260 S. Main St. Seneca, IL. 61360
Office# 815-357-6858 Fax# 815-357-6857

Patient Information Sheet

Date:_____

Patient Name:_____Gender_____

(First Name) (Middle Initial) (Last Name)

Mailing Address:_____

(Street No./Name) (City) (State) (Zip)

Home Phone:_____Work Phone:_____ Cell Phone:_____

SS#_____-____-_____ DOB:_____/_____/_____ Age:____Marital Status_____

Employer:_____Occupation:_____Referred By:_____

Date Of Injury, If an accident:_____(Auto, Personal Injury, Home/Work related)

Drivers License #_____Spouse/Parent Name:_____

Spouse/Parent Employer:_____Work#:_____

Primary Insurance Co.:_____ID#:_____Group#:_____

Policy Holders Name:_____Policy Holders DOB _____/_____/_____

Secondary Insurance Co.:_____ID#_____Group#_____

Policy Holders Name:_____Policy Holders DOB_____/_____/_____

_____(initial) **RIVERSIDE CHIROPRACTIC CENTER** has my permission to leave a message on my voicemail or with a family member.

Insured's Signature:_____**Date:**_____

Riverside Chiropractic Center of Seneca, Limited **Office Policy** *(Revised Oct.2024)*

RCC does accept self-pay patients as well as a large number of insurance carriers. As a Blue Cross/ Blue Shield of IL (BCBSI) PPO contracted provider, RCC will file and accept assignment for all BCBSI patient claims. For all other insurance carriers, including Medicare, **you pay for your visit at the time of service**, we file your claims to your carrier, then you will be reimbursed by your carrier. To be able to file your claim in an efficient and timely manner, you must provide us with the complete insurance information including primary and secondary insurance company names with complete addresses, policy numbers and group numbers. **If at any time there is a change in your insurance**, please contact us with the correct information as soon as possible.

*It must be understood that the contract is between you and your insurance company. You are **fully responsible** for any amount not paid by your insurance for any reason. ***We cannot guarantee that insurance will pay***. RCC will not enter into a dispute over your insurance claim. This is your responsibility and obligation.

***If you have BCBS, your copays are due at the time of service.** BCBS patients will not be responsible for any amount over BCBSI maximum allowances should our fees exceed these limits.

***Medicare** does not pay for physical exams, x-rays or any type of massage therapy. You are therefore responsible for the balance of these services at the time they are rendered. Medicare fees will be adjusted in compliance with non-participating fee limits.

***Auto Accident & Personal Injury (PI) patients** must provide us with all the correct information needed. **RCC will not increase or decrease its fees and services according to the settlement received.** We will bill your insurance, i.e. Med Pay. Your insurance company is expected to pay until a settlement is reached. At that time the insurance company of the person deemed responsible for the collision will reimburse the other insurance company. **We are unable to hold accounts receivable throughout the duration of the case, litigation or arbitration, therefore if for any reason timely payments are not being made by the insurance, you will be responsible for making payments.**

***Worker's compensation** patients must present all required insurance information ASAP. Patients must identify their injuries as a work injury prior to exam and treatment. Fees will be adjusted according to Illinois state limits. If your worker's comp. case is closed, you may continue care with us, but will be responsible for the bill at the time of service.

***If a payment is not received by 60 days of services rendered, RCC reserves the right to refer your account to a collection agency. If you fail to pay on time and RCC refers your account(s) to a third party for collection, a collection fee of 33.3% will be assessed and will be due and owing at the time of the referral to the third party. A 2% billing charge will be added for each month that the account is past due, as well as reasonable attorney fees and court costs should the account go to litigation.**

*Beginning January 1, 2020, a **$10.00** statement charge will be added to accounts with a balance 60 days past due, for each month balance is due, until paid, to help defray the cost of sending out statements.

*Beginning May 1, 2022, a **3.75%** fee is charged for all credit/debit cards and any health saving cards processed.

