Nauvoo Health & Chiropractic Dr. Tom Grant DC 217-250-1800 1390 Mulholland St, Nauvoo, IL 62354

PATIENT INFORMATION FORM

Patient Name: _____ Date: _____

Birth Date: _____ Age: _____ Social Security # _____Gender: F M U Decline

Phone # _____

E-mail address: _____

Is your condition or injury due to an accident or work-related cause? ☐ YES ☐ NO Date of accident: _____

Height: _____Weight: _____ Right or Left Handed

Did/Do you Smoke? Never – Former – Light – Heavy Smoking since _____ Are you currently pregnant? Yes / No

Job Duties/Activites: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Marital Status: ☐ Married ☐ Separated ☐ Widowed ☐ Single

Name of Spouse: _____

Who should we contact in the event of an emergency? _____

Relationship of emergency contact to patient: _____Phone # _____

Address of contact person: _____

How did you learn about us? _____

Name of Primary Insured: _____Relationship: _____

Birth Date: _____Phone # _____

If a minor, Self/Parent/guardian Name: _____

Self/Parent/guardian Signature: _____

Sign Here _____

Rate your **D**isfunction - **S**tiffness - **P**ain below with 1-10 (1 = Slight, 5= Significant, 10 = Extreme)

Date:

Before appointment:: Headache _____Jaw _____Neck _____Upper Back _____Mid Back _____Low Back _____Tailbone _____Shoulder _____

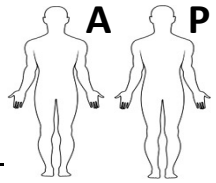
Ribs _____Elbow/Wrist _____Hip _____Knee _____Ankle _____ Foot _____Anxiety _____Dizziness _____Other _____

After appointment: Headache _____Jaw _____Neck _____Upper Back _____Mid Back _____Low Back _____Tailbone _____Shoulder _____

Ribs _____Elbow/Wrist _____Hip _____Knee _____Ankle _____ Foot _____Anxiety _____Dizziness _____Other _____

Abnormal Motion Findings: P: Pain T: Taut muscles A: Abnormal Motion **Tech:** DIV Thompson ACT (ABC PNT FDM)

P	OCC	C2	C4	C6	**P**	T1	T3	T5	T7	T9	T11	**P**	L1	L3	L5	Sac	Coc
T					**T**							**T**					
A	C1	C3	C5	C7	**A**	T2	T4	T6	T8	T10	T12	**A**	L2	L4	Pelv	Ilium	SI



Shldr B L R **UE** _____ B L R **Rib** B L R **Hip** B L R **Knee** B L R **Ankl** B L R **Foot** B L R **Other** _____

Manual (97140): Neck UB MB LB UE _____LE _____

VIB (97112) _____Min: _____

LLLT (0552T): Location: _____

Type: _____Min: _____

TAC (97530): Neck UB MB LB UE _____LE _____

LMT (97124) _____Min: _____

ADL (97535): Device _____

_____Min: _____

Notes: _____

_____

Dr. _____ Next Appt: [ ] CA CC CK V $_____

Thomas E Grant Jr DC

Sign Here _____

Rate your **D**isfunction - **S**tiffness - **P**ain below with 1-10 (1 = Slight, 5= Significant, 10 = Extreme)

Date:

Before appointment:: Headache _____Jaw _____Neck _____Upper Back _____Mid Back _____Low Back _____Tailbone _____Shoulder _____

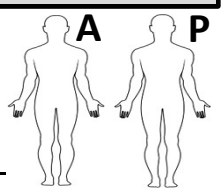
Ribs _____Elbow/Wrist _____Hip _____Knee _____Ankle _____ Foot _____Anxiety _____Dizziness _____Other _____

After appointment: Headache _____Jaw _____Neck _____Upper Back _____Mid Back _____Low Back _____Tailbone _____Shoulder _____

Ribs _____Elbow/Wrist _____Hip _____Knee _____Ankle _____ Foot _____Anxiety _____Dizziness _____Other _____

Abnormal Motion Findings: P: Pain T: Taut muscles A: Abnormal Motion **Tech:** DIV Thompson ACT (ABC PNT FDM)

