Barton Chiropractic Clinic, P.C.
Diane M. Barton, D.C.
18665 Dixie Highway
Homewood, IL 60430
(708)922-1400

Our Financial Policy

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility. The following need to be completed by all patients prior to being served at Barton Chiropractic Clinic:

- All patients must complete our Patient Information Form before seeing the doctor
- Assignment of Benefits Agreement must be signed
- Co-payment is due at time of service

Billing

You as the patient are obligated to pay all co-pays, deductibles and any other fees for services rendered per any insurance plans you may have.

Please understand, it is your responsibility to know what your insurance policy coverages and fees are.

Any balance not paid by your insurance company within 45 days is your responsibility.

- Failure to make a payment on an overdue account or failure to communicate may result in legal action, payable by the patient.
- There will be a 28% processing fee added to the balance of any account placed into collections with Collection Professionals, Inc.

As a courtesy to our patients, we offer flexible payment options:

_____ Payment by cash _____ Payment by check _____ Payment by credit card _____ Automatic monthly billing to Visa, Mastercard or Discover (set amount $_____monthly) _____ Guarantee any amount not covered by insurance with Visa, Mastercard or Discover.

We also offer ChiroHealthUSA as legal cash discount plan for services.

Please make your choice, sign below and return to office manager before treatment.

_____ _____

Signature Date

_____ Printed Name

Insurance

We file insurance claims as a courtesy to our patients. If you have insurance we will help you receive maximum benefits. Your insurance policy is a contract between you and your insurance company. We are not party to that contract. It is up to you to contact your insurance company and inquire as to what your benefits are. Insurance company deductibles, co-payments, covered charges, etc are the patients responsibility. Please be aware some or perhaps all of the service provided may not be covered by your policy. Any balance is your responsibility whether or not your insurance company pays any portion.

Insurance Authorization

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government or private benefits to the party who accepts assignment. This is permanent authorization that I may revoke at any time by written notice.

_____ _____

Signature of patient or guardian Date

_____

Print Name

My Financial Responsibility

I understand that I am personally financially responsible for all services not paid for by my insurance. I am also responsible for any annual deductible applicable, co-payments, or non-covered services as may be required by my insurance plan. Missed appointments not cancelled 24 hours in advance are subject to a fee at the rate of a normal office visit. NSF checks, Uncollected Funds or any collection reasons will be subject to fee.

_____ _____

Signature of patient or guardian Date

_____

Print Name

Medicare/Workers Compensation/Personal Injury

If you are covered by Medicare, Workers Compensation or Personal Injury, please discuss your payment situation with our office prior to date of service.

Note: Barton Chiropractic Clinic accepts only limited Workers Compensation and Personal Injury cases. Please contact our office to discuss your situation.

_____ _____

Signature of patient or guardian Date

_____

Print Name

Notice of Patient Privacy Acknowledgement

Barton Chiropractic Clinic adheres to HIPAA Privacy requirements in protecting your privacy.

When coming in to the office for your first visit, you will be asked to sign verification of receiving a Notice Of Patient Privacy. If you would like to view the notice ahead of time, you will find it on the bottom of the Home page of our website.

Patient Information Form

Patient Name: Last_____ First_____ MI_____

Home Address (city, state zip)_____

Race_____ Hispanic _____Preferred Language _____

Home Phone_____ Email Address_____

Cell Phone_____ Cellular Provider for text reminder of appointments_____

Date of Birth_____ SSN_____ Marital Status_____

Employment Status ____ FT _____PT ____Retired ____Self Employed ____Student FT ____Student PT

Employer _____Work Number_____

Insured's Name_____ Insured's Date of Birth_____

Person Responsible for the bill: _____ Phone_____

Nearest friend/relative not living with you _____ Phone _____

Physician _____ Phone _____

Emergency Contact _____ Phone _____

Referred to us by _____ Phone _____

I have read all the information or had it read to me and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my life status on the above information.

_____ _____

Signature of Patient of person acting on patient behalf Date

Patient Name: Last_____ First_____ MI_____

Home Address (city, state zip)_____

Race_____ Hispanic _____Preferred Language _____

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Name_____ Date_____

Present Complaints: Please check all answers and check appropriate blanks pertaining to your present complaint(s) which brought you in today. The information you provide concerning your past and present symptoms and diseases assists the doctor in obtaining an early understanding of you state of health.

