Welcome to Thalman Chiropractic and Wellness Center!

1. PATIENT INFORMATION

Last Name _____ MI _____ First Name _____

Date _____ What do you prefer to be called? _____

Home Address _____ City _____ State/Zip _____

Age _____ Birth Date _____ (Circle one) Gender: **M F** Marital Status: **S M W D O**

Patient Social Security # (required for billing) _____ Height/Weight _____/_____

E-mail Address: _____

2. PATIENT PHONE NUMBERS

Patient Mobile Phone: _____

Patient Home Phone: _____

Patient Work Phone: _____

Patient Other Phone: _____

In event of emergency:

Name: _____ Relationship: _____

Home Phone _____ Work Phone: _____

Who is your Medical Dr.? _____ Phone: _____

3. PATIENT INSURANCE INFORMATION

Do You Have Health Insurance? ☐ Yes ☐ No Please Give Card(s) to Front Desk to Copy

Carrier _____ Member# _____ Group# _____

Do You Have a Secondary Health Insurance Policy? ☐ Yes ☐ No Please Give Card(s) to Front Desk to Copy

Carrier _____ Member# _____ Group# _____

4. PATIENT EMPLOYER / SCHOOL INFORMATION

(Please check one) ☐ Employed ☐ Retired ☐ Student ☐ Other _____

School/Employer Name, Address: _____ City: _____ State/Zip: _____

Phone: _____ Occupation: _____

5. REFERRAL INFORMATION

How did you hear about our office? (please check one of the following)

☐ Yellow Pages/Phone Book ☐ Yellow Pages Online ☐ Newspaper ☐ Sign ☐ Dr. _____

☐ Family/Friend _____ ☐ Patient _____ ☐ Website _____

☐ Insurance Directory_____ ☐ Other _____

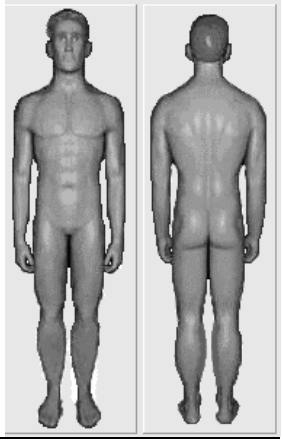
- **I understand the information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.**

Patient Signature _____ **Date** _____

☐ Adult Patient ☐ Parent or Guardian ☐ Spouse

6. PATIENT CONDITION

1st Symptom



Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, tingling, or other symptoms

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of Pain:

☐ Sharp	☐ Dull	☐ Throbbing	☐ Numbness
☐ Burning	☐ Tingling	☐ Cramps	☐ Stiffness
☐ Aching	☐ Swelling	☐ Shooting	☐ Other

Is it constant or does it come and go? _____

Does anything aggravate the condition? _____

Does anything make the condition better? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Doctor's Notes

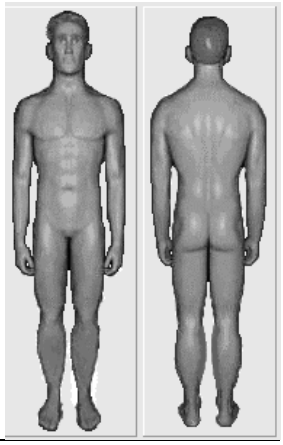
_____

_____

_____

_____

2nd Symptom



Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, tingling, or other symptoms

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of Pain:

☐ Sharp	☐ Dull	☐ Throbbing	☐ Numbness
☐ Burning	☐ Tingling	☐ Cramps	☐ Stiffness
☐ Aching	☐ Swelling	☐ Shooting	☐ Other

Is it constant or does it come and go? _____

Does anything aggravate the condition? _____

Does anything make the condition better? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Doctor's Notes

_____

_____

_____

_____

"3RD SYMPTOM" ON NEXT PAGE.

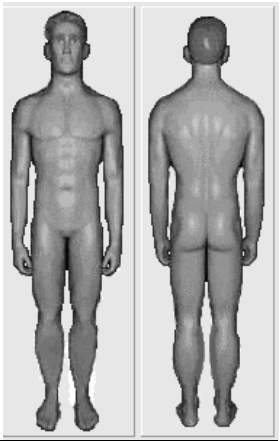
3rd Symptom

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, tingling, or other symptoms



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of Pain:

☐ Sharp	☐ Dull	☐ Throbbing	☐ Numbness
☐ Burning	☐ Tingling	☐ Cramps	☐ Stiffness
☐ Aching	☐ Swelling	☐ Shooting	☐ Other

Is it constant or does it come and go? _____

Does anything aggravate the condition? _____

Does anything make the condition better? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Doctor's Notes

_____

_____

_____

_____

_____

7. HEALTH HISTORY

What Treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of Doctor(s) who have treated your condition _____

Date of Last:

Physical Exam	_____	Spinal X-Ray	_____	Blood Test	_____
Spinal Exam	_____	Chest X-Ray	_____	Urine Test	_____
Bone Mineral Density Test	_____	MRI, CT-Scan	_____		

Place a mark on "Yes" or "No" to indicate if you have had any of the following

AIDS/HIV	☐ Yes	☐ No	Chicken Pox	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Sexually Transmitted Disease	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Herniated Disc	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Other	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No			
Chemical			High Cholesterol	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No			
Dependency	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			

GENERAL SYMPTOMS

Indicate symptoms you have or have had in the past. Mark √ for present, X for past.

