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

6315 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 personal or HSA 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 personal or HSA 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.

HSA ___ MC/Visa/Discover _____
Circle one Card Number

Name on Card _____

_____ _____
Expiration Date Security Code

PERSONAL ___ 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**

_____ _____
Cell 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:** _____

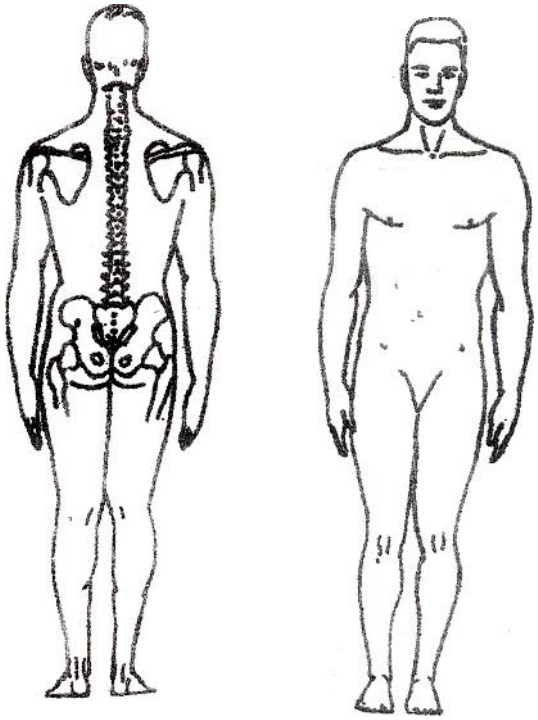
Problem - Focused History

(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

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 <u>physical</u> 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)

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

6315 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: _____