P	OCC	C2	C4	C6	**P**	T1	T3	T5	T7	T9	T11	**P**	L1	L3	L5	Sac	Coc
T					**T**							**T**					
A	C1	C3	C5	C7	**A**	T2	T4	T6	T8	T10	T12	**A**	L2	L4	Pelv	Ilium	SI



Shldr B L R **UE** _____ B L R **Rib** B L R **Hip** B L R **Knee** B L R **Ankl** B L R **Foot** B L R **Other** _____

Manual (97140): Neck UB MB LB UE _____LE _____

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LLLT (0552T): Location: _____

Type: _____Min: _____

TAC (97530): Neck UB MB LB UE _____LE _____

LMT (97124) _____Min: _____

ADL (97535): Device _____

_____Min: _____

Notes: _____

_____

Dr. _____ Next Appt: [ ] CA CC CK V $_____

Thomas E Grant Jr DC

What is **ONE** problem/symptom you are having now? _____

Circle the number to rate your pain/symptom **TODAY**: No Pain 1 2 3 4 5 6 7 8 9 10 Worst/extreme Pain

Circle the number to rate your pain/symptom **at it's WORST**: No Pain 1 2 3 4 5 6 7 8 9 10 Worst/extreme Pain

---

How **often** do you have your pain? (Circle) **ONE** best answer–

None -- Infrequent -- Occasional -- Intermittent -- Frequent -- Constant

Does the pain radiate? Yes No Where? _____

How does this condition **feel**? (Circle) **all** words that apply

Sharp – Dull – Stabbing – Aching – Radiating – Burning – Throbbing – Numbness

---

What makes this condition **worse**? (Circle) **all** words that apply

Sleeping -- Standing -- Sitting -- Lifting -- Walking -- Running -- Bending -- Working -- Changing Position

---

What makes this condition **better**? (Circle) **all** words that apply

Sleeping -- Standing -- Ice – Heat – Stretching – Sitting -- Resting – Pain Meds, OTC / RX -- Increased Activity – Nothing

---

What other healthcare providers have you seen for this condition?

Name _____ (MD-DC-DO) Last Visit _____ Name _____ (MD-DC-DO) Last Visit _____

Notes: _____

What is a **SECOND** problem/symptom you are having now? _____

Circle the number to rate your pain/symptom **TODAY**: No Pain 1 2 3 4 5 6 7 8 9 10 Worst/extreme Pain

Circle the number to rate your pain/symptom **at it's WORST**: No Pain 1 2 3 4 5 6 7 8 9 10 Worst/extreme Pain

---

How **often** do you have your pain? (Circle) **ONE** best answer–

None -- Infrequent -- Occasional -- Intermittent -- Frequent -- Constant

Does the pain radiate? Yes No Where? _____

How does this condition **feel**? (Circle) **all** words that apply

Sharp – Dull – Stabbing – Aching – Radiating – Burning – Throbbing – Numbness

---

What makes this condition **worse**? (Circle) **all** words that apply

Sleeping -- Standing -- Sitting -- Lifting -- Walking -- Running -- Bending -- Working -- Changing Position

---

What makes this condition **better**? (Circle) **all** words that apply

Sleeping -- Standing -- Ice – Heat – Stretching – Sitting -- Resting – Pain Meds, OTC / RX -- Increased Activity – Nothing

---

What other healthcare providers have you seen for this condition?

Name _____ (MD-DC-DO) Last Visit _____ Name _____ (MD-DC-DO) Last Visit _____

Notes: _____

Patient Name _____ Date

Patient Symptoms & Conditions. Mark C for Current & P for Previous with Age of occurrence.

