SYCAMORE
INTEGRATED HEALTH

New Patient Intake Form

Patient Data

Name_____ Date_____ Email*_____

*Email will not be shared and will only be used for occasional office announcements and appointment reminders

Address_____ City_____ State_____ Zip_____

Cell Phone_____ Home Phone_____ Work Phone_____

Sex □ M □ F Birth Date_____ Age_____ Social Security Number_____

□ Single □ Married □ Widowed □ Separated □ Divorced Number of Children_____

Occupation_____ Employer_____

Spouse's Name_____ Spouse's Occupation_____ Spouse's Employer_____

Emergency Contact_____ Phone _____

How did you hear about this clinic?_____ Name of person who referred you_____

Current Complaints

Nature of the Injury: □ Automobile □ Work □ Other

Please Describe _____

_____

What caused the problem? _____

Date of injury_____ Date symptoms appeared_____

Did your pain come on: □ Suddenly □ Gradually Is the pain: □ Mild □ Moderate □ Severe

Do you experience pain every day? □ Yes □ No

Do your symptoms interfere with daily life? □ Yes □ No

Does the pain wake you up at night? □ Yes □ No

Are your symptoms worse at certain times of the day? □ Yes □ No

Do changes in weather affect your symptoms? □ Yes □ No

Do you wear orthotics? □ Yes □ No

Do you take vitamins or supplements? □ Yes □ No

Which activities aggravate your symptoms _____

Have you ever had this same condition before? □ Yes □ No If yes, when?_____

List other practitioners seen for this condition_____

Payment Information

Name of party responsible for payment_____ Phone _____

Do you have health insurance? □ Yes □ No Name of insurance company _____

***If auto accident, please provide:**

Insurance company name _____ Contact Person _____

Phone_____ Claim Number _____

Patient Signature _____Doctor Signature_____

Medical History

Have you been treated for any conditions in the last year? □ Yes □ No

If yes, please describe_____

Date of last physical exam_____ Is there a chance that you are pregnant? □ Yes □ No

What medications are you taking and for what conditions? Please list dosage and amounts _____

_____

What Vitamins minerals or herbs do you currently take? Please list for what conditions, dosage and frequency

_____

Are you allergic to any medication?_____

Have you ever:		If yes, please explain:
Broken bones	□ Yes □ No	_____
Been hospitalized	□ Yes □ No	_____
Been in an auto accident	□ Yes □ No	_____
Had sprains/strains	□ Yes □ No	_____
Been struck unconscious	□ Yes □ No	_____
Had surgery	□ Yes □ No	_____
Have a pacemaker	□ Yes □ No	_____
Have a defibrillator	□ Yes □ No	_____

Habits	**None**	**Light**	**Moderate**	**Heavy**
Alcohol	□	□	□	□
Coffee	□	□	□	□
Tobacco	□	□	□	□
Drugs	□	□	□	□
Exercise	□	□	□	□
Sleep	□	□	□	□
Appetite	□	□	□	□
Soft Drinks	□	□	□	□
Water	□	□	□	□
Salty Foods	□	□	□	□
Sugary Foods	□	□	□	□
Artificial Sweetener	□	□	□	□

Women Only

Can you become pregnant? □ Yes □ No If not, why?_____

Date of last period_____ Normal? □ Yes □ No

Are you now or could you be pregnant? □ Yes □ No

Approximate date of last mammogram: _____ Approximate date of last pap smear: _____

Patient Signature _____Doctor Signature_____

Please mark any condition that you now have or you have had in the past:

□ Severe headaches	□ Chest pain/angina	□ Kidney Stones	□ Claudication
□ Hypertension	□ Heart Palpitations	□ Renal Disease	□ Ulcer
□ Stroke	□ Heart murmur	□ Diabetes	□ Venereal disease
□ Epilepsy	□ Arrhythmia	□ Endocrine Disease	□ Mental illness
□ Fatigue	□ Congenital heart disease	□ Urinary or genital problems	□ Alcohol/Drug problems
□ Dizziness/Fainting	□ Rheumatic or Scarlet	□ Prostate problems	□ Low back pain
□ Anemia	□ Gall stones	□ Sexual dysfunction	□ Shoulder pain
□ Shortness of breath	□ Pancreatitis	□ Ovarian cysts	□ Neck Pain
□ Asthma	□ Liver disease	□ Digestive problems	□ Knee Pain
□ Gout	□ Arthritis	□ HIV/AIDS	□ Numbness/tingling in arms/hands
□ Ears ring	□ Allergies	□ Cancer	□ Numbness/tingling in legs/feet

