Ideal Family Health Center P.C.
2010 S Arlington Heights Rd. Arlington Heights, IL 60005 Suite #110
Tel: 847-357-0636 Fax: 847-357-0637

Patient Name: _____ Date: ____/____/2025
***Sign in time**: _____ This form is revised on 7/21/2025

New Patient Exam Codes

____99201N/P $85
____99202 N/P $100 ____CONV Conversation $0
____99203 N/P $175 ____36410 Venipuncture $15
____99204 N/P $200 ____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. ǀ Div. ǀ Single ǀ Sep.ǀ Widowed	(*circle*): Mr. ǀ Mrs. Miss. ǀ Ms. ǀ Other: _____
Sex: ☐Male ☐Female ☐Prefer Not to Say ☐Other	Birthdate: _____/_____/_____ Age: _____

Street Address:_____ City: _____

State:_____ ZIP Code:_____

(Cell) Phone: _____

Occupation: _____ Employer: _____

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

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

EMERGENCY CONTACT INFORMATION

Name of Emergency Contact:		
Relationship to Patient:	Phone (Cell):	Phone (Work):

Insurance Questionnaire

Do you have insurance?

☐ Yes ☐ No, I will self-pay $185 for first visit and $85 for each additional visit

If yes, list the provider(s):_____

Accepted Providers: Blue Cross Blue Sheild, Aetna, United Health Care, and Medicare

We do **NOT** accept any HMO plans, Medicaid, Cigna, and Humana.

Current Health Concern

Current health concern: _____

Have you seen other doctors for this condition? Y / N

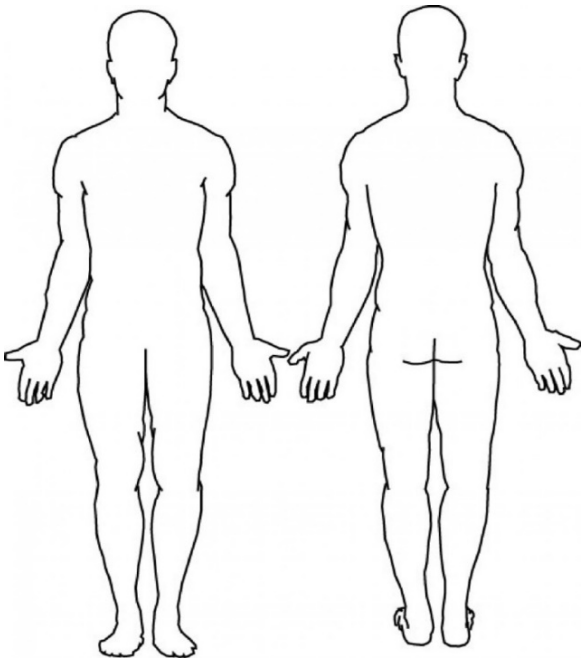
Previous treatments (if applicable): _____

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 or discomfort.

Put an X on areas with metal or ceramic implants.

Previous Health Conditions

Major Falls or Accidents: _____

Surgeries (applicable): _____

Recent Hospitalizations: _____

Previous chiropractic care: No 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
__ Smallpox
__ Chicken Pox
__ Cancer
__ Heart disease
__ Thyroid
__ Influenza
__ Polio
__ Diabetes
__ Arthritis
__ Epilepsy
__ Mental Illness
__ 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
__ Earaches
__ Hearing Difficulty
__ Stuffed Nose

__ Menstrual Irregularity
__ Menstrual Cramps
__ Vaginal Pain
__ Vaginal Infection
__ Breast 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

We are committed to protecting your privacy. This policy outlines how Ideal Family Health Center collects, uses, and shares your information, in accordance with federal and state law.

Our Legal Duty

We are required by law to maintain the privacy of your protected health information (PHI) and to inform you of our practices.

How We Collect Information

We only collect personal information that you voluntarily provide. Such as when scheduling appointments, completing intake forms, or communicating with our office via phone or email. 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 or lease its customer lists to third parties.

Uses and Disclosures of Your Health Information

We may use or disclose your PHI in the following ways:

- **Treatment**: Shared with providers within our clinic involved in your care.
- **Payment**: Shared with your insurance company or billing providers.
- **Healthcare Operations**: For internal quality improvement and administrative purposes.
- **Workers' Compensation**: As required by state law.
- **Public Health & Safety**: To report certain conditions or events as required by law (e.g., infectious diseases, abuse, medication reactions).
- **Legal Requirements**: In response to a subpoena, court order, or law enforcement request.
- **In Case of Death**: With medical examiners or coroners, as permitted by law.

