Patient Information

Date: _____

Name: _____
Last First MI

Email address: _____

Mailing Address: _____

_____

Phone # (H)_____ (W) _____ (Other) _____

Can we call you at work? ☐ Yes ☐ No

Date of Birth: _____ Sex: ☐ Male ☐ Female SS#: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

How did you hear about our practice? _____

Emergency contact: Name: _____ Relation: _____ Phone #: _____

Phone #: (H) _____ (W) _____

Accident Information

Is this visit due to an accident? ☐ Yes ☐ No If yes, what type? ☐ Auto ☐ Work ☐ Other _____

Has it been reported? ☐ Yes ☐ No If yes, to whom? _____

Financial Information

Name of person responsible for this account: _____ Insured's DOB: _____

Relationship to patient (if other than self): _____ Phone # _____

Do you have health insurance? ☐ Yes ☐ No Name of Carrier: _____

Do you have secondary insurance? ☐ Yes ☐ No Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, **Harmony Healthcare, Ltd**., INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) _____ **DATE** _____

Health History

Who is your primary care physician? (doctor and/or practice) _____

Please check to indicate if you are currently experiencing any of the following conditions:

☐ Neck Pain/Stiffness	☐ Pins/Needles in Arms	☐ Light Bothers Eyes	☐ Sudden Weight Loss	☐ Nausea
☐ Back Pain/Stiffness	☐ Pins/Needles in Legs	☐ Depression	☐ Loss of Taste	☐ Cold Feet
☐ Arm/Hand Pain	☐ Fatigue	☐ Nervousness	☐ Loss of Memory	☐ Chest Pain
☐ Leg/Knee Pain	☐ Sleeping Difficulties	☐ Tension	☐ Jaw Problems	☐ Fever
☐ Headaches	☐ Loss of Smell	☐ Cold Sweats	☐ Constipation	☐ Fainting
☐ Dizziness	☐ Allergies	☐ Stomach Problems	☐ Shortness of Breath	
☐ Asthma	☐ Blurred Vision	☐ Night Pain	☐ Bowel/Bladder Changes	

Please check to indicate if you have ever had any of the following:

☐ Aids/HIV	☐ Cancer	☐ Hepatitis	☐ Osteoporosis	☐ Stroke
☐ Alcoholism	☐ Cataracts	☐ Hernia	☐ Pacemaker	☐ Suicide Attempt
☐ Allergy Shots	☐ Chemical Dependency	☐ Herniated Disc	☐ Parkinson's Disease	☐ Thyroid Problems
☐ Anemia	☐ Chicken Pox	☐ Herpes	☐ Pinched Nerve	☐ Tonsillitis
☐ Anorexia	☐ Diabetes	☐ High Cholesterol	☐ Pneumonia	☐ Tuberculosis
☐ Appendicitis	☐ Emphysema	☐ Kidney Disease	☐ Polio	☐ Tumors/Growths
☐ Arthritis	☐ Epilepsy	☐ Liver Disease	☐ Prostate Problems	☐ Typhoid Fever
☐ Asthma	☐ Fractures	☐ Measles	☐ Prosthesis	☐ Ulcers
☐ Bleeding Disorders	☐ Glaucoma	☐ Migraines	☐ Psychiatric Care	☐ Vaginal Infections
☐ Breast Lump	☐ Goiter	☐ Miscarriage	☐ Rheumatoid Arthritis	☐ Venereal Disease
☐ Bronchitis	☐ Gonorrhea	☐ Mononucleosis	☐ Rheumatic Fever	☐ Whooping Cough
☐ Bulimia	☐ Gout	☐ Multiple Sclerosis	☐ Scarlet Fever	
	☐ Heart Disease	☐ Mumps	☐ Other _____	

Are you currently under drug and/or medical care? ☐ Yes ☐ No If yes, explain _____

Please list any medications you are currently taking: _____

_____

Please list any surgeries and/or hospitalizations you have had (type & date): _____

_____

_____

Please list any allergies: _____

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

Is there a family history of any of the following conditions? (indicate family member including parents, grandparents & siblings)

☐ Heart Disease _____ ☐ Diabetes _____
☐ Cancer _____ ☐ Arthritis _____ ☐ Other _____

Do you exercise: ☐ Frequently ☐ Moderately ☐ Occasionally ☐ None

Do your work activities mostly involve: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

Do you sleep on your: ☐ Back ☐ Side ☐ Stomach Do you use a cervical pillow? ☐ Yes ☐ No

What is your daily/weekly intake of the following:

Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes _____ packs/day

- I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE (X) _____ **DATE** _____

