**ORMAN CHIROPRACTIC**
**PATIENT CONSENT**
**FOR USE AND/OR DISCLOSURE OF**
**PROTECTED HEALTH INFORMATION**
**TO CARRY OUT TREATMENT, PAYMENT**
**AND HEALTHCARE OPERATIONS**

________________, hereby states 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 may 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 operations.

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 operations. 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 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 | Relationship (e.g., Attorney-In-Fact, Guardian, Parent if a minor): |
| Date Signed ____/____/____ | Witness: ________________________ |

# Orman Chiropractic

5833 W. Dempster Ave Morton Grove, IL 60053 847-967-0101

## Authorization For Payment

Your signature on this form authorizes Orman Chiropractic to automatically process payment to your credit card on file for deductibles, co-insurance and co-pays which have become due. This will prevent the accrual of late fees and help make your account more manageable. The amount of payment is determined by direct notification from your insurance carrier to us and is processed to your credit card and posted to your account. You can terminate this agreement at any time by notification in writing to the office. Please submit this card at the time of your first visit.

MC/Visa/Discover ______________________________
Circle one Card Number

Name on Card ______________________________

__________ Expiration Date __________ Security Code

**I have read and understand this agreement.** __________ accept __________ decline

__________ **Date** ______________________ **Patient Signature**

__________ **Home Phone #** ______________________ **Print Name**

**Orman Chiropractic Patient Information** (please print)

Name: ______________________________ Date: __________

Address: ______________________________

City: ______________________________ State: ________ **9 Digit ZIP**: ______-______

Date of Birth: ______________ Age: __________ Social Security #: ______________

Home Phone: ______________________ Mobile Phone: ______________________

Work Phone: ______________________ Email: ______________________

Marital Status: ______________ Occupation: ______________________

Place of Employment: ______________________________

How did you hear of us? ______________________ Were you in a car or work accident? YES NO
Date of accident: ______________

**Emergency or Spouse Information:**

Name: ______________________________ Relationship: ______________

Home Phone: ______________________ Other Phone: ______________________

**Billing Information:** **Same as your address above?** YES NO

Name: ______________________________

Address: ______________________________

City: ______________________________ State: __________ ZIP: __________

Home Phone: ______________________ Other Phone: ______________________

Place of Employment: ______________________ Social Security #: ______________

**Insurance Information:** **Do you have health insurance?** YES NO (Please provide your insurance card)

Insurance Company: ______________________________

Type of Insurance: HMO POS HMO Other: ______________________

Primary policy holder (name of insured): ______________________________

Date of birth: ______________ ID#: ______________________ Group#: ______________

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non-covered. If the doctor is a contracted provider for my managed care plan, I understand that I am responsible for all copays and fees for non-covered services prior to seeing the doctor. I understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.
I understand that unpaid fees for services beyond thirty (60) days are subject to a 1.5% monthly finance charge (18% annually). If my account becomes delinquent and it becomes necessary to place my account in collection, I understand that I am responsible for any and all associated costs and charges. I (we) authorize the doctor and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney, in order to process any claim, for reimbursement, or charges, incurred by me as a result of professional services rendered and hereby release him/her of any consequences thereof. I (we) hereby authorize and direct payment of any medical/chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. This payment shall not exceed my indebtedness to the assignee. I agree that a photostatic copy of this agreement shall serve as the original.

**Patient's signature:** ______________________________ **Date:** __________

**Spouse's or Guardian's signature:** ______________________________ **Date:** __________

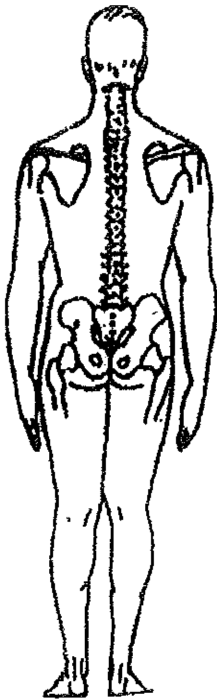
# Problem - Focused History

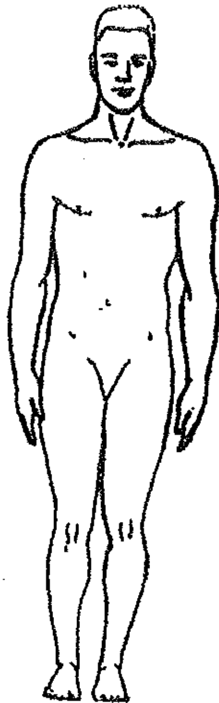
(PLEASE PRINT)

