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Integrative Medical Clinic

NEW PATIENT REGISTRATION

Instructions: Please complete this form, printing clearly and to the best of your knowledge.

PATIENT INFORMATION

Today's Date: ____/____/____ Last Name: _____

First Name: _____ Middle Name: _____

Street Address: _____ City, State, Zip: _____

Primary Phone: _____ Secondary Phone: _____

Birthdate: ____/____/____ Social Security #: _____

Gender: ☐Male ☐Female Driver's License #: _____

Occupation: _____ e-mail: _____

Employer Name: _____

Employer Address: _____
Street City State Zip Code

Relationship Status: ☐Divorced ☐Live-in-Partner ☐Single ☐Married ☐Separated ☐Widowed

Primary Care Physician: _____
Name Address Telephone #

How did you hear about our office? _____

INSURANCE INFORMATION

Insurance Name: _____ ID#: _____

Group#: _____ Telephone: _____

Insurance Address: _____
Street City State Zip Code

Insured's Name: _____ Relationship: ☐Self ☐Spouse ☐Dependent

Insured's Address: _____
Street City State Zip Code

Insured's Birthdate: ____/____/____ Insured's Telephone: _____

Insured's Employer Address: _____
Street City State Zip Code

Is patient's condition related to work? ☐Yes ☐No If yes; date of injury: ____/____/____

Employer at time of Injury: _____

Is patient's condition related to auto accident? ☐Yes ☐No If yes; date of Accident: ____/____/____

EMERGENCY CONTACT

Name: _____ Telephone#: _____

Address: _____
Street City State Zip Code

I hereby state that the above information is true and correct to the best of my knowledge:

Patient's Signature _____

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To Our Patients: We are required by Federal Law entitled "Health Insurance Privacy and Accountability" or HIPPA to present you with the following form for your review and signature.

With patient consent, Healthworks IMC, may use and disclose protected health information to carry out treatment, payment, and healthcare operations only. This includes, but is not limited to:

- Appointment reminders calls to your home
- Contacting insurance companies regarding payment for services
- Mailing account statements to your home
- Filling and mailing natural apothecary orders
- Mailing letters pertaining to clinical care to your primary care doctor
- Mailing laboratory and test results to the home address listed on your file
- Mailing your medical records to the home address listed on your file
- Consulting a specialist to make referrals
- Calling and faxing prescription authorization to your pharmacist

Please refer to Healthworks IMC Notice of Privacy Practices for a complete description of such uses and disclosures, available at the front desk.

Certain practices are NOT approved uses for your protected health information and will not ever be performed. These include:

- Selling your information to any third parties for marketing purposes
- Releasing your information for any purposes without your signed consent

To help us protect your health information, we will maintain a copy of your driver's license or state identification card with your signature in your file. If we receive a telephone request to release your medical records, we may ask certain questions (such as your Social Security number) to verify your identity.

If you wish, you do have the right to review the Notice of Privacy Practices prior to signing this consent. You will likely be seeing this notice, or ones similar to it, at other healthcare facilities. Healthworks IMC reserves the right to revise its Notice of Privacy Practices at anytime, within the parameters of HIPAA. A revised Notice of Privacy Practices may be obtained by sending a written request to the Healthworks IMC Privacy Officer.

You have the right to review your medical records and make amendments to those records. Records may be obtained by sending a written request to the Healthworks IMC Privacy Officer.

You have the right to submit a written request that Healthworks IMC restrict how it uses or discloses your protected health information.

You may revoke this consent in writing except to the extent that the practice has already made disclosures with this prior consent.

Please initial where you <u>deny</u> consent to the following:

_____ Healthworks IMC may call my home, or another designated number and leave a message, recorded or with a person, regarding items that assist the practice in carrying out treatment, payment, and operations.

_____ Healthworks IMC may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment, and operations.

_____ Healthworks IMC may e-mail to my home or other designated location any items that assist the practice in carrying out treatment, payment, and operations.