Changes to this Statement

Ideal FHC reserves the right to change this Privacy Policy from time to time. The current version will always be available on our website or by request at the front desk.

For Patient to fill out:

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

Date:____/____/_____ Name of Patient: _____

Print Name

Signature of Patient or Representative: _____

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 those listed below.

1. Name _____
   Relationship: _____
   Contact Information: _____

2. 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 voluntarily consent to receive chiropractic care from Dr. Chang Rung Han, D.C., and/or any licensed chiropractic providers working with or on behalf of Ideal Family Health Center. This care may include chiropractic adjustments, physical therapy, and diagnostic imaging (such as X-rays), as deemed necessary.

I understand the nature and purpose of these procedures, as well as the potential risks, which may include (but are not limited to) muscle strains, joint sprains, fractures, or, in rare cases, neurological complications. I acknowledge that all reasonable questions about the treatment, alternatives, and risks have been answered to my satisfaction.

I understand that no guarantee of results has been made, and I trust the doctor to use their best judgment during the course of care. This consent applies to my current condition and any future conditions for which I seek care at this office.

By signing below, I confirm I have read and understand this consent form and agree to proceed with 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

Email Communication Consent Form

Ideal Family Health Center offers email communication for billing, clinic updates, and general information. This allows for convenient access to your account and clinic-related materials.

Please note: Email communication carries risks. By consenting, you acknowledge and accept the following:

- Email is not guaranteed to be private or secure.
- Messages can be misdirected or intercepted.
- Employers and service providers may access emails sent through their systems.

By agreeing to email communication, you understand that:

- Email messages may become part of your medical record and accessible to authorized staff (e.g., billing personnel).
- We will not share your emails with third parties without your written permission, unless required by law.
- If you request a response and do not receive one promptly, it is your responsibility to follow up.
- You may update or withdraw your consent at any time by notifying our office in writing.

While we take reasonable steps to protect your privacy, we cannot guarantee the security of email exchanges. By signing below, you consent to receive communications from Ideal Family Health Center via email.

_____ _____

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

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I voluntarily consent to receive acupuncture and related treatments from the licensed acupuncturist(s) at Ideal Family Health Center. These treatments may include acupuncture, acupressure, cupping, moxibustion, Tui-Na (Chinese massage), electrical stimulation, herbal medicine, and nutritional counseling.

I understand the following:

- **Common risks** may include bruising, soreness, dizziness, numbness, tingling, and minor bleeding.
- **Less common risks** may include burns (from moxibustion), infection (though sterile needles are used), organ puncture (such as lung), or nerve damage.
- **Herbal supplements** may cause side effects like nausea, diarrhea, rashes, or allergic reactions. I will notify my provider of any adverse effects immediately.
- **Pregnancy risks**: Some herbs and techniques may not be safe during pregnancy; I will inform my provider if I am or become pregnant.

I understand that while acupuncture is generally safe, results are not guaranteed, and my acupuncturist will use their best clinical judgment during care.

I also acknowledge that clinic staff may access my medical records for treatment or administrative purposes, and my records will remain confidential unless I provide written consent.

By signing below, I confirm that I have read and understood this consent, had the opportunity to ask questions, and agree to treatment. This consent applies to my current condition and any future conditions I seek treatment for.

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. Our goal is to provide high-quality, personalized care. To help us serve you efficiently, please review and agree to the following financial policies:

Payment

- Payment is due at the time of service unless prior arrangements have been made.
- We accept cash, in-state checks, Visa, Mastercard, and Discover.

Arrival Policy

- Please arrive on time. Patients arriving 15+ minutes late may be asked to reschedule.

Insurance

- We accept most managed care plans and will bill your insurance when possible.
- If we are **not** in-network with your plan, payment is required at the time of service unless otherwise arranged.
- Any amount not covered by your insurance is your responsibility.
- Please contact your insurance company directly for questions about coverage, benefits, or network status.

Proof of Insurance

- You must provide up-to-date insurance information prior to treatment.
- If no insurance is provided, full payment is required.
- Insurance verification is an **estimate only** and does not guarantee payment.
- Copays, deductibles, and coinsurance are due at the time of service.

By signing below, you acknowledge and agree to the terms of this Financial Policy.

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

For Physician / Office to fill out only:

S.O.A.P INTAKE AND PROGRESS NOTES

Subjective **O**bjective **A**ssessment **P**lans

Patient Name: ______________________________________ Birthdate: ___/____/_______

Prob # Date: ___________________

For Physician / Office to fill out only:

Documentation of Good Faith Effort to Obtain Written Acknowledgement

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):

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

_____

_____

_____

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

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