National University Of Health Sciences

FINANCIAL/TREATMENT CONSENT
WHOLE HEALTH CENTER – LOMBARD

Please complete and sign for treatment. Thank you.

DATE:_____

Circle one:
CHIROPRACTIC ACUPUNCTURE & ORIENTAL MEDICINE NATUROPATHIC NUTRITION

MEDICAL RADIOLOGY FACULTY PRACTICE Doctor assigned:_____

PATIENT INFORMATION:

Name_____Date of Birth_____/_____/_____
(Last) (First) (MI)
Address_____Responsible party_____
(If different)
City_____ State_____ Zip_____

Soc. Security #_____/_____/_____Home Phone (_____)_____-_____Cell (_____)_____-_____

Primary contact number preferred_____ Work Phone (_____)_____-_____

Emergency Contact _____Relationship_____Phone (_____)_____-_____

How did you hear about us? Circle: Friend/Family Patient Health Screen/Fair Marathon

Circle one: INSURANCE SELF-PAY DISCOUNT PROGRAM (list program)_____

We are in network with Blue Cross Blue Shield of Illinois PPO and Medicare. Insurance is accepted for services rendered in the following departments only: Chiropractic, Faculty and Medical. Our Faculty practice physicians may be participating providers with additional insurance companies. All other insurances will be processed as "out of network" and payment is expected at the time services are rendered.

Insurance Company_____ Effective date_____

Member ID# _____ Group#_____

Policy holder name (if self, note self)_____Policy holder's birthdate_____

Relationship to insured (circle one): SELF SPOUSE CHILD

STATEMENT OF FINANCIAL RESPONSIBILITY AND AUTHORIZATION TO TREAT:

I understand that I am financially responsible for all services rendered to me or my dependent at NUHS. I hereby authorize NUHS or its successors to submit claims to my insurance company or other third party on my behalf. If my insurance company denies payment on my behalf I understand that I am financially responsible for any remaining balance.

I further authorize my insurance company to direct payment to NUHS on my behalf.

I authorize the physician to diagnose and treat me or my dependent/minor child and to use any diagnostic modality needed to make a clinical diagnosis and develop a treatment plan.

Signature_____Date_____/_____/_____

I HAVE RECEIVED A COPY OF THE PRIVACY PRACTICES POLICY. _____Initial, please.

OFFICE USE ONLY: LOMBARD PATIENT NUMBER_____

NEW RE-CHECK EXAM MASSAGE TX Verified _____

MEDICARE ABN_____HIPAA policy _____ Entered _____

COMPREHENSIVE MEDICAL HISTORY

National University Of Health Sciences

Patient:_____DOB: _____ Date: _____ File #:_____
Last, First MM/DD/YYYY MM/DD/YYYY

NAME OF GENERAL PRACTITIONER:
_____

DATE OF LAST PHYSICIAL EXAMINATION: _____
_____

INSTRUCTIONS FOR PAST MEDICAL-SYSTEMS REVIEW: *Please check if you now, or ever, have experienced the following:*

CONSTITUTIONAL
1. ____Cancer
2. ____Allergies
3. ____Fever or chills
4. ____Weight loss or gain
5. ____Night sweats
6. ____Fatigue
7. ____Insomnia or changes in sleep
8. ____Other

ENDOCRINE
9. ____Diabetes
10. ____Thyroid disease
11. ____Intolerance to heat or cold
12. ____Increased thirst
13. ____Other

EYE, EAR, NOSE, THROAT
14. ____Glaucoma
15. ____Sinusitis
16. ____Poor vision
17. ____Pain in eye
18. ____Deafness/Difficulty hearing
19. ____Nosebleeds
20. ____Dental problems
21. ____Hoarseness
22. ____Other

PULMONARY
23. ____Asthma
24. ____COPD
25. ____Tuberculosis
26. ____Pneumonia
27. ____Difficulty breathing/ shortness of breath
28. ____Wheezing
29. ____Chronic cough or phlegm
30. ____Coughed up blood
31. ____Other