Printed Name _____

Signature _____ Date _____/_____/_____

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CONSENT TO TREATMENT

The undersigned acknowledges that he/she has requested healthcare services. Many of the therapies offered at our center are considered unconventional, although some treatments have been in continuous use for a long period of time, and have been deemed "unproven" by the Food and Drug Administration. Any therapy suggested to you can be refused and/ or terminated at any time. You are never under any obligation to accept or complete any therapeutic recommendations.

Confidentiality and Disclosure of Information

All information provided to Healthworks IMC staff is strictly confidential. A copy of our complete Confidentiality Policy is available at your request.

Financial Terms

If your insurance carrier denies payment for any reason, you will be 100% responsible for the amount owed to Healthworks IMC. A full disclosure of our Financial Policy is attached.

Canceled/Missed Appointments & Late Arrivals

When you make an appointment, we are reserving time on a practitioner's schedule that is no longer available to other patients. If for some reason you have to cancel, we ask that you do so at least 24 hours in advance. You may call (312) 255-9444 and leave a message on our voice mail, 24 hours a day. **Our policy is to charge for missed appointments at the rate of $75.00, unless canceled at least 24 hours in advance.** The office staff has been instructed not to reserve any appointments for patients who accumulate unpaid cancellation charges. Please help us serve you and our other patients better by keeping your scheduled appointments.

Late arrivals also create scheduling problems. We understand that traffic can cause unexpected delays so if you believe you are running late, please call as soon as possible. **If you arrive more than 15 minutes late, we may not be able to honor your appointment.** If a practitioner is behind schedule, we will do our best to notify you as soon as possible.

Prescription and Supplement Refills

Prescriptions which run out of refills will be renewed for patients only if the patient has been seen in the office within the past two weeks prior to the renewal request. The practitioner may decide to not renew a prescription for a patient for any reason and may still require that the patient be seen in the office prior to renewing the prescription. Nutritional supplements will only be refilled for current patients. Patients not seen in the past six months will not be able to have refills of their supplements without having an appointment with the practitioner.

Parent/Child

Any patient over the age of 18 is allowed medical privacy by law, independent of payment arrangements made by the parent or legal guardian. We cannot release a patient's medical information to parents of a legal adult without a signed consent on file.

Legal Assignment of Benefits and Release of Medical and Plan Documents

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the previously mentioned, and hereby assign and convey directly to Healthworks IMC all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information up on written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chosen action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as the result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chosen action or right against my insurers and/or employee health care plan, including, if necessary, bringing suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor's and clinic's expense.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Printed Name _____

Relationship to patient (if minor) _____

Signature _____ Date _____/_____/_____

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OUR FINANCIAL POLICY

Thank you for choosing Healthworks IMC as your health care provider. We are committed to your successful treatment. Please understand that full payment of your bill is very important for our financial survival and to avoid the "assembly line' visits so common in health care today. We hope the following will avoid any misunderstandings concerning reimbursement for professional services. Like any sensible business, we accept cash, personal check, Visa, MasterCard, and American Express. We are not affiliated with any HMO insurance plans, nor are we contracted with Medicare or Medicaid.

Regarding Insurance

"In-Network" Insurance Plans: **The 'in-network' plan with which we are affiliated is BlueCross/BlueShield PPO.** Payment for all co-pays, co-insurance, deductibles, and non-covered services are due at the time of service. In the unlikely event that Blue Cross has not responded to our claim after 60 days, you will receive a statement from us. You are responsible for payment of any services for which your insurance company may refuse payment.

