Ideal Family Health Center P.C.
55 W. Golf Rd. Arlington Heights, IL 60005
Tel: 847-357-0636 Fax: 847-357-0637

Patient Name: ____ Date: ____/____/2024
***Sign in time**: ___________________ This form is revised on 12/21/2024

New Patient Exam Codes

____99201N/P $85
____99202 N/P $100
____99203 N/P $150
____99204 N/P $200
____CONV Conversation $0
____36410 Venipuncture $15
____97039 Low Level Laser
__ CDL$89

Existing Patient Exam Codes
___ 99211R/E $45
____99212 R/E $65
____99213 R/E $85

Therapy Codes

____G0283 Electric Stimulation(Medicare/United HealthCare) GP GY__$25
____97014 Electric stimulation $25
____97035 Ultrasound $30 GP GY __
____97810 Acupuncture 1st $65
____ 97811 Acupuncture 2st $40
____ 97813 Acupuncture w/ E Stim 1st $75
____ 97814 Acupuncture w/ E Stim 2st $45
____ Acu1 Acupuncture for W $30
____ Acu2 Acupuncture for W $45
____L3020 Casting for orthotics $400
____99002 Shipping fee for orthotics $20
____97504 Fitted & Training/ how to insert when arrived $35
____97703 Follow up for orthotics $35

New Onset ___________
Chang of Dx 1.______2._______3,_______4.______

Supplements:

Name	Charge

Radiology Study Codes

____72040 Cervical Spine AP/LAT APOM $90 ($30 each)
____72050 Cervical Spine AP/LAT APOM, BL Oblique $150
____72100 Lumbosacral AP/LAT $90 ($45 each)
____72070 Thoracic AP/LAT $90 ($45 each)
____73565 Knee B/L AP/LAT $140 ($35 each)
____73560 Knee AP/LAT $70 ($35 each)

CMT Codes

____98943extraspinal, one or more regions $55
____98940 CMT spinal one to two regions $60 AT__
____ 98941 Spinal three to four regions $65AT__
____98942 Spinal more than five $70 AT_
____ 97140 Manual therapy technique $35
____ 97124 Massage by massage therapist $30

____97001 PT evaluation each $100/ unit
____97002 PT re-evaluation each $40/ unit
____97110 Therapeutic procedure each $40/ unit GP_GY_
____97112 Neuromuscular re-education $40/ unit
____97530 Therapeutic activities $50/ unit
____97116 Gait training $30
____97535 ADL $40
____97537 Work re-integration training, work environment modification $35
____97750 Physical performance test $35
____ Same Charge as Last Visit.
__97140 Manual Therapy Technique $40 ___unit ___ initial ___unit ___ initial, unit ___ initial
__ 97110 Therapeutic Exercises $40 __unit __initial ___unit ___initial, __unit___initial
*Initial of the staff who were one on one contact with patient

Amount to pay $ ______________________

Total amount paid $ _____________________

Pay method:

Check # ________ Cash ____ Credit Card _____

How are you functioning or feeling after today's treatment? Same__, Better__ , Much Better __ , Worse__

*Patient sign here stating that patient was one on one contact with Dr. or Staff during the most of the treatment time. (If you have a questions about it ask Dr.)

Patient Signature: ______________________________________

IDEAL FAMILY HEALTH CENTER
CONFIDENTIAL PATIENT HEALTH RECORD FORM

General Patient Information

Patient's Last Name: First: Middle:

____

Email: ______________________________________ Today's Date____/____/________

Marital Status (Circle): Mar.	Div.	Single	Sep.	Widowed	(*circle*): Mr.	Mrs. Miss.	Ms. | Other: ______________________
Sex: ☐ Male ☐ Female ☐ Prefer Not to Say ☐ Other	Birthdate: _____/_____/____________ Age: ________