NEUROLOGICAL/ MRI/ VASCULAR PATIENT QUESTIONNAIRE

NAME _____ **DATE** _____

For any YES answer, please explain under comment and notify the Doctor:

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? ☐NO ☐YES
   Comment: _____
2. Do you have weakness, numbness or burning in your shoulder, arms or hands? ☐NO ☐YES
   Comment: _____
3. Do your hands or arms fall asleep regularly? ☐NO ☐YES
   Comment: _____
4. Do you have reduced feeling (sensation) or swelling in your hands or arms? ☐NO ☐YES
   Comment: _____
5. Do you suffer from a loss of handgrip strength? ☐NO ☐YES
   Comment: _____
6. Do you suffer from back pain with pain in your buttocks, legs or feet? ☐NO ☐YES
   Comment: _____
7. Do you have weakness, numbness or burning in your buttocks, legs or feet? ☐NO ☐YES
   Comment: _____
8. Do our legs or feet fall asleep regularly? ☐NO ☐YES
   Comment: _____
9. Do you have reduced feeling (sensation) or swelling in your legs, feet? ☐NO ☐YES
   Comment: _____
10. Do you suffer from cold hands or feet? ☐NO ☐YES
    Comment: _____
11. Have you tried any medications (i.e. anti-inflammatory, pain control)? ☐NO ☐YES
    If yes, what kind of medication? _____
12. Have you tried any Physical Therapy or Chiropractic treatments before? ☐NO ☐YES
    If yes: When? For how long? What kind? _____
    _____
13. Have you had an MRI? ☐NO ☐YES
    If yes: When? Who ordered it? What was it ordered for? _____
    _____
14. Have you used any splint or braces or other prescribed treatment by an MD? ☐NO ☐YES
    If yes: When? What kind? Who ordered it? _____
15. If you have tried any treatment or medications, did this make your problem better? ☐NO ☐YES
    Comment: _____

NOTE: Your health information will be kept strictly confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

APPOINTMENT CANCELLATION POLICY
(updated 11/11/17)

Please know that cancellation of appointments should be done via phone or text **within 24 hours** of your scheduled appointment.

Please contact us at (224) 535-8435 to notify us of any changes or cancellations.

If prior notification is not given, you will be charged the cost of the session; this will not be covered by your insurance company. We understand that emergencies come up and we do ask to be notified as soon as possible when appointment obligations cannot be filled.

If an appointment is missed without notification, the first time, we will allow booking another appointment. If an appointment is missed without notification a second time, we will not allow any future appointments to be scheduled until the missed appointment has been paid in full.

The fee for a missed appointment is $150.

Please understand that the reason for this policy is to protect our staff from having blocks of time scheduled out that will not be fulfilled with services, to protect Paradigm Performance Center from loss of revenues especially in busy times, and also to allow time in our schedules for others who are trying to make appointments. We simply cannot commit to scheduling appointments for those who may not show. If a customer is unable or unwilling to pay for the missed appointment but would still like to receive services at Paradigm Performance Center, it would be allowed on a "walk-in" basis only and we would happily offer services if and when available.

Please sign below to consent to these terms.

_____ _____

Printed Name Signature

Date: _____

FINANCIAL OFFICE POLICY

1. All patients are on a cash basis until our staff can verify all insurance coverage(s).
2. Your insurance will be verified promptly and will be reviewed with you if applicable.
3. After coverage and deductible are verified, this office may accept assignment on most policies provided the insured/patient signs an appropriate statement of benefits and/or a lien authorizing payment to be sent to the doctor.
4. Waiting for the insurance payment is a courtesy and it may be withdrawn under certain circumstances.
5. As a patient, it is your responsibility to take care of the co-payment (usually a percent or fixed dollar amount) and any non-covered services on a monthly basis. This office may make payment arrangements on an individual basis. Any such plan or arrangements will be discussed during your report of findings.
6. This office does not warrant or guarantee that your insurance company will pay, nor does this office promise that an insurance company will or should pay the fees charged. Insurance policies are an arrangement between the insurance carrier and the patient/insured.
7. Any service not covered or coverage reductions by your insurance carrier will be the patient's responsibility.
8. This office will submit an insurance claim for you. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly with your insurance adjuster or agent. Any denied or disputed claims will be treated as uncovered.
9. If your account should go to collections for any reason, it will be the patient's responsibility for any court costs, attorney's fees, and or collection costs incurred in collecting the account balance.
10. I authorize the release of any medical or other records or information from my health record. I authorize release of records or information necessary to process any claims.
11. All insurance payments, regardless of which company issues a check first, are applied to your account as long as any balance is due. This means refunds are made only after your balance is completed and cleared with this office.
12. If you receive correspondence of checks from your insurance company, you agree to bring these into our department so that we may determine if any action needs to be taken or if the check is on assignment to this office.
13. If you change insurance companies or employers, you agree to provide this office with the current information immediately.
14. If this office gives you any professional or accounting discount for treatment and you decide to drop out of care then our standard fees will apply.
15. This office accepts MasterCard, Visa, American Express, Discover Card, personal checks and cash.
16. If you have any questions concerning this or any other matter, please speak with the receptionist or our insurance department prior to seeing the doctor.
17. If you stop care and have a financial agreement signed with our office, you will be responsible for any/all charges that you have incurred at our office.