***Returned checks** will be charged **$50.00**. The amount of check and fees will have to be paid with secure funds.

***Payment Plan**: When in need, an individual payment program may be established for you prior to rendering of services. The balance will never be allowed to exceed $200.00 while on a payment plan. You will also be required to pay 50% of any new visits, at the time of the visit. A billing charge of 2% for accounts over 30 days and the $10.00 statement charge will be added. A guarantee of payment with credit, debit card or check must be used. If monthly payment is missed, the credit or debit card will be charged and no statement charge added.

*A copy of our fee schedule may be requested.

*If you discontinue care without doctor's release, the balance will be due and payable in full at that time.

Riverside Chiropractic Center will do our very best to keep on schedule to minimize any inconveniences to our patients. We ask that our patients continue with this effort by making and keeping appointment times. We require at least 24 hour notice should you need to cancel your appointment.

* ***As of July 15th, 2022, Riverside Chiropractic Clinic will be enforcing our current Massage and Office Policy. Missed and non-cancelled appointments will be billed to your account at the rate of 50% of the total cost of the scheduled appointment. Your copay or coinsurance is invalid if you miss or do not cancel within 24 hours or in a timely manner.***

Patients will only be accepted if patient and/or guarantor understand and accept our policy in its entirety. If you understand and agree with all of the office policies, please sign and date below.

I authorize RCC to release any of my information that is needed to file my insurance claim.

_____*(please initial)* **Assignment of benefits: If I am a BCBSI, WC or PI patient,** I hereby authorize payment of medical (chiropractic) benefits to the provider of services as indicated on the submitted claims.

_____ *(please initial)* I am aware and understand RCC's Protected Health Information **(HIPPA)** Policy is available to me in the white 3 ring binders in the waiting room and consultation room. All of my questions have been answered to my satisfaction and I agree to the policy terms.

_____ _____

Printed Patient Name Patient (Guarantor) Signature Date

RIVERSIDE CHIROPRACTIC CENTER
INFORMED CONSENT

INTRODUCTION

The profession of chiropractic, dentistry, medicine and surgery, nursing, optometry, osteopathy, osteopathic medicine and surgery, pharmacy, physical therapy, podiatry, psychology, and others are regulated in the state of Illinois by the Illinois Department of Professional Regulation. Patient care provided by those above listed professions, including chiropractic, have known risks which may include death, brain damage, quadriplegia, paraplegia, the loss or loss of function of any organ or limb, or disfiguring scars associated with such care and treatment. For you information, the following is routinely furnished to all who consider chiropractic care in this clinic.

Both chiropractic physicians providing care at Riverside Chiropractic Center are licensed under the Illinois Medical Act by the Illinois Department of Professional Regulations. Chiropractic is a science which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) of the body as that relationship may affect the restoration and preservation of health.

NATURE AND PURPOSE OF CHIROPRACTIC PROCEDURES

The practice of chiropractic includes many standard examination and testing procedures. These include physical examination, orthopedic and neurological testing, palpation, specialized instrumentation's, laboratory tests, radiology examinations, physical therapy and rehabilitative procedures. Additionally, there is a procedure unique to the chiropractic profession- the chiropractic spinal adjustment.

Adjustments are made by chiropractors to correct spinal and extremity joint subluxations. One of the most common disturbances to the nervous system is the vertebral subluxation. This condition exists where one or more vertebrae in the spine are misaligned sufficiently to cause interference and/or irritation of the nervous system. The primary goal in chiropractic health care is the removal of nerve interference caused by such subluxation(s).

There are a number of different adjusting techniques, some utilizing specially designed equipment. Adjustments are usually performed by hand but may be performed by hand-guided instruments. A chiropractic adjustment is the application of a quick precise movement over a very short distance to a specific segmental contact point of a vertebra.

Not only should you understand the benefits of chiropractic care in restoring and maintaining good health, but also you should be aware of the existence of some inherent risks and limitations. These are seldom enough to contraindicate care, but should be considered in making the decision to receive chiropractic care. All health care procedures, including those used in varying degrees, have some risks associated with them. Risks associated with some chiropractic adjusting procedures may include musculoskeletal sprain/strain, neurological deficits, osseous fracture, vertebral artery syndrome(VAS), including stroke and perhaps, death through complicating factors.

initial _____

AUTHORIZATION FOR CHIROPRACTIC CARE

I have been informed of the nature and purpose of the chiropractic care, the possible consequences of the care, and the risk of the care, including the risk that the care may not accomplish the desired objective. Reasonable alternative treatment have been explained, including the risk, consequences, and probable effectiveness of each and I have been advised of the possible consequences if no care is provided. I acknowledge that no guarantees have been made to me concerning the results of the care and treatment.