Street Address:_____________________________________ City: ____________________

State:____ ZIP Code:_________________

(Cell) Phone: __________________________ (Home) Phone:______________________

Occupation: ________________________ Employer: ______________________________

Height: _______ Weight: _______ Are you: ☐ Left-Handed ☐ Right-Handed

Referred By: ☐ Doctor ☐ Insurance ☐ Family/Friend ☐ Web/Online

EMERGENCY CONTACT INFORMATION

Name of Relative or Friend:		
Relationship to Patient:	Phone (Cell):	Phone (Work):

Insurance Information (Skip if you have an insurance card)

Person Responsible for Bill: Birthdate: Phone (cell):

____ ___/__/______ __________________

Address (if different): _________________________________ Subscriber SSN: ___________

Subscriber's Name: ___________________________________ D.O.B: ____/____/____ ___

Policy Number: __________________________ Group Number: ______________________

Patient's Relation to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other	Is Patient Covered by Insurance? ☐ Yes ☐ No

Secondary Policy Name (If Applicable): ____

Policy Number:_____________________________ Group Number: ______________________

Current Health Concern

Current Health Condition: ____

Have you seen other doctors for this?: ____

Previous Treatments (If Applicable.): ____

When did the issue begin: ______________________ Has this happened before?: Y / N

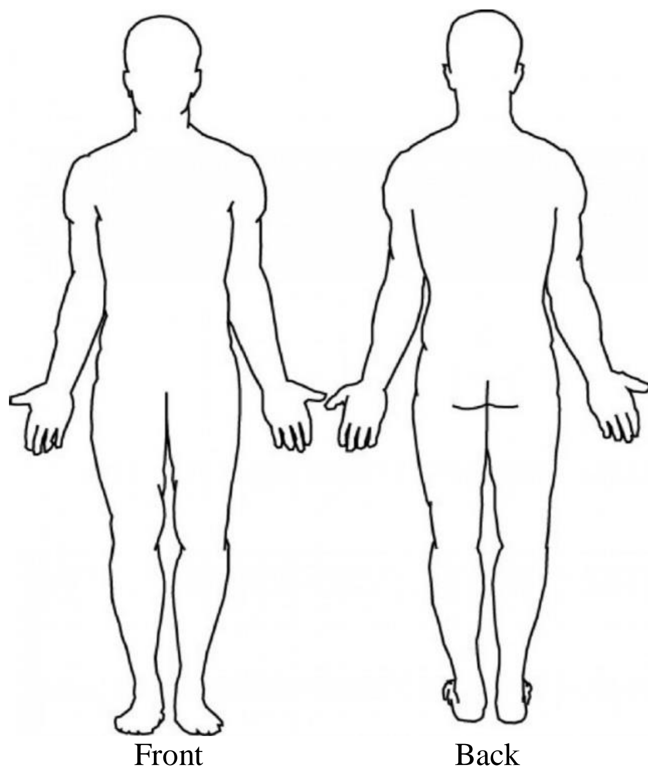
Condition Cause: ☐ Job Accident
☐ Auto Accident ☐ Home Injury
☐ Fall ☐ Genetic Issue
Other: ____________________

Accident Date: ___/___/______
If work related, is it reported/ is employer aware: Y / N

Do you wear a shoe lift?
Y / N

Current Medications (If Applicable.): ____

____



Front Back

Please use the Front/Back diagram to circle the areas of pain/discomfort.

Put an X on areas with metal or ceramic implants, if applicable.

Previous Health Conditions

Major Falls or Accidents:____

____

Surgeries (ALL): ____

____

Hospitalizations: ____

Previous Chiropractic Care: None Yes, Doctors Name: ________________________

Below are lists of diseases and conditions which may seem unrelated to your visit. However, these questions must be answered carefully and thoroughly as these problems can affect your overall course of care.