ALLERGIC-IMMUNOLOGIC: ☐ **None**

☐ Hives ☐ Catch colds easily ☐ Frequent sinus trouble ☐ Frequent influenza

☐ HIV ☐ Allergies

CARDIOVASCULAR: ☐ **None**

☐ Murmur ☐ Chest pain ☐ Dizziness ☐ Shortness of breath

☐ Swollen ankles ☐ Heart attack ☐ Irregular heartbeat ☐ Pressure over the chest ☐ Pain down the left arm

☐ High cholesterol ☐ Profuse sweating

☐ Low blood pressure ☐ Fainting spells ☐ High blood pressure ☐ Difficulty lying flat

EAR/NOSE/THROAT: ☐ **None**

☐ Difficulty hearing ☐ Buzzing in ears ☐ Ringing in ears ☐ Vertigo ☐ Sinus trouble ☐ Nasal stuffiness

☐ Hearing loss ☐ Ear pain ☐ Mouth sores ☐ Hoarseness ☐ Nose bleeds ☐ Dental problem

☐ Frequent sore throat ☐ Difficulty swallowing

ENDOCRINE: ☐ **None**

☐ Excessive loss of hair ☐ Heat/Cold Intolerance ☐ Hypothyroidism ☐ Hyperthyroidism ☐ Diabetes ☐ Goiter

EYES: ☐ **None**

☐ Glasses/Contacts ☐ Eye pain ☐ Light sensitivity ☐ Double vision ☐ Cataracts ☐ Other vision problems ☐ Blurred vision

☐ Glaucoma

GASTROINTESTINAL: ☐ **None**

☐ Heartburn/Reflux ☐ Nausea/Vomiting ☐ Constipation ☐ Change in BMs ☐ Diarrhea

☐ Black or bloody BM ☐ Gallbladder problem ☐ Liver problem ☐ Hepatitis

☐ Ulcers ☐ Heartburn ☐ Hiatal hernia ☐ Colitis

☐ Colon cancer ☐ Abdominal pain ☐ Burning in stomach ☐ Pancreatitis ☐ Jaundice

☐ Pain over stomach ☐ Mucus in stool

GENITOURINARY: ☐ **None**

☐ Burning/Frequency ☐ Blood in urine ☐ Incontinence

☐ Kidney infection ☐ Kidney stones ☐ Difficulty in starting urination

MUSCULOSKELETAL: ☐ **None**

☐ Pain and/or stiffness in: ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand ☐ Hip ☐ Knee ☐ Ankle ☐ Foot

☐ Joint Pain/Swelling ☐ Stiffness ☐ Muscle pain ☐ Neck pain ☐ Stiff neck ☐ Back pain

☐ Osteoarthritis ☐ Rheumatoid arthritis ☐ Bone spurs ☐ Broken bones ☐ Compression fracture ☐ Head injury

☐ Back injury ☐ Spinal trauma ☐ Birth trauma ☐ Birth defects ☐ Bone Cancer ☐ Muscle weakness

☐ Muscular dystrophy ☐ Scheuerman's disease ☐ Scoliosis ☐ Lupus ☐ Spina bifida ☐ Spondylolisthesis

☐ Arthritis ☐ Neck injury ☐ Osteoporosis

Patient Name _____ Date

HEMATOLOGY/LYMPH: ☐ **None**

☐ Easy bruising ☐ Gums bleed easily ☐ Enlarged glands ☐ Anemia ☐ Bleeding disorder ☐ Lymphoma

NEUROLOGICAL: ☐ **None**

☐ Loss of strength ☐ Numbness ☐ Headaches ☐ Heavy head ☐ Tremors ☐ Memory loss

☐ Difficulty speaking ☐ Multiple sclerosis ☐ Parkinson's disease ☐ Fainting ☐ Concussion ☐ Migraines

☐ Disorientation ☐ Loss of coordination ☐ Difficulty in walking ☐ Stroke ☐ Alzheimer's disease ☐ Weakness

☐ Disk problem ☐ Light Headed/Dizzy ☐ Epilepsy/Seizure ☐ Tingling

PSYCHIATRIC: ☐ **None**

☐ Anxiety ☐ Depression ☐ Mood swings ☐ Difficult sleeping ☐ Nervousness ☐ Tension/stress

RESPIRATORY: ☐ **None**

☐ Persistent cough ☐ Coughing blood ☐ Wheezing ☐ Chills ☐ Chronic cough ☐ Pneumonia

☐ Asthma ☐ Superficial breathing ☐ Chest pain ☐ Tuberculosis ☐ Bronchitis ☐ Emphysema

☐ Difficulty breathing ☐ Lung cancer ☐ COPD

SKIN: ☐ **None**

☐ Rash/Sores ☐ Lesions ☐ Itching/Burning ☐ Skin problem ☐ Slow healing

☐ Psoriasis/eczema ☐ Change in moles ☐ Change in skin color ☐ Skin cancer ☐ Scars ☐ Discolorations

MEN'S HEALTH ISSUES: ☐ **None** ☐ Prostate trouble ☐ Prostate cancer

WOMEN'S HEALTH ISSUES: ☐ **Not Applicable** ☐ **None**

☐ Hot flashes ☐ Menstrual cramps ☐ Premenstrual depression ☐ Menopause Age _____

GENERAL: ☐ **None**

☐ Recent weight gain ☐ Loss of sleep ☐ Recent weight loss ☐ Loss of appetite ☐ Fatigue

☐ Polio ☐ Other cancers _____ ☐ Prosthetics or hardware _____

FAMILY HISTORY: ☐ **Decline** ☐ **None** Use **F** = Father **M** = Mother **S** = Sibling

☐ Alcoholism ☐ Anemia ☐ Arteriosclerosis ☐ Arthritis ☐ Asthma ☐ Bleed Easy

☐ Cancer ☐ Diabetes ☐ Emphysema ☐ Epilepsy ☐ Glaucoma ☐ Heart Disease

☐ High Blood Pressure ☐ High Cholesterol ☐ Multiple Sclerosis ☐ Osteoporosis ☐ Stroke ☐ Thyroid Disease

PERSONAL HABITS

Alcohol: None – Occasional – Frequent – Constant

Coffee: None – Occasional – Frequent – Constant

Tobacco: None – Occasional – Frequent – Constant

Drugs: None – Occasional – Frequent – Constant

Soft Drinks: None – Occasional – Frequent – Constant

Sugar: None – Occasional – Frequent – Constant

Water: _____ oz per day Sleep: _____ hours nightly Exercise: _____ minutes per day _____x weekly Type _____

Notes _____

_____

Patient Name _____ Date:

NECK DISABILITY INDEX

THIS QUESTIONNAIRE IS DESIGNED TO HELP US BETTER UNDERSTAND HOW YOUR NECK PAIN AFFECTS YOUR ABILITY TO MANAGE EVERYDAY -LIFE ACTIVITIES. PLEASE MARK IN EACH SECTION THE **ONE BOX** *THAT APPLIES TO YOU. ALTHOUGH YOU MAY CONSIDER THAT TWO OF THE STATEMENTS IN ANY ONE SECTION RELATE TO YOU, PLEASE MARK THE BOX THAT* **MOST CLOSELY** *DESCRIBES YOUR PRESENT -DAY SITUATION.*

SECTION 1 - PAIN INTENSITY

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

SECTION 2 - PERSONAL CARE

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally, but it causes extra pain.
- ☐ It is painful to look after myself, and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self -care.
- ☐ I do not get dressed. I wash with difficulty and stay in bed.

SECTION 3 - LIFTING

- ☐ I can lift heavy weights without causing extra pain.
- ☐ I can lift heavy weights, but it gives me extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4 - WORK

- ☐ I can do as much work as I want.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I can't do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

SECTION 5 - HEADACHES

- ☐ I have no headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that come frequently.
- ☐ I have headaches almost all the time.

SECTION 6 - CONCENTRATION

- ☐ I can concentrate fully without difficulty.
- ☐ I can concentrate fully with slight difficulty.
- ☐ I have a fair degree of difficulty concentrating.
- ☐ I have a lot of difficulty concentrating.
- ☐ I have a great deal of difficulty concentrating.
- ☐ I can't concentrate at all.

SECTION 7 - SLEEPING

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed for less than 1 hour.
- ☐ My sleep is mildly disturbed for up to 1-2 hours.
- ☐ My sleep is moderately disturbed for up to 2-3 hours.
- ☐ My sleep is greatly disturbed for up to 3-5 hours.
- ☐ My sleep is completely disturbed for up to 5-7 hours.

SECTION 8 - DRIVING

- ☐ I can drive my car without neck pain.
- ☐ I can drive as long as I want with slight neck pain.
- ☐ I can drive as long as I want with moderate neck pain.
- ☐ I can't drive as long as I want because of moderate neck pain.
- ☐ I can hardly drive at all because of severe neck pain.
- ☐ I can't drive my care at all because of neck pain.

SECTION 9 - READING

- ☐ I can read as much as I want with no neck pain.
- ☐ I can read as much as I want with slight neck pain.
- ☐ I can read as much as I want with moderate neck pain.
- ☐ I can't read as much as I want because of moderate neck pain.
- ☐ I can't read as much as I want because of severe neck pain.
- ☐ I can't read at all.

SECTION 10 - RECREATION

- ☐ I have no neck pain during all recreational activities.
- ☐ I have some neck pain with all recreational activities.
- ☐ I have some neck pain with a few recreational activities.
- ☐ I have neck pain with most recreational activities.
- ☐ I can hardly do recreational activities due to neck pain.
- ☐ I can't do any recreational activities due to neck pain.

Score _____ [50]

Patient Name_____ Date:

OSWESTRY LOW BACK DISABILITY QUESTIONNAIRE

Instructions: this questionnaire has been designed to give us information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which applies to you at this time. We realize you may consider 2 of the statements in any section may relate to you, but please mark the box which most closely describes your current condition.

1. PAIN INTENSITY

D I can tolerate the pain I have without using pain killers
D The pain is bad but I manage without taking pain killers
D Pain killers give complete relief from pain

D Pain killers give moderate relief from pain
D Pain killers give very little relief from pain
D Pain killers have no effect on the pain and I do not use them

2. PERSONAL CARE (e.g.Washing, Dressing)

D I can look after myself normally without causing extra pain
D I can look after myself normally but it causes extra pain
D It is painful to look after myself and I am slow and careful
D I need some help but manage most of my personal care
D I need help every day in most aspects of self care
D I don't get dressed, it was too difficult and stay in bed

3. LIFTING

D I can lift heavy weights without extra pain
D I can lift heavy weights but it gives extra pain
D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, i.e. on a table
D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
D I can lift very light weights
D I cannot lift or carry anything at all

4. WALKING

D Pain does not prevent me walking any distance
D Pain prevents me walking more than one mile
D Pain prevents me walking more than ½ mile
Pain prevents me walking more than ¼ mile
D I can only walk using a stick or crutches
D I am in bed most of the time and have to crawl to the toilet

5. SITTING

☐ I can sit in any chair as long as I like
D I can only sit in my favorite chair as long as I like
Pain prevents me from sitting more than one hour
D Pain prevents me from sitting more than ½ hour
D Pain prevents me from sitting more than 10 minutes
D Pain prevents me from sitting at all

6. STANDING

D I can stand as long as I want without extra pain
D I can stand as long as I want but it gives me extra pain
D Pain prevents me from standing for more than one hour
D Pain prevents me from standing for more than 30 minutes
D Pain prevents me from standing for more than 10 minutes
D Pain prevents me from standing at all

7. SLEEPING

D Pain does not prevent me from sleeping well
D I can sleep well only by using medication
D Even when I take medication, I have less than 6 hrs sleep
D Even when I take medication, I have less than 4 hrs sleep
D Even when I take medication, I have less than 2 hrs sleep
D Pain prevents me from sleeping at all

8. SOCIAL LIFE

D My social life is normal and gives me no extra pain
D My social life is normal but increases the degree of pain
D Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. dancing, etc.
D Pain has restricted my social life and I do not go out as often
D Pain has restricted my social life to my home
D I have no social life because of pain

9. TRAVELLING

☐ I can travel anywhere without extra pain
D I can travel anywhere but it gives me extra pain
D Pain is bad, but I managejourneys over 2 hours
Pain restricts me tojourneys of less than 1 hour
D Pain restricts me to short necessary trips under 30 minutes
D Pain prevents me from traveling except to the doctor/hospital

10. EMPLOYMENT/ HOMEMAKING

D My normal homemaking/job activities do not cause pain.
My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
D I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (e.g. lifting, vacuuming)
D Pain prevents me from doing anything but light duties
D Pain prevents me from doing even light duties
D Pain prevents me from performing any homemaking/job tasks

Patient Name _____ Date:

AUTHORIZATION and ASSIGNMENT

I the undersigned and/or responsible party, in addition to continuing personal responsibility and in consideration of treatment rendered or to be rendered, assign to **Nauvoo Health & Chiropractic**, including all doctors, applicable staff and service providers hereafter known collectively as "Facility", the following rights, power, and authority:

RELEASE OF INFORMATION: You are authorized to release and permit the examination or copying of any of my medical records, x-rays, laboratory reports, and the results of all tests of any type or character as needed for treatment, consultations, expert advice, payment, and health care operations.

ASSIGNMENT OF RIGHTS: I assign to the Facility the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for benefits to the extent of Facility's bill for total services if such benefits are owed within the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court costs, and other legally compensable amounts owed to the Facility by an insurance company or other designated payer who is determined to be the legal party that must pay for treated injuries. I, as the patient and/or responsible party, further agree to cooperate, provide information as needed, and appear as needed, wherever/whenever to assist in the prosecution of such claims for benefits upon request. The Facility is also assigned the exclusive, irrevocable right to request and receive from any insurance company or health care plan any and all information, including PIP/MedPay ledger(s) and documents pertaining to my policies and loss benefits including a copy of such policy, and any information or supporting documentation concerning or touching upon the handling, calculation, processing, or payment of any claim made.

SUPERSEDED HEALTH CARE POLICIES: I understand that my personal injury care claim is a separate treatment agreement and that this document supersedes all my current and prior private health care policy contracts and coverages and is not subject to the limitations of said private policy contracts throughout the duration of treatment for my injuries. Though I may request the Facility to bill my private health insurance policy for my personal injury treatments, I agree that the difference in the Facilities billed services, whether or not the Facility is approved as an "in-network" or "out-of-network" provider, is not limited to said health care policy limitations and I agree to pay for any difference between my health care covered treatment reimbursements and the Facility's reasonably billed services prior to final settlement distribution.

DEMAND FOR PAYMENT: Regarding related insurance company benefits to me for treatment rendered by the Facility as named above, you are hereby tendered demand to pay in full the bill for services rendered by the Facility named above following receipt of such bills for services to the extent such bills are payable under the terms of the legitimate policy for benefits to which I am entitled, less any amounts which I owe personally which are not payable under the terms of the policy. I reserve the right to demand and have payment made in full to this Facility at any time when provided in writing.

THIRD PARTY LIABILITY: If my treatment(s) for injuries are the result of the negligence of any third party, then I grant a lien against any recovery from such third party(s) to the extent of the billings for treatment in favor of the Facility named above. I also grant authority to demand such liable third parties to make payment for my claims to the Facility named above for any and all payable claims for such injuries.

STATUTE OF LIMITATIONS: I waive the right to claim any Statute of Limitations regarding claims for services rendered or to be rendered by the Facility named above, in addition to reasonable costs of collection including attorney fees and court costs, if incurred. I also agree to pay a minimum finance charge of **1.5% per month (annual percentage rate of 18%)** or a minimum of $30.00 whichever is more on any amount not paid after 30 days following provided treatments. If collection is made by suit or otherwise, I and/or responsible party agree to pay collection costs of up to 50% of the remaining balance, plus all attorney fees and court costs and all interest accrued until the unpaid balance is satisfied.

LIMITED POWER OF ATTORNEY: I hereby grant to the Facility named above the power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and health care rendered by the Facility. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my account or forwarded to my address upon request in writing to the Facility named above. In the event that any provision of this Agreement is determined to be invalid or unenforceable, all other provisions of this Agreement shall remain enforceable.

A PHOTOCOPY OF THIS INSTRUMENT SHALL SERVE AS ORIGINAL

Signatures of Patient(s) and Responsible Party: Relationship to Insured: _____

Name: _____ Signature: _____ Date:

Informed Consent to Care

You are the decision maker for your health care. Part of Nauvoo Health and Chiropractic's role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent/Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept them as a patient, it is essential for both to be working towards the same objective. It is important that you understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Here are important terms that are used in this clinic:

Adjustment: An adjustment is the specific application of forces to aid in the body's correction of subluxations. Our chiropractic method of correction will be by specific adjustment of your spine and extremities.