GASTROINTESTINAL
32. ____Appendicitis
33. ____Jaundice, Hepatitis, or Cirrhosis
34. ____Ulcer
35. ____Gallbladder disease
36. ____Colon polyps
37. ____Hemorrhoids
38. ____Poor appetite
39. ____Abdominal pain
40. ____Black or bloody stool
41. ____Frequent heartburn
42. ____Frequent bloating or gas
43. ____Frequent nausea or vomiting
44. ____Frequent diarrhea or constipation
45. ____Difficult swallowing
46. ____Other

CARDIOVASCULAR
47. ____Heart disease
48. ____High cholesterol or triglycerides
49. ____High blood pressure
50. ____Stroke
51. ____Rheumatic fever
52. ____Chest pain
53. ____Irregular/rapid heartbeat
54. ____Fainting/lightheadedness
55. ____Ankle swelling
56. ____Varicose veins
57. ____Other

BLOOD/LYMPH
58. ____Anemia
59. ____Bleeding disorder
60. ____Enlarged lymph nodes
61. ____Other

SKIN
62. ____Change in mole
63. ____Itching or rash
64. ____Other

Clinician/Intern Comments:

COMPREHENSIVE MEDICAL HISTORY

National University Of Health Sciences

Patient:_____DOB: _____ Date: _____ File #:_____
Last, First MM/DD/YYYY MM/DD/YYYY

GENITOURINARY
65. ____Kidney disease or stones
66. ____Urinary infection
67. ____Sexually-transmitted disease
68. ____Sexual difficulties
69. ____Frequent or painful urination
70. ____Bloody or discolored urine
71. ____Incontinence
72. ____Other

MALE SPECIFIC
73. ____Prostate disease
74. ____Testicular pain or swelling
75. ____ Impotence/erectile dysfunction
76. ____Difficulty urinating
77. ____Other

FEMALE SPECIFIC
78. Date last period began: _____
79. ____Live births
80. ____Miscarriage or abortion
81. ____Painful periods
82. ____Irregular or heavy periods
83. ____Breast lump or pain
84. ____Hot flashes
85. ____Other

NEUROLOGIC/PSYCH
86. ____Epilepsy or seizures
87. ____Headache
88. ____Psychiatric disorder
89. ____Weakness
90. ____Numbness/tingling
91. ____Dizziness
92. ____Tremor or twitching
93. ____Arm/leg pain
94. ____Depression or Anxiety
95. ____Other

MUSCULOSKELETAL
96. ____Fracture or dislocation
97. ____Arthritis
98. ____Scoliosis/ Spinal curvature
99. ____Neck or upper back pain
100. ____Lower back pain
101. ____Swollen/painful joint(s)
102. ____Other

CHILDHOOD DISEASES
103. ____Measles
104. ____Mumps
105. ____Chicken Pox
106. ____Other

TRAUMA
107. ____Motor vehicle accident
108. ____Other

HOSPITALIZATIONS and SURGERIES
(list dates and reasons)
109._____
110._____

SOCIAL HISTORY
111. ____Smoking/ tobacco use
112. ____Alcohol use
113. ____Recreational drug use
114. ____Sexually active with multiple partners
115. Are you married/partnered?
Yes No

Describe your exercise:
116._____
Describe your diet:
117._____
What is your occupation?
118._____
Do you have a supportive home environment?
119._____

FAMILY HISTORY
120. ____Kidney disease
121. ____Heart disease or stroke
122. ____High blood pressure
123. ____Cancer
124. ____Thyroid disease
125. ____Diabetes
126. ____Neurological disease
127. ____Musculoskeletal disease
128. ____Psychiatric disease
129. ____Other

Clinician/Intern Comments:

☐ **Reviewed Medication Sheet**
☐ **Completed APHR**

_____
Clinician's Initials

MEDICATION LIST

National University Of Health Sciences

Patient:_____DOB: _____ Date: _____ File #:_____
Last, First MM/DD/YYYY MM/DD/YYYY

ALLERGIES:

Prescription Medications

Name	Dosage	How Often	Reason	Date started	Follow-up Dates			

Over-the-counter Medications

Supplements/Herbs/ Homeopathic Remedies

PAIN CHART

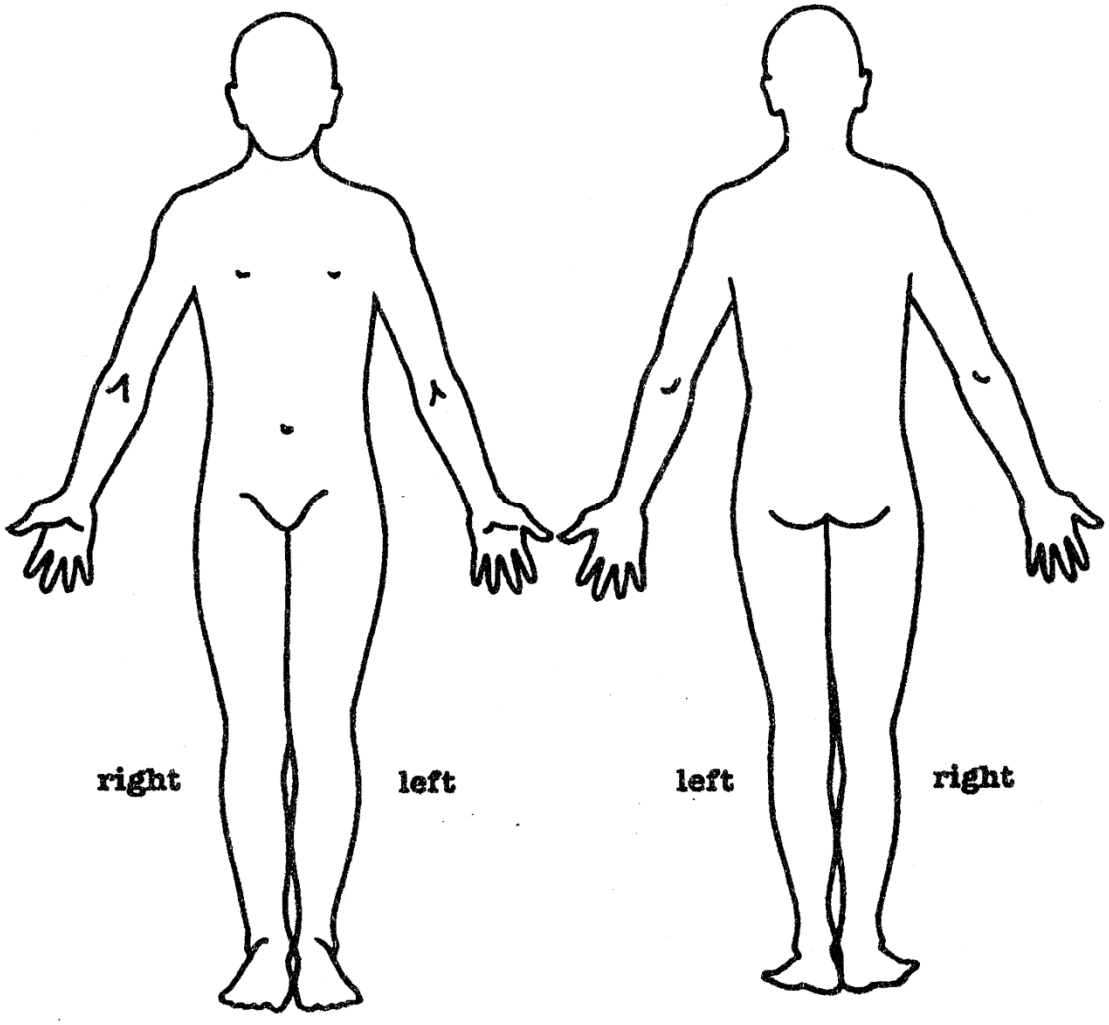
National University Of Health Sciences

Patient:_____DOB: _____ Date: _____ File #:_____
Last, First MM/DD/YYYY MM/DD/YYYY

Show area(s) of pain or unusual feeling on the diagrams below.

Mark the areas on the diagrams where you feel the described sensations. Use the indicated symbols and include all affected areas.

