INAPC
INTEGRATIVE NEUROLOGY & ATHLETIC PERFORMANCE CLINIC

1607 E. Main Street Unit 2A
St. Charles, IL 60174
Office: (331) 222-9667
Fax: (331) 222-9657

Patient Registration

Patient_____**Today's Date**_____
Last Name First Name Initial
Social Security #_____**Sex: ( ) M ( ) F Age**_____ **Birth Date**_____

Email_____ **Home Phone**_____ **Cell Phone**_____

Street Address_____ **City**_____ **State**_____ **Zip**_____

Marital Status_____ **Spouse/Guardian**_____

Emergency Contact Name_____ **Phone Number**_____

Name of Employer_____ **Phone Number**_____

Who were you referred by? _____

Patient Medical Information

Do you have vertigo (dizziness)?	Yes	No
Do you pass out easily (faint or loss of consciousness)?	Yes	No
Do you have double vision or have you lost sight in one eye?	Yes	No
Do you have any slurred speech or difficulty with speech?	Yes	No
Do you have indigestion or difficulty swallowing?		
Do you have any difficulty walking, with coordination, or falling to one side?	Yes	No
Do you have nausea or vomiting?	Yes	No
Do you have numbness on one side of your face or body?	Yes	No
Do you have any visual disturbances or rapid eye movement?	Yes	No
Dou you have or have you ever had difficulty in arranging words properly?	Yes	No
Do you have a headache or head pain that is unlike any you have had before?	Yes	No
Do you have headaches for hours or days?	Yes	No
Do you have a history of stroke in your family?	Yes	No
Do you have chest pain?	Yes	No
Do you have any change in bowel or bladder habits?	Yes	No
Do you have a sore that does not heal?	Yes	No
Do you have any unusual bleeding or discharge?	Yes	No
Do you have any thickening in your breasts or elsewhere?	Yes	No
Do you have a change in any wart or mole?	Yes	No
Do you have nagging couch or hoarseness?	Yes	No
Do you have night sweats?	Yes	No
Do you have pain in neck, jaw, or face?	Yes	No

INAPC
INTEGRATIVE NEUROLOGY & ATHLETIC PERFORMANCE CLINIC

1607 E. Main Street Unit 2A
St. Charles, IL 60174
Office: (331) 222-9667
Fax: (331) 222-9657

Do you have a drooping eyelid or change in your pupils?	Yes	No
Do you have any ringing in your ears?	Yes	No
Do you take birth control pills?	Yes	No

What prescription medications are you taking, if any?
( ) High blood pressure medication
( ) Blood thinners
( ) Herb, vitamins, or over the counter products
( ) Other_____

Have you ever had cancer?	Yes	No
Does your pain ever wake you from a sound sleep?	Yes	No
Are you losing weight now without trying?	Yes	No
Are you coughing up blood or noticing it in your stools or urine?	Yes	No
Have you had any loss of bladder or bowel control?	Yes	No
Have you lost consciousness or had double vision recently?	Yes	No
Are you seeing any other doctor now for any reason?	Yes	No

Note:_____

Social History

SMOKER Yes No If Yes, how many packs? _____

ALCOHOL Yes No If Yes, how much? _____

Family History

Did your mother or father have any of the following:

(Put **M** for mother, **F** for father, and **B** for both).

( ) High Blood Pressure	( ) Ulcer or Stomach Problems	( ) Cancer
( ) Heart Attack	( ) Stroke	Comments:_____
( ) Emphysema	( ) Arthritis-Rheumatism	_____
( ) Seizure-Convulsions	( ) Mental Illness	_____
( ) HIV Positive	( ) Thyroid Disease	_____
( ) Asthma	( ) Circulation Problems	_____
( ) Diabetes	( ) Kidney Disease	_____

