Midwest Pain Management Associates Ltd.
45 S. Park Blvd Ste. 155
Glen Ellyn IL 60137
P: 630-858-9780 F: 630-858-9793

WELCOME TO OUR OFFICE

Please fill out the information below as accurately as possible

NAME________________________________ DATE_____/_____/_____

PLEASE MARK YOUR MAJOR COMPLAINTS THAT YOU HAVE EXPERIENCED:

	PAST	PRESENT
Low back pain	____	____
Mid back pain	____	____
Neck pain	____	____
Shoulder pain	____	____
Headaches	____	____
Hip pain	____	____

	PAST	PRESENT
Arthritis	____	____
Knee pain	____	____
Foot pain	____	____
Heel pain	____	____

Have you ever had numbness/tingling?
____ No ____Yes Where?________________

WHEN DID THIS COMPLAINT BEGIN? ________ IS YOUR COMPLAINT GETTING: BETTER SAME WORSE

DID THIS INJURY OCCUR: ____AT WORK ____AUTO ACCIDENT ____OTHER

PLEASE EXPLAIN HOW THIS INURY HAPPENED:________________________________

____

HAVE YOU BEEN TO A CHIROPRACTOR BEFORE? N OR Y WHEN?________________

TYPE OF PAIN: ___SHARP ___DULL ___THROBBING ___NUMBNESS ___ACHING
___SHOOTING ___BURNING ___TINGLING ___CRAMPING ___STIFF ___OTHER

AGGREVATED BY: ___SITTING ___STANDING ___WALKING ___BENDING ___SLEEPING
___LAYING DOWN ___SNEEZING ___COUGHING ___BOWEL MOVEMENT ___OTHER____________

IS YOUR PAIN: ____CONSTANT ____COMES AND GOES?

WHAT MAKES IT: WORSE? ________________ BETTER? ________________

WHAT HAVE YOU DONE FOR IT? Hot packs, ice, stretching,...________________________

ARE YOU TAKING MEDICATIONS FOR THIS PROBLEM?________________________

TREATMENT BY OTHER DR.'S? please name them________________________

WHAT IS YOUR OCCUPATION?________________________

CHILDREN? Yes or No
Name____________ Age___
Name____________ Age___
Name____________ Age___

WHAT WOULD YOU LIKE TO ACCOMPLISH THROUGH CHIROPRACTIC CARE?________________________
____
____

OTHER COMPLAINTS? ________________________

WHO REFERRED YOU TO OUR CLINIC? ___Friend/Family________________________
___Health Pass ___Newspaper ___Mailing ___Sign ___Ins Provider Listing ___Other ________________
____Health screening/which one? ________________

HISTORY AND PHYSICAL

Please Check And Describe: ____Appendectomy ____Tonsilectomy ____Gall Bladder ____Hernia
Back/Neck Surgery ____Broken Bones ____Other/Description:____________________

Major Accident or Falls:____________________
Hospitilization (Other Than Above)____________________

Below are a list of diseases which may seem unrelated to the purpose of you appointment. However, these questions must be answered carefully as these problems can affect your overall chiropractic care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

___Pneumonia	___Mumps	___Pleurisy	___Measles	___Epilepsy/Seizures
___Rheumatic Fever	___Polio	___Tuberculosis	___Anemia	___Eczema
___Whooping Cough	___Small Pox	___Diabetes	___Cancer	___Mental Disorders
___Heart Disease	___Thyroid	___Arthritis	___Epilepsy	___Asthma
___High Bld Pressure	___Ulcers/Gerd	___Glaucoma	___Hepatitis	___Bleeding problems

If yes, please explain why:____________________

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL
___Low Back Pain
___Shoulder pain
___Neck Pain
___Arm Pain
___Joint Pain/Stiffness
___Walking Problems
___Difficult Chewing/Clicking Jaw