Previous Treatment

Please indicate all therapies previously used to treat your condition, where given, and the amount of relief obtained:

	Procedure/Therapy	Performed by/description of therapy	Relief obtained
□	Physical Therapy		
□	Chiropractic Manipulation		
□	Biofeedback		
□	Massage Therapy		
□	Acupuncture		
□	Herbal or homeopathic		
□	TENS unit		
□	Home traction unit		
□	Surgery/Nerve blocks		
□	Counseling for pain/depression		

Family History

Has anyone in your immediate family (mother, father, grandparents, brothers, sisters, children) had the following:

	Conditions	Who		Conditions	Who
□	Heart Disease		□	Epilepsy	
□	Hypertension		□	Glaucoma	
□	Stroke		□	Bleeding Disorders	
□	Cancer		□	Kidney Disease	
□	Diabetes		□	Thyroid Disease	

Patient Signature _____Doctor Signature_____

Authorization for Care

I hereby authorize the Doctor to work with my condition through the use of chiropractic care and other treatment techniques to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. Understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account on receipt.

Ownership of X-ray Films:

It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.

_____ _____

Patient Signature (Parent or Guardian if under 18) Date

Terms of Acceptance

When a patient seeks chiropractic care and we accept such a patient for care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

I understand and am informed that, as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation.

I, _____have read and fully understand the above statement.

Open Floor Environment
Sheedy Family Chiropractic utilizes an "open treatment area" in which several people may be treated at the same time and in close proximity, and any exercises and therapies will be done in a group setting in this open environment. Complete privacy may not be possible in this setting, therefore if you would prefer to be seen in a private room or have a question or concern that you wish to be addressed in private, it is your responsibility to let us know and we will do our best to accommodate your wishes.

Children in the Office
Children are always welcome in the office; however their safety and wellbeing are not the responsibility of the doctors or staff. By bringing children into the office you understand and agree to the fact that they are solely your own responsibility and must be kept off the treatment floor and under complete control at all times.

By my signature below I acknowledge that any questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction and I have a full understanding of the office policies and practices. I therefore accept chiropractic care on this basis.

Patient's Signature _____ Date_____

Witness_____

SYCAMORE INTEGRATED HEALTH

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT
We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. In certain cases, it may be necessary to disclose information about you when referring you to another doctor or clinic for other health care or services, or in the event that we may need copies of your health information from another professional that you may have seen before us. These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

PAYMENT
We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, both in our office and through a billing agency. In the event that we need to collect unpaid dues, your information may be used in preparing and sending bills through our office as well as through a collection agency or attorney.

HEALTHCARE OPERATIONS
Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION
There are certain circumstances under which we may use or disclose your health information without first obtaining your Acknowledgement or Authorization. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time via phone or mail to provide appointment reminders or to reschedule a missed appointment, or about information about treatment alternatives or other health-related benefits and services that may be of interest to you. You should also be aware that we utilize an “open treatment area” in which several people may be treated at the same time and in close proximity. Complete privacy may not be possible in this setting. If you would prefer to be seen in a private room or have a question or concern that you wish to be addressed in private, it is your responsibility to let us know and we will do our best to accommodate your wishes.

OTHERS INVOLVED IN YOUR HEALTHCARE
Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person’s involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

COMMUNICATION BARRIERS OR EMERGENCIES

We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without you written authorization.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

- You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.
- You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.
- You have the right to inspect, copy and request amendments to you health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.
- All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.
- You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.
- If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have, as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will make it known to you and have copies of the new notice available to you in our office.

COMPLAINTS

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. If you wish to complain to our office, please send or fax a written complaint to the information provided at beginning of this notice. If you wish to file a complaint in person or over the phone, please make it known to the office manager and set up a scheduled appointment to address your concerns.

FOR MORE INFORMATION

If you would like more information about our privacy practices, call or visit the office at the address or phone number shown at the beginning of this notice.

HIPAA Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, "I" and "my" refer to the patient,
And the "Chiropractor" refers to Sycamore Integrated Health

I consent to the use or disclosure of my protected health information by the Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Chiropractor is not required to agree to the restrictions that I may request. However, if the Chiropractor agrees to a restriction that I request, the restriction is binding on the Chiropractor.

I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of the Chiropractor and understand that I have a right that Notice 's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Chiropractor. The Notice of Privacy Practices for Chiropractor is also available at the front desk at 920 W. Prairie Dr., Suite J, Sycamore, IL 60178. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

The Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative | Printed Name of Patient

_____ _____

Date of Signing | Description of Personal Representative's Authority

_____

Witness Signature