"Out-of-Network" Insurance Plans: Any health insurance policy is a contract between you and your insurance company in which they agree to pay for your health care expenses. Because we are 'out-of-network', we do not have any contract with insurance plans other than those previous listed. However, for your convenience, we will bill your insurance company for services normally covered (doctors visits and labs). When we bill your insurance company, we require that you provide a credit card with authorization to bill that account in the event that your insurance company unconscionably delays or refuses payment. If your insurance company has not paid your account in full within 50 days, you will receive notification from our office that the balance will be transferred to your credit card in the next 10 days. We cannot predict your insurance company's reimbursement for our services. We cannot bill your insurance company unless you give us your correct and current insurance information. If payment is delayed because you provide incorrect or outdated information, you will be charged a **$10 rebilling fee**.

Non-Covered Services

Please be aware that some of our services provided may simply not be covered by health insurance. From our extensive experience in dealing with insurance companies we simply do not bill for certain services, including: acupuncture, massage, homeopathy consultations, Chi Kung, DRX 9000, nutritional counseling, prolotherapy, mesotherapy, auto sanguis and most intravenous therapies.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients while charging "usual and customary" fees for our area. We do conduct surveys of area rates and find we are 'mid-range'. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Minor Patients

The adult, parent or guardian accompanying a minor will be responsible for full payment on the minor's account. For unaccompanied minors, non-emergency treatment can be only performed when charges have been pre-authorized to an approved credit card, or payment by cash or check at time of service has been verified.

Late Fees

We depend on timely payment from our patients. As soon as we receive notification and/or reimbursement from your insurance company, we will send you a statement for any remaining balance due. **If after 3 weeks, you have not contacted us to make payment arrangements, the balance will be billed to your credit card on file. If the credit card you have on file for us is denied for any reason, the balance will be referred to collections including a $15 collections fee.** Other finance charges include: **return check fee: $25; rebilling fee: $10.** Patients whose accounts are in arrears will be asked to bring these accounts current prior to receiving additional services.

Thank you for taking the time to review our Financial Policy. Our entire staff is familiar with our policy and anyone you speak with will make every effort to clarify any questions you may have concerning your account.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Signature _____ Date _____/_____/_____

2731 N. Lincoln Ave, Chicago, IL, 60614 ◆ (312) 255-9444 ◆ Fax (312) 255-9446

PATIENT CARE PAYMENT AGREEMENT

In consideration for undertaking my care, I agree to the following:

For Charges billed to insurance

1. In the event my insurance company does not make payment to you within sixty (60) days of your billing, I will become personally responsible for the amount on my credit card listed below.
2. Any insurance check that may be forwarded to me for services received at Healthworks IMC and not previously paid for, will be endorsed by me and turned over to Healthworks IMC with five (5) business days of receipt, for payment of my account. If I do not clear this portion of my account within five (5) business days of said payment, I hereby authorize you to collect the full amount of my account balance on the credit card listed below.
3. In those instances in which an insurance company has made partial payment for services, I authorize you to collect outstanding balances ("patient responsibility," including co-pays, co-insurance, deductibles, non-covered services) on my credit card listed below.
4. In the event my insurance company reimburses you for services that I have previously paid for, I authorize you to reimburse the overage to my credit card listed below.

For Charges not billed to insurance

1. Any appointment cancellations that I make less than 24 hours prior to the reserved time, I authorize you collect up to, but not exceeding, the full price of the visit fee on my credit card listed below.
2. If I should make payment by check that proves to have insufficient funds, I authorize you to collect the non-payment, plus $25 returned check fee, on the credit card listed below.

If the card number provided is invalid or does not accept charges, I understand that I will be charged a $10 rebilling fee.

Name _____

Credit Card (circle) **MasterCard** **Visa** **Amex**

Card Number _____ Expiration Date _____/_____/_____

CV Code (found on the back of your card) _____ Street Address Number _____ Billing Zip Code _____

Signature_____ Date _____/_____/_____

Witness_____ Date _____/_____/_____

_____ I prefer to have statements mailed to me before charging my credit card so that I have the opportunity to pay by check. However, I understand that if payment is not received within 3 weeks of the statement date, the balance due will be charged to the credit card listed above.

