FULLER HEALTH GROUP

CHICAGO
211 N. Clinton St.
Unit 2N
Chicago, IL. 60661

OAK PARK
1049 Lake Street
Suite 201
Oak Park, IL. 60301

www.fullerhehealthgroup.com

P: 312-262-7969 F: 708-221-7108 info@fullerhealthgroup.com

PATIENT REGISTRATION FORM

Last Name:	First Name:	Middle Initial:	
Address:	City:	State:	Zip:
	DOB: (mm/dd/yyyy) Age:	Sex: ❍ M ❍ F	Marital Status: ❍ S ❍ M ❍ W ❍ D
Home Phone:	Cell Phone:	Work Phone:	
e-Mail Address:		Preferred Method of Contact: ❍ Home ❍ Work ❍ Cell ❍ e-Mail	
Reason for Appointment:		Which Side of the body? ❍ Left ❍ Right	Date Symptoms began?

PHYSICIAN INFORMATION

* Primary Care Physician:		* Primary Care Physician Phone:	
* Address:	* City:	* State:	* Zip:
* OB/GYN		* OB/GYN Phone:	
* Address:	* City:	* State:	* Zip:
* Dentist:		* Dentist Phone:	
* Address:	* City:	* State:	* Zip:
* Personal Trainer:		* Personal Trainer Phone:	
* Address:	* City:	* State:	* Zip:

HOW DID YOU FIND OUT ABOUT FULLER HEALTH GROUP?

❍ I was a former client ❍ Yellow Pages ❍ Family/Friend Recommendation Name _____

❍ Internet Search ❍ Doctor Recommendation Name _____

❍ Website _____ ❍ Chiropractor Recommendation Name _____

❍ Comments / Other Referral: _____

Photo ID and Insurance card are required on day of visit. If you did not bring insurance cards with you, all chargeswill be your responsibility and payable at time of service. Obtaining a treatment pre-certification is the patient's responsibility. ALL UNPAID BALANCES AND/OR DENIED CLAIMS ARE YOUR RESPONSIBILITY.

Patient/Guardian Signature:	Date:

Fields marked with an (*) are optional.

PRINT

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WELLNESS CONTRACT

The goal of the Fuller Health Group is to promote total wellness of the mind, body, and spirit.
By consenting to treatment, we are asking you to make a commitment to yourself. Treatment is not about a simple adjustment, rather a promise to understand the cause of your condition. Please indicate that you are on board by signing below.

Patient/Guardian Signature: _____ Date: _____

FINANCIAL POLICIES AND PROCEDURES

When seeking treatment, most patients look for answers to four main questions:

- What is wrong?
- How long will it take?
- Will treatment help?
- How much will it cost?

To accurately answer these questions, we must give what is called "A Trial of Care" over the course of three visits. This is necessary to answer the basic assessment questions of "How long will it take" and "How much will it cost". About 80% of common complaints, such as low back pain, can be solved in just these three visits. If you require more treatment to resolve pain, to promote a total resolution from systemic dysfunction pain, or to accomplish a more complex goal of health and wellness, further appointments are necessary.

After three visits, you will have the option of continuing care for a set period to accomplish goals within the ups and downs of the healing process. For this set period, it usually takes seven visits to see a change in the biomechanical and structural components that hold your pain/disease pattern. Fuller Health Group offers a variety of treatment plans to address structural, mental/emotional, and chemical concerns.

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INSURED PATIENTS

HEALTH INSURANCE Please provide your insurance card.

PRIMARY PROVIDER _____ ID#_____ GROUP # _____

If you are not the primary holder on your insurance policy, provide info below.

Guarantor's Name (as listed on card) _____ Birth Date _____

Fuller Health Group, PC can bill for both IN and OUT of network plans. Fuller Health is currently In Network with Blue Cross/Blue Shield, Aetna, Cigna, Humana, and United Health Care.

Insurance cards are required at every visit. We will verify your insurance coverage at the time of your first visit. Depending on your insurance, Fuller Health Group, PC will be reimbursed based on a percentage of the amount billed. We do not know the exact amount until we receive payment. All co-payments, deductibles, and payments for non-covered services (nutrition, homeopathy, and herbs) are due at the time of service.

As the recipient of services from Fuller Health Group, PC, you are ultimately responsible for all services provided. Our office will submit one (1) claim to your Health Insurance Provider. Fuller Health Group, PC is under no obligation to pursue reimbursement on the patient's behalf other than the one-time submission of the claim. If payment from your Insurance Provider is not received in full within thirty (30) days after submission of the request for payment, a courtesy letter will be written to your attention notifying you that your bill has not been paid. It is thereafter your responsibility to ensure that your health insurance pays your bill for services. If payment is not received in full within sixty (60) days, by providing your card and receiving provided services, you are authorizing Fuller Health Group, PC to charge your provided credit card for any unpaid bills or claims. Without a card on file, payment is due in full at the time services are rendered. Any claims paid after your credit card has been billed will be refunded to the patient.

