Chicago Sport and Wellness

First Name:	Last Name:
Address:	Email Address:
City, State & ZIP:	Home Phone:
Referred by:	Cell Phone:
Referral Source (i.e. doctor, family, friend, trainer):	Work Phone: Ext:
Marital Status (Please Circle): MARRIED SINGLE DOMESTIC PARTNER OTHER_____	Preferred Method of Communication (Please Circle): CELL # HOME # WORK # EMAIL TEXT OTHER _____
Age:	Birth Date:
Occupation:	

Parent/Guardian Name:	Parent/Guardian Phone:
Emergency Contact Name: Phone Number:	Relation to Emergency Contact:

Reason for visit:
If this complaint is due to an injury, what is the nature of the injury? (Please Circle): AUTOMOTIVE WORKER'S COMP PERSONAL INJURY SPORTS/ACTIVITY RELATED OTHER _____
Date of Injury/Accident:
IF THIS IS A WORKERS' COMP, AUTO ACCIDENT OR PERSONAL INJURTY CLAIM PLEASE PROVIDE:
Insurance company name:

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Contact person:
Contact phone:
Claim number:
Claim address:
PAYMENT/ INSURANCE INFORMATION
Name of the party responsible for payment:
Phone of the party responsible for payment:

Informed Consent

I hereby request and consent to treatment by the chiropractic physician and give the doctor permission and authority to treat me in ways that are judged beneficial to me based on chiropractic tests, diagnosis, and analysis. I understand that results are not guaranteed and I am aware that there are some risks to treatment. It is the responsibility of the patient to disclose any underlying physical defects, illnesses, or deformities that may not otherwise come to the attention of the physician and that may render the patient susceptible to injury. The chiropractic physician will not provide treatment if he/she is made aware of adverse conditions as stated above. My signature below certifies that I have read and understand the above information regarding informed consent.

Release of Information and Assignment of Benefits

I give permission to Chicago Sport and Wellness to release information, written and verbal, contained in my medical record, and other related information, to my insurance company, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries as it relates to my treatment and/or payment for services provided. I authorize Chicago Sport and Wellness to obtain medical records and/or professional information as it relates to my treatment and/or medical benefits. I have insurance and/or employee health care benefits as stated on the patient information form. I authorize payments directly to Chicago Sport and Wellness of medical benefits and/or insurance reimbursement for services rendered. This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. My signature below certifies that I have read and understand the above information regarding release of information and assignment of benefits.

Notice of Privacy Practices

I have reviewed the notices of privacy practices (HIPPA). I will be given a copy of the privacy practices upon request. I hereby consent to the use and disclosure of my personal health information for the purposes of treatment and payment. I have read and understood the terms outlined above and consent to all necessary treatment as determined by Chicago Sport and Wellness.

_____ _____

Signature of patient or responsible party Date