NUMBNESS	PINS & NEEDLES	BURNING	ACHING	STABBING
----------	OOOOOOOOO	XXXXXX	*********	//////////



_____ _____
Patient Signature Clinician's Initials

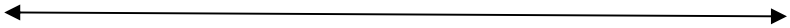
VISUAL PAIN SCALE

National University Of Health Sciences

Patient:_____DOB: _____ Date: _____ File #:_____
Last, First MM/DD/YYYY MM/DD/YYYY

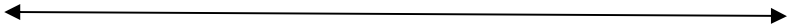
The lines below are used to represent the intensity of discomfort you might have in your body. Please ***indicate the area or region of the body***, then ***place an "X" at the position on the line*** that indicates how much discomfort you feel in that area.

AREA #1:_____



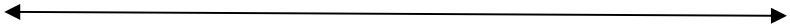
No Discomfort — Worst Pain Imaginable

AREA #2:_____



No Discomfort — Worst Pain Imaginable

AREA #3:_____

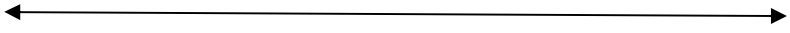


No Discomfort — Worst Pain Imaginable

AREA #4:_____

No Discomfort — Worst Pain Imaginable

AREA #5:_____



No Discomfort — Worst Pain Imaginable

_____ _____
Patient Signature Clinician's Initials

SF-12™ HEALTH SURVEY

National University Of Health Sciences

Patient:_____DOB: _____ Date: _____ File #:_____
Last, First MM/DD/YYYY MM/DD/YYYY

Marital/Relationship Status: __Single __Married __Civil Union __Separated __Divorced ___Widow/er

Occupation: _____

Please answer every question. Some questions may look like others, but each one is different. Please take the time to read and answer each question carefully by circling the number that best represents your response.

1. In general, would you say your health is:

1. Excellent 2. Very Good 3. Good 4. Fair 5. Poor

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

2. **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?
   1. Yes, limited a lot 2. Yes, limited a little 3. No, not limited at all

3. Climbing **several** flights of stairs?
   1. Yes, limited a lot 2. Yes, limited a little 3. No, not limited at all

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?

4. **Accomplished less** than you would like:
   1. Yes 2. No

5. Were limited in the **kind** of work or other activities
   1. Yes 2. No

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

6. **Accomplished less** than you would like
   1. Yes 2. No

7. Didn't do work or other activities as carefully as usual
   1. Yes 2. No

8. During the **past 4 weeks**, how much did **pain** interfere with your normal work (including both work outside the home, and housework)?

1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

Over Please

SF-12™ HEALTH SURVEY-2

National University Of Health Sciences

Patient:_____DOB: _____ Date: _____ File #:_____
Last, First MM/DD/YYYY MM/DD/YYYY

These next three questions are about how you feel and how things have been with you **during the past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time **during the past 4 weeks**...

	All of the time	Most of the time	A good bit of the time	Some of the time	A little the time	None of the time
9. Have you felt calm and peaceful?	1.	2.	3.	4.	5.	6.
10. Did you have a lot of energy?	1.	2.	3.	4.	5.	6.
11. Have you felt downhearted and blue?	1.	2.	3.	4.	5.	6.

12. During the **past 4 weeks**, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

1. All of the time 2. Most of the time 3. Some of the time 4. A little of the time 5. None of the time

For Office Use Only

Physical Health Score ..... _____
Mental Health Score ..... _____

Physical Functioning Score ..... _____
Role Limitation Physical Score ..... _____
Pain Score..... _____
General Health Score ..... _____
Vitality Score ..... _____
Role Limitation Emotional Score..... _____
Social Functioning Score..... _____
Mental Health Score ..... _____

_____
Clinician Initials

National University Of Health Sciences

AUTHORIZATION TO USE CLINICAL RECORDS AND CASE HISTORIES IN TEACHING, RESEARCH AND PROFESSIONAL PUBLICATIONS

The National University of Health Sciences clinic is a resource for the training and education of students in the professional curriculum leading to the doctor of chiropractic degree.

The faculty and the staff of the clinic utilize case histories of patients in their teaching and research. These case histories serve as examples of the use of chiropractic to illustrate the need for and utilization of chiropractic techniques, and to develop methods and new applications of chiropractic. The case histories also serve to inform the profession through published articles of specific clinical problems and their resolution through chiropractic treatment.

