



WELCOME TO OUR OFFICE

We would like to make your visits pleasant and successful... therefore, if you have any questions regarding treatments, financial arrangements, or scheduling of appointments, please feel free to ask. We are here to help!

There are several payment alternatives available. Please check the payment plan that applies to you listed below.

_____ **INSURANCE-** I am covered by an insurance policy and I am responsible for paying any co-payments, deductibles and noncovered services. Any portion not paid by my insurance company will be my responsibility

_____ **AUTO ACCIDENT, WORKER'S COMPENSATION, OR SLIP AND FALL-** (Other party responsible) This usually covers your medical bill at 100%. Please supply the front desk with the complete mailing address of the party responsible for the charges. For auto cases, please be aware that should your medical payment benefits become exhausted, you will be responsible for any unpaid charges. Also, in all cases, if we agree to wait for settlement, you will be responsible to make sure that this office does receive payment for services rendered at the time settlement is made. In the unlikely event that a problem arises with the settlement, you will agree to make arrangements for full payment to this office.

_____ **SELF PAY-** I will be paying daily or weekly on a cash basis.

_____ **NONE OF THE ABOVE-** If none of the above applies to you please ask for a consultation with one of the assistants before seeing the doctor.

If you have insurance, we will need to make a copy of your card and have you complete and sign an insurance form for our records.

Returned checks and balances over 30 days may be subjected to additional collection fees and interest charges of 1 ½% per Month.

I UNDERSTAND THAT ALL CHARGES NOT COVERED BY INSURANCE, REGARDLESS OF THE REASON, ARE MY FULL RESPONSIBILITY.

(Print Name)

(Signature)

(Date)

NEW PATIENT DEMOGRAPHICS

Please print all responses.

Name _____

Address _____

Telephone Numbers

OK to leave a message?

Home () _____

Y N

Cell () _____

Y N

Date of Birth: _____

Gender: M F

Social Security Number _____

Marital Status _____

Emergency Contact _____

Telephone () _____

Relationship _____

Financial Information

Insurance Worker's Comp Self-Pay (Cash) Personal Injury/Auto Other (Please explain) _____

Primary Insurance

Name _____

Relationship to insured: Self Spouse Parent

Insured's Name: _____
 (Other than self)

ID # _____

Group # _____

Date of birth of Policy Holder: _____

Secondary Insurance

Name _____

Relationship to insured: Self Spouse Parent

Insured's Name: _____
 (Other than self)

ID# _____

Group # _____

Date of birth of Policy Holder _____

Employer

Status: Full Time Part Time Retired Unemployed

Name _____

Address _____

Tel () _____ Fax () _____

School

Status: Full Time Part Time Not a Student

How did you hear about our office?

To the best of my knowledge the information contained in this form is true and accurate.

 (Print Name)

 (Signature)

 (Date)



HEALTH HISTORY

Patient Name: _____ Today's Date _____

What is your reason for today's visit? _____

Check conditions you currently have or have had in the past

GENERAL

- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Loss of weight
- Nervousness
- Numbness
- Sweats

GASTROINTESTINAL

- Bloating
- Bowel Change
- Constipation
- Diarrhea
- Excessive Hunger
- Excessive Thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Vomiting

CARDIOVASCULAR

- Chest pain
- High blood pressure
- Poor Circulation
- Rapid Heartbeat
- Swelling of Ankles
- Varicose Veins

SKIN

- Bruise Easily
- Hives
- Itching
- Rash
- Scars

MUSCLE/JOINT/BONE

- Arms
- Neck
- Back
- Hips
- Legs
- Shoulder
- Elbow
- Wrist
- Knee
- Feet

GENITOURINARY

- Blood in urine
- Frequent Urination
- Painful Urination
- Discoloration of urine
- Lack of bladder control

MEN ONLY

- Breast Lump
- Erection Difficulties
- Lump in testicle
- Penis discharge
- Sore on penis
- Other _____