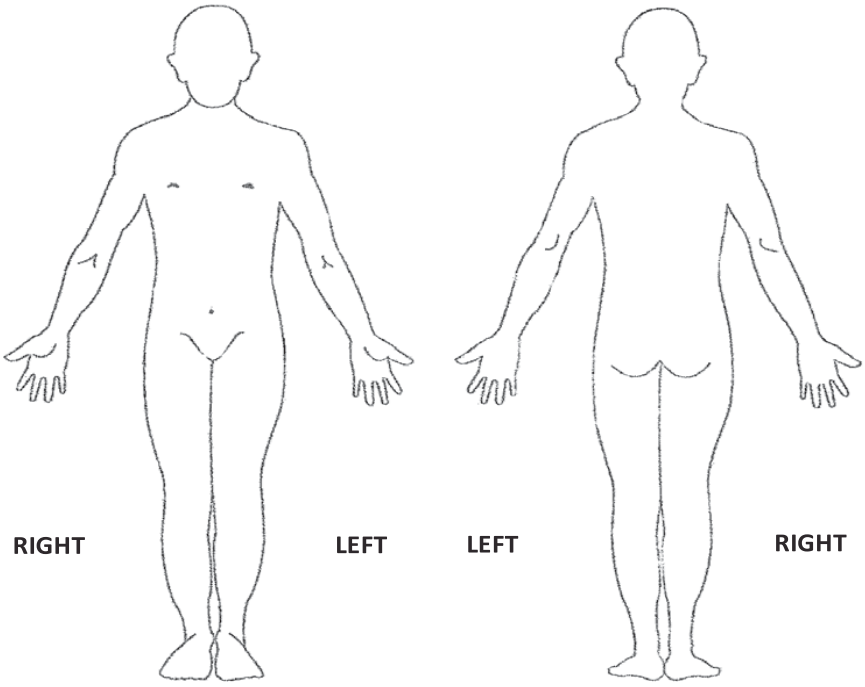
INAPC
INTEGRATIVE NEUROLOGY & ATHLETIC PERFORMANCE CLINIC

1607 E. Main Street Unit 2A
St. Charles, IL 60174
Office: (331) 222-9667
Fax: (331) 222-9657

SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

Please mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - - -	00000	xxxxx	* * * * *	I I I I I



Please mark on the pain scale from Zero to 10 the pain you feel with this condition. 10 being the worst pain you have felt with this condition.

Neck-Shoulder-Arm-Pain
On a scale of zero to 10, rate the discomfort as follows:

(_____)
0 10
No Pain Severe Pain

Mid Back Pain
On a scale of zero to 10, rate the discomfort as follows:

(_____)
0 10
No Pain Severe Pain

Low Back and Leg Pain
On a scale of zero to 10, rate the discomfort as follows:

(_____)
0 10
No Pain Severe Pain

SIGNATURE_____ **DATE**_____

INAPC
INTEGRATIVE NEUROLOGY & ATHLETIC PERFORMANCE CLINIC

1607 E. Main Street Unit 2A
St. Charles, IL 60174
Office: (331) 222-9667
Fax: (331) 222-9657

PATIENT RIGHTS

Following is a statement of patient rights with respect to your protected health information. (Revised 4/16).

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 purpose of treatment, payment, or healthcare operations. You may also disclose request that any part of your personal health information 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 Protection. Your request must 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 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 to 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 i.e. 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 information.

We reserve the right to change the terms of this 1otice and will inform you by mail of any changes. You then have the right to object or withdrew as provided 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. This notice was published and becomes effective on/or before July 23, 2007.

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.

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

* Please check the appropriate block and sign below.

I have read ( ) or have had read to me ( ) the above material and explanations of the possible therapy, treatment or diagnostic procedures that could be related to my situation. I feel I have had and will make the proper effort to discuss my entire condition with a doctor at this facility and will be honest and complete on the entire part of my condition. I will ask any and all questions about my condition and will make an attempt to get and follow through with the proper treatment. I understand that if I do not I may be dropped from care or referred to another practitioner or poor results from partial care may result. Upon signature I also state that I have made a good attempt to have all my questions answered about the related services and procedures. By signing below, I state that I have weighed the risks involved in undergoing treatment and or diagnostic procedures and have myself decided that it is in my best interest (or said minors interest) to undergo the treatment recommended or to be recommended. Having been informed of the risks I hereby give the doctors and personnel at this facility the right to examine, diagnose by the proper means and treat my specific condition fully understanding and acknowledging that there is no guarantee or assurance as to the results that may be obtained from this treatment that has been given to me.

Date_____
Patient Signature_____
Witness Signature_____
Signature of Parent or Guardian_____
If Interpreted, Signature of Interpreter_____

INAPC
INTEGRATIVE NEUROLOGY & ATHLETIC PERFORMANCE CLINIC

1607 E. Main Street Unit 2A
St. Charles, IL 60174
Office: (331) 222-9667
Fax: (331) 222-9657

CONSENT FOR CARE/TREATMENT

1. I hereby authorize and voluntarily consent to care/treatment for my condition(s) at the Integrative Neurology and Athletic Performance Clinic (hereinafter referred to as INAPC). Which may include the performance of diagnostic procedures. Interpretation of diagnostic studies including imaging, the administration of medication, nutritional supplementation, chiropractic care, joint and soft tissue manipulation, physical therapy and procedures requiring the use of needles as deemed necessary by my physician(s), his or her assistants, consultants, or designees for the diagnosis or treatment of my disorder(s)/illness(es).

2. I understand and am informed that in the practice of medicine and chiropractic, as in other forms of health care delivery there are some risks associated with some diagnostic tests and therapeutic procedures, including but not limited to bruises, pain, fractures, allergic reactions, disc injury, stroke, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts as then known, and is in my best interest.

3. Realizing that outpatient care/treatment requires the cooperation of physicians and support healthcare personal to include nurse's therapist and technicians, I hereby give consent for their communication and all procedures provided to me by qualified physicians and other personnel working under the supervision and direction of my attending physician at INAPC.

4. I am aware that the practice of medicine and chiropractic is not an exact science and I hereby acknowledge that no guarantees have been made to me as a result of examinations, treatments or recommendations.