☐Headache	☐Upper Leg/Hip Pain (R L)	☐Heartburn/Indigestion	☐ Chronic Sinusitis
☐Migraine	☐Lower Leg/Knee Pain (R L)	☐Loss of Appetite	☐ Allergies
☐Jaw Pain	☐Ankle/Foot Pain (R L)	☐Abnormal Weight ☐Gain ☐Loss	☐ General Fatigue
☐Neck Pain	☐Stiff Joints	☐Excessive Thirst	☐Skin Rash
☐Upper Back Pain	☐Fainting	☐Chronic Cough	☐Numbness
☐Chest Pain	☐Visual Disturbances	☐Difficulty in Swallowing	☐Nervousness
☐Mid-Back Pain	☐Convulsions	☐Loss of Bladder Control	☐Other: _____
☐Abdominal Pain	☐Dizziness	☐Painful Urination	_____
☐Low Back Pain	☐Muscular Incoordination	☐Frequent Urination	_____
☐Shoulder Pain (R L)	☐Tinnitus (Ear Noises)	☐Irregular or ☐Profuse Menstrual Flow	
☐Upper Arm Pain (R L)	☐Rapid Heart Beat	☐Breast Soreness	
☐Hand/Wrist Pain (R L)	☐Angina	☐Irregular Bowel Habits	

List associated health problems of relatives:

Do you wear: ☐ Heel Lifts ☐ Orthotics ☐ Other_____

Please describe your job, duties, and work schedule:

Describe your lifestyle (hobbies, level of exercise, recreational activities, alcohol, tobacco, caffeine and drug use, diet):

8. ACCIDENT	*WORK ACTIVITY*	*HABITS*	
Is Condition due to an accident? ☐ Yes ☐ No ***Date of Accident:**_____ ***Location of Accident:**_____ Type of Accident ☐ Auto ☐ Work ☐ Home ☐ Other _____ To whom have you made a report of your accident: ☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other _____ Attorney Name (if applicable) _____	☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor	☐ Smoking ☐Alcohol ☐Coffee/Caffeine Drinks ☐ High Stress Level	Packs/Day___ Drinks/Week ____ Cups/Day ____ Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____ Date of the beginning of your last menstrual period? _____

9. Injuries/Surgeries you have had	*Description*	*Date*
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

10. MEDICATIONS	*ALLERGIES*	*VITAMINS / HERBS / SUPPLEMENTS*

Richard L. Thalman, D.C.
600 West Main Suite One
Carbondale, IL 62901-2604

Telephone 618-549-8228

OFFICE AND INSURANCE ASSIGNMENT POLICY

* **Welcome and Thank You** for choosing Thalman Chiropractic for your healthcare needs. As you will soon discover, it is our goal to provide you with the finest, friendliest, most comprehensive care available. Please read the remaining information carefully and feel free to ask questions if necessary.

* Appointments are Mondays through Fridays. **We reserve the right to charge for missed appointments, so please be courteous enough to call 24 hours in advance.** We really do not like to charge this fee, but we also like to keep appointment times available to other patients who would like to come in if you are not able to make it.

* **Payment may be made by cash, check, debit or credit card.** As a benefit to you, we will accept assignment from your insurance company(s). This means that we will bill your insurance company(s) charges incurred and then we will apply their payment(s) to your balance. After your insurance has responded, **any remaining amount that is your responsibility will be billed to you in the form of a statement** from Dr. Thalman. We allow 30 days for the payment to be made after the 1st statement has been mailed to you. If at any time you feel that there is a discrepancy or that we have made an error in posting, please bring this to our attention immediately so we may rectify the problem. **Any co-pays should be paid the same day of your visit.** This policy is required unless previously arranged by the office manager.

*Keep in mind that your insurance policy is an agreement between you and your insurance company and that a quote of benefits is not a guarantee of benefits or payment. You will be responsible for charges your insurance does not cover, such as the deductible, co-payment, and any service that is not covered or beyond benefit allowance. In the event your insurance company decides not pay for any or our services, we will provide you with the necessary appeals form to the Illinois Dept of Insurance, so that you may appeal your claims.

Contact us if you are having any financial difficulties or if you need a payment plan. **Late payments and past due accounts will be charged late fees.** If you receive any insurance checks/payments, please bring them to our office to see if they need to be applied to your account.