It is not the responsibility of Fuller Health Group, PC to continually track your coverage. If there is a lapse in your coverage or you have maxed out your coverage, you are responsible for payment in full of the billed amount. If there are any changes to your insurance including, but not limited to, new insurance member identification number and/or group number, please inform the office. Not updating your personal information can delay and/or deny your insurance claims. If you have not provided our office with the correct insurance information, you will be responsible for any balance due. Please understand that your insurance is an agreement between you and your insurance company, and all services rendered to you are ultimately your responsibility.

WORKER'S COMPENSATION/PERSONAL INJURY PATIENTS

We are happy to accept your worker's compensation claim. You will need to provide us with the appropriate documentation, including your claim number and claim representative's contact information at the time of your visit. All services not covered by the claim will be your responsibility.

CLAIM # _____ DATE OF INCIDENT _____

CLAIM REPRESENTATIVE _____ PHONE _____

ASSIGNMENT OF BENEFITS TO DOCTOR

In considering the amount of medical expenses to be incurred I, the undersigned, have insurance and/or employee health care benefits coverage with the above mentioned Health Insurance Provider, and hereby assign and convey directly to Fuller Health Group, PC all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments.

Patient/Guardian Signature: _____ Date _____

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PAYMENT INFORMATION

If you will not be going through insurance, your balance is due at the time of your visit.

Self-Pay Prices:

Initial Visit
$175.00 due at the time of visit

Follow-up Visits:
15-minute: $50.00; 30-minute: $100.00
45-minute: $150.00; 60-minute: $200.00

For insurance patients, patient responsibility, such as deductible, co-pay, and co-insurance, is due at the time of service.
For Self-pay Patients, payment in full is due at time of service before the appointment.

MONTHLY BILLING STATEMENTS

Our office sends out a monthly billing statement to every patient with balances due over what was collected at time of service. The balance due is the remainder owed after your insurance has paid. It is your responsibility to pay your monthly statement even if you and your insurance company are disputing coverage. After 30 days, all appointments will be suspended until payment is received.

Additional Information

EXCHANGE OF MEDICAL INFORMATION

All requests by patients for medical information must be signed in writing by letter, fax, or a medical release of information form.

PRESCRIPTIONS

The scope of Dr. Fuller's practice prohibits him from prescribing, recommending, or prohibiting medications. Patients are instructed to always consult a medical physician before changing prescriptions.

LABORATORY TESTS & TEST PANELS

Comprehensive test kits can be a powerful tool to evaluate stress, fatigue, hormone-related disease, and other health conditions. FHG has established relationships with the industry's top lab and test providers. The cost of test kits cannot be billed to insurance, however, patients may submit for reimbursement independently. Once agreed upon with FHG, these test kits are NOT refundable or returnable to FHG.

CANCELLATION POLICY

We ask that you provide Fuller Health Group at least 24 hours advanced notice if you need to cancel or change your appointment time. If you need to cancel after the 24 hour period, please note your credit card on file will be charged $25.00.

ONLINE COMMUNICATION

Fuller Health Group utilizes email as a valuable tool for patient communication, education, and to share information and resources. It is an acceptable method for scheduling appointments in advance and making general queries, but should not be used for urgent or sensitive matters. E-mail communication is, however, non-secure and confidentiality cannot be guaranteed.

_____ Please initial here to give consent to receive email communications from Fuller Health Group.

I UNDERSTAND AND AGREE TO THE POLICIES OF THE FULLER HEALTH GROUP, PC.

Patient/Guardian Signature _____ Date _____

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FULLER HEALTH GROUP CREDIT CARD AUTHORIZATION

I, _____ , hereby authorize Fuller Health Group to charge my credit/debit card for the portion of the services that are my responsibility. This includes any patient responsibility from services rendered (deductibles, co-payments, and co-insurances) and/or fees incurred (cancellations within 24 hours or no-show appointments). I understand my card will be charged on a weekly basis for these amounts. I also understand that in the event my card declines, I will be required to provide a different method of payment. I will also be expected to pay for any previously unpaid charges resulting from the decline, in addition to the current charges.

I authorize my card to be charged for:

_____ patient responsibility and fees incurred.

_____ fees incurred only.

Credit Card Number: _____

Exp. Date: _____ CVV Code _____

Billing Address for the Debit/Credit Card listed above:

_____

_____

Patient Name: _____ Date: _____

Patient Signature: _____

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