1. Present Complaint:_____

_____

2. Please describe the character of your pain:
( ) Aching ( )Annoying ( ) Burning ( ) Cramping ( )Deep ( )Diffuse ( )Dull ( )Heavy ( )Intolerable ( ) Numbness ( ) Pulling ( )Radiating ( ) Sharp( ) Stiffness ( )Shock like ( ) Stabbing ( )Tightness ( )Tingling ( )Throbbing

3. How often are the complaints present? ( ) Constant ( ) Frequent ( ) Occasional

4. How bad is your ache or pain? On a scale from 1-10 enter a number _____

5. Since the problem began is your pain: ( ) Increasing ( ) Decreasing ( ) Unchanged

6. When did your problem begin: Specific date if possible _____

7. Did your problem begin:
( ) Immediately after a specific incident ( ) Multiple Incidents ( ) Gradual over time

8. Describe how your pain began:

_____

9. What treatment have you received for this present condition?
( ) Surgery ( ) Spinal Injections ( ) Physical Therapy ( ) Back Support ( ) Other ( ) None

10. Were you previously treated for a different occurrence of this same condition?
( ) Yes If yes, you were treated by: ( ) Chiropractor ( ) M.D. ( ) Therapist
( ) Other_____

Specific dates_____Type of Treatment_____ Results_____

11. What aggravates the symptoms?
( ) Bathing ( )Bending ( ) Caring for Family ( ) Carrying ( ) Changing Positions ( ) House Chores
( ) Computer use ( ) Concentrating ( ) Coughing ( ) Driving ( ) Exercise ( ) Lying Prone ( ) Lifting
( ) Looking Up ( ) Looking Down ( )Lying ( )Supine ( ) Movement ( ) Reaching ( ) Rest
( ) Scooping ( ) Sitting ( ) Sleeping ( ) Sneezing ( ) Straining ( ) Stairs ( ) Stooping ( ) Standing
( ) Twisting ( ) Typing ( ) Walking ( ) Unknown Action/Movement ( ) None

12. What are you symptoms relieved by?
( ) Analgesic Topical ( ) Chiropractic Adjustment ( ) Cold Packs ( ) Exercise ( ) Heat Packs ( ) Ice
( ) Knees Bent Up ( ) Lying ( ) Massage ( ) Medication ( ) Movement ( ) No Movement ( ) Nothing
( ) Over the Counter Medications ( ) Physical Therapy ( ) Redirect Attention ( ) Rest ( ) Sitting
( ) Standing ( ) Stretching ( ) Support

13. Are your complaints affecting your ability to work or otherwise be active?
( ) Am Totally Disabled ( ) Cannot Care For Self At All ( ) Need Limited Assistance w/ Everyday Tasks
( ) Some Physical Restrictions (able to perform light duty tasks)

14. Activity of Daily Living Most Affected?
( ) Employment ( ) Homemaking ( ) Lifting ( ) Personal Care ( ) Sitting ( ) Sleeping ( ) Social Life
( ) Standing ( ) Traveling/Driving ( ) Walking

15. Specific to this complaint, which of the following causes difficulty?
( ) Bending Over ( ) Caring for Family ( ) Climbing Stairs ( ) Concentrating ( ) Driving ( ) Exercising
( ) Getting In/Out Car ( ) Getting to Sleep ( ) Grocery Shopping ( ) Household Chores
( ) Intimate Moments ( ) Lifting Objects ( ) Looking Over Shoulder ( ) Lying Down ( ) Reaching Up
( ) Rising Out of Chair or Bed ( ) Self Care ( ) Sitting ( ) Standing ( ) Using Computer ( ) Walking
( ) Yard Work

16. What are your therapeutic goals?
( ) Decrease Stiffness ( ) Decrease Swelling ( ) Get out of Bed or Chair w/out Pain ( ) Hunt w/out Limitation ( ) Improve Range of Motion w/out Limitation ( ) Improve Overall Flexibility
( ) Improve Strength ( ) Lift w/out Pain ( ) No Functional Limitations ( ) Relieve Pain
( ) Return to Sport w/out Limitation ( ) Return to Work w/out Limitation ( ) Sleep w/out Interruption
( ) Stand-Up w/out Pain

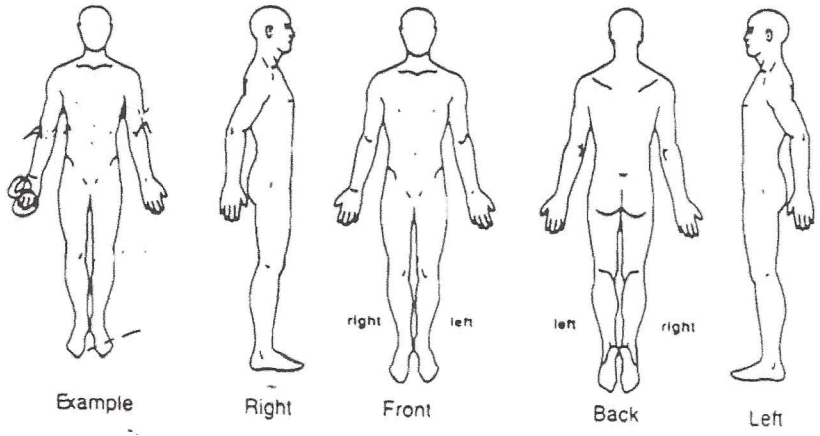
_____ _____

Signature of patient or person acting on patient's behalf Date

Show Us Where It Hurts

Please mark area(s) of injury or discomfort as shown below in the example. Indicate the degree of pain using a scale of 1 (discomfort) to 10 (extreme pain).

Numbness	Pins\Needles	Burning	Aching	Stabbing
------	OOOOOOO	^^^^^^	XXXXX	******



Health History

Please list all medications you are taking:_____

_____

Please list any serious injuries you have had in the last 10 years:_____

_____

Falls:_____

Head Injuries:_____

BrokenBones/Dislocations:_____

Surgeries:_____

Women

Pregnant? ____no____yes How far along?_____ Nursing ? ____no ____yes

Medical Conditions

Please circle any medical conditions you ever had or currently have:

Alcohol/Drug Abuse Anemia Arm Pain Arthritis Artificial Bones/Joints Cancer

Congenital Heart Problems Diabetes Difficulty Breathing Dizziness Epilepsy/Fainting

Frequent Neck Pain Gout Heart Attack/Stroke Hepatitis HIV/Aids Hypertension

Jaw Pain Kidney Problems Leg Pain Low Back Problems Psychiatric Problems

Severe/Frequent Headache Shingles Shoulder Pain Tinnitus Tuberculosis Ulcer Wrist Pain

Numbness, Where?_____ Tingling, Where?_____ Muscle Spasm, Where?_____

Allergies? _____ Allergic to?_____

Main Health Problems:_____

_____

X-Ray, CT Scan or MRI of your low back spine in the past 28 days?_____

Family History Health Issue	Family Member
_____	_____
_____	_____
_____	_____

Social History (how many per day/week/month)

Alcohol _____ Coffee_____ Soda Pop____ Water_____ Sleep____ Pain Relievers_____ Drug Use____

Healthy Eating 1-10 (ten being awesome)____ Exercise (minutes a day) ____ Exercise (days a week)___

Physical Stress 1-10 (ten being exhausted)____ Emotional Stress 1-10 (ten being frazzled)____

Have you ever smoked?_____ Do you smoke now? _____Interest in quitting 1-10 _____

Major Stressors_____

Things to Improve_____

_____ _____

Signature of patient or person acting on patient behalf Date

Informed Consent

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if anything is unclear.

The Nature of the Chiropractic Adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulation therapy. I will use the procedure to treat you. I may use my hands or mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click", like the "crack" you experience when cracking your knuckles. You may feel a sense of movement.

Analysis/Examination/Treatment

As a part of the analysis, examination and treatment, you are consenting to the following:

Spinal Manipulative Therapy Palpation Vital Signs Range of Motion Testing
Orthopedic Testing Basic Neurological Testing Muscle Strength Testing Radiographic Studies

The Material Risks Inherent in Chiropractic Adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contribution to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contradictions to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The Probability of those Ricks Occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during the examination and possible X-ray. Stroke has been the subject of tremendous disagreement. The incidences of the stroke are exceedingly rare and are estimated to occur between one and one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The Ability and Nature of the Other Treatment Options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs ie. anti-inflammatory, muscle relaxants and pain-killers

If you choose to use one the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The Risks and Dangers Attendant to Remaining Untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Diane M. Barton D.C. and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated:_____ **Dated:**_____

_____ **Diane M. Barton D.C**

Patient Printed Name

_____ _____

Signature of patient or person acting on patient behalf **Signature of Dr. Barton**

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