Support Therapy: balancing of muscles and supporting tissue structures to give strength and stability to the adjustment, through massage, exercise, stretching, instructed home therapy life style modifications and education to help you regain your health.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Misalignment: if one or more of the 24 vertebrae in your spinal column, your skull placement, sacrum and hips, and also the joints in the extremities become misaligned, it can cause an alteration of nerve function and interfere with the proper transmission of nerve communication, resulting in a weakening of the body's ability to express its maximum health potential.

Appointment: Your health recovery is very important to us. We ask that you also make it a priority. Be on time! This is a very busy clinic, and reschedules and cancellations cause unwanted disruption to the quality and outcome of care for yourself and others. Scheduling changes will result in a diminished level of care due to the unavailability of certain procedures and services which are being provided to other patients. This clinic schedules therapy tailored to your needs, therefore, PLEASE BE ON TIME!

If during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings we will advise you. If you desire advice, diagnosis or treatment for those findings we will provide you with recommendations for care in this office or through the services of another healthcare provider.

Our objective is to eliminate major interferences to the recovery of your health. Our methods include specific adjusting to correct biomechanical dysfunctions, provide massage therapy, exercise and physical therapy, nutritional and homeopathic supplements. Additional services may be added from time to time as determined by our clinic director.

Financial Arrangements: Your appointments are provided under a variety of payment options. Health insurance will pay for portions, but not necessarily all of your care needs. We will notify you of covered services and we will obtain your permission prior to providing service not covered by your policy. Cash payments at time of service may qualify for a discount. If there is a liability policy, we will accept those on liens, but we reserve the right to charge 1.5% interest on all balances due until paid in full. We also reserve the right to alter this policy as deemed appropriate by our management. You will be informed of such changes prior to implementation.

Your Patient Agreement:

I understand that the clinic will provide a designated appointment time for me and I agree that I will respect the importance of that time and I will make every reasonable effort to keep my appointment and to be on time. Any cancellations or reschedules that are not given a 24 hour notice may be personally charged an administration fee of $30.00 per occurrence, which is not billable to my insurance. I agree to contact this office as soon as possible to reschedule my appointment.

I have read, fully understand and agree to the above statements.

Please review my application and accept me as a new patient in Nauvoo Health & Chiropractic.

Name: _____ Signature: _____ Date:

Nauvoo Health & Chiropractic - Dr. Tom Grant DC
217-250-1800 - 1390 Mulholland St, Nauvoo, IL 62354 - NauvooHealth.com

Insurance Verification Form

Patient Name: _____ Date: _____

Birth Date: _____

Is your condition due to an accident or work-related cause? □ NO □ YES, Date of accident: _____

Name of Insurance Company: _____

Name of Primary Insured: _____ Relationship: _____

Birth Date: _____ Phone # _____

Coverage Start Date: _____ Coverage End Date: _____

Please specify with your insurance carrier that you are verifying coverage of
CHIROPRACTIC CARE IN A CHIROPRACTIC CLINIC.

Deductible: Individual $ _____ Family $ _____ Amount Met: Individual $ _____ Family $ _____

Chiropractic Copay $ _____ Visit Limits per Year: _____ **Pre-Authorization Required**: □ NO □ YES

Amounts Covered for Chiropractic Services:

New Patient Exam - 99202 - $ _____

New Patient Exam - 99203 - $ _____

Existing Patient Exam - 99212 - $ _____

Existing Patient Exam - 99213 - $ _____

Existing Patient Exam - 99214 - $ _____

Spinal Adj. 1-2 Regions - 98940 - $ _____

Spinal Adj. 3-4 Regions - 98941 - $ _____

Spinal Adj. 5-6 Regions - 98942 - $ _____

Extra Spinal Adjustment - 98943 - $ _____

Therapeutic Cold Laser - 0552T - $ _____

Therapeutic Exercise - 97110 - $ _____

Neuromuscular Re-Ed - 97112 - $ _____

Manual Therapy - 97140 - $ _____

Therapeutic Activities in Office - 97530 - $ _____

Home Exercise Program - 97535 - $ _____