Expect Miracles

PATIENT INFORMATION

Date: ______________________________

Name: ______________________________ Birthdate: ____________________ Age: __________ ☐ Male ☐ Female

Address: ____________________________________ City: _________________ State: ________________ Zip: __________________

Home: (   ) _________________ Cell: (   ) ____________________ Work: (   ) __________________

Email: ____

Preferred method of contact: ☐ Home ☐ Cell ☐ Work ☐ Email

Emergency Contact Name: ____________________________________ Phone: (   ) ________________

Status: ☐ Single ☐ Married ☐ Civil Union ☐ Divorced ☐ Widowed

\# of Children: __________ Names/Ages: ____

Occupation/School: ____

Employer/School Address: ____

Most patients are referred to us by a caring family member or friend. How or who referred you to us? _________________________

HEALTH CONCERNS

Please list your concerns in order of importance:

1. ____ 3. ____

2. ____ 4. ____

Since concern #1 started, it is: ☐ Same ☐ Getting Better ☐ Worse

What makes it better? ____

What makes it worse? ____

Does it interfere with: *(Check all that apply)* ☐ Leisure ☐ Work ☐ Sleep ☐ Sports ☐ Other

Please explain: ____

Have you seen other doctors for this condition? *(Check all that apply)* ☐ Chiropractor ☐ MD ☐ Other

Name/Address: ____

Please list all medications you are taking and why: ____

____

____

Have you had any surgeries and/or hospitalizations? ☐ Yes ☐ No

If yes, please explain: ____

Auto and Work related injuries can cause serious spinal problems. Is this visit related to an accident or injury? ☐ Yes ☐ No

If yes, please explain: ____

Please check all symptoms you have ever had, even if they do not seem related to your current problem:

☐ Headaches/Migraines	☐ Buzzing in ears	☐ Cold hands	☐ Mood swings
☐ Pins & needles in arms	☐ Ringing in ears	☐ Cold feet	☐ Loss of smell
☐ Pin & needles in legs	☐ Numbness in toes	☐ Fever	☐ Loss of taste
☐ Dizziness	☐ Depression	☐ Urinary problem	☐ Back pain
☐ Numbness in fingers	☐ Constipation	☐ Fainting	☐ Neck pain
☐ Fatigue	☐ Menstrual pain	☐ Sensitive to bright light	☐ Stiff neck
☐ Sleeping problems	☐ Menstrual irregularity	☐ Upset Stomach	☐ Stiff joints
☐ Tension	☐ Hot flashes	☐ Diarrhea	
☐ Ulcers	☐ Irritability	☐ Cold Sweats	

Please check if you have had any of the following:

☐ AIDS/HIV	☐ Bulimia	☐ Herniated Disc	☐ Rheumatoid Arthritis
☐ Anemia	☐ Cancer	☐ High Blood Pressure	☐ Stroke
☐ Anorexia	☐ Diabetes	☐ High Cholesterol	☐ Thyroid Problems
☐ Arthritis	☐ Gout	☐ Multiple Sclerosis	☐ Other
☐ Asthma	☐ Heart Disease	☐ Osteoporosis	

Stress can cause or accelerate spinal damage. On a scale of 1 to 10 (1 = none, 10 = extreme), rate your stress levels in the past 90 days: Occupational ____________ Personal ____________

Poor posture leads to poor health and often indicates a spinal problem. How would you rate your posture?

Poor 1 2 3 4 5 6 7 8 9 10 Excellent

On a scale of 1 to 10 (1 = poor, 10 = excellent), please rate your habits regarding the following:

Eating _____ Body Weight _____ Exercise _____ Sleep _____ Energy _____ Digestion _____ Overall Health _____

Do you have health goals? If so what are they? ____

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DISCLOSURE & 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 physical therapy and diagnostic X-rays on me (or the patient named below, for whom I am legally responsible) by Dr. Steven Bourdage (the "Doctor") and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now, or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor.

I understand chiropractic care contributes to my overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I understand that some of the risks to exam and treatment include, but are not limited to fractures, disc injuries, sprains, increased symptoms, pain, no improvement of symptoms or pain, and in extremely remote conditions strokes. I do wish to rely on the Doctor to exercise judgment during the course of the procedure which the Doctor feels at the time, based on the facts then known, and is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

FINANCIAL POLICY

Thank you for choosing us for your chiropractic services. We are dedicated to helping you improve your health. **Full payment is due at the time of service** unless prior arrangements are made. We accept cash, checks, Visa, Mastercard, American Express and Discover. **PAYMENT OF THE FIRST VISIT IN FULL IS REQUIRED.**

INSURANCE ASSIGNMENT

You are considered to be a cash patient until our office "qualifies" your coverage to determine the extent of benefits under your insurance policy. All deductible payments MUST be made prior to submitting insurance claims. All co-payments and any other charges not covered by your insurance policy are to be paid at the time of service. This office does not file for or accept co-payment for secondary insurance coverage. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare program and/or other insurance.

The balance is **YOUR** responsibility, whether your insurance company pays or not. This office cannot guarantee that your insurance company will reimburse for the usual and customary charges submitted by this office, nor will we enter into any dispute with your insurance company over the amount of reimbursement. All insurance companies make clear that verification of coverage does not guarantee payment of benefits. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We provide the service of billing your insurance company as a convenience for you, free of charge. We may ask for your active assistance in the event that we experience difficulty collecting from your insurance company. If your insurance company has not paid your account in full within 90 days, the balance will automatically be transferred to you. Should you discontinue care for any reason other than discharge by the doctor, any and all balances due will become immediately payable in full, regardless of any claims submitted. You are responsible for notifying the office of any changes in your insurance coverage.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best care for you and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MISSED APPOINTMENTS

Our office policy is to charge for missed appointments and those cancelled without 24 hours notice. We reserve the right at our discretion, to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments, and/or by calling 24 hours in advance so another patient may be fit in.