5. I hereby authorize INAPC to retain, preserve and use for scientific or teaching purposes, or dispose of at their convenience, any specimens or tissue taken, if applicable, from my body during my care at INAPC.

6. I hereby understand that the responsible third party or I may be billed for the review of any outside medical records or imaging studies. This includes record reviews for the purpose of a second opinion and clinical correlation.

7. I understand that a specialized diagnostic or focused therapeutic approach to neurological or related orthopedic conditions at INAPC is not to take the place of my general healthcare. I understand that I should consult with my personal/family medical physical/medical internist for general care and for the coordination of my healthcare with other specialists. It is the policy of INAPC to recommend that each patient receive at a minimum semi-annual comprehensive examination from their attending medical internist/medical family physical unless deemed otherwise. This approach helps facility timely diagnosis and intervention.

8. I understand that if I am seeking or limited to a diagnostic opinion at INAPC I am responsible to follow up with the recommended physician(s) for review of therapeutic options and/or intervention. If I do not follow through with the recommended course of care including diagnostic follow-up. I understand that it could lead to an unwanted outcome including but not limited to chronic pain, physical disability, loss of limb, cognitive impairment or death.

9. I understand that INAPC may provide facilities, equipment and clerical support services for the use of physicians in rendering diagnostic and therapeutic services to their patients. I recognize with the exception of designated "staff INAPC physicians", the physicians rendering services to me, including but not limited to, attending physicians, consultants, pathologies, radiologists and neurosurgeons are independent practitioners and are not employees or agents of INAPC and may not by covered by INAPC managed care plans. In some cases, I can expect to receive a separate bill from the independent physicians providing services at INAPC.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about the content, and by signing below I certify that I understand its contents. I intend this consent form to cover the entire course of evaluation and care for my present condition, complications related to my condition and for any future condition(s) for which I seek treatment.

Date_____
Signature of Patient/Legal Guardian_____
Printed Name_____
Signature of Witness_____
Printed Name_____

INAPC
INTEGRATIVE NEUROLOGY & ATHLETIC PERFORMANCE CLINIC

1607 E. Main Street Unit 2A
St. Charles, IL 60174
Office: (331) 222-9667
Fax: (331) 222-9657

INAPC FINANCIAL POLICY

We would like to thank you for choosing Integrative Neurology & Athletic performance Clinic (INAPC) as your healthcare provider. Integrative Neurology & Athletic performance Clinic is committed to providing you with the best possible medical care. We are sure you understand that payment for this healthcare is your responsibility. The following information outlines your financial responsibilities related to payment for professional services. INAPC reserves the right to revise this policy at any time.

INAPC is a private institution that operates for the benefit of people who seek the services of our medical staff. We provide quality care at what we believe to be a fair and reasonable fee. Since we do not receive financial assistance from any outside source we must recover the cost of providing services for our patients. It is our policy, that the responsibility of paying for care, will be placed upon those who receive it; therefore, all accounts will be under the following guidelines:

1. Missed Appointment(s): If you are unable to keep a scheduled appointment, we require sufficient time to fill that time spot. It is expected that you call AT LEAST 24 hours ahead of time for any cancellations.
2. Cost of Service(s): The cost of service(s) rendered varies based on the extent, focus and testing required at your visit. You will be held responsible for these services and/or supplies at the time of service. Payments will be expected to be paid at the time of arrival for visits. Insurance is not directly accepted through our practice. Reimbursement forms are available at the front desk if a patient chooses to self-submit.
3. Payment Options: Payment options include cash, check, Visa, MasterCard, American Express, money order, traveler check or certified check. If you have special financial needs, please discuss this with the billing department to see if you qualify for a payment plan or an extension of credit terms.
4. The practice will not waive, fail to collect, or discount patient financial responsibility in accordance with state and federal law, as well as participating agreements with payers.
5. Transaction ledgers are always available upon request at the front desk.

Patient Signature_____**Date**_____

INAPC
INTEGRATIVE NEUROLOGY & ATHLETIC PERFORMANCE CLINIC

1607 E. Main Street Unit 2A
St. Charles, IL 60174
Office: (331) 222-9667
Fax: (331) 222-9657

HIPAA 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!

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) 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 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 service.

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, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment
We will use and disclose your protected health information 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. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information 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.

Payment
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations
We may use or disclose, as needed, your protected health information 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 medical/chiropractic students, licensing, marketing and fund-raising activities, dictation and transcription, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical/chiropractic students that see 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 your physician. 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 protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: law Enforcement: Coroners: Funeral Director, and Organ Donor Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: inmates: 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.

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 physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.
Please list below the name, phone number, address, and relation to you of any individuals you grant access to your health information, i.e. family member, referring physician, etc.:

Patient Signature_____**Date**_____

INAPC
INTEGRATIVE NEUROLOGY & ATHLETIC PERFORMANCE CLINIC

1607 E. Main Street Unit 2A
St. Charles, IL 60174
Office: (331) 222-9667
Fax: (331) 222-9657

(For Chiropractic Physician) Interviewer Observations