Please note that filing insurance is a courtesy we extend to all new patients, however it is your responsibility to know the coverage and benefits of your policy. **We encourage you to contact your insurance company to verify your deductible, co-pay and general chiropractic benefits.** Call the number on the back of your card and follow the prompts. Ask the representative to verify your coverage for chiropractic care. **We are happy to provide an Insurance Verification Form upon your request to assist you when calling to verify your benefits.**

If after 8 weeks we have not received payment from your insurance company, you will be asked to take an active part in the recovery of your claim. If after 90 days the account remains delinquent, you may be asked to make payment in full of any outstanding balance and to seek reimbursement on your own.

* Monthly statements will be sent to keep you abreast of your account balance. Please make sure to provide appropriate contact information for this purpose. **It is your responsibility to inform us of any changes in your contact and/or account information.**

If you have any questions, please direct them to the front desk staff.

Please sign below as an acknowledgment of our office and insurance policy stated.

_____	_____	_____
Date	Patient Signature	Print Name

Consultation completed with: _____ on _____
Office Manager Date

Consent to Receive Chiropractic Care

I hereby consent to the performance of examination, diagnosis, adjustments, other chiropractic procedures on me (or the patient named above, for whom I am legally responsible) by Richard L. Thalman, D.C. and/or other professionals working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as an associate for Dr. Richard L. Thalman. I understand and I am informed that, in the practice of chiropractic that there is the unlikely possibility of adverse events from examination and treatment including, but not limited to, soreness, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I agree that if I suspect any adverse event that I will inform Dr. Thalman. 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 on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatments. I intend this consent form to cover the entire course of treatment of my present condition and for any future condition(s) for which I seek treatment. I understand that I may refuse treatment at any time and that I am responsible for my healthcare choices.

By signing below, I understand the terms above and agree to the Consent to Receive Chiropractic Care.

_____	_____	_____
Date	Patient Signature	Print Name

Records Release

At times it is necessary to request records such as examination results, x-rays, MRI reports, progress notes, etc. from other healthcare providers. We also send reports to your primary care physician and specialists to keep them informed of your current condition(s) and response to care. Also, your insurance company may request your records to assist in processing your insurance claims.

By signing below, I understand the terms above and allow the release of my medical records for the purpose of communication about my health related condition(s) between Dr. Thalman, my other healthcare providers, attorneys/represenatives and insurance company(s).

_____	_____	_____
Date	Patient Signature	Print Name

Assignment of Insurance Payments

I hereby instruct and direct my insurance company or their intermediaries to pay for services rendered to the order of Richard L. Thalman, D.C. and to be mailed to 600 W. Main St. Ste 1, Carbondale IL 62901, for the professional medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment towards the total charges for services provided. This is a direct assignment of my insurance benefits. This payment will not exceed indebtedness to Dr. Thalman. I agree to cooperate with the Office of Dr. Thalman to pursue any third party that is responsible for any balance of said professional service charges. A photocopy of this Assignment shall be considered as effective and valid as the original document. I understand that there is no guarantee that my insurance companies or pre-paid health plan will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges.

By signing below, I understand the terms above and agree to the Assignment of Insurance Payments.

_____	_____	_____
Date	Patient Signature	Print Name

PRIVACY NOTICE

This notice describes how Thalman Chiropractic may use or disclose your protected health information (PHI). PHI is individual identifiable health information, including actual medical information, your name, address, phone number, identification number, insurance information or other identifiers.
Please review this notice carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandates that patients be provided with advance written notice of the practice's policies regarding the use/and or disclosure of protected health information. This notice takes effect **April 14, 2003.**

A patient's information may be used and/or disclosed for the following reasons:

Treatment-We may use PHI to provide you with medical treatment or services. This includes communications between other healthcare professionals, and other healthcare facilities, and other providers for administering treatment.

Payment-We may use and/or disclose your PHI so the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party. This includes typical payment activities, such as verification of coverage, pre-certifications, referrals, and claims processing.

Administrative or Healthcare Operation Activities-We may use and/or disclose medical information about you for certain administrative, healthcare and management activities, such as compliance monitoring, quality improvement, and business planning. These uses and/or disclosures are necessary to run the practice and to ensure that our patients receive quality care and services.

For Communicable Diseases/Public Health Safety-We may disclose your PHI, if authorized by law, if the public may have been exposed to a communicable disease.

For Legal Proceedings-We may disclose PHI in response to a court order.
The patient reserves the right to request restrictions on the policies listed in this notice, and receive a copy of all information used and/or disclosed. Requests for the patient's own PHI will be provided only with a photo proof of identification from the patient**.**

You have the right to designate a personal representative to authorize the disclosure of protected health information.

Thalman Chiropractic reserves the right to contact patients regarding appointments and accounts.
If you believe your privacy rights have been violated with respect to our protection of your PHI please contact us in writing.

By signing below, I hereby verify that I have read and understand this notice of privacy practices.

_____	_____	_____
Date	Patient Signature	Print Name