



PATIENT FINANCIAL ACKNOWLEDGEMENT

Please read thoroughly. Initial your acknowledgement, then sign and print your name and date. Thankyou.

ASSIGNMENT OF BENEFITS

I assign all benefits payable to me for my care at Northwestern Health Sciences University. I understand that this health care facility will be paid directly by the insurance company or other payer. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

GUARANTEE OF PAYMENT

I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of this health care facility.

CANCELLATION POLICY

To maintain our excellence in customer service and to acknowledge the student intern's time and patient requirement, we require a 24-hour cancellation notification for our student and professional acupuncture, massage, naturopath, nutrition, and Oriental medicine appointments. Please notify the clinic within 24 hours to avoid a \$20 charge for the missed appointment.

SIGNATURE (PATIENT | GUARDIAN)

PRINT NAME

DATE

Office Use Only

United Health Care	Medica	Preferred One	Landmark/CCMI (Health Partners, Cigna, Patient Choice)	Medicare	Medical Assistance	Select Care	BCBS	Other
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<input type="checkbox"/> CHIROPRACTIC 1. Deductible/co-insurance? _____ 2. Is there a co-pay? \$ _____ 3. Limit on visits or services? _____ <input type="checkbox"/> 992XX (Examination) <input type="checkbox"/> 97110 (Therapeutic exercise) <input type="checkbox"/> 97112 (NMS re-education) <input type="checkbox"/> EXTRA SPINAL MANIPULATION <input type="checkbox"/> LABORATORY <input type="checkbox"/> Orthotics _____ # per year <input type="checkbox"/> Orthotics NOT verified <input type="checkbox"/> Radiology non-spinal <input type="checkbox"/> Radiology-spinal <input type="checkbox"/> STRAPPING <input type="checkbox"/> 97010 (Hot/cold packs) <input type="checkbox"/> 97032 (EMS Attended) <input type="checkbox"/> 97035 (Ultrasound) <input type="checkbox"/> S8948 (Cold laser) <input type="checkbox"/> 97012 (Mechanical Traction)	<input type="checkbox"/> ACUPUNCTURE 1. Deductible/co-insurance? _____ 2. Co-pay? \$ _____ 3. Limit on visits or services? _____ 4. Authorization/Precertification needed? _____ <input type="checkbox"/> ACUPUNCTURE BENEFITS NOT VERIFIED <input type="checkbox"/> ACUPUNCTURE NOT A BENEFIT ON THIS PLAN	<input type="checkbox"/> NURSE PRACTITIONER 1. Deductible/co-insurance? _____ 2. Co-pay? \$ _____
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BASED ON THE INFORMATION PROVIDED BY THE HEALTH INSURANCE PLAN, SERVICES CHECKED ABOVE ARE NOT COVERED.



NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT

The Northwestern Health Sciences University (NWHUSU) Care Delivery System is committed to patient privacy and the confidentiality of personal health information entrusted to us.

The ways in which we may use or disclose your health information are detailed in the Notice of Privacy Practices.

Your Right to Limit Uses or Disclosures: You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, we will provide you with a Limitation of Use and Disclosure of Protected Health Information Request form.

Your Right to Request that Your Patient Record be Amended: You have the right to request that we amend the information in your patient record. If you would like to amend any information in your record we will provide you with a Request to Amend Protected Health Information form.

Your Right to Revoke Your Authorization: You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

YOU HAVE A RIGHT TO REFUSE CONSENT FOR DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION. WITHOUT YOUR CONSENT, HOWEVER, THE NWHUSU-CLINIC SYSTEM WILL NOT BE ABLE TO SUBMIT CLAIMS TO INSURANCE CARRIERS OR OTHER THIRD PARTY PAYERS AND MAY NOT ACCEPT YOU AS A PATIENT/CLIENT.

Initial here [] *I acknowledge receipt of the NWHUSU-Notice of Privacy Practices*

By signing below, I give consent to the NWHUSU-clinicians or staff to use or disclose my personal health information as noted in the Notice of Privacy Practices.

Printed Name

Authorized Provider Representative

Signature

Date

Date



PATIENT INTAKE FORM

Patient's Name: _____ Date of Birth: _____

(LAST, FIRST, MIDDLE INITIAL)

Patient's Guardian Name (if applicable): _____

What is your current gender identity: Male Female Transgender MtoF Transgender FtoM GenderQueer

Gender Fluid Additional gender category (please describe): _____ Choose not to disclose

What sex were you assigned at birth on your original birth certificate: M F Current legal sex: M F

Address: _____

Phone: _____ Email: _____

Primary Healthcare Provider and/or Clinic: _____

Please tell us who you were referred by so we may thank them:

Physician: _____ Other (friend/family/patient): _____

Marital status? (Please check most current status)

- Single
- Married
- Living with Significant Other
- Divorced/Separated
- Widowed

Are you being seen for:

- Motor Vehicle Accident
- Workers Compensation

What is your race?