NEW ADULT PATIENT INTAKE FORM

To our new patients: *Welcome* to the private Osteopathic Medical practice of Dr. David J. Zeiger and Healthworks IMC. To help us establish you with our practice, please provide us with your complete health history: body, mind and spirit.

PERSONAL HISTORY

Name: _____ Date of Birth: ____/____/____ Age:____ Date: ____/____/____
Occupation: _____ Birthplace: _____
Date of Last Examination: ____/____/____ Your Doctor: _____
Referred by:_____

ALLERGIES:

_____
_____
_____

MAIN PROBLEMS/REASON FOR THIS APPOINTMENT*:
(If possible, rank in terms of importance to you)

1. _____
   _____
2. _____
   _____
3. _____
   _____

ADDITIONAL PROBLEMS OR CONCERNS YOU WOULD LIKE TO ADDRESS:

_____
_____
_____
_____

*Note: we may not be able to address every problem during the course of one visit.

PHYSICIAN NOTES

(For physician completion only.)

HPI:
Onset
Life at the time
Frequency
Intensity
Duration
Triggers
Relievers
Related symptoms
Diagnoses given
Treatments tried
Primary MD
Goals
Biographical issues

CURRENT MEDICATIONS	DOSE	TIMES/DAY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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NEW ADULT PATIENT INTAKE FORM

PATIENT NAME: _____ Date: ____/____/____

CURRENT HERBS, VITAMINS AND SUPPLEMENTS	DOSE	TIMES/DAY

PHYSICIAN NOTES
(For physician completion only.)

Residual complications

Ongoing MD relationships

Satisfaction with care

PAST MEDICAL HISTORY: List prior illness, Injury, hospitalization, surgery, and trauma.

REASON:	DATE
	____/____/____
	____/____/____
	____/____/____
	____/____/____
	____/____/____
	____/____/____

PERSONAL AND FAMILY HISTORY **Number of siblings: ____ Your birth order: ____**
(Please check all that apply.)

	Self	Mother	Father	Grand-parents	Sister/ Brother	Spouse	Children
AIDS							
Alcoholism							
Allergies							
Alzheimer's							
Anemia							
Arthritis							
Asthma							
Birth Defects							
Bleeding Disorder							
Breast Cancer							
Cancer							
Colon Cancer							
COPD							
Depression							
Diabetes							
Emphysema							
Epilepsy							
Glaucoma							
Heart Attack							
Heart Trouble							

Dysfunctional issues

Special concerns

NEW ADULT PATIENT INTAKE FORM

PATIENT NAME: _____ Date: ____/____/____

PERSONAL AND FAMILY HISTORY CONTINUED
(Please check all that apply.)

	Self	Mother	Father	Grand-parents	Sister/ Brother	Spouse	Children
High Blood Pressure							
IBS							
Kidney Disease							
Liver Disease							
Mental Illness							
Migraine Headaches							
Pneumonia							
Prostate Cancer							
Sickle Cell Anemia							
Stroke							
Suicide							
Tuberculosis							
Ulcers							
other							

SOCIAL HISTORY (Please check those that apply.)

Marital Status:
☐Single
☐Married
☐Divorced
☐Widowed
☐Other

Education Level:
☐High School
☐College
☐Technical School
☐Other

Childhood Memories:
☐Mostly happy
☐Mostly painful
☐Average
☐Don't recall

Define Your Life:
☐Satisfactory
☐Boring
☐Generally Unsatisfactory
☐Too Demanding
☐Other

Living Arrangement:
☐Alone
☐Family
☐Roommate(s)
☐Significant Other
☐Children (list ages/sex) _____

Major Stress in past 6 months:
☐Money
☐Job
☐Home life
☐Marriage
☐Children

Other Stressors: _____
_____

Pertinent travel history:(out of USA, epidemic areas): _____
_____
_____

Anticipated changes

Financial concerns

Stressful aspects

LIFESTYLE / SELF-CARE ISSUES *(You may also bring any item up confidentially with the doctor.)*