NERVOUS SYSTEM
___Nervous
___Numbness
___Dizziness
___Forgetfulness
___Confusion/Depression

___Cold/Tingling Extremities

GENERAL
___Fatigue
___Allergies
___Loss Of Sleep
___Fever
___Headaches

GASTROINTESTINAL
___Poor/Excessive Appetite
___Excessive Thirst
___Diarrhea
___Constipation
___Hemorrhoids
___Weight Trouble
___Gas/Bloating After Meals
___Heartburn
___Black/Bloody Stool
___Colitis

GENITO-URINARY
___Bladder Trouble
___Painful/Excessive Urination

___Discolored Urine

C-V-R
___Chest Pain
___Short Breath
___Heart Problems
___Ankle Swelling
___Stroke

MALE/FEMALE
___Menstrual Irregularity
___Menstrual Cramps
___Breast Pain/Lumps
___Prostate/Sexual Dysfunction
___Other Problems__________
____

FEMALES ONLY:
Are You Pregnant?
___Yes ___No ___Not Sure
Due Date:__________

FAMILY HISTORY
Please advice us if the following members have a the same problems as you or if they suffer from other problems on this list.

___Mother________	___Sister__________
___Father________	___Spouse__________
___Brother________	___Child__________

EXERCISE	WORK ACTIVITY	SOCIAL HISTORY
____None	____Sitting	____Smoking Pack/Day_____
____Moderate	____Standing	____Alcohol Drinks/Week____
____Daily	____Light Labor	____Coffee/Pops Cups/Day____
____Heavy	____Heavy Labor	____Sugar Per Day____
Do You Stretch? ____Yes ____No	____Computer Work	____Stress Reason__________
	Do You Like Your Job? __Y __N	____Rec. Drugs

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
____________________	____________________	____________________

Midwest Pain Management Associates, Ltd.
640 E. St. Charles Rd #212
Carol Stream, Illinois 60188

Name ____
(Last) (First) (Middle Initial)

Address ____

City ______________________ State __________ Zip __________

Home Phone ______________________ Work Phone ______________________

Date Of Birth ______________ Sex _____ Social Security # ______________

Employer ____

Address ____

Billing Information. Fill out if the Insured Party is a Different person than the patient.

Name ____ Sex ______
(Last) (First) (Middle Initial)

Address ____

Home Phone ______________ Work Phone ______________ Birth date ______________

Employer ______________________ Social Security # ______________

Address ____

Insurance Information

Primary Insurance Company ______________________ Group Number __________

Address ____

Name Of Policyholder ______________________ I D Number ______________
(Usually Social Security #)

Claim # ______________________

Relationship To Insured Self ________ Spouse ________ Child ________ Other ______

Secondary Insurance Company ______________________ Group Number __________

Address ____

Name Of Policyholder ______________________ I D Number ______________
(Usually Social Security #)

Relationship To Insured Self ________ Spouse ________ Child ________ Other ______

Medical Information

Briefly Describe Symptoms, Illness Or Accident ____

____

Is Illness/Accident Work Related? ____ Auto Accident? ____ Date Of Illness/Accident __________

Emergency Care Required? ____ Date __________ Where ______________________

ASSIGNMENT AND RELEASE: I hereby assign my insurance benefits to be paid directly to the above physician. I am financially responsible for non-covered services. I authorize the physician to release any information required to process this claim. This authorization shall remain in effect until such time as it is revoked by me.

PATIENT SIGNATURE ____ DATE ______________

Office personnel, please make copy of front and back of insurance card.

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Midwest Pain Management Associates Ltd.
Consent to Operation, Procedure, Anesthesia and other Medical Services
Release of Information/Financial Policy

Thank you for choosing Midwest Pain Management Associates Ltd. as your health care provider. The following is a statement of our Release of Information/Financial Policy which we require you to read and sign prior to any treatment. All patients must also complete and sign our Patient Registration Form.