I HAVE READ THE ABOVE PARAGRAPHS. I UNDERSTAND THE INFORMATION PROVIDED. THE INFORMATION PROVIDED HAS BEEN EXPLAINED TO ME, AND ALL QUESTIONS WHICH I HAVE ASKED HAVE BEEN ANSWERED TO MY SATISFACTION.

CONSENT FOR TREATMENT (IF NOT A MINOR)

I hereby authorize Riverside Chiropractic Center of Seneca, Limited and whomever they may designate as doctors and assistants to examine and administer treatments as they do deem necessary to, _____

(Print full legal name)

HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE RIVERSIDE CHIROPRACTIC CENTER TO PROCEED WITH CHIROPRACTIC CARE AND TREATMENT.

DATE THIS _____/_____/_____,SENECA, IL.

_____

(PATIENT SIGNATURE)

_____

(DOCTOR OF CHIROPRACTIC'S SIGNATURE)

CONSENT TO TREAT MINOR

I hereby authorize Riverside Chiropractic Center of Seneca, Limited and whomever they may designate as doctors and assistants to examine and administer treatments as they do deem necessary to my Son / Daughter, _____

(circle one) **(child's full legal name)**

I authorize Riverside Chiropractic Center of Seneca, Limited and said Doctors and Assistants to treat the above listed child in the absence of my presence under normal office visit circumstances.

Parent/Guardian Signature_____DATE_____

Riverside Chiropractic Center of Seneca, Limited

Infant Physical Exam (birth – 1 year)

Patient Name: _____ Parent Name_____

Age: _____ Male / Female Date of Exam_____

Vital Signs

Temperature:_____*F (tympanic) Heart Rate: _____ beats/min.

Respiratory rate: _____ breaths/min. Heart rhythm: regular / irregular

Resp. rhythm: regular / irregular Amplitude: +1 +2 +3

Respiration is: unlabored / labored Contour is: rounded /

Chart Data

Length: _____ cm / in Cranial circumference: _____ cm / in

Weight: _____lbs _____ oz. Chest circumference: _____ cm / in

FONTANEL:

Anterior (2 yr) open / closed normal / sunk in / bulging _____

Posterior (2 mos) open / closed normal / sunk in / bulging _____

Head and Neck

Hair and Cranium	NAD	ABN _____
MacEwen's (percuss parietal)	NAD / "cracked pot sign"	_____
Transillumination of skull	NAD / localized / global	ABN _____
Salivary glands & lymph nodes	NAD	ABN _____
Facial Nerve	NAD	ABN _____

Skin

NAD / pallor / mottled / cyanosis / Mongolian spots / jaundice / erythema

Eyes

Near point	NAD	ABN _____
Cardinal planes of gaze	NAD	ABN _____
Red reflex	NAD	ABN _____
External eye exam	NAD	ABN _____
Blinking / dazzle reflex (0-1yr)	NAD	P / A _____

Ears

External exam	NAD	ABN _____
Internal exam	NAD	ABN _____
Acoustic blink reflex (0-?)	NAD	P / A _____

NAD = No abnormality detected
ABN = abnormal
P = present
D = diminished
A = absent

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Riverside Chiropractic Center of Seneca, Limited

Infant Physical Exam (birth – 1 year)

Nose and Sinus

External exam	NAD	ABN _____
Internal exam	NAD	ABN _____

Mouth and Throat

Inspection	NAD	ABN _____
Extrusion reflex (0-4mo)	NAD	ABN _____
Glossopharyngeal (CN IX)	NAD	ABN _____
Hypoglossal (CN XII)	NAD	ABN _____
Tonsils	NAD	ABN _____

