KANE AND KENDALL
SPINE MANAGEMENT
630.906.1700

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ENTRANCE APPLICATION

Welcome! We are honored you chose us to evaluate your health. So we may better serve you. Please fill out the personal information below. If you need assistance please inform the front desk team member. Thank you!

First Name: _____ Middle: _____ Last: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____ Phone Provider: _____
Email Address: _____
Gender: Birthdate: _____ Age: _____ Marital Status:
☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Divorced
Job Title: _____ Work Phone: _____
Spouse's Name: _____ Spouse's Birthdate: _____
Children Name & Ages: _____ _____
_____ _____
_____ _____
Person responsible for this account: _____
Name of person on your health insurance card: _____
Name of their employer: _____ City: _____ Employer Phone: _____
In case of emergency whom should we contact: _____
Relation to patient: _____ Phone Number: _____
Family Physician: _____
Physician's Office Name: _____
Physician's Address: _____
Physician's Phone: _____ May we send your Family Physician updates on your progress: ☐ Yes ☐ No
What is your primary complaint? _____
_____
Workers Compensation: ☐ Yes ☐ No Personal Injury: ☐ Yes ☐ No Auto Accident: ☐ Yes ☐ No

PATIENT INFORMED CONSENT

I, _____, the undersigned, consent to care at this office. I understand that I have the opportunity to discuss with the chiropractor and/or with other office personnel, the nature and purpose of chiropractic adjustments and progressive wellness. I hereby request and consent to the performance of chiropractic procedures, including various modes of physic therapy, diagnostic x-rays, and any supportive therapies on me (or on the patient above, for whom I am legally responsible) by the doctor of chiropractic and support team at Premier Posture Health & Wellness. I also understand that as is with all healthcare treatments, results are not guaranteed, there is no promise to cure and that there are some risks. Risks include, but are not limited to; aggravating and/or temporary increase in symptoms, muscle spasms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the chiropractor to be able to anticipate and explain all risks and complications, and I wish to rely on the chiropractor's judgement, based upon the facts than known, it's in my best interests. I further understand that chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures.

Guardian/Patient Signature _____

(Office use only) Account Number:	Date:

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an "arterial dissection" that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature: _____ Date:

Witness Name: _____ Signature: _____ Date:

HIPAA PATIENT AUTHORIZATION FORM

We are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to maintain the privacy of your protected health information (PHI) and to provide you with a Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your PHI, and contains a section describing your rights as a patient under the law. You have the right to review our Notice before signing this Authorization and you are advised to do so. This authorization for release of information covers the period of healthcare from _____, 20___ to _____, 20___.

By signing this form, you authorize our use and disclosure to third parties, including but not limited to our billing and scheduling software provider, Phunkey Inc., and our Clinic's franchisor, HealthSource Chiropractic, Inc., of your PHI for treatment, payment, and health care operations, and for certain marketing purposes, as described in our Notice of Privacy Practices. If you sign this Authorization but later change your mind, you have the right to revoke this Authorization by delivering to us a written, dated document signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Authorization.

The patient understands and agrees that:

The Clinic has a Notice of Privacy Practices. The patient has received, and had the opportunity to review, this Notice before signing this Authorization. The Clinic encourages all patients to review the Notice of Privacy Practices.

The Clinic reserves the right to modify the Notice of Privacy Practices to keep up with changes in the law or office practices. We will make all modifications available for review by patients.

All my medical records and protected health information may be disclosed or used for treatment, payment, or health care operations, and for certain marketing purposes. The Clinic will not receive any payment from a third party for marketing purposes in connection with the use or disclosure of your PHI.

The Clinic or its business affiliates may use your PHI to contact you with appointment reminders and educational and promotional items in the future via email, U.S. Mail, telephone, fax and/or prerecorded messages. We **WILL NOT** ever sell or "SPAM" your personal contact information.

The patient has the right to restrict the uses of his or her information, but the Clinic does not have to agree to all such restrictions.

