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
A Healthy Touch from Pediatrics to Geriatrics

Welcome to our office! Please take a few minutes to fill out your information as accurately as you can, so we can fully understand your condition. Please feel free to ask our office staff if you need assistance. Thank you.

Full legal name:_____ **Date:**_____

Name you prefer to use:_____ **SSN#:**_____-_____-_____

Birth date:_____/_____/_____ **Age:**_____Yrs.

Email:_____

Parents/Legal guardians:_____

Gender: M/F **Approximate Height:** _____ **Approximate Weight:** _____

Phone:

Cell:_____

Home:_____

Work:_____

Race (circle one)

Declined to state
White/Caucasian
Black/African American
Hispanic/Latino
Asian

Ethnicity(circle one)

Declined to state
Non Hispanic/latino
Hispanic/Latino

Current Conditions

Please list any *major* complaints.

1._____

2._____

3._____

When did this start?

_____

_____

Is this a result of: Work injury ____Auto accident ___Personal injury ___Other_____

Have you ever had similar symptoms? Yes/ No If yes, when?_____

Does anything make symptoms better?

_____

Does anything make your symptoms worse?

_____

_____

Please rate the intensity of your symptoms (circle)

At time of onset: No pain/problem 0 1 2 3 4 5 6 7 8 9 10

Worst pain: No pain/problem 0 1 2 3 4 5 6 7 8 9 10

What percentage of the day are you in pain?: _____0-100% (Least to Greatest)

What percentage do you rest due to pain? _____0-100% (Least to greatest)

Has your condition affected your employment, home life, social life or physical activities? Yes/No

Explain:_____

_____

What other doctors have you seen for this condition?_____

Date of that visit?_____/_____/_____Their diagnosis?_____

Choose the best descriptions for your problem: (Check all that apply)

_steady/constant	_comes & goes	_throbbing	_aching	_pulling/tight band
_sharp/stabbing	_shooting	_electrical	_boring	_fatigue/weak
_vise-like	_heavy pressure	_itching	_crawling	_colic
_numbness	_tingling	_stiffness	_catching	

Previous treatments and tests for any condition at any time (check all that apply)

- ☐ Acupuncture
- ☐ Chemotherapy
- ☐ Chiropractic adjustments
- ☐ CT scan
- ☐ Echocardiogram
- ☐ Heel Lift/Orthotics
- ☐ Joint Mobilization
- ☐ Massage Therapy
- ☐ Muscle Stimulation
- ☐ MRI
- ☐ Radiation
- ☐ Traction
- ☐ Ultrasound
- ☐ X-rays

Please check the box for each symptom you have *currently* or have had in the *last year*.

Hematologic/Lymphatic

- ☐ Anemia
- ☐ Bleeding
- ☐ Blood clotting
- ☐ Blood transfusions
- ☐ Bruise easily
- ☐ Lymph node swelling

Allergic/Immunologic

- ☐ History of anaphylaxis
- ☐ Itchy eyes
- ☐ Sneezing
- ☐ Specific food intolerance
  What food? _____

Endocrine

- ☐ Cold intolerance
- ☐ Diabetes
- ☐ Excessive appetite
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Goiter
- ☐ Hair loss
- ☐ Heat intolerance
- ☐ Unusual hair growth
- ☐ Voice changes

Constitutional

(General Symptoms)

- ☐ Backache
- ☐ Bronchitis
- ☐ Chills
- ☐ Convulsions
- ☐ Dizziness
- ☐ Drowsiness
- ☐ Epilepsy
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Food allergy
- ☐ Headaches
- ☐ HIV positive
- ☐ Influenza
- ☐ Loss of sleep
- ☐ Nervousness
- ☐ Night sweats
- ☐ Weakness
- ☐ Weight gain

Eyes

- ☐ Blindness
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Change in vision
- ☐ Double vision
- ☐ Dry eyes
- ☐ Eye pain
- ☐ Field cuts
- ☐ Glaucoma
- ☐ Sensitivity to light
- ☐ Tearing
- ☐ Wearing contacts
- ☐ Wearing glasses

Cardiovascular

- ☐ Angina
- ☐ Chest pain
- ☐ Claudication
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Orthopnea
- ☐ Palpitations
- ☐ Poor circulation
- ☐ Rapid heart
- ☐ Shortness of breath
- ☐ Slow heart
- ☐ Strokes
- ☐ Swelling ankles
- ☐ Varicose veins

Respiratory

- ☐ Chest pains
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Spitting blood
- ☐ Spitting phlegm
- ☐ Asthma
- ☐ Dry cough
- ☐ Productive cough
- ☐ Coughing up blood
- ☐ Bronchitis
- ☐ Hemoptysis
- ☐ Pneumonia
- ☐ Sputum production
- ☐ Wheezing

Musculoskeletal

- ☐ Arthritis
- ☐ Decreased motion
- ☐ Foot trouble
- ☐ Gout
- ☐ Hernia
- ☐ Injuries
- ☐ Joint stiffness
- ☐ Locking joints
- ☐ Muscle cramps
- ☐ Muscle pain
- ☐ Muscle twitching
- ☐ Muscle weakness
- ☐ Neck pain
- ☐ Pain between shoulders
- ☐ Painful tail bone
- ☐ Spinal curvature
- ☐ Stiff neck
- ☐ Swelling
- ☐ Swollen joints
- ☐ Tremors