Check any diseases you have had:

__ Pneumonia
__ Rheumatic Fever
__ Tuberculosis
__ Whooping Cough
__ Anemia
__ Measles
__ Pleurisy
__ Small Pox
__ Chicken Pox
__ Cancer
__ Heart Disease
__ Thyroid
__ Influenza
__ Polio
__ Diabetes
__ Arthritis
__ Epilepsy
__ Mental Disorders
__ Lumbago
__ Eczema
__ Mumps

Are you HIV positive?
☐Yes ☐No

Do you ingest:
__Coffee __Alcohol
__ Tea __Tobacco/Nicotine

When was your last Menstrual Cycle?
_____/____/_______ ☐ Not Applicable
Are you Pregnant? **Y / N / Unsure**

Check any of the following you have had in the past 6 months:

Musculo-Skeletal:
__ Low Back Pain
__ Pain Between Shoulders
__ Neck Pain
__Arm Pain
__ Joint Pain/Stiffness
__ Walking Issues
__ Painful, Clicking Jaw
__ General Stiffness

Cardio Vascular:
__ Chest Pain
__ Short Breath
__ High Blood Pressure
__ Low Blood Pressure
__ Irregular Heartbeat
__ Heart Conditions
__ Lung Problems
__ Varicose Veins
__ Ankle Swelling
__ Stroke
__ Heart Attack

Nervous System:
__ Nervousness
__ Numbness
__ Paralysis
__ Dizziness
__ Forgetfulness
__ Confusion
__ Depression
__ Fainting
__ Convulsions
__ Cold Extremities
__ Tingling Extremities
__ Stress

Genito-Urinary:
__ Bladder Pain
__ Painful Urination
__ Excessive Urination
__ Discolored Urine
__ Kidney Stones

Gastro-Intestinal:
__ Poor Appetite
__ Excessive Appetite
__ Excessive Thirst
__ Frequent Nausea
__ Vomiting
__ Diarrhea
__ Constipation
__ Hemorrhoids
__ Liver Problems
__ Gall Bladder Problems
__ Gas/Bloating After Meals
__ Black/Bloody Stool
__ Abdominal Pain
__ Weight Loss
__ Weight Gain
__ Heartburn
__ Colitis

General:
__ Fatigue
__ Allergies
__ Loss of Sleep
__ Excessive Sleep
__ Headaches
__ Fever
__ Vision Issues
__ Dental Issues
__ Sore Throat
__ Ear aches
__ Hearing Difficulty
__ Stuffed Nose

__ Menstrual Irregularity
__ Menstrual Cramps
__ Vaginal Pain
__ Vaginal Infection
__ Brest Pain / Lumps
__ Prostate Issues
__ Sexual Issues

The following family members have the same or similar issues to me:
__ Mother
__ Father
__ Sibling
__ Spouse
__ Grandparent
__ Aunt/Uncle
__ Cousin
__ Child

OTHER:
____
____
____
____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

Notice: This policy contains 2 pages of information, read carefully.

Protecting your private information is our priority. This Statement of Privacy applies to Ideal Family Health Center and governs data collection and usage. For the purposes of this Privacy Policy, unless otherwise noted, all references to Ideal Family Health Center also known as Ideal FHC. The Ideal FHC website is a Practice Website site. By using the Ideal FHC website, you consent to the data practices described in this statement.

Chicago Chiropractic Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Chicago Chiropractic 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.

Collection of your Personal Information

We do not collect any personal information about you unless you voluntarily provide it to us. However, you may be required to provide certain personal information to us when you elect to use certain products or services. These may include: (a) registering for an account; (b) entering a sweepstakes or contest sponsored by us or one of our partners; (c) signing up for special offers from selected third parties; (d) sending us an email message; (e) submitting your credit card or other payment information when ordering and purchasing products and services. To wit, we will use your information for, but not limited to, communicating with you in relation to services and/or products you have requested from us. We also may gather additional personal or non-personal information in the future.

Sharing Information with Third Parties

Ideal FHC does not sell, rent or lease its customer lists to third parties.

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. On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Chicagoland Chiropractic Health Center. As well, it is our policy to provide a substitute health care provider, authorized by Chicago Chiropractic, to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation.