(Defined by the federal government; please check one)

- Asian or Pacific Islander
- Black/African American
- Hispanic
- American Indian or Alaskan Native
- White
- Other _____

What is the reason for your visit today? _____

Was there a triggering event? _____

How long have you had the problem? _____

What do you want your treatment to accomplish? _____

Please indicate where you have pain or other symptoms below:

NUMBNESS
 =====
 PINS & NEEDLES
 00000
 BURNING
 XXXXX
 STABBING
 /////
 ACHING
 +++++
 Other

Please list any significant traumas or injuries you have had: _____

Patient/Guardian Signature _____ Date _____



PATIENT REVIEW OF SYSTEMS

Please check the “**Current**” box for all conditions that you are now experiencing and mark the “**Past**” box for any condition or symptom(s) experienced previously. Please do not write in the spaces marked “**Clinician’s Notes Only**”.

	Current	Past	Clinician’s Notes Only Please do not write in this space.		Current	Past	Clinician’s Notes Only Please do not write in this space.
GENERAL				LUNGS			
Fever				Difficulty breathing			
Sweats				Asthma			
Chills				Pneumonia			
Fatigue				Wheezing			
Weight loss/gain				Persistent cough			
Sleep disturbance				Coughing up phlegm			
Change in routine				Coughing up blood			
HEAD				Tuberculosis			
Headache				CARDIO VASCULAR			
Dizziness				Chest pain			
Head trauma				Palpitations			
Fainting				Ankle swelling			
Blacking out				Cold/hot feet or hands			
EYES				Discolored foot/hand			
Change in vision				Leg cramps/calf pain			
Glasses/Contacts				Varicose veins			
Blurry/double vision				High/low blood pressure			
Cataracts				G-I SYSTEM			
Sensitive to light				Gas			
Flashes in vision				Heartburn/Indigestion			
Spots in vision				Ulcers			
EARS				Vomiting/Nausea			
ringing in ears				Abdominal pain			
Frequent infection				Diarrhea/constipation			
Hearing loss				Blood in stool			
Drainage				Hemorrhoids			
Ear pain				Gall bladder disease			
NOSE				Liver disease			
Post nasal drip				Colonoscopy			
Nosebleeds				G-U SYSTEM			
Sinus problems				Difficulty urinating			
MOUTH				Pain urinating			
Bleeding gums				Blood in urine			
Cold sores				Incontinence			
Dentures				Foul odor of urine			
Trouble Swallowing				Increase/decreased urination			
Sore throat				Urinary infection			
Jaw pain				Genital infection			
Changes in taste				Kidney stones			
Swelling				Last prostate exam (males) _____			
Hoarseness				Last PSA (males) _____			
Last dental appt _____				Last testicular exam (males) _____			
MEDICAL				MEDICATION			
Substance abuse				Prescription medications			(please bring)
Hospitalization				OTC medication			(please bring)
Psychiatric care				Vitamins			(please bring)
Surgeries _____				Herbs			
Last chest x-ray (for those over age 55) _____				Drug allergies _____			

	Current	Past	Clinician's Notes Only Please do not write in this space.		Current	Past	Clinician's Notes Only Please do not write in this space.
PSYCHOLOGIC				NECK			
Excessive Stress				Masses			
Depression				Swelling			
Anxiety				Stiffness			
Mood swings				SOCIAL			
SKIN				Consume alcohol			
Rash				Consume caffeine			
Bruising				Tobacco use			
Hair loss				Recreational drugs			
Brittle nails				Exercise	Y	N	
Changes in moles				Safe at home	Y	N	
Itching/peeling				Guns at home	Y	N	
NEUROLOGIC				Seat belts used	Y	N	
Seizures/Epilepsy				Text while driving	Y	N	
Strokes				Hobbies _____			
Tingling/numbness				Drink _____ glasses water/day			
Weakness				Sleep _____ hours/night			
Difficulty walking				Occupation _____			
Poor coordination				OB GYN (females)			
MUSCLE/BONE				Pregnancy			
Osteoporosis				Breast cancer			
Joint pain				Lumps in breast			
Stiffness				Nipple discharge			
Muscle ache				PMS			
Arthritis				Irregular periods			
Deformity				Hot flashes			
Bone pain				Menopause			
Dislocations				Menstrual cramps			
Fractures (please list):				Age period began _____			
LABORATORY				Last breast exam _____			
Last fasting blood glucose _____ (date)				Last PAP _____			
Last cholesterol _____ (date)				Last mammogram _____			
VACCINATIONS (if age >60 y/o)				PAST MEDICAL HISTORY			
Flu				Allergies			
Varicella				Hypertension			
Pneumonia				Diabetes			
Tetanus				Cancer/Tumor			
FAMILY HISTORY (immediate family members)				Anemia			
Cancer				Other _____			
Alcoholism							
Depression							
Epilepsy							
Alzheimer's							
Heart Disease							
Other _____							
Patient Name _____ Date _____							
Patient Signature _____							
Clinician's Name _____							