Integumentary

- ☐ Breast lumps/pain
- ☐ Bruising easily
- ☐ Change in nail texture
- ☐ Change in skin color
- ☐ Dry skin
- ☐ Eczema
- ☐ Hair growth
- ☐ Hair loss
- ☐ History of skin disorders
- ☐ Hives
- ☐ Itching
- ☐ Paresthesia
- ☐ Rash
- ☐ Sensitive skin
- ☐ Skin eruptions
- ☐ Skin lesions

ENMT

- ☐ Bad breath
- ☐ Deafness
- ☐ Dentures
- ☐ Deviated septum
- ☐ Difficulty swallowing
- ☐ Discharge
- ☐ Dry mouth
- ☐ Ear discharge
- ☐ Ear noises
- ☐ Ear pain
- ☐ Earache
- ☐ Frequent colds
- ☐ Frequent sore throats
- ☐ Hay fever
- ☐ Head injury
- ☐ Hoarseness
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Nasal congestion
- ☐ Nasal obstruction
- ☐ Nose bleeds
- ☐ Post nasal drip
- ☐ Sinus infections
- ☐ Sinusitis
- ☐ Snoring
- ☐ Thyroid problems
- ☐ TMJ problems

Other

- ☐ Polio
- ☐ Chicken pox
- ☐ Pleurisy
- ☐ Whooping cough
- ☐ Rheumatic fever
- ☐ Mumps
- ☐ Lumbago
- ☐ Cancer
- ☐ Tuberculosis
- ☐ Venereal disease
- ☐ Measles

Gastrointestinal

- ☐ Abdominal pain
- ☐ Abnormal stool color
- ☐ Abnormal stool consistency
- ☐ Acid reflux
- ☐ Belching
- ☐ Black tarry stool
- ☐ Bloody stools
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gall bladder problems
- ☐ Heart burn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Irritable bowel
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

Psychiatric

- ☐ Agitation
- ☐ Alcoholism
- ☐ Anxiety
- ☐ Appetite changes
- ☐ Behavioral changes
- ☐ Bipolar disorder
- ☐ Confusion
- ☐ Convulsions
- ☐ Depression
- ☐ Hormonal indication
- ☐ Insomnia
- ☐ Location disorientation
- ☐ Memory loss
- ☐ Mental disorder
- ☐ Substance abuse
- ☐ Suicidal indication

Genitourinary

- ☐ Bed wetting
- ☐ Birth control
- ☐ Blood in urine
- ☐ Cramps
- ☐ Erectile dysfunction
- ☐ Frequent urination
- ☐ Hormone therapy
- ☐ Hot flashes
- ☐ Inability to control urine
- ☐ Irregular cycle
- ☐ Irregular menstruation
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Painful periods
- ☐ Painful urination
- ☐ Prostate trouble
- ☐ Urine retention
- ☐ Vaginal bleeding
- ☐ Vaginal discharge

- Are you pregnant now? Yes/No

Expected due date_____

Neurological

- ☐ Change in concentration
- ☐ Change in memory
- ☐ Dementia
- ☐ Dizziness
- ☐ Headache
- ☐ Imbalance
- ☐ Loss of consciousness
- ☐ Loss of memory
- ☐ Numbness
- ☐ Seizures
- ☐ Sleep disturbances
- ☐ Slurred speech
- ☐ Stress
- ☐ Strokes tremors
- ☐ Tremors

Other Illness/Problem: _____

_____

Social history:

- ☐ Drinking Alcohol: Yes/No (cups/day) ____
- ☐ Do not drink alcohol
- ☐ Soft drink : Yes/No (cups/day)____
- ☐ Coffee: Yes/No (cups/day)____
- ☐ Water: Yes/No (cups/day)____

History of drug use? _____

Exercise (circle one): None Moderate Intense

Are you on any special diet? _____

_____

Smoking status:

A. Current Every day smoker Start date:_____
B. Current Some day smoker
C. Former smoker End date:_____
D. Other tobacco user List:_____
E. Never smoker

History of Allergies? Yes/No

Allergy:_____Reaction:_____
Allergy:_____Reaction:_____
Allergy:_____Reaction:_____
Allergy:_____Reaction:_____

Do you want to learn about nutritional information during your visit? Yes/No

Work patterns: Occupation: _____ Hours/week?_____

How many hours of the day do you spend.....

Sitting?_____Standing?_____Overhead arm work?_____

What is the average weight of the objects you lift each day? _____lbs.

Are you currently taking any medications? Yes/No

Medication name: _____ Medication name:_____

Medication name:_____Medication name:_____

Medication name:_____Medication name:_____

Are you currently taking vitamins or supplements? Yes/No

Vitamin name:_____Vitamin name:_____

Vitamin name:_____Vitamin name:_____

Surgical History: Yes/No

Appendectomy	____	Heart Surgery	____	Ovary removal	_____
Biopsies	____	Hernia Repair	____	Thyroid	_____
Breast surgery	____	Hip Replacement	___	Spinal Fusion	_____
Carpal tunnel surgery	____	Hysterectomy	____	Prostate Surgery	_____
Cataract surgery	____	Joint Replacement	__	Knee Replacement	____
Caesarian section	____	Knee scope	____	Varicose Vein surgery	__
Disc repair	____	Stomach surgery	___	Other surgery (List)	_____
Free skin Graft	____	Tonsillectomy	____	_____	
Gall bladder removal					