is completed and cleared with this office.
12. If you receive correspondence of checks from your insurance company, you agree to bring these into our department so that we may determine if any action needs to be taken or if the check is on assignment to this office.
13. If you change insurance companies or employers, you agree to provide this office with the current information immediately.
14. If this office gives you any professional or accounting discount for treatment and you decide to drop out of care then our standard fees will apply.
15. This office accepts Credit/Debit Cards, personal checks and cash.
16. If you have any questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the doctor.
17. If you stop care and have a financial agreement signed with our office, you will be responsible for any/all charges that you have incurred at our office.
18. Any deductible, coinsurance, or copayment costs for lab work ordered will be your responsibility.

Thank you for your cooperation with our financial policy.
I have read and fully understand the financial office policy and agree to abide by these terms.

Patient Name:____ Patient DOB:____________

Patient Signature:_____________________________________ Date:_________________