Do you smoke cigarettes?	☐ YES ☐ NO	If yes, how many? #____ of years #____ of packs per day
Did you ever smoke?	☐ YES ☐ NO	If yes, when did you quit? ____/____/____
Do you drink alcohol?	☐ YES ☐ NO	If yes, how much? Kind_____ & #____ drinks per week
Do you drink caffeinated beverages?	☐ YES ☐ NO	If yes, which? _____
Do you use recreational drugs?	☐ YES ☐ NO	If yes, which? _____
Do you manage stress well?	☐ YES ☐ NO	☐ NOT SURE ☐ NEED HELP
Do you exercise regularly?	☐ YES ☐ NO	If no, why? _____
Do you enjoy your job?	☐ YES ☐ NO	If no, why ? _____

NEW ADULT PATIENT INTAKE FORM

PATIENT NAME: _____ Date: ____/____/____

LIFESTYLE / SELF-CARE ISSUES CONTINUED

Do you allow time to unwind and relax? ☐ YES ☐ NO If no, why? _____
Do you sleep soundly? ☐ YES ☐ NO If no, why? _____
Are you satisfied with your sex life? ☐ YES ☐ NO If no, why? _____
Are you satisfied with your social life? ☐ YES ☐ NO If no, why? _____
Are you satisfied with your spiritual life? ☐ YES ☐ NO If no, why? _____
Is your diet healthy enough? ☐ YES ☐ NO ☐ NOT SURE ☐ NEED HELP

Typical breakfast: _____
Typical lunch: _____
Typical dinner: _____
Typical snacks: _____

Do You Use:
☐ Eyeglasses ☐ Contact Lens ☐ Hearing Aid ☐ Dentures
☐ Brace (Neck, Back) ☐ Pacemaker ☐ IUD, Diaphragm ☐ Artificial Limbs

REVIEW OF SYSTEMS *Check any symptoms that currently apply to you.*

Constitutional
☐ poor appetite
☐ fevers
☐ chills
☐ food cravings
☐ weight loss
☐ weight gain
☐ fatigue

Muscles, Bones & Joints
☐ neck pain
☐ back pain
☐ muscle pain
☐ painful joints: ☐ R ☐ L
☐ shoulder ☐ elbow
☐ hip ☐ knee ☐ ankle
☐ wrist ☐ fingers
☐ joint swelling
☐ muscle weakness
☐ muscle cramps

Digestion & Intestine
☐ indigestion
☐ belching
☐ difficulty swallowing
☐ heartburn
☐ nausea
☐ liver trouble
☐ vomiting
☐ diarrhea
☐ cramping bowels
☐ gassy gut
☐ constipation
☐ abdominal pain
☐ rectal pain or itching
☐ hemorrhoids, piles
☐ blood in stools
☐ foods that upset your system: _____
_____

Heart & Circulation
☐ chest pain
☐ lightheadedness
☐ palpitations
☐ cold hands/feet
☐ fainting
☐ swelling feet
☐ blood clots
☐ varicose veins

Nerve, Movement, Brain
☐ seizures
☐ nerve pains
☐ poor balance
☐ poor coordination
☐ tremors or shaking
☐ numbness
☐ dizziness
☐ poor memory
☐ trouble sleeping

Ears,Nose,Mouth,Throat
☐ ringing ears
☐ nosebleed
☐ postnasal drip
☐ sinus problems
☐ trouble with taste/smell
☐ poor hearing
☐ earaches
☐ headaches
☐ facial pain
☐ jaw clicks
☐ teeth problems
☐ grinding teeth
☐ trouble chewing
☐ sore throat
☐ mouth sores
☐ bad breath

Eyes
☐ eye pain
☐ blurred vision
☐ poor vision ☐ day
☐ poor vision ☐ night
☐ wear corrective lenses
☐ nearsighted
☐ farsighted
☐ other

