Today's Date: _____

BrightLife Chiropractic & Wellness

442 E Roosevelt Rd. Lombard, IL 60148

Patient Name_____ DOB: _____Email: _____

SS #/SIN_____ ☐Male ☐Female Home phone_____ Cell Phone _____

Check appropriate Box**:** ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Patient's Address _____City _____ State_____ Zip_____

Employer Name: _____

Spouse or Patient's Guardian name_____ Spouse's Employer_____

Whom may we thank for referring you? _____

Person to contact in case of an emergency_____ Phone_____

Primary Care Physician: _____ **Phone**: _____

May we send health updates to this physician? ☐Yes ☐No

In case of a medical emergency, if the patient is of school age 15+, it is ok to treat in my absence.

_____ _____

Parent or Guardian Signature Date

Responsible Party

Name of The Person responsible for this account _____Relationship to Patient _____

Address _____Home Phone _____

E-Mail _____Cell Phone _____DOB: _____Driver's License # _____

Is the person currently a patient at our office? ☐Yes ☐No

Do you have any Medical insurance? ☐Yes ☐No if yes, Please provide a copy to our front desk or complete the following:

Subscriber Name _____ DOB_____ Relationship to patient_____

Name of Employer_____ Address of Employer_____City _____

Insurance ID: _____ Group #_____Ins Carrier Select Carrier Union or local # _____

Ins. Co. Address _____ City _____ State _____ Zip_____

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE
AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **BrightLife Chiropractic & Wellness** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

X_____ (SEAL) Signed this Day day of Month, 20 _____.
(Patient Signature)

X_____ X_____(SEAL)
(Please Print Patient Name) (Signature of Guardian if applicable)

Health History

Patient Name: _____DOB: _____Date:_____

Chief Complaint: _____

History of Present illness:

Location: _____ (Where is the pain/problem?)

Quality: _____ (Example:Sharp, shooting, aching, dull, numbness etc..)

Severity: _____ (How severe is the pain/problem on a scale of 1-10 with 10 being the most severe?)

Duration: _____ (How long have you had this pain/problem? When did it start?)

Timing: _____ (Does the pain/problem occur at a specific time?)

Context: _____ (Where were you at the onset of this pain/problem?)

Associated Signs/Symptoms _____ (What other associated problems have you been having?)

Modifying Factors _____ (What makes the pain/problem worse or better? Have you had previous episodes?)

Past Medical History

(Have you ever had the following: (Check"yes" or "no"/ leave blank if you are uncertain.)

Measles	☐No ☐Yes	Anemia	☐No ☐Yes	Back Trouble	☐No ☐Yes
Mumps	☐No ☐Yes	Bronchitis	☐No ☐Yes	High Blood Pressure	☐No ☐Yes
Chicken Pox	☐No ☐Yes	Epilepsy	☐No ☐Yes	Low Blood Pressure	☐No ☐Yes
Whooping Cough	☐No ☐Yes	Migraines	☐No ☐Yes	Hemorrhoids	☐No ☐Yes
Scarlet Fever	☐No ☐Yes	Tuberculosis	☐No ☐Yes	Chest X-Ray Date:	☐No ☐Yes
Diphtheria	☐No ☐Yes	Diabetes	☐No ☐Yes	Blood or Plasma Transfusion	☐No ☐Yes
Smallpox	☐No ☐Yes	Cancer	☐No ☐Yes	Hives or Eczema	☐No ☐Yes
Pneumonia	☐No ☐Yes	Polio	☐No ☐Yes	Bleeding Tendency	☐No ☐Yes
Rheumatic Fever	☐No ☐Yes	Glaucoma	☐No ☐Yes	Infectious Mono	☐No ☐Yes
Arthritis	☐No ☐Yes	Hernia	☐No ☐Yes	Bladder Infection	☐No ☐Yes
Venereal Disease	☐No ☐Yes	Asthma	☐No ☐Yes	Mitral Valve Prolepses	☐No ☐Yes
Stroke	☐No ☐Yes	AIDS / HIV	☐No ☐Yes	Any other disease	☐No ☐Yes
Hepatitis	☐No ☐Yes	Thyroid Disease	☐No ☐Yes	Please list here:	☐No ☐Yes
Ulcer	☐No ☐Yes	Kidney Disease	☐No ☐Yes		

Previous Hospitalizations/Surgeries/Serious Illnesses When? Hospital, City, State

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medication:(include nonprescription)

_____

_____

Have you ever taken Fen-Phen/Redux? ☐NO ☐YES

Have you been vaccinated against Covid-19? ☐NO ☐YES

- if yes, how many doses have you received? _____

Patient Social History:

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

Use of Alcohol Never:☐ Rarely:☐ Moderate:☐ Daily:☐

Use of Tobacco Never:☐ Rarely:☐ Moderate:☐ Daily:☐

Use of Drugs Never:☐ Type/Frequency:_____

Excessive Exposure

At home or at work to: Fumes:☐ Dust:☐ Solvents:☐ Airborne Particles:☐ Noise:☐

CLINICIAN SIGNATURE: _____ **DATE REVIEWED:**_____

BrightLife Chiropractic & Wellness
CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic manipulation and manual therapy techniques and other chiropractic procedures, including various modes of physical therapeutic modalities and procedures and diagnostic X-rays, where warranted, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic, James Sronkoski and/or other licensed doctors of chiropractic who now or in the future work at BrightLife Chiropractic & Wellness - Lombard.

I have had an opportunity to discuss with the doctor of chiropractic named above the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment and diagnostic services including but not limited to:

Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations and sprains.

Therapeutic Modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.

Radiographs: ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The doctor named above has additionally explained the risks associated with my refusal of treatment.

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. 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.

Patient/Guardian Signature_____ Date _____

Witness Signature _____ Date_____

HIPAA

Notices of Privacy Practices

BrightLife Chiropractic & Wellness

This notice, effective immediately describes how medical information about you may be used and disclosed and how you can get access to this information, please review carefully. Our office is required by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment – We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations.

Payment – We may disclose your health care information to your insurance company provider for the purpose of payment or health care operations. We have your permission to disclose your health care information to your insurance company for the purpose of appealing claims on your behalf.

We may disclose your health care information as necessary to comply with State Workers' Compensation laws, Public Health Authorities, Emergency situations, Judicial and Administrative proceedings, Law Enforcement, Medical examiners, Researcher that has been approved by an Institutional Review Board, when necessary to prevent a health or safety issue, to military or national security and government benefit purposes, for company approved marketing purposes, showing gratitude and appreciation for referrals, and change of ownership.

We reserve the right to change and amend this Notice of Privacy Practices at any time. Our office is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact our Compliance Officer by calling (630) 261-0001.

Complaints – Complaints about your privacy rights, or how our office has handled your health information should be directed to our Compliance Officer by calling (630) 261-0001. You may make an appointment for a personal conference in person or by telephone. If you are not satisfied with the manner in which this office handles your complaint, please call (630) 261-0001.

I understand and have been provided with a Notices of Privacy Practices, which provides a description of the information uses and disclosures. I understand and had the right to review this notice prior to signing the consent, the right to object the use of my health information for directory purposes and the right to request restriction as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

_____ _____

Patient Name Date

_____

Patient/Guardians Signature