Northwestern Health Sciences University

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 theoriginal.

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

☐ CHIROPRACTIC

1. Deductible/co-insurance? _____
2. Is there a co-pay? $_____
3. Limit on visits or services? _____

- ☐ **992XX (Examination)**
- ☐ **97110 (Therapeutic exercise)**
- ☐ **97112 (NMS re-education)**

- ☐ **EXTRA SPINAL MANIPULATION**
- ☐ **LABORATORY**
- ☐ **Orthotics_____# per year**
- ☐ **Orthotics NOT verified**
- ☐ **Radiology non-spinal**
- ☐ **Radiology-spinal**
- ☐ **STRAPPING**
- ☐ **97010 (Hot/cold packs)**
- ☐ **97032 (EMS Attended)**
- ☐ **97035 (Ultrasound)**
- ☐ **S8948 (Cold laser)**
- ☐ **97012 (Mechanical Traction)**

☐ ACUPUNCTURE

1. Deductible/co-insurance? _____
2. Co-pay? $_____
3. Limit on visits or services? _____
4. Authorization/Precertification needed?____

- ☐ **ACUPUNCTURE BENEFITS NOT VERIFIED**
- ☐ **ACUPUNCTURE NOT A BENEFIT ON THIS PLAN**

☐ NURSE PRACTITIONER

1. Deductible/co-insurance? _____
2. Co-pay? $_____

BASED ON THE INFORMATION PROVIDED BY THE HEALTH INSURANCE PLAN, SERVICES CHECKED ABOVE ARE NOT COVERED.

Northwestern Health Sciences University

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT

The Northwestern Health Sciences University (NWHSU) 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 NWHSU-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 NWHSU-Notice of Privacy Practices***

By signing below, I give consent to the NWHSU-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	

Northwestern Health Sciences University

PEDIATRIC PATIENT INTAKE FORM

Patient's Name: _____ Date of Birth: _____
(LAST, FIRST, MIDDLE INITIAL)

Patient's Guardian Name: _____

Address: _____

Phone: _____ Email: _____ Gender: M / F

Primary Healthcare Provider and/or Clinic: _____

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

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

Are you being seen for:
☐ Motor Vehicle Accident
☐ Workers Compensation

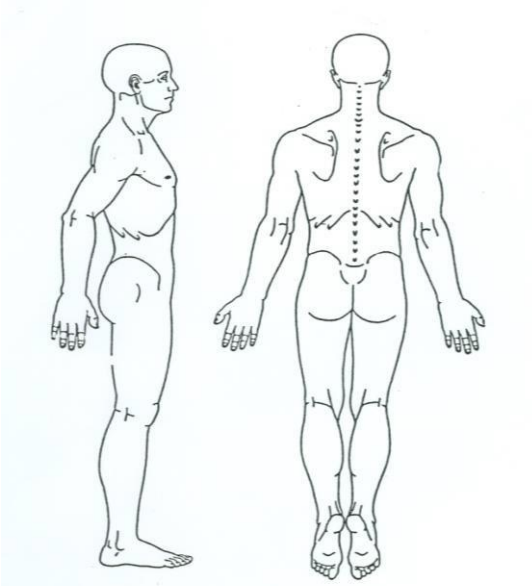
What is your race?
(Defined by the federal government; please check <u>one</u>)
☐ Asian or Pacific Islander
☐ Black/African American
☐ Hispanic
☐ American Indian or Alaskan Native
☐ White
☐ Other _____

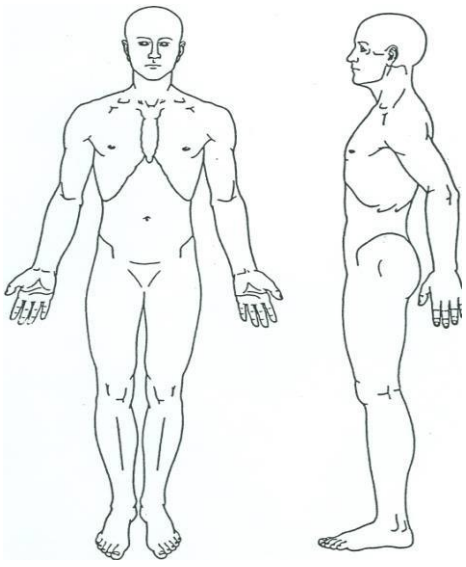
What is the reason for your visit today? _____

Was there a tiggering event? _____

How long has the problem persisted? _____

Please indicate the area of pain or other symptoms below:





NUMBNESS
=====

PINS & NEEDLES
000000

BURNING
XXXXX

STABBING
//////

ACHING
+++++

Other
****

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

_____

PREGNANCY

Please check any areas that applied to the patient's mother during her pregnancy:

_____ Complications
- ⎦ Excessive Weight Loss
- ⎦ Excessive Weight Gain
- ⎦ Bleeding
- ⎦ Premature Contractions
- ⎦ Back Pain
- ⎦ Toxic Exposures
- ⎦ Allergic Reactions
- ⎦ Mental Trauma
- ⎦ Physical Injury

_____ Vitamins/Minerals
_____ Medications
_____ Any diagnosed Illnesses
_____ Hospitalization
_____ Immunization
_____ Prenatal Classes
_____ Chiropractic Care
_____ Prenatal Care
_____ Carried to Full Term

_____ Attitude – Mostly Happy
_____ Attitude – Mostly Depressed
_____ Recreational drugs
_____ Smoking
_____ Alcohol
_____ Caffeine (Cola/Coffee/Tea)

LABOR AND DELIVERY

_____ Home Birth
_____ Hospital
_____ Greater than 12 Hours
_____ Less than 5 hours
_____ Complications
Other_____

_____ Forceps
_____ Vacuum Extraction
_____ Fetal Monitor Used
_____ Caesarian
_____ Premature Delivery

_____ Medications (list below)
1. _____
2. _____
3. _____
4. _____

PERINATAL HISTORY – *If known please indicate*

The duration of the pregnancy was_____weeks.
The apgar score at birth was_____The apgar score at five minutes was _____
The length at birth was_____The birth weight was _____
Please check any problems the patient had at birth

_____Breathing Nursing __Choking Jaundice_____Coloring Sleeping

_____Crying _____Other (please explain) _____

Please check if any item(s) applied to the patient at birth:

_____Medication Surgery Artificial Feeding Erythromyocin Vitamin K

_____Circumcision_____Other (please explain)_____

Please check if the patient has received any of the following items:
_____Breast milk Commercial Formula Cow's milk Goat' milk Solid food
_____Sweets Fruit juice Vegetable juice Vitamins Medications
_____Other _____

IMMUNIZATION

Please list immunizations, date received and any reactions:_____

_____

Note foreign travel:_____

Patient/Guardian Signature_____**Date**_____

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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/l ow 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.
PSYCHOLOGIC			
Excessive Stress			
Depression			
Anxiety			
Mood swings			
SKIN			
Rash			
Bruising			
Hair loss			
Brittle nails			
Changes in moles			
Itching/peeling			
NEUROLOGIC			
Seizures/Epilepsy			
Strokes			
Tingling/numbness			
Weakness			
Difficulty walking			
Poor coordination			
MUSCLE/BONE			
Osteoporosis			
Joint pain			
Stiffness			
Muscle ache			
Arthritis			
Deformity			
Bone pain			
Dislocations			
Fractures (please list):			
LABORATORY			
Last fasting blood glucose_____(date)			
Last cholesterol_____(date)			
VACCINATIONS (if age >60 y/o)			
Flu			
Varicella			
Pneumonia			
Tetanus			
FAMILY HISTORY (immediate family members)			
Cancer			
Alcoholism			
Depression			
Epilepsy			
Alzheimer's			
Heart Disease			
Other _____			

	Current	Past	Clinician's Notes Only Please do not write in this space.
NECK			
Masses			
Swelling			
Stiffness			
SOCIAL			
Consume alcohol			
Consume caffeine			
Tobacco use			
Recreational drugs			
Exercise	Y	N	
Safe at home	Y	N	
Guns at home	Y	N	
Seat belts used	Y	N	
Text while driving	Y	N	
Hobbies _____			
Drink_____glasses water/day			
Sleep_____hours/night			
Occupation_____			
OB GYN (females)			
Pregnancy			
Breast cancer			
Lumps in breast			
Nipple discharge			
PMS			
Irregular periods			
Hot flashes			
Menopause			
Menstrual cramps			
Age period began _____			
Last breast exam _____			
Last PAP _____			
Last mammogram _____			
PAST MEDICAL HISTORY			
Allergies			
Hypertension			
Diabetes			
Cancer/Tumor			
Anemia			
Other _____			

Patient Name_____**Date**_____

Patient Signature _____

Clinician's Name _____

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Patient Medications & Supplements List

Patient Name _____

Patient ID _____

Allergies (include medication, food and environmental) _____

_____

_____

Medication Name (include prescribed drugs, OTC drugs, herbs & supplements)	**Prescribed By**	**Dosage & Frequency**	**Reason for Taking**