

Confidential Health History

Please fill out this questionnaire completely. Your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. **THANK YOU.**

Name _____ SS# _____ Date _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Work Phone _____ Cell _____ E-mail _____
 Birthday _____ Age _____ M F Marital Status _____ Spouse's Name _____ No. Children _____
 Occupation _____ Is your condition due to an injury at work? Yes No
 Employer's Name _____ Address _____
Who referred you to us? _____ **Who is responsible for paying for your treatment?** _____
 Do you have health insurance? _____ If yes, with which insurance company? _____
 Have you ever had previous chiropractic care? _____ If yes, date of last care: _____
 Name of your medical doctor: _____ Address _____

If we are able to accept your case, what type of care do you want? **Corrective Care** **Pain Relief Only**

Please check the appropriate box for any of the following symptoms which you have experienced. **Only check the box if you have experienced the symptom; otherwise please leave it blank.** We need all the facts about your health history before we accept your case. **THIS INFORMATION IS CONFIDENTIAL**

O – OCCASSIONAL	F – FREQUENT	C – CONSTANT
<p>O F C</p> <p>GENERAL</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Allergy</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chills</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Convulsions</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fever</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Headache</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of sleep</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Weight loss</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nervousness/depression</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Neuralgia</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sweats</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tremors</p> <p>MUSCLE & JOINT</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bursitis</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Foot problems</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hernia</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Low back pain</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lumbago</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Neck pain or stiffness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain between shoulder blades</p> <p>Pain or numbness in:</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Shoulders</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Arms</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Elbows</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hands</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hips</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Legs</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Knees</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Feet</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tail bone</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor posture</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sciatica</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spinal curvature</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swollen joints</p>	<p>O F C</p> <p>GASTRO-INTESTINAL</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Belching or gas</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colitis</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colon trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficult digestion</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Distension of abdomen</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Excessive hunger</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gall bladder trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Intestinal worms</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Jaundice</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Liver trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Stomach pain</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor appetite</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vomiting of blood</p> <p>EYES, EARS, NOSE & THROAT</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colds</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Deafness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dental decay</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Earache</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ear discharge</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ear noises</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Enlarged glands</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Enlarged thyroid</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Eye pain</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Failing vision</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Far sightedness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gum/teeth trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hay fever</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hoarseness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nasal obstruction</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Near sightedness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nosebleeds</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sinus problems</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sore throat</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tonsillitis</p>	<p>O F C</p> <p>CARDIO-VASCULAR</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hardening of arteries</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Low blood pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor circulation</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Rapid heart beat</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Slow heart beat</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swelling of ankles</p> <p>RESPIRATORY</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chronic cough</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficult breathing</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spitting up blood</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spitting up phlegm</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Wheezing</p> <p>SKIN</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Boils</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bruise easily</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dry skin</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hives or allergy</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Itching</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Skin eruptions/rashes</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Varicose veins</p> <p>GENITO-URINARY</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bed wetting</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Inability to control urination</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Kidney infection or stones</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful urination</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Prostate trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pus in urine</p> <p>FOR WOMEN ONLY</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fibrotic breasts</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Menstrual cramps or backache</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Excessive menstrual flow</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hot flashes</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Irregular cycle</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Menopausal symptoms</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vaginal discharge</p> <p>Are you pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Last gynecological exam: _____</p>

Please check the following conditions you have had in the past:

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Cold sores	<input type="checkbox"/> Goiter	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Scarlet fever
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Gout	<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Stroke
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Mumps	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Eczema	<input type="checkbox"/> Influenza	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Typhoid fever
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Low back pain	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Malaria	<input type="checkbox"/> Polio	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Chorea	<input type="checkbox"/> Fever blisters	<input type="checkbox"/> Measles	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Whooping cough

What health problem do you want us to treat? _____
 How long have you had these symptoms? _____ Have you had similar symptoms in the past? _____
 How did it happen? _____
 What activities make your symptoms worse? _____
 Are your symptoms getting worse? Yes No Are your symptoms: Constant They come and go
 Is this condition interfering with your: Work Sleep Daily routine Family or spouse relationship Other _____

What things can't you do now that you hope to be able to do after your treatments are done?

How long has it been since you really felt good? _____

List previous diagnoses and treatments you have received for your present condition: _____

What do you believe is wrong with you? _____

What other health problems do you have: _____

List any surgeries and dates: _____

Drugs you now take: Nerve pills Pain killers Muscle relaxers Heart pills Tranquilizers Antibiotics Birth control pills Others _____

How often do you go to the dentist? Every six months Yearly Toothache or emergency only

How old is your mattress? _____ Is it Comfortable? Uncomfortable?

Do you wear: Heel lifts? Inner soles? Arch supports?

Have you been in an car crash (even a "fender-bender") in the: Past year Past five years Five to ten years ago Over ten years ago Never

Please describe the crash _____

Have you ever had any mental or emotional disorders? Yes No If so, when? _____ Type _____

Have others in your family had such disorders? Yes No If so, when? _____ Type _____

FAMILY HEALTH INFORMATION (Many health problems are hereditary. Thus, information about your family members will give us a better picture of your total health picture.)

NAME	RELATIONSHIP to YOU	PAST AND PRESENT HEALTH PROBLEMS

HAVE YOU EVER: YES NO Please describe briefly

Been knocked unconscious? _____

Used a cane, crutch, or other support? _____

Been treated for a spine or nerve disorder? _____

Had a fractured bone? _____

Been hospitalized for other than surgery? _____

DO YOU: _____

Now take vitamins or minerals? _____

Think you may need vitamins or minerals? _____

Have an allergy to any drug? _____

DATE OF LAST: Less than 6 months 6-18 months Over 18 months Never

Physical examination

Spinal examination

Blood test

Urine test

Spinal x-ray

Chest x-ray

Dental x-ray

HABITS Heavy Moderate Light None

Alcohol

Coffee

Tobacco

Drugs

Appetite

Sleep

Exercise

List below all conditions for which you have been treated in the past 10 years.

WHO SHOULD WE CONTACT IN CASE OF EMERGENCY? (Name of relative or close friend NOT living with you):

Name _____ Relationship _____

Address _____ Phone _____

City _____ State _____ Zip _____



Dr. Albertina Logan
1S450 Summit Avenue, Suite
380 Oakbrook Terrace, IL 60181
Phone: 630.705.1475
Fax: 630.705.1556

I truly care about your Health and Wellness

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s) and physical therapy techniques, on me **Patient's Name:** _____ which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for the doctor of chiropractic named below.

I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Those Complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read () or have had read to me () the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

Printed name of Patient

Signature of Patient

Date

Witness to Patients' Signature

Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

The Body Connection Health and Wellness Center

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of the Body Connection Health and Wellness Center's "NOTICE OF PRIVACY PRACTICES," revision date _____.

As required by the Privacy Regulations, _____ from
Name of Staff Member

The Body Connection has explained the "NOTICE OF PRIVACY PRACTICES" to my satisfaction.

As required by the Privacy Regulations, I am aware that **The Body Connection** has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

Requests:

- I wish to file a "Request for Restriction" of my Protected Health Information.
- I wish to file a "Request for Alternative Communications" of my Protected Health Information.
- I wish to object to the following in the "Notice of Privacy Practices:"

I understand that this office is not required to honor any changes to the "Notice of Privacy Practices."

Signature Date

Print Name

(OFFICE USE ONLY)

Signed form received by: _____ Date: _____

Good faith effort to obtain receipt: (Describe) _____

The Body Connection Health and Wellness Center

NOTICE OF PRIVACY PRACTICES

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.

The Body Connection Health and Wellness Center. is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (example)

“On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with The Body Connection.”

“It is our policy to provide a substitute health care provider, authorized by Albertina D. Logan, D.C. to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider’s absence due to vacation, sickness, or other emergency situation.”

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)

“As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Albertina D. Logan, D.C. for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received.”

Workers’ Compensation

We may disclose your health information as necessary to comply with State Workers’ Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings.

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons.

We may disclose your health information to coroners or medical examiners.

Organ Donation.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing.

We may contact you for marketing purposes or fundraising purposes, as described below: (example)

“As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.”

“It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable

activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of The Body Connection Health and Wellness Center. sponsored fund-raising events.”

Change of Ownership.

In the event that The Body Connection. is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that the Body Connection. is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that the Body Connection. amend your protected health information. Please be advised, however, that the Body Connection. is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by the Body Connection.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

The Body Connection reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, the Body Connection. is required by law to comply with this Notice.

The Body Connection is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Albertina D. Logan, D.C. by calling this office at (630)705-1475. If Albertina D. Logan, D.C. is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy rights, or how the Body Connection has handled your health information should be directed to Albertina D. Logan, D.C. by calling this office at (630)705-1475. If Albertina D. Logan, D.C is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of ____/____/____

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide the Body Connection. with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

Patient's Name (print)

Patient's Signature

Date

Authorized Facility Signature

Date

FINANCIAL RESPONSIBILITY

It is our office policy that payment for services is due at the time those services are rendered, unless prior arrangements have been made.

[] Cash Payment

If you prefer to pay with cash, personal check, or Visa/MasterCard/Discover, payment is expected at the time service is rendered. If you then choose to send a claim to your insurance company, we will gladly assist you with the necessary paperwork to process the claim.

[] Group / Private Health Insurance

Most health insurance policies reimburse to one extent or another for chiropractic office visits. However, your policy's particular provisions must be verified with your insurance company. We will do this for you when you bring in your insurance identification card(s). *Until insurance coverage is verified, you must pay for each visit at the time of that visit.* When we accept assignment of your insurance benefits, you need to pay your deductible (if it has not been met for the year) and the percentage of the charges that your insurance policy does not cover (your co-insurance or co-payment) at the time those respective services are rendered. You are also responsible for any charges not paid by your insurance company.

[] Worker's Compensation

If your injury occurred in the course of your employment, your employer's worker's compensation insurance will pay for 100% of the care you receive, assuming there are no complications or disputes arising from the incident. As required by law, it is imperative that your employer complete an "Employer's First Report of Injury or Illness." *You will need to pay for services as they are rendered until your Worker's Compensation has been verified.*

[] Personal Injury / Automobile Accident

If you have been involved in a personal injury or injured in an automobile accident, you will need to provide: 1) your auto insurance identification card, 2) the auto insurance information of the other person(s), 3) your health insurance card(s) and 4) the name, address and telephone number of the attorney(s) handling your case. *Until all insurance information is obtained and verified you will need to pay for services as they are rendered.*

[] Medicare

Medicare Part B is your primary health insurance. Medicare coverage is explained on a separate sheet of paper that we will provide to you. Currently, the deductible for Medicare is \$100.