WOMAN ONLY

- Breast Lump
- Hot Flashes
- Nipple discharge
- Vaginal Discharge
- Other _____
- Are you Pregnant? Yes/No

CONDITIONS

- Aids
- Alcoholism
- Anemia
- Anorexia
- Appendicitis
- Arthritis
- Asthma
- Bleeding Disorders
- Breast Lump
- Bronchitis
- Bulimia
- Cancer
- Cataracts

- Chemical Dependency
- Chicken Pox
- Diabetes
- Emphysema
- Epilepsy
- Glaucoma
- Goiter
- Gonorrhea
- Gout
- Heart Disease
- Hepatitis
- Hernia
- Herpes

- High blood pressure
- HIV Positive
- Kidney Disease
- Liver Disease
- Measles
- Migraine Headaches
- Miscarriage
- Mononucleosis
- Multiple Sclerosis
- Mumps
- Pacemaker
- Pneumonia
- Polio

- Prostate Problem
- Psychiatric Care
- Rheumatic Fever
- Scarlet Fever
- Stroke
- Suicide Attempt
- Thyroid Problems
- Tonsillitis
- Tuberculosis
- Typhoid Fever
- Ulcers
- Vaginal Infection
- Venereal Diseases

MEDICATIONS

List medications you are currently taking

ALLERGIES

Family History

Relation	Age	State of Health	Age of death	Cause of death	Check if your blood relatives had any of the following:	
					√	Relationship to you
Father						Disease
Mother						Arthritis, Gout
Brothers						Asthma, Hay Fever
						Cancer
						Chemical Dependency
						Diabetes
Sisters						Heart Disease, Stroke
						High Blood Pressure
						Kidney Disorder
						Tuberculosis
						Other

Hospitalization/Serious Illness/Injuries

Date	Hospital	Reason for Hospitalization and Outcome

Pregnancies

Year of Birth	Sex of Birth	Complication

Occupational

Occupation:			
Check if your work exposes you to the following:			
<input type="checkbox"/>	Stress	<input type="checkbox"/>	Hazardous Substances
<input type="checkbox"/>	Heavy Lifting	<input type="checkbox"/>	Other

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

(Print Name)

(Signature)

(Date)

Consolidated Chiropractic Health Associates Inc.

dba: HealthCore Clinic

180N.BarringtonRoad,Streamwood,IL60107 P)630.483.8920 F)630.483.8930

Irshad Kassim, DC

ASSIGNMENT OF BENEFITS

-IRREVOCABLE

From Patient: _____

Accident Date: _____

Medical Provider: Irshad Kassim, DC

In consideration of your undertaking to render care, I agree to the following:

Release of Information

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred by me at your treatment facility.

Right to Receive Payment

2. I authorized and assign to you, the medical provider, the right to receive direct payment from my attorney or any insurance company who may become obligated to pay me any sums. I further authorize the endorsement of my name to any draft or check containing my name to which you are legally entitled.

Assignment of Right to Sue

3. In the event any insurance company or attorney, obligated by contractual agreement to issue payments to me for your service charges, refuses to pay upon demand by you, I hereby assign an transfer to you the cause of action that exists in my favor against any such company or attorney and authorize you to prosecute said action either in my name or your name as you otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from said insurance proceeds (whether it be all or part of what is due) shall be paid by me.

4. I also assign to you, the medical provider, and grant the right of lien against any and all claims against any third party whose negligence may have caused my injury, including their insurance, up to the amount of the bill for treatment.

5. I waive the Statute of Limitations regarding my doctor’s right to recover from me directly.

6. I hereby direct my attorney to cooperate, assist and not interfere with you, the medical provider, in recovering any MedPay benefits that I may be entitle to.

I HEREBY AGREE THAT THIS ASSIGNMENT OF BENEFITS IS IRREVOCABLE.