Breathing & Lungs
☐ shortness of breath
☐ wheezing/asthma
☐ repeated colds/flus
☐ cough, dry/irritating
☐ cough up mucous
☐ cough up blood

Skin, Hair & Breasts
☐ breast lumps or pains
☐ breast leaks fluid
☐ rashes
☐ itching, hives
☐ hair loss
☐ mole changes
☐ dry skin, eczema

Urine, Kidneys, & Bladder
☐ painful urination
☐ wake up to urinate
☐ kidney stones
☐ loss of control of urine
☐ frequent urination
☐ sudden urges to urinate
☐ blood or puss in urine
☐ decreased urine flow

NEW ADULT PATIENT INTAKE FORM

PATIENT NAME: _____ Date: ____/____/____

REVIEW OF SYSTEMS CONTINUED *Check any symptoms that currently apply to you.*

Immune System
- ☐ too many infections
- ☐ allergies to food
- ☐ allergies to environment
- ☐ other concerns

Blood System
- ☐ lymph gland
- ☐ Anemia
- ☐ easy bruising

Hormones & Metabolism
- ☐ thyroid trouble
- ☐ fluid retention
- ☐ weight and diet troubles

Sexual Organs
- ☐ sores on genitals
- ☐ lumps or swelling
- ☐ erection problems
- ☐ poor sexual response
- ☐ pain with sex
- ☐ infertility
- ☐ repeated infections

Women
- ☐ pelvic pain
- ☐ vaginal discharge
- ☐ painful periods
- ☐ premenstrual syndrome
- ☐ hot flashes
- ☐ itching or soreness

Reproductive
- ____age period started
- ____ # of pregnancies
- ____ # of abortions
- ____ # of miscarriages
- ____ # of live births
- ____ # of living children
- ____age of menopause

Moods, Thoughts, & Emotions
- ☐ depression
- ☐ loneliness
- ☐ apathy (don't care anymore)
- ☐ panic or fear attacks
- ☐ anxiety, overstressed
- ☐ isolated from family, friends, or co-workers
- ☐ hopelessness
- ☐ anger problems
- ☐ manic episodes
- ☐ spiritual needs
- ☐ sex energy issues

Sexually Transmitted Diseases
- ☐ Herpes
- ☐ Hepatitis
- ☐ Syphilis
- ☐ Gonorrhea
- ☐ Chlamydia
- ☐ HIV/AIDS

HEALTH SCREENING HISTORY *List the date of your most recent test or exam.*

Mammogram ____/____/____ Self Breast Exam ____/____/____ Breast Exam by Doctor____/____/____
Pap smear ____/____/____ Blood test for Cholesterol ____/____/____ Blood Sugar ____/____/____
Blood tests_____
Immunizations: Polio____/____/____ Tetanus____/____/____ Hepatitis____/____/____ Pneumonia____/____/____
Flu Shot ____/____/____
Test for Blood in stool____/____/____ Rectal Exam ____/____/____ Scope Lower Bowel ____/____/____
Feeling the Prostate ____/____/____ Self Exam Testicle ____/____/____ Testicle Exam by Doctor ____/____/____

Anatomy\Procedure	X-ray	MRI	CT Scan	Ultrasound	Bone Scan	Pet Scan	EMG
Back							
Brain							
Chest							
Colon							
Extremities (Arm/ Leg)							
Gallbladder							
Kidney							
Neck							
Pelvis							
Stomach							
Other:							

MAY WE CONTACT YOUR REGULAR OR REFERRING DOCTOR? _____

This history record has been designed to facilitate our patients continuity of care at Healthworks. This is a confidential record and will be kept in this facility . Information contained here will not be released to anyone without your authorization to do so.

____/____/____ _____
Date Signature of patient/guardian who completed the forms

____/____/____ _____
Date **Signature of physician**

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