**Briefly describe your pain / problems in order of severity:** **1.** ______________________

**2.** ____________________ **3.** ____________________ **4.** ______________________

**Using the following symbols, indicate the area(s) of your problem(s):**





| | |
|---|---|
| \\\\\\\\\\\\ | SHARP / STABBING |
| OOOOO | DULL / ACHY |
| ********** | PINS & NEEDLES |
| NNNNN | NUMBNESS |
| SSSSS | THROBBING |
| TTTTTT | TIGHTNESS |

| | |
|---|---|
| ______ | CONSTANT (75-100% OF TIME) |
| ______ | FREQUENT (50-75% OF TIME) |
| ______ | OCCASIONAL (25-50% OF TIME) |
| ______ | INTERMITTENT (5-25% OF TIME) |
| ______ | RARELY (0-5% OF TIME) |

**What is your pain *right now*?**

NO PAIN ________________________________________ WORST POSSIBLE PAIN
0 10

**What is your pain *at its worst*?**

NO PAIN ________________________________________ WORST POSSIBLE PAIN
0 10

**What is your pain *at its best*?**

NO PAIN ________________________________________ WORST POSSIBLE PAIN
0 10

**When did it start?** ________________________________________

**Why did it start?** ________________________________________

**How did it start?** SUDDEN ONSET GRADUAL ONSET NOT SURE

**Since onset, has it:** GOTTEN WORSE GOTTEN BETTER STAYED SAME BEEN ERRATIC

**Does the pain radiate of refer?** YES NO **Where?** ______________________________

**Have you had similar pain/problems in the past?** YES NO **How long ago?** ______________________

**Since initial onset, have you had any changes in the following bodily functions?** YES NO

| | | | |
|---|---|---|---|
| ___ BALANCE | ___ BOWEL HABITS | ___ BREATHING | ___ COORDINATION |
| ___ COUGHING | ___ GAIT | ___ GRIP | ___ HEARING |
| ___ MENSTRUAL | ___ SEXUAL | ___ SLEEP | ___ SNEEZING |
| ___ URINATION | ___ VISUAL | ___ WEAKNESS | ___WEIGHT |

**Do you have difficulty performing any of the following daily activities:**

- **Getting in and out of you car** YES NO
- **Climbing stairs** YES NO
- **Sitting comfortably** YES NO
- **Dressing yourself** YES NO
- **Hygiene (teeth, hair, etc)** YES NO
- **Bending and / or lifting** YES NO
- **Concentrating and / or reading** YES NO

**Are there any other daily activities that have been affected?** YES NO

**What other activities?** ______________________________

**What makes the pain *worse*?** SITTING STANDING WALKING LAYING CHANGING POSITIONS

**What else makes the pain *worse*?** ______________________________

**When is the pain the *worst*?** MORNING DAYTIME AT WORK NIGHTTIME DOESN'T MATTER

**What else makes the pain *better*?** ______________________________

**Have you seen any other doctors for your current complaint(s)?** YES NO

**Name of Treating Doctor:** ______________________________

**Tests Performed:** ______________________________

**Diagnosis:** ______________________________

**Are you taking any store-bought or prescription medication for your complaint(s)?** YES NO

**Names of medications:** ______________________________

**What other treatments have you tried?** ______________________________

**Work Status:** FULL TIME PART TIME RETIRED UNEMPLOYED STUDENT DISABLED

**Have you missed any work due to your pain / problem?** YES NO **How much?** ____________________

## ADDITIONAL QUESTIONS

**Do you have recurring headaches?** YES NO

**Are you losing weight without trying?** YES NO

**Does the pain wake you up at night?** YES NO

**Do you have constant pain regardless of what position you are in?** YES NO

**Do you have any sores that never heal?** YES NO

**Have you had a change in your bowel habits?** YES NO

**Have you recently had any unusual bleeding or discharge?** YES NO

**Do you have a thickening or lump in the breast or somewhere else?** YES NO

**Do you have frequent indigestion or difficulty swallowing?** YES NO

**Do you have a nagging cough or hoarseness?** YES NO

**Do you have a pacemaker or any other implanted device, including artificial joints?** YES NO

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## SOCIAL HISTORY

**Race:** Caucasian African American Hispanic Asian Other: ____________________

**Do you exercise outside of your work activities?** YES NO

**What type of exercise and how often?** ____________________

**Describe your work habits:** ____________________

**Are your physical demands at work…** Heavy Moderate Mild Sedentary

**Is your stress level at work…** High Medium Low

**Describe any recreational activities, including how often:** ____________________

**Do you smoke?** YES NO **If yes, what and how often:** ____________________

**Do you drink alcoholic beverages?** YES NO **If yes, what and how often:** ____________________

**Do you drink caffeinated beverages?** YES NO **If yes, what and how often:** ____________________

**Is your diet…** Balanced Fair Poor Excessive Restricted Other: ____________________

**FEMALES:** **Are you pregnant?** YES NO **Taking birth control?** YES NO **Nursing?** YES NO

(For Doctor) Reviewed by ____________________ Date __________

## CONFIDENTIAL HEALTH HISTORY

**Have you ever at any time had any of the following conditions:** (please check off and specify on the line)

- O AIDS/HIV
- O Alcoholism
- O Allergies: ______
- O Anemia
- O Anorexia
- O Appendicitis
- O Arthritis: ______
- O Asthma
- O Bleeding Disorder
- O Bronchitis
- O Bulimia
- O Cancer: ______
- O Cataracts
- O Chemical Dependency: ______
- O Chicken Pox
- O Depression
- O Diabetes: type I type II
- O Emphysema
- O Epilepsy
- O Fractures: ______
- O Glaucoma
- O Goiter
- O Gonorrhea
- O Gout
- O Heart Disease
- O Hepatitis: ______
- O Herniated Disc: ______
- O Herpes: ______
- O High Cholesterol
- O Kidney Disease: ______
- O Liver Disease: ______
- O Miscarriage
- O Mononucleosis
- O Multiple Sclerosis
- O Mumps
- O Osteoporosis
- O Pacemaker
- O Parkinson's Disease
- O Pinched Nerve: ______
- O Digestive Problems: ______
- O Polio
- O Prostate Problems
- O Prosthesis
- O Psychiatric Care
- O Rheumatoid Arthritis
- O Rheumatic Fever
- O Scarlet Fever
- O Stroke
- O Suicide Attempt
- O STD: ______
- O Thyroid Condition
- O Tonsillitis
- O Tuberculosis
- O Tumor
- O Typhoid Fever
- O Ulcer: ______
- O Vaginal Infections
- O Whooping Cough
- O Pneumonia

**Other Disease(s) not listed above:** ______

**List any surgeries you have had:** ______ **when?** ______
______ **when?** ______
______ **when?** ______
______ **when?** ______

**Have you been hospitalized for any other reason besides surgery?** YES NO **What?** ______

**Are you currently under doctor's care for any other condition?** YES NO **What?** ______

**List all medications you are currently taking:** ______
______

**Name of your primary care medical doctor:** ______
**Clinic name and address:** ______
______

**Name(s) of any other doctor's you see (i.e. Ob/Gyn, etc):** ______

### FAMILY HISTORY

**List any other diseases or conditions that are common among your family members:** (i.e. heart disease, cancer, stroke)

mother: ______ grandma (mom's side): ______
father: ______ grandpa (mom's side): ______
brother(s): ______ grandma (dad's side): ______
sister(s): ______ grandpa (dad's side): ______

**List any congenital or hereditary problems:** ______
______

# X-RAY ASSIGNMENT AGREEMENT AND CONSENT

I understand that this office will have my X-Rays interpreted by John R. Henry DC DACBR, a radiologist certified by the American Chiropractic Board of Radiology.

I acknowledge that I have reviewed, with my doctor, and understand and agree to the Notice of Privacy Practices of BRC, Inc.

Patient's/Guardian's Signature: ______________________________

Patient's Printed Name: ______________________________

Date : ____________

# Communication Consent Form

In order to comply with HIPAA (Health Insurance Portability And Accountability Act of 1996) regulations, we ask that our patients review and sign this Communication Consent Form.

I, ____________________________ authorize Orman Chiropractic to contact me and/or named authorized person(s) and to convey Protected Health Information (PHI) by the following methods and assume responsibility to notify Orman Chiropractic whenever this information changes:

Email No ___ Yes ___ ______________@_____________

Home Mail No ___ Yes ___

Home Tel # No ___ Yes ___ #____________________

Work Tel # No ___ Yes ___ # ____________________

Cell Phone No ___ Yes ___ #____________________

Who may we contact in case of an emergency?

Name: _____________________ Relationship: _______________

Phone #(s) ______________________________________________

Please list names of other people authorized to receive information about your care:

Spouse: ___________________________________

Parent: ___________________________________

Other: ___________________________________

Client Signature: ____________________________ Date: __________

Parent/Guardian Signature: ___________________ Date: __________

(If patient is less than 14 years of age)

Witness Name: ______________________________ Date: _________

Witness Signature: ___________________________ Date: _________

A copy of this document will be provided to you upon request.

# Orman Chiropractic

5833 Dempster Ave Morton Grove, IL 60053 847-967-0101

## Consent to Treat a Minor

Patient: ________________________

File Number: _______

I hereby request and authorize Dr. Daniel Orman to perform diagnostic test and render Chiropractic adjustments and other treatment to

__________________________, age _______.

This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, ____________, I have the legal right to select and authorize health care services for the above named minor.

Date: ____________

Witness: ________________________

Authorizing Signature: __________________________

Printed Name of Above: __________________________

Relationship to Patient: __________________________