The patient may revoke this Authorization in writing at any time and all future disclosures that require the patient's prior written authorization will then cease. See the Notice of Privacy Practices for additional details.

The Clinic may not condition your treatment or payment on whether you sign this Authorization.

Information used or disclosed pursuant to this Authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law.

The Authorization was signed by:_____
Printed Name – Patient or Representative

_____
Signature Date

Relationship to Patient
(if other than patient) _____

Witness: _____
Printed Name – Clinic Representative

_____
Signature Date

For Internal Use:

☐ Patient Refused to Sign ☐ Patient unable to sign for the following reason:_____

Patient's Name: _____ ID #: _____ Date: _____

■ ALLERGIES ☐ No Allergies ☐ Allergic To:

_____

_____

■ MEDICATION ☐ Patient Denies Taking Any Medication ☐ Medications Taken: (include non-prescription)

_____

_____

■ REVIEW OF SYSTEMS

CONSTITUTIONAL: ☐ No weight loss, fever, chills, weakness or fatigue. ☐ Other _____

HEENT: ☐ No visual loss, blurred vision, double vision or yellow sclera. ☐ No hearing loss, sneezing, congestion, runny nose or sore throat.

SKIN: ☐No rash or itching. ☐ Other _____

CARDIOVASCULAR: ☐ No chest pain, chest pressure or chest discomfort. No palpitations or edema. ☐Other _____

RESPIRATORY: ☐ No shortness of breath, cough or sputum ☐ Other _____

GASTROINTESTINAL: No anorexia, nausea, vomiting or diarrhea. No abdominal pain or blood.

GENITOURINARY: ☐Burning on urination. Pregnancy. Last menstrual period, _____. ☐ Other _____

NEUROLOGICAL: ☐ No headache, dizziness, syncope, paralysis, ataxia, numbness or tingling in the extremities. No change in bowel or bladder control ☐ Other _____

MUSCULOSKELETAL: ☐ No muscle, back pain, joint pain or stiffness ☐ Other _____

HEMATOLOGIC: ☐No anemia, bleeding or bruising ☐ Other _____

LYMPHATICS: ☐ No enlarged nodes. No history of splenectomy ☐ Other _____

PSYCHIATRIC: ☐ No history of depression or anxiety ☐ Other _____

ENDOCRINOLOGIC: ☐ No reports of sweating, cold or heat intolerance. ☐ No polyuria or polydipsia ☐ Other _____

ALLERGIES: ☐ No history of asthma, hives, eczema or rhinitis ☐ Other _____

■ RESULTS OF PREVIOUS TREATMENT & TESTS PERFORMED ☐ None (include last date of treatment)

_____

_____

■ SOCIAL/FAMILY MEDICAL HISTORY (M=Mother, F=Father S= Sibling)

☐ Heart Disease __ ☐ Stroke __ ☐ Circulatory Disorder __ ☐ Blood Pressure __ ☐ Diabetes __ ☐ Other:

☐ Denies Smoking, Alcohol or Drug Abuse ☐ Smoker # of packs /day _____ ☐ History of drug abuse

☐ Alcohol Consumption # of glasses per day ____ ☐ Recovering Alcoholic ☐ Other: _____

■ HISTORY OF PRE-EXISTING ILLNESSES (include last date of treatment)

_____

_____

■ WORKER'S COMPENSATION QUESTIONS

Date of Injury: Time: AM/PM

Location (City and state where injury occurred):

Did patient go to the hospital? ☐ Yes ☐ No Via: ☐ Ambulance ☐ Other (Indicate):

Did patient suffer any cuts or contusions? ☐ Yes ☐ No (Describe)

Is the patient working at the present time? ☐ Yes ☐ No Date last worked:

Has the patient missed any time from work? ☐ Yes ☐ No Dates:

At work patient is required to (in hours): Stand: Drive: Walk: Lift: Sit: Type: Other (Describe):

What limitations does patient experience as a result of the injury? (circle affected area(s) below):

Standing Driving Walking Lifting Sitting Typing Other (Describe):

Further describe limitations: