Chiropractic-Li Yours

4667 N. Manor Ave.
Chicago, IL 60625
(773) 509-1116

Check List:

_____ New Patient Form
_____ Informed Consent of Treatment
_____ Privacy Notice
_____ Appointment Policy
_____ Financial and Office Policies
_____ Sign up for the Wellness Minute

Please complete **all** of the forms to the best of your ability. It will help make our first visit more productive, and may help you clarify what your goals for chiropractic care are. If you should have any questions, please feel free to discuss this. (You can fill this out on your computer, print it and bring them for your schedule visit. **Please do not email the forms**, for privacy reasons.)

Patient Information: (please print)

Name _____ Date _____ Sex: ____M ____F

Address_____City_____ State_____ Zip_____

Phone (H) _____ (C)_____(W) _____

Date of Birth _____ Email _____

Do you prefer to receive calls at: _____(H) _____(C) _____(W) _____No Preference

_____Married ____Widowed _____Single _____Separated ____Divorced _____Partnered for_____ years

Patient Employer/School _____Occupation _____

Employer Address _____City _____ State _____ Zip _____

Spouse or parent's name _____Employer _____

Whom may we thank for referring you to us? _____

Person to contact if case of emergency _____Phone _____

Have you ever been to a chiropractor before? ____Yes ____No Good results? ____Yes ____No

Approximate date of last chiropractic visit _____

Responsible Party:

Name of person responsible for this account _____

Relationship to patient _____

Address _____City _____State _____ Zip_____

Insurance Information:

Name of Insured _____ Relationship to patient _____

Birthdate _____ Social Security #_____Date Employed_____

Name of Employer _____ Work Phone _____

Address _____ City _____ State _____ Zip_____

Insurance Co. _____Phone _____ ID#_____

Group# _____

Let's Find Out Why You're Here:

What is the main reason for your visit today?

_____Wellness/Prevention

_____Other (Please describe in detail) _____

_____

What OTHER health challenges are you currently experiencing? _____

_____

_____

When did you first notice the symptoms/health challenges? _____

Is this condition getting progressively worse? _____ Is it constant or come and go? _____

Where specifically is the problem? _____

Describe the pain or concern: _____

What activities are difficult to perform? _____

List ALL surgeries (if any) throughout your life and approximate date/year: _____

_____

_____

List ALL health conditions (e.g., heart disease, diabetes cancer, etc.) you have been diagnosed with throughout your life: _____

_____

List ALL medications (including over the counter) you are currently taking and what are they for:

_____

Any allergies _____

List ALL supplements, herbals, or homeopathic or natural remedies you are currently taking:

_____

List ALL your family health history/problems that is significant to you:

_____

Your Lifestyle:

Rate your habits (from 1 being very poor to 10 being very excellent) to the following:

Eating _____ Quality of Sleep _____ Exercise _____ General Health _____

Do you use artificial sweeteners? Yes ____ No _____

How much water do you drink per day? _____

Do you or have you follow any special diet? (gluten free, weight watchers, Aktins, etc..) _____

_____

If yes, when and for how long? _____ Was it successful? _____

What is your average hour of sleep? _____ Do you feel tired in the morning?_____

If you do exercise, what kind of exercise do you do? _____

How often do you exercise? _____ Do you stretch on a regular basis? _____

Do you smoke? _____ How many packs or cigarettes per day? _____

Have you smoked before? If yes, how long you smoked and when did you quit? _____

How much liquor do you consume on weekly basis? (wine, beer, cocktails) _____

How much coffee or caffeinated beverages do you consume on a daily basis? _____

Is your job requires lots of sitting or physical labor that is light, moderate, or heavy? _____

_____

Please rate your stress levels associated with each category on a scale of 1-10 (1=low stress, 10=high stress):

_____Personal relationships (spouse/significant other, family, friends, etc.)

_____Business or work relationships

_____Your job itself

_____Finances

_____Your health

_____Uncertainty of the future

_____Other (please specify and explain) _____

Looking to the future and your health:

How **committed** are you to actively in getting yourself toward greater level of happiness, health, and wellness? What is your commitment level? _____

Not at all 1 2 3 4 5 6 7 8 9 10 100% committed

Certification and Assignment:

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance with _____ and assigned
name of Ins. Co.
directly to Dr. Melissa Li, DC all insurance benefits, if any, otherwise payable fully for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Print of patient, guardian, parent or personal rep. Date

_____ _____
Signature of patient, guardian, parent or personal rep. Date

INFORMED CONSENT FOR TREATMENTS AND CARE

I hereby request and consent to the performance of chiropractic treatments and other procedures, including acupuncture, various modes of physical therapy and modalities and other techniques, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic and/or other licensed doctors who now or in the future treat me, is working or associating or serving at the clinic listed below.