Thank you for your cooperation in this matter.
I have read and fully understand the financial office policy and agree to abide by these terms.

_____ _____/_____/_____
Patient Signature or Responsible Party Date

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

To provide timely and accurate payment to Harmony Healthcare, Ltd for any services furnished the patient listed above by Harmony Healthcare, Ltd. physicians and health care providers:

- I certify that the insurance information that I have provided is accurate, complete and current and that no other coverage or insurance exists.
- I assign my right to receive payment of authorized benefits to Harmony Healthcare, Ltd.
- I request that payment of authorized benefits be made on my behalf to Harmony Healthcare, Ltd for any services furnished the patient listed above by Harmony Healthcare, Ltd physicians and health care providers.
- I authorize Harmony Healthcare, Ltd. to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided.
- If my Health Insurance Plan will not direct payment to Harmony Healthcare, Ltd, I agree to forward to Harmony Healthcare, Ltd. all health insurance payments which I receive for the services rendered by Harmony Healthcare, Ltd. and its health care providers.
- I authorize Harmony Healthcare, Ltd. or any holder of medical information about me or the patient listed above to release to my Health Insurance Plan such information needed to determine these benefits or the benefits payable for related services. I further acknowledge and agree:
- That I am responsible for all charges for services provided to the patient listed above which are not covered by my Health Insurance Plan or for which I am responsible for payment under my Health Insurance Plan.
- That I agree to pay all charges which are not covered by my Health Insurance Plan or for which I am responsible for payment under my Health Insurance Plan.
- I further agree that, if permissible by law, I will reimburse Harmony Healthcare, Ltd. for all costs, expenses and attorney's fees that may be incurred by Harmony Healthcare, Ltd. to collect those charges.
- That this financial form with assignment of benefits applies and extends to subsequent visits and appointments at Harmony Healthcare, Ltd.

I certify that I have read and understand the above statements, that all of my questions have been answered to my satisfaction, and that I agree with each statement above.

_____ _____/_____/_____

Patient's Printed Name Date

Patient's Signature

Harmony Healthcare, Ltd.
Paradigm Performance Center
870 Church Road
Elgin IL 60123

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ DOB: _____

I acknowledge that I have the option to receive the Notice of Privacy Practices of Harmony Healthcare, Ltd. (Please initial **one** of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I wish to receive an electronic copy of Privacy Notice. My email address is: _____@_____

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please initial below:

_____ I acknowledge that it is the policy of Harmony Healthcare, Ltd. is to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

_____ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer, Dr. Stuart C. Hui, about my concerns.

_____ _____
Signature of Patient/Guardian Date

_____ _____
Witness (Office Staff) Date

PATIENT HIPAA CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

****

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but written acknowledgement could not be obtained because:

¨ Individual refused to sign

¨ Communication barriers prohibited obtaining written acknowledgements

¨ An emergency situation prevented us from obtaining acknowledgement

¨ Other (please Specify): _____

Informed Consent to Treatment

I hereby request and consent to the performance of chiropractic manipulation, therapeutic procedures, and athletic training on me (or on the patient named below, for whom I am legally responsible) by the chiropractic physician and/or anyone working in this office authorized by the chiropractic physician.

I further understand that such rehabilitation services may be performed by the Physician at Paradigm Performance Center / Harmony Healthcare, Ltd., other licensed professionals, therapists, and trainers who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Stuart C Hui and/or with other office personnel the nature and purpose of such rehabilitative therapies and other procedures. I understand that results are not guaranteed. I understand and am informed that, as in the practice of medicine and all healthcare, the practice of chiropractic and other therapies carries some risks to treatment; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility.

To be completed by the patient: To be completed by the patient's representative, if necessary, (i.e. if the patient is a minor or is physically or mentally incapacitated)

_____	_____
Print Patient's Name	Print Name of Representative
_____	_____
Signature of Patient	Signature of Representative
_____/_____/_____	_____/_____/_____
Date	Date
_____	_____/_____/_____
Physician Signature	Date