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

Workers Compensation

We may disclose your health information as necessary to comply with State Workers Compensation Laws.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceeding

We may disclose your health information during any administrative or judicial proceeding.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons

We may disclose your health information to coroners or medical examiners.

Changes to this Statement

Ideal FHC reserves the right to change this Privacy Policy from time to time. We will notify you about significant changes in the way we treat personal information by sending a notice to the primary email address specified in your account, by placing a prominent notice on our website, and/or by updating any privacy information. Your continued use of the website and/or Services available after such modifications will constitute your: (a) acknowledgment of the modified Privacy Policy; and (b) agreement to abide and be bound by that Policy.

For Patient to fill out:

I acknowledge that I have received and understand Ideal Family Health Center's Notice of Privacy Practices for protected health information.

Date:____/____/________ Name of Patient: ____

Print Name

Signature of Patient or Representative: ____

For Physician / Office to fill out only:

<u>Documentation of Good Faith Effort to Obtain Written Acknowledgement</u>

Physician: I made a good faith effort to obtain the patient's written acknowledgement of our Notice of Privacy Practices for protected health information by (check applicable):

- Showing the patient the Notice of Privacy Practices to read prior to receiving any treatment or service.
- Giving the patient a copy of our Notice of Privacy Practices to read prior to receiving any treatment or service.
- Giving the patient all necessary information to obtain our Notice of Privacy Practices on our website.
- Asking the patient to sign this acknowledgement form.
- Other: (Explain in detail)

  ____

____

____

I was unable to obtain the patient's written acknowledgement because:
(check applicable)

- The patient refused to sign the form.
- The patient would not sign the form because the individual stated that they did not understand the notice.
- Other: ____

____

Date: ____/____/________

Name of Doctor: ____

Doctor's Signature: ____

Notice: This written acknowledgement must be completed no later than the first date healthcare services or treatments are provided to the patient. This acknowledgement must be retained in the patient's permanent records.

HIPAA RIGHT OF MEDICAL ACCESS FORM

(Optional)

I, ________ ______ ____________, direct my health care and medical services provider, Ideal Family Health Center, to disclose and release my protected health information below to:

1. Name ____
   Relationship: ____
   Contact Information: __________________________________

2. Name ____
   Relationship: ____
   Contact Information: __________________________________

3. Name ____
   Relationship: ____
   Contact Information: __________________________________

4. Name ____
   Relationship: ____
   Contact Information: _________________________________

_______________________________________ _____________

Name of Individual Giving this Authorization Date

_______________________________________ _____________

Signature of Individual Giving this Authorization Date

Notice: If left blank, Ideal Family Health Center will be unable to share medical information with ANY individual that claims to know the patient, related or not, as it would be a violation of the patient's medical rights under HIPAA. This form can be updated by the patient at any time upon request.

INFORMED CONSENT TO CHIROPRACTIC SERVICES

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible for) by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic who now or in the future treat me while employed by, working or associated with or serving as a backup for the Doctors of Chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have hand an opportunity to discuss with the Doctor of Chiropractic named below and/or with other office or clinic personnel the scope of practice, the nature and purpose of chiropractic care: specifically manual care; adjustments and other procedures. I understand that with manual care, i.e., adjustments, there is a certain risk of but not all inclusion of: muscle or ligament strains, bony fractures, cerebral vascular or neurological insult.

I understand that and am informed as to the nature and purpose of the procedures, possible alternatives, the risks involved, the possible consequences, and the possibility of complications have been explained to me by the below Doctor of Chiropractic and/or his associates and assistants and do not expect the Doctor to be able to anticipate and explain all the risks and complications, and wish to rely on the Doctor to exercise judgment during the course of the procedure which the Doctor feels at the time, based upon the facts then known, is in my best interest.

Ideal Family Health Center P.C. -- Chang Rung Han D.C.

I have read, or have read to me, the above consent. I have also had the opportunity to ask questions about its contents, 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.

