Windy City Wellness

Date:__________

Name:____

Birthdate:_____/________/_______

SSN#________________________

Address____

City__________________________ State_________ Zip___________

Phone (h)_______________ (c)__________________ (w)_______________

Email________________________________

Emergency Contact

Name______________________ Relation_________ Phone____________________

Patient Financial Responsibility

Your insurance policy is a contract between you, your employer, and the insurance company. Not all medical services are covered by all insurance policies. Some plans pay fixed allowances for each procedure and office visit, while others pay only a percentage of the cost. **It is the patient's responsibility to understand their insurance coverage.** As a courtesy, we will help you process your insurance claim form for reimbursement, however the patient or responsible party is ultimately responsible for the charges. Any co-payments are due at the time of service. **If we do not participate in your insurance plan, you may still choose to be seen by the practice, but we will require payment in full at the time services are rendered.** In this situation, we will provide you with the documentation necessary for you to file with your insurance carrier on your own behalf. **This office cannot accept responsibility for negotiating a settlement on a disputed claim.**

_______ **I fully understand the above statement and have received a (paper or electronic) copy of my insurance policy verification details**. I understand and agree that it is my responsibility to know if my insurance has any deductible, copayment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full.

_______ **I understand that the verification of my insurance policy details is not a guarantee of payment or coverage by my insurance provider**. I understand that if my policy has a deductible and co-insurance, those amounts are my financial responsibility to this office and that I am responsible for any unpaid balance

________ **I understand that if I have a deductible or coinsurance that has not been met, this office reserves the right to collect an office visit fee of (at minimum) $85 per visit.** Any additional fees that are a result of being applied to my deductible or coinsurance are also my responsibility.

________ **I understand and agree that I am financially responsible for all charges for any and all services rendered.** This includes any medical service or visit, routine examination, muscle manipulation and any other screening ordered by the doctor or staff.

________**I agree to inform the office of any changes in my insurance coverage.** If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

________**If I am a Medicare patient**, I understand that I need to provide the office both my Medicare ID card and my secondary ID card. If the office does not have the proper information for a secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement. By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations, and/or as required by law. I have the right to revoke this Consent, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior Consent. LLCEA/PS provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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(print name) (sign name) (date)

▲ INFORMED CONSENT ▲

Please Read and Sign:

I hereby authorize Dr. Pontarelli and the staff at Windy City Wellness to treat my condition as deemed appropriate. I also authorize Dr. Pontarelli and the qualified practitioners at Windy City Wellness to perform examinations, chiropractic adjustments, physiotherapy, muscle work, massage, the procedures within Chiropractic Plus Kinesiology and Applied Kinesiology, and Scenar Therapy in my treatment plan to for optimal health. I know that all the recommendations he makes are intended to promote my optimal health and are not to be misconstrued as prescriptions that treat disease. I will have the opportunity to ask questions about the nature and purpose of such procedures, possible risks, and alternative procedures. I have the right to refuse any procedure.

I understand that Dr. Pontarelli will prepare any necessary reports and forms to assist me in collection from any insurance company or attorney involved in my claim, and I authorize the release of any and all health information, treatment records, and the prognosis of my condition to my employer, attorney, or any insurance company involved.

I understand and agree that health and accident insurance policies are and arrangement between an insurance carrier and myself. I understand that any amount authorized to be paid directly to Windy City Wellness will be credited to my account upon receipt. I also clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I understand and agree that if I suspend or terminate my care and treatment, any fees for care rendered me will be immediately due and payable. . I will be responsible for any costs of collection, attorney's fees, or court costs required to collect my bill.

Chiropractic is a system of health care delivery and therefore, as with any health care delivery system, Windy City Wellness cannot promise a cure for any symptom, condition, or disease as a result of treatment in the clinic. An attempt to provide me with the very best care is their goal and if the results are not acceptable, they will refer me to another provider who they feel can further assist me.

Specific Risk Possibilities Associated with Chiropractic Care
Soreness- Chiropractic adjustments and rehab procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to chiropractic care. While it is not generally dangerous, please advise your doctor if you experience soreness or discomfort.

Soft Tissue Injury- Occasionally, chiropractic treatment may aggravate a disc injury or cause other minor joint, ligament, tendon, or other soft tissue injury.

Stroke- Stroke is the most serious complication of chiropractic treatment. The most recent studies (Journal of the CAA, Vol. 37 No.2, June, 1993) estimate that the incidence of this type is one in every three million upper cervical adjustments.

Any other types of side effects should be reported to your doctor promptly.

Having carefully read the above and the policies and procedures of Windy City Wellness, I hereby give my informed consent to have chiropractic treatment administered.

Patient Signature Printed Name Date

Parent/Legal Guardian Signature Printed Name Date

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.
You may revoke this authorization, at any time, in writing, except to the extent that your chiropractor or the chiropractor's practice has taken action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. 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 protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health care information not be disclosed to family members or friends who may be involved with your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your chiropractor is not required to agree to a restriction that you may request. If chiropractor believes it is in your best interest to permit the use and disclosure or your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. 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 alternatively ie. electronically.

You may have the right to have your physician amend your protected health information. 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.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health care information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

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.**

We are required by law to maintain the privacy of , and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA compliance officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:__________________ Signature________________________ Date______

Email Communications Waiver

I, ____________________, hereby consent to have Windy City Wellness, SC, communicate with me via e-mailing regarding the following aspects of my medical care and treatment: [test results, prescriptions, appointments, billing, etc.].

I understand that e-mail is not a confidential method of communication. I further understand that there is a risk that e-mail communications between my chiropractor/Windy City Wellness Staff and myself, or between my chiropractor/Windy City Wellness Staff and other referring healthcare providers regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties.

I also understand that any e-mail communications between my chiropractor and myself or other referring healthcare providers regarding my medical care and treatment will be documented and made a part of my medical record. You are advised to retain all electronic correspondence for you own files.

Email communication will be considered and treated with the same degree of privacy and confidentiality as written medical records. Designated staff may receive and read your email. Designated staff will attempt to electronically confirm your appointments via email. Your email address will not be used for external marketing purposes.

I agree and release my provider and practice from any and all liability that may occur due to electronic communication over a non-secure network. I further agree to be held accountable and to comply with the patient responsibilities as outlined in this consent.

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(Date) Signature

Name: ______________________ Today's Date: ______________

REVIEW OF SYSTEMS

For new patients, established patients who may be having a new problem, or our patients who we haven't seen for a while, we need to update our records as to your general medical health. In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed. If you have any questions about this, please ask one of the technicians, or your doctor.

Const. (Health in General) ❑ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer. Other: ______________

Ears, Nose, Mouth & Throat ❑ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness. Other: ______________

C-V (Heart & Blood Vessels) ❑ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other: ______________

Resp. (Lungs & Breathing) ❑ No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other: ______________

GI (Stomach & Intestines) ❑ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other: ______________

GU (Kidney & Bladder) ❑ No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other: ______________

MS (Muscles, Bones, Joints) ❑ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other: ______________

Integ. (Skin, Hair & Breast) ❑ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: ______________

Neurologic (Brain & Nerves) ❑ No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other: ______________

Psychiatric (Mood & Thinking) ❑ No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: ______________

Endocrinologic (Glands) ❑ No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other: ______________

Hematologic (Blood/Lymph) ❑ No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: ______________

Allergic/Immunologic ❑ No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other: ______________