All such use of clinical reports and case histories is done without identifying the patient. The only information concerning the patient that may be revealed is defining the individual's gender and age.

You have the right to refuse to give us this authorization. If you do not give us this authorization, it will not affect the treatment that the clinic provides in any way.

If you give authorization, you may change your mind and request that we not use your information. This request must be in writing and will not affect any information used prior to your written request.

I, _____, do/do not (circle one) authorize National University of Health Sciences to use my clinical records in the form of case reports for teaching, research and professional publications and understand that my identity will remain confidential.

Signature _____

Date _____

National University Of Health Sciences

Patient's Bill of Rights

These rights can be exercised on the patient's behalf by a designated surrogate or proxy decision-maker if the patient lacks decision-making capacity, is legally incompetent, or is a minor.

The patient has the right to considerate and respectful care.

The patient has the right to and is encouraged to obtain from physicians and other direct caregivers relevant, current and understandable information concerning diagnosis, treatment and prognosis.

Patients have the right to know the identity of physicians, nurses, residents, interns, or other trainees. The patient also has the right to know the immediate and long term financial implications of treatment choices, insofar as they are known.

The patient has the right to make decisions about the plan of care prior to and during the course of treatment and to refuse a recommended treatment or plan of care to the extent permitted by law and clinic policy, and to be informed of the medical consequences of this action. In case of such refusal, the patient is entitled to other appropriate care and services that the clinic provides or transfer to another health care provider. The clinic should notify patients of any policy that might affect patient choice within the institution.

The patient has the right to have an advance directive (such as a living will, health care proxy, or durable power of attorney for health care) concerning treatment or designating a surrogate decision-maker with the expectation that the clinic will honor the intent of that directive to the extent permitted by law.

The patient has the right to every consideration of privacy. Case discussion, consultation, examination, and treatment should be conducted so as to protect each patient's privacy.

The patient has the right to expect that all communications and records pertaining to his/her care will be treated as confidential by the clinic, except in cases such as suspected abuse and public health hazards when reporting is permitted or required by law. The patient has the right to expect that the clinic will emphasize the confidentiality of this information when it releases it to any other parties entitled to review information in those records.

The patient has the right to review the records pertaining to his/her medical care and to have the information explained or interpreted as necessary, except when restricted by law.

NUHS Whole Health Center – Lombard

200 East Roosevelt Road ❑ Lombard, Illinois 60148-4583 ❑ 630-629-9664

National University Of Health Sciences

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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.

Uses and Disclosures

Here are some examples of how we are allowed to disclose your private health care information for treatment, payment or clinic operations.

1. **Your health care provider or a staff member may disclose your health information including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment or treatment of your health condition.**
2. **Our insurance and billing staff may disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are potentially responsible for the payment of your services.**
3. **Your health care provider and members of the practice staff may use your health information, examination and treatment records, and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run our practice.**
4. **Your health care provider and member of the practice staff may use your name, address, telephone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. 164.250 (b)(1)(iii)(A). If you are not at home to receive an appointment reminder, a message will be left on your answering machine.**

Research

Our research team is considered part of our practice staff. This team may need information in your medical records for a research study. For example, they may need to know your medical diagnosis or know about allergies you may have. The team may also need to collect health information about you from other health care providers because the information may be important to the study. For example, the research team may need to get your lab test results from your doctor.

Selection for participation in a research study is based on very specific criteria. You will need to give additional authorization to participate. This authorization will tell you:

- **Who will use, share and receive your personal information;**
- **What personal health information is needed for the research study;**
- **Why your personal health information will be used or shared;**
- **Your right to change your mind and cancel your authorization at any time; and**
- **Information on what happens if you do not sign the authorization form, and how long your information will be used or shared.**

The HIPAA privacy rule permits us to communicate with you regarding your health care. We will notify you by phone if we have to change, alter or cancel your scheduled appointment. Appointments are considered part of our treatment. Authorization or permission to call is not required. HIPAA allows a message to be left on an answering machine, voice mail or with a third party. Information will be limited to no more than necessary.