____ ____________________

Print Patient Name Date

____ ____________________

Signature of Patient Date

Patient Representative, complete if Patient is a Minor or is physically and/or legally incapacitated.

____ ____________________

Print Rep's Name and Relationship to Patient Date

____ ____________________

Signature of Representative Date

Created on: 12/28/2023, Updated 01/01/2024.

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible for) by the acupuncturist, named below and/or other licensed acupuncturists who now, or in the future treat me while being employed by, working or associated with, or serving as a back-up for the acupuncturist named below, (including those working at this office or any other office or clinic, whether signatories to this form or not). I understand the methods of treatment may include, but are not limited to, acupuncture, acupressure, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counselling. I have been informed that acupuncture is a safe method of treatment but that it may have side effects, including but not limited to bruising, numbness or tingling near the needling sites that may last a few days, dizziness, and fainting. I understand that I should not move while the needles are being inserted, retained, or removed. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, organ puncture (including lung puncture.) Infection is another possible risk, although the acupuncturist below uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are potential risks to moxibustion. I understand that while this documentation describes the major risks of treatment other side effects and risks may occur.

The herbs and nutritional supplements (which are from plants, minerals, and animal sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. I will notify the acupuncturist to be able to anticipate and explain all the risks and complications associated of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand that the office medical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I have read, or have read to me, the above consent. By voluntarily signing below I have been told of the risks and benefits of acupuncture and other procedures, I have also had the opportunity to ask questions about its contents. 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.

Acupuncturist: Chang Rung Han D.C. – Ideal Family Health Center

____ ____________________

Print Patient Name Date

____ ____________________

Signature of Patient Date

Patient Representative, complete if Patient is a Minor or is physically and/or legally incapacitated.

____ ____________________

Print Rep's Name and Relationship to Patient Date

____ ____________________

Signature of Representative Date

OFFICE FINANCIAL POLICY AGREEMENT

Thank you for choosing Ideal Family Health Center for your medical care. We are committed to providing you with quality, one on one health care, and appreciate your commitment to adhering to this Financial Policy Agreement. By understanding our policy, we can provide you with the best service. Agreement to this policy is required for all medical care visits.

Payment is required at the time services are provided unless other arrangements have been made in advance or except as indicated below. We accept cash, personal in-state checks, Visa, Mastercard, and Discover cards.

As a courtesy to other patients, we request you to arrive on time. If you arrive more than 15 minutes late, you may be asked to reschedule.

INSURANCE: We participate in most managed care plans and will bill your insurance plan as may be necessary. If we do not participate with your managed care plan, payment is required at the time services are provided unless other arrangements have been made in advance. We may be able to bill your plan as a courtesy to you and credit your account if receive any additional payment. Knowing your insurance benefits – including eligibility, covered benefits, and medically necessary procedures is your responsibility; please contact customer services at your company for any questions you may have regarding your coverage. **You are responsible for any charges not covered by your plan.**

- **Proof of insurance.** Our office is committed to helping our patients get the most out of their benefits. All patients must provide us with their up-to-date medical insurance; without this we are unable to estimate coverage for you. Failure to provide Ideal Family Health Center with your current medical insurance will result in payment in full for services rendered. Understand that prior verification for insurance coverage is only an estimation and never guarantee of payment per the insurance company. Copays, coinsurance and deductibles are due at time of service.

By signing below, I confirm to understand the above policy and agree to abide by it.

____ ____________________

Print Patient Name Date

____ ____________________

Signature of Patient Date

Patient Representative, complete if Patient is a Minor or is physically and/or legally incapacitated.

____ ____________________

Print Rep's Name and Relationship to Patient Date

____ ____________________

Signature of Representative Date

Created on: 12/28/2023, Updated 01/01/2024.

For Physician / Office to fill out only:

S.O.A.P INTAKE AND PROGRESS NOTES

S u b j e c t i v e **O** b j e c t i v e **A** s s e s s m e n t **P** l a n s

Patient Name: ____ Birthdate: ___/____/_______

Prob # Date: ___________________