Thorax

Anterior		
Inspection	NAD	ABN _____
Palpation	NAD	ABN _____
Ausculation	NAD	ABN _____
Posterior		
Inspection	NAD	ABN _____
Palpation	NAD	ABN _____
Ausculation	NAD	ABN _____

Cardiovascular

Apical pulse (4th intersp)	NAD	DIM	ABSENT_____
Carotid	NAD	DIM	ABSENT_____
Brachial	NAD	DIM	ABSENT_____
Femoral	NAD	DIM	ABSENT_____
Ausculation			
Aortic	NAD	ABN	_____
Pulmonic	NAD	ABN	_____
Erbs	NAD	ABN	_____
Tricuspid	NAD	ABN	_____
Mitral	NAD	ABN	_____
Epigastric	NAD	ABN	_____
Supersternal	NAD	ABN	_____

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Infant Physical Exam (birth – 1 year)

Abdomen

Inspection	NAD	ABN	_____
Contour	NAD	ABN	_____
Umbilicus	NAD	ABN	_____
Hernia	NAD	ABN	_____
Palpation			_____
Liver	NAD	ABN	_____
Spleen	NAD	ABN	_____
Kidneys	NAD	ABN	_____
Scratch Test (liver)	NAD	ABN	_____

Genitalia

Inspection	NAD	ABN	_____
Development	NAD	ABN	_____

Deep Tendon Reflexes	Right	Left
Patellar (L4)	0 1 2 3 4	0 1 2 3 4
Achilles (6mo) (S1)	0 1 2 3 4	0 1 2 3 4
Biceps (C5, C6)	0 1 2 3 4	0 1 2 3 4
Brachioradialis (6mo)	0 1 2 3 4	0 1 2 3 4
Triceps (6mo) (C7, C8)	0 1 2 3 4	0 1 2 3 4

Infantile Automatisms		Right	Left
Rooting (0-3/4 mo)	NAD	P / D / A	P / D / A
Tonic Neck / Fencer (0-3* - 6mo)	NAD	P / D / A	P / D / A
Palmer Grasp (0-1/2* - 3mo)	NAD	P / D / A	P / D / A
Planter Grasp (0-8 mo)	NAD	P / D / A	P / D / A
Babinski (0-2y)	NAD	P / D / A	P / D / A
Clonus	NAD	P / D / A	P / D / A
Moro / Startle (0-2* - 6mo)	NAD	P / D / A	P / D / A
Galant / Trunk Incurvation (0-2mo) (parasag. S to I)	NAD	P / D / A	P / D / A
Perez (0-2/3 mo)	NAD	P / D / A	P / D / A
Landu (6/8mo – 18 – 3y) Horizontal	NAD	P / D / A	P / D / A

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Infant Physical Exam (birth – 1 year)

Infantile Automatisms(cont.)		**Right**	**Left**
Placing Reflex (4day – 4mo)	NAD	P / D / A	P / D / A
Dorsum			
Stepping (0/8 wks – walking)	NAD	P / D / A	P / D / A
Parachute (6/8 mo – death)	NAD	P / D / A	P / D / A
Doll's eye	NAD	P / D / A	P / D / A

Neurological Assessment (check all that apply)

2 months	_____Keeps hands fisted	_____Smiles responsively
	_____Lifts head for several seconds	_____Begins to vocalize
3 months	_____Lifts head above body plane	_____Watches own hands
	_____Turns head toward object	_____Smiles and vocalizes in response
4 months	_____Sits with head steady	_____Turns head toward sounds
	_____Reaches for objects	_____Smiles Spontaneously
5-6 months	_____Lifts head while supine	_____Babbles
	_____Exhibits no head lag	_____Localizes direction of sound
7-8 months	_____Sits alone tripod fashion	_____Mouths all objects
	_____Feeds self cracker	_____Non specific "dada" , "baba"
9-10 months	_____Sits well w/o support	_____Waves "bye-bye"
	_____Stands holding on	_____Drinks from a cup w/ assistance
11-12 months	_____Walks w/ assistance	_____Uses 2-4 words w/meaning
	_____Crawls well	_____Assists w/ dressing

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