You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

Permitted Uses and Disclosures Without Your Consent or Authorization

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

1. **We are permitted to use or disclose your health information if we are providing health care services to you based on the orders of another health care provider.**
2. **We are permitted to use or disclose your health information if we provide health care services to you as an inmate.**
3. **We are permitted to use or disclose your health information if we provide health care services to you in an emergency.**
4. **We are permitted to use or disclose your health information if we are required by law to treat you and we are unable to obtain consent after attempting to do so.**
5. **We are permitted to use or disclose your health information if there are substantial barriers to communication with you, but in our professional judgment we believe that you intend for us to provide care to you.**

Other than the circumstances described in the preceding five examples, and in the section Uses and Disclosures of this document, any other use or disclosure of your health information will only be made with your written authorization.

Your Right to Revoke Your Authorization

You may revoke your authorization to us at ay time; however, your revocation must be in writing and mailed to our office. There are two circumstances under which we will not be able to honor your revocation request:

1. **If we already released your health information before we received your request to revoke your authorization. 164.508(b)(5)(i)**
2. **If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims.**

If you wish to revoke your authorization, please write to us at:

National University of Health Sciences
Clinics Business Office
200 E. Roosevelt Road
Lombard, IL 60148

Your Right to Limit Uses or Disclosures

If there are health care providers, hospitals, employers, insurers, or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restrictions are binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

Your Right to Receive Confidential Communication Regarding Your Health Information

We normally provide information about your health information to you in person at the time you receive services from us. We may also mail you information regarding your health or the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home or, if you would like information in a different form. To help us respond to your needs, please make any request in writing.

Your Right to Inspect and Copy Your Health Information

You have the right to inspect and/or copy your health care information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to inspect and/or copy your health information to be in writing.

Your Right to Amend Your Health Information

You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting use to make.

Your Right to Receive an Accounting of the Disclosures We Have Made of Your Records

You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except:

- **Those disclosures required for your treatment, to obtain payment for your services, or to run our practice.**
- **Those disclosures made to you.**
- **Those disclosures necessary to maintain a directory of individuals in our facility or to individuals involved in your care.**
- **Those disclosures for national security or intelligence purposes.**
- **Those disclosures made to correctional officers or law enforcement officers.**
- **Those disclosures that were made prior to the effective date of the HIPAA privacy law.**

We will provide you the first accounting within any 12-month period without charge. There is a fee for any additional requests during the next 12 months. When you make your request, we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

Your Right to a Paper Copy of This Notice

If you have agreed to receive privacy notices by email, you may request a paper copy of this notice at any time.

Our Duties

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement, we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms, the change will apply for all of your health information in our files.

Re-Disclosure

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

Your Right to Complain

You may complain to us or to the Secretary for Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you my make an oral complaint at any time, written comments should be addressed to us at:

National University of Health Sciences
Clinics Business Office
200 E. Roosevelt Road
Lombard, IL 60148

Marketing

From time to time, our practice works with marketing organizations to make you aware of products or services that you may have an interest in purchasing. We may need to use your health information including your name, address, telephone number, and your clinical records for the purpose of marketing products or services to you. The authorization form you sign for this purpose contains the name of the organization and/or the products and services we are marketing.

You have the right to refuse to give us authorization to contact you for marketing purposes. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to market products and/or services to you at any time. Our practice and staff will receive direct or indirect remuneration from our marketing activities.

Fund Raising

From time to time, our practice raises money for charitable causes. We may need to use your health information including your name, address, telephone number, and your clinical records to contact you to request your assistance with these fund raising efforts. The authorization form you sign for this purpose contains the name of the organization(s) for whom we are raising money.

You have the right to refuse to give us authorization to contact you for fund raising purposes. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you about fund raising efforts at any time. Our practice and staff will receive direct or indirect remuneration from our fund raising activities.

Our Privacy Pledge

We have and always will respect your privacy. Other than the uses and disclosures we described above, we will not sell or provide any of your health information to any outside organizations.

Contact Us

If you would like further information about our privacy policies and practices, please contact:

National University of Health Sciences
Clinics Business Office
200 E. Roosevelt Road
Lombard, IL 60148