Patient - (PRINT & SIGNATURE)

Date

Policy Holder

Date

Consolidated Chiropractic Health Associates Inc.

dba: HealthCore Clinic

180N.BarringtonRoad,Streamwood,IL60107 P)630.483.8920 F)630.483.8930

Irshad Kassim, DC

ASSIGNMENT OF BENEFITS

-IRREVOCABLE

ENGLISH:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand **Consolidated Chiropractic Health Associates Inc – dba: HealthCore Clinic/Irshad Kassim, DC** will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to **Consolidated Chiropractic Health Associates Inc. – dba: HealthCore Clinic/Irshad Kassim, DC** will be credited to my account on receipt. I permit this office to endorse co-issued remittances for the convenience of credit to my account. I **Consolidated Chiropractic Health Associates Inc. – dba: HealthCore Clinic/Irshad Kassim, DC** to furnish information concerning my present illness or injury. I authorize my insurance company to direct payments for service performed **Consolidated Chiropractic Health Associates Inc. – dba: HealthCore Clinic/Irshad Kassim, DC** directly to:

**Consolidated Chiropractic Health Associates Ins. dba: HealthCore Clinic
Irshad Kassim, DC
180 N. Barrington Road
Streamwood, IL 60107**

I am also aware that *I AM PERSONALLY RESPONSIBLE FOR CHARGES AND/OR BALANCE NOT COVERED BY INSURANCE*. In the case where **Consolidated Chiropractic Health Associates Inc. – dba: HealthCore Clinic/Irshad Kassim, DC** needs to contact attorneys or collection agencies to collect on my account, I agree to pay all costs for these and any other expenses incurred in the collection of this account. I further understand that this agreement is irrevocable.

ESPAÑOL:

Comprendo y estoy de acuerdo que mi póliza de seguros es un acuerdo entre la compañía de seguros y yo. Yo comprendo que **Chiropractic Health Associates Inc. – dba: HealthCore Clinic** preparara formas y reportes para ayudarme a coleccionar de la compañía de seguros y que esas cantidades coleccionadas serán aplicadas a mi cuenta. Yo autorizo a **Consolidated Chiropractic Health Associates Inc. – dba: HealthCore Clinic/Irshad Kassim, DC** a cambiar estos cheques para que sean aplicados a mi cuenta. Autorizo a **Consolidated Chiropractic Health Associates Inc. – dba: HealthCore Clinic** a mandar información a las compañías de seguros y a mis abogados incluyendo información de mi enfermedad. Yo autorizo a mi compañía de seguros a hacer pagos por servicios dados por **Consolidated Chiropractic Health Associates Inc. – dba: HealthCore Clinic/Irshad Kassim, DC** directamente a:

**Consolidated Chiropractic Health Associates Ins. dba: HealthCore Clinic
Irshad Kassim, DC
180 N. Barrington Road
Streamwood, IL 60107**

YO TAMBIEN COMPRENDO QUE LAS CUENTAS NO PAGADA POR LA COMPANIA DE SEGUROS SON MI RESPONSABILIDAD. En caso de que mi seguro no cubriese todos mis gastos Yo asumiré la responsabilidad de dicha deuda y si a **Consolidated Chiropractic Health Associates Inc. – dba: HealthCore Clinic/Irshad Kassim, DC** necesita emplear abogados o agencias de colecciones para cobrar esa cuenta, yo pagare dichos gastos. Yo también entiendo que este acuerdo es irrevocable.

PRINT: (X) _____ **Patient/Policy Holder** **Date:** _____

SIGNATURE: (X) _____ **Patient/Policy Holder** **Date:** _____

SIGNED: _____ **Policy Holder** **Date:** _____

SIGNED: _____ **Guardian** **Date:** _____

**INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS
AND CARE**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physiotherapy, physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by working or associated with or serving as back-up for the doctor of chiropractic named below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I 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 judgement during the course of the procedure which the doctor feels at the time, based on facts then known, is in my best interest.

I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any further condition(s) for which I see treatment.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of Consolidated Chiropractic Health Associates Inc. Notice of Privacy Practices.

(Print Name)

(Signature)

(Date)