PAYMENTS

It is the policy of this office that all services rendered are charged directly to you, the patient, and that ultimately, you are responsible for all services, including those not reimbursed by third party payors. Your balance may not exceed $200.00 at any time. All payments are due within 30 days of the monthly billing date. A service charge of 1.5% per month will be applied on any balance over 60 days. All accounts not paid within 90 days will automatically be put through your personal credit card for collection. Returned checks will be subject to an additional fee. If payment has not been received, you are in default and are responsible for any collection, filing, court, or attorney fees incurred in attempting to collect the amount or any future outstanding account balances.

I have read, or have had read to me the above consent and financial policy. I have had an opportunity to ask questions, and all of my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan and also agree to the financial policy. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment at this office. I have also received a copy of the Notice of Privacy Practices.

____

Print Patient Name and Name of Legal Guardian if applicable

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Signature of Patient or Legal Guardian

____

Date

Bourdage Chiropractic
Dr. Steven R. Bourdage
6015 N. Cicero Ave., Chicago, IL 60646
(773) 545-9379

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. If you have any questions about this Notice please contact Dr. Steven R. Bourdage.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.
We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your written request, we will provide you with any revised Notice of Privacy Practices, or you may call the office and request that a revised copy be sent to you in the mail, or ask for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your PHI may also be used and disclosed to pay your health care bills and to support the operation of the physician’s practice. Following are examples of the types of uses and disclosures of your PHI that the physician’s office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.
Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected PHI. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. We will also disclose PHI to other physicians who may be treating you when we have the necessary permission from you to disclose your PHI. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance to your physician with your health care diagnosis or treatment.
Payment: Your PHI will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for extended chiropractic care requires that your relevant PHI be disclosed to the health plan to obtain approval for that care. Dates and costs of services information may be disclosed to a third party when attempting to collect past due payments from you.
Healthcare Operations: We may use or disclose, as-needed, your PHI in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of staff, chiropractic students, and chiropractic assistants for training fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your PHI to chiropractic school students and chiropractic assistants that see or assist our patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate if we need to change any information we currently have on file. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may leave a message regarding specifics of the time and date of appointment with any person or devise who answers at the phone number of record for you. We will share your PHI with third party “business associates” that may at any time perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI. We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Contact and request in writing that these fundraising materials not be sent to you.
Uses and Disclosures of Protected Health Information Based upon Your Written Authorization. Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.
Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object. We may use and disclose your PHI in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use or disclosure of the PHI, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your health care will be disclosed.
Facility Directories: Unless you object (either in person or by telephone or electronic means), we will use and disclose verbally that you are on the premises or not on the premises (or disclose when you are expected or when you were last seen) to people that ask for you by name. Anyone who asks about you by name regarding your general condition or “how you are doing” will be told you are either “doing a little better” or “not doing too well”. No specifics will be revealed except to those friends and family members you have indicated are directly involved with your healthcare, on the “Others Involved in My Healthcare Form” (see below). Phone calls may be made to any phone number of record you give us. Messages will be left with any person or answering device that responds. If you wish us not to call any number you have given us, please advise us in writing. We may periodically send out newsletters or announcements to any physical or electronic address of record. You may request in writing to be removed from this list
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 PHI 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 PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location and/or general condition. Finally, we may use or disclose your PHI 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 health care. You may affix additional names of family and friends (who may live at a distance or with whom the physician is not personally familiar) to this list by requesting a copy of our Others Involved in My Healthcare form.
Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object. We may use or disclose your PHI in the following situations without your authorization. These situations include:
Required By Law: We may use or disclose your PHI to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.
Public Health: We may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your PHI, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your PHI to a person or company required by the FDA to report adverse events, product defects or problems, biologic product deviations, track products, to enable product recalls, to make repairs or replacements, or to conduct post-marketing surveillance, as required.

Legal Proceedings: We may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. PHI may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your PHI to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your PHI, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military service. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your PHI may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your PHI if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

2. Your Rights

Following is a statement of your rights with respect to your PHI and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may, upon written request, within ten business days, inspect and obtain a copy of PHI about you that is contained in a designated record set for as long as we maintain the PHI. You will be charged a reasonable fee for copying any records. A "designated record set" contains medical and billing records and any other records that your physician and the practice use for making decisions about you. While seldom a part of offices' records forwarded by others to this physician, we must advise you that under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to PHI. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have specific questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us, in writing, not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by requesting a form entitled Others Involved in My Healthcare.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location (such as when traveling). We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment (for such things as long distance phone charges, etc.) will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request as needed, in writing, to our Privacy Contact.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this information. This amendment can only be done to records that the physician has personally created, not those received from other providers of care. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Both your request and our rebuttal will then become a part of your personal record. If you would like to request an amendment to a portion of the record that was not created by this physician, that request and your explanation of the discrepancies will be added to your chart and become a part of the record, but the cited information itself will not be changed or purged. Please contact our Privacy Contact to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for the facility, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. You may contact our Privacy Officer, Dr. Steven R. Bourdage at (773) 545-9379 for further information about the complaint process. This notice was published January 1, 2009 and becomes effective on January 1, 2009.