Welcome to the Office

Confidential Patient Information

Name: _____
Street: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Email: _____
Social Security #: _____ Date of Birth: _____
Marital Status: M S D W Children: _____
_____

Emergency Contact: _____ Relationship: _____
Phone: _____

Occupation: _____
Employer: _____
Work Phone: _____
Family Physician: _____ Phone: _____
How did you hear about us? _____

Describe Symptoms Briefly _____
_____
_____

Is this an auto accident: N Y Date _____
Is this an on the job injury? N Y Date _____
Ever had same/similar conditions? N Y Date
Other doctors you have seen for this condition? _____
Other health problems? _____
_____
Current list of medications: _____
_____

Do you smoke? N Y – Quantity? _____
Do you exercise regularly? N Y

_____

I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Patient signature: _____ Date: _____

Katherine Bendis, DC 303 E Army Trail Rd, Ste. 101, Bloomingdale, IL 60108 (Ph) 630-529-2225 (Fax) 630 – 529 - 0137

PATIENT INFORMED CONSENT

PATIENT NAME_____

Katherine Bendis, DC
303 E. Army Trail Rd.
Suite 101
Bloomingdale, IL 60108

The primary treatment used by doctors of chiropractic is the spinal adjustment. I will use that procedure to treat you.

***The nature of chiropractic adjustment.**

I will use my hands or a mechanical device upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel or sense movement.

***The material risks inherent in chiropractic adjustment.**

As with any health care procedure, there are certain complications that may arise during a chiropractic adjustment. Those complications include: fractures, disc injuries, dislocations and muscle strain, Homer's syndrome, diaphragmatic paralysis, cervical myelopathy, and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications, including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

***The probability of those risks occurring.**

Fractures are rare occurrences and generally result from some underlying weakness of the bone, which we check for during the taking of your history and during examination and X-rays. Stroke has been the subject of tremendous disagreement within the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination that are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as "rare."

Please sign_____

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Katherine Bendis, DC

Receipt of Notice of Privacy Practices Form

I, _____, hereby acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved the right to change his privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available upon request.

Signed:_____Date:_____

If you are not the patient, please specify your relationship to the patient_____

-Patient's file

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Katherine Bendis, DC

Agreement of Financial Responsibility

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

• Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider

• It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.

• We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.

• If we have a contract with your insurance company we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.

• If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.

• Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.

• Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

_____ _____

Signature of Patient /Responsible Party Date

_____ _____

Name of Patient/Responsible Party (please print) Relationship to Patient

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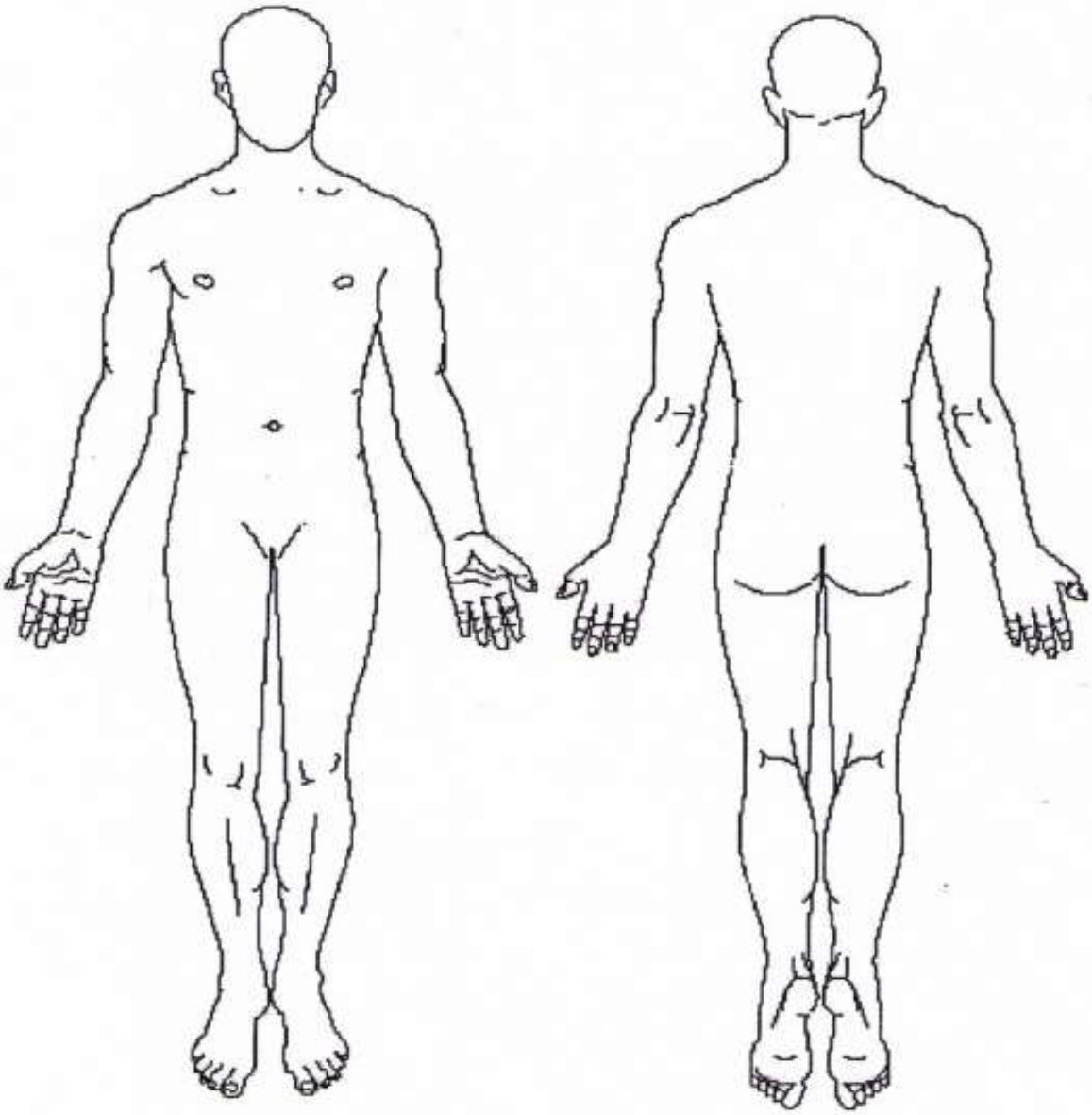
PAIN DRAWING

Patient Name: _____ Date: _____
Attending Dr.: _____

Using the letters below, mark the areas on your body where you feel the described sensations. Include all affected areas. Please complete the picture by drawing your face.

A = Ache **B** = Burning **N** = Numbness **P** = Pins & Needles **S** = Stabbing



Patient Signature: _____
Date: _____

SUBJECTIVE and OBJECTIVE NUMERICAL OUTCOME MEASURE ASSESSMENT

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