I have had the opportunity to discuss with the doctor of chiropractic named below the nature and purpose of chiropractic adjustments and other procedures. I also understand that although chiropractic practice is considered to be one of the safest forms of treatment, I am aware that there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains, and those, which relate to physical aberrations unknown or reasonably undetectable by the doctor. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I rely on the doctor to exercise his/her judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, is in my best interest.

I also hereby agree by the doctor of chiropractic and/or other licensed doctors to reserve the right to charge me for missed appointment visits broken without 24 hour advance notice. I agree that I am financially responsible for all charges rendered to me to be paid at time of services rendered.

I have read or have had read to me, the above consent. Any questions I have had regarding procedures or about its contents have been answered to my satisfaction, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

TO BE COMPLETED BY PATIENT

Patient's Name _____Signature of Patient _____
PLEASE PRINT

Date Signed _____ Witness or Patient's Signature _____

TO BE COMPLETED BY PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED

Patient's Name _____ Signature of Patient _____
PLEASE PRINT

Date Signed _____ Signature of Representative _____

Relationship or Authority of Patient's Representative _____

Translated by _____ Date_____

TO BE COMPLETED BY DOCTOR OR STAFF

Name of Clinic or Office _____
Address_____
Name of Doctor's Treating This Patient _____

PRIVACY NOTICE CONSENT FORM

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice would be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following reminders that will be used by the Practice: a) a correspondence mailed to me at the address provided by me; and b) telephoning my home/or mobile and leaving a message on my answering machine/or voicemail or with the individual answering the phone.

4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restriction that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6. I understand that this Consent is valid for seven years from the date signed. I further understand that I have the right to revoke this Consent, in writing, at any time for all ***future*** transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already take action in reliance on this consent.

7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____
Name of Individual (Printed) Signature of Individual Date

_____ _____
Signature of Legal Representative Relationship Date
(e.g., Attorney-In-Fact, Guardian, Parent if a minor)

_____
Witness Date

APPOINTMENT POLICY

Thank you for choosing Chiropractic-Li Yours, Dr. Melissa Li as your health provider. In order to provide you and our other patients with the best care, we request that you follow our guidelines regarding missed appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hour notice in advance in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients that need care.

A charge of $25 fee will be incurred for missed appointments without calling our office 24 hour notice. Payment for the missed appointment is the responsibility of the patient. The fee will be billed to you or collected on your next visit.

Thank you for your consideration and for the opportunity to be your health provider of choice.

I understand that I will be charged a fee of $25 for any missed appointment that I fail to call at least 24 hours in advance.

_____ _____
Patient's Name (print) Date

_____
Patient's Signature

_____ _____
Name of Parent/Guardian (if minor) Date

_____
Signature of Parent/Guardian (if minor)

OFFICE & FINANCIAL POLICIES

1. Fees are due and payable at the time services are rendered. We accept cash, checks, and major credit cards (VISA, MC, Discover, AMEX).

2. Checks returned for any reason will incur a $35 fee.

3. Please be aware that insurance companies DO NOT cover homeopathic treatment or the cost of remedies or any other nutritional supplements.

4. Healthcare Savings Accounts and Flexible Spending Account dollars may be used to pay for services.

5. Homeopathic Product Information:

    - Remedies are based upon individual needs and discussed with clients during consultations. We can only offer a ROUGH estimate of remedy costs because remedies are dependent on each patient's individual needs.

    - The AVERAGE cost for remedies is $250-$400 per month more or less. Average monthly remedy costs vary so widely because each person's needs are different and can vary on a monthly basis.

    - Typically, the more serious and chronic the condition, the more remedies are required for healing. One can usually expect to spend more on remedies the first several visits and less on subsequent visits.

    - Non-alcohol remedies are available in special circumstances and cost $4 more per bottle.

6. No refunds on services and ALL products.

I understand the OFFICE & FINANCIAL POLICIES outlined above and agree to abide by them.

_____ _____

Signature Date

Sign Up For The "WELLNESS MINUTE"
Feeling Better…One Byte At A Time

Each week we send out an email with a short 3-5 minute video on a nutritional topic for you and your family. If you have any ongoing health challenges, or if you just want to have more energy, watch the Wellness Minute each week. We want you to know that we're here to be your local wellness clinician and can help with all your health questions.

Sample Wellness Minute Topics

- How To Relieve Breast Tenderness……In 5 Minutes
- The New "Flat Belly Diet" ….Why It Really Works!
- Natural Relief For Allergies
- How to KNOW Which Nutritional Supplements Are Right For You
- Which Eggs Are Best: cage free, free roaming, organic, omega 3???
- Men ….. A Simple Way to Increase Testosterone
- Natural Relief For Anxiety
- Should I Consider A Detox?
- Managing Blood Sugar
- And Many More……..

To register: Just fill in your name and email address below and we'll start sending you the **FREE** Wellness Minute via email once a week. You can always unsubscribe later if you wish.

Please start emailing me the weekly Wellness Minute

Clinic or Doctor Name**: Dr. Melissa Li**

My Email Address is _____

Signature Required _____