RELEASE OF INFORMATION/MEDICAL RECORDS

By signing this form, you authorize Midwest Pain Management Associates Ltd. or his/her designee(s) to release and disclose such medical records, information and documentation as may be necessary or appropriate in order to process insurance claims and to obtain payment on your behalf. You also authorize the release of information acquired in the course of your examination or treatment and all information pertaining to your history and progress in your case. This includes any alcohol or drug abuse data may be protected by Federal Regualtions-42CFR Part 2. You agree that a photocopy your original authorization shall be considered equally authentic.

REGARDING INSURANCE

We cannot bill your insurance company unless you provide us with your insurance information and any special claim forms required by your insurance company. We accept assignment of insurance benefits. That means your insurance will pay us directly the amount due based upon your benefit coverage. By signing this form, you authorize assignment of your benefits to Midwest Pain Management Associates Ltd. for treatment and related services. However, we do require, as your insurance benefits require, payment of co-pays, co-insurance and deductibles at the time of service. Your insurance policy is a contract between you and your insurance company. *Please know your benefits. Please be aware that only your insurance company can tell you if the services provided are covered under your benefit plan.*

While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. In the event that your account is turned over to an outside collections agency, you will be responsible for an additional 30% of the balance owed and/or all the attorney fees and costs incurred to collect the unpaid debt.

Those Insurance Plans in which we are a Participating Provider.
All co-pays and deductibles are due at the time of treatment. Prior to seeking payment from you, we will work with these plans to obtain payment. In the event that your insurance coverage changes to a plan in which we are not a participating provider, refer to the paragraph below.

Those Insurance Plans in which we are NOT a Participating Provider.
If your insurance company has not paid your account in full within 45 days of the billed date, the balance is your responsibility. Your assistance in collection from your insurance company may be required.

WE ACCEPT PAYMENT IN THE FORM OF CASH, PERSONAL CHECK, VISA OR MASTERCARD

CONTINUED ON NEXT PAGE

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients. We charge what is usual and customary for our area. The federal government agency that administers the Medicare and Medicaid programs, has determined that except for certain circumstances, the discounting or waiving of a patient's co-pay or deductible is unlawful. Additionally, under the new HIPAA regulations, we are now not allowed to discount or waive patient's co-pays or deductibles as outlined by benefit plans offered by other third party payers. You are responsible for payment unless we are a participating provider for our insurance company.

PATIENT BALANCES

Patients are responsible for full payment at the time of service if not covered by some other third party such as Medicare, Medicaid or private insurance.

REFUNDS

Refunds will be issued on a quarterly basis unless a specific request is made.

CASES INVOLVING AN ATTORNEY

If you are receiving services for an auto accident, worker's compensation case or personal injury and you are working with an attorney, we expect a minimum monthly payment of $25 in order to continue treatment. We also require information relating to your group health coverage. Both your group health and the appropriate auto carrier will be billed at the same time. This procedure is necessary in order to have a claim on file with the group health in case the auto carrier does not pay or is exhausted at some point during your treatment. This procedure not only protects Midwest Pain Management Ltd. but you as a patient.

MISSED APPOINTMENTS

Please help us serve you better by keeping scheduled appointments. We recognize there are times when it is not possible to keep appointments. If you are unable to keep an appointment, please call our office at least 24 hours prior to the appointment time. If you consistently miss scheduled appointments, our policy is to charge $25.00 for missed appointments and you will be held responsible for payment.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

HIPAA is a protective measure safeguarding patient privacy and confidentiality. By signing this agreement I acknowledge that I have received information pertaining to my rights as covered under to Health Insurance and Portability and Accountability Act of 1996.

I have read and understand the above statements in the Release of Information/Financial Policy concerning my payment responsibility.

X______________________________ ______________________________ ________
Signature of Patient or Responsibility Party   Print Name   Date

X______________________________ ______________________________ ________
Signature of Co-Responsible Party   Print Name   Date