1210 WASHINGTON ST, HIGHLAND, IL 62249

Required portions are highlighted

Phone: 618-654-4520 **Email**: Alvaradohealthcare@gmail.com **Website**: Alvaradohealth.com

General Information

Patient Name:		Nickname:	
Sex M / F	**Date of Birth:**	Social Security #:	
Mailing Address:	**City:**	**State:**	**Zip code:**
Email Address:			
Primary Phone #:	**Secondary Phone #:**	**Your Primary Doctor's Name**	
Employer:	Occupation:		
Have you ever been to a Chiropractor ? Y / N			
Number of Children:	Marital Status: S / M / D / W		

In Case of Emergency

Contact name:		
Relationship:	Address:	
Home Phone:	Cell Phone:	Work Phone:

How did you hear about our office?

If the Insurance Card is present, this part can be skipped

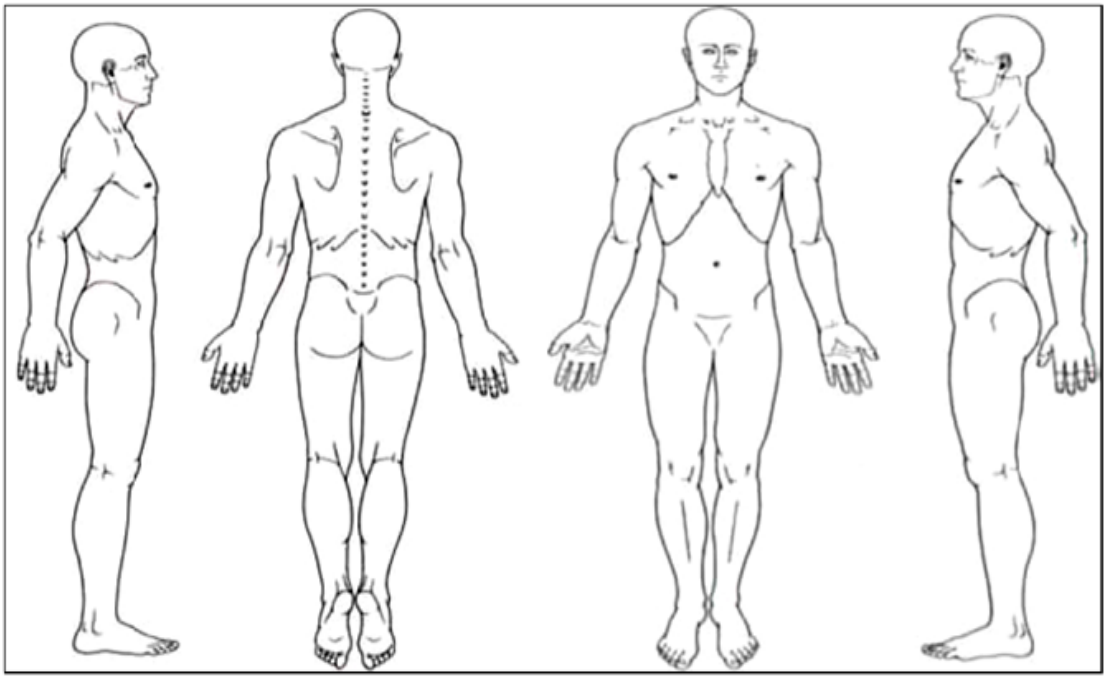
Primary Insurance Information

Primary Insurance Company Name:			
ID#:	Group #:	Subscriber Name:	Subscriber SSN:

Secondary Insurance Company Name:			
ID#:	Group #:	Subscriber Name:	Subscriber SSN:

Today's Visit

Reason for Today's Visit:			
How long have you had this problem:	**YEARS**	**MONTHS**	**WEEKS**
What makes it better:	**What makes it worse:**	**Rate the Pain : _____** **0 = Nothing, 10 = Worst Imaginable**	
I have filled this page out in its entirety to the best of my knowledge. Initial:_____			



A = Ache

B = Burning

N = Numbness

P = Pins & Needles

S = Stabbing

O = Other

On the diagram Above, please indicate where you are experiencing pain right now. Please use the key to the right on the diagram to further explain what type of sensations you are experiencing in each area.

Are you a: (Please circle one) Current Smoker Former Smoker Never Smoked Pipe Smoker Cigar Smoker If yes, how much did you smoke? 3 cigarettes or less per day ½ A pack per day more than a pack per day Vape Smokers + -
Do you drink alcohol? (Please circle one) YES NO If yes, How frequently? Socially Only Several times per week Everyday
Do you or have you ever used illicit drugs? (Please circle one) YES NO If yes, what kind? IV DRUGS PILLS MARIJUANA OTHER
Are you Currently participating in sports? (Please circle one) YES NO If yes, what sport? GOLF TENNIS FOOTBALL SOCCER BASEBALL BASKETBALL OTHER

Please circle any of the following symptoms that you've experienced recently:			
Constitutional:	Fever	Night sweats	Weight Loss
Eyes:	Red Eyes	Blurred Vision	Vision Loss
Ears / Nose / Mouth:	Nose Bleeds	Sore Throat	Hearing Loss
Cardiovascular:	Chest Pains	Palpitations	Leg Swelling
respiratory:	Shortness of Breath	Chronic Cough	Wheezing
gastrointestinal:	Nausea	Vomiting	Diarrhea
genitourinary:	Burning w/ Urination	Blood in Urine	Urinary Inconsistency
skin:	Rash	Hives	Skin Infection
neurological:	Headache	Tremor	Seizures
psychiatric:	Depression	Panic Attacks	Suicidal Ideation
endocrine:	excessive Thirst	Cold Intolerance	Excessive Sweating
hematological:	Easy Bruising	Swollen Glands	Easy Bleeding
allergy / immune:	Runny Nose	Sinus Congestion	Itchy Eyes

I have filled this page out in its entirety to the best of my knowledge. Initial: _____

Past Medical History (Please circle)

High Blood Pressure	Coronary Artery Disease	Vascular Disease	Emphysema
Diabetes	Congestive Heart Failure	Heart Disease / Attack	Thyroid Disease
Lyme's Disease	Bleeding Disorder	Seizures	Gastric Reflux
Multiple Sclerosis	Enlarged Prostate	Hepatitis	Liver Disease
Osteoarthritis	Rheumatoid Arthritis	Stomach Ulcers	Kidney Disease
Asthma	COPD	Cancer	Scoliosis
Depression	Crohn's disease	IBS	OTHER:

Family History (Please circle)

Bleeding Disorder	Coronary Artery Disease	Hepatitis	Cancer
heart Disease / Attacks	Seizures	Lung Disease	Rheumatoid Arthritis
Kidney Disease	Malignant Hyperthermia	Scoliosis	Asthma
Other:			

Surgery History

(If you have a list of your past surgeries, please give to the front desk & we will make a copy)

SURGERY	DATE	SURGERY	DATE
Knee Arthroscopy (right / Left)		Shoulder Arthroscopy (right / Left)	
Spine Surgery		Joint Replacement Surgery	
Hernia Repair		Laparotomy	
Eye Surgery		Thyroid Surgery	
Peripheral Bypass Surgery		Cardiac Catheterization	
Coronary Artery Bypass Surgery		Hysterectomy	
Pacemaker		defibrillator	

Please list any other surgery you may have had in the past not previously mentioned:

_____

_____

_____

Please list any Medications you are on, or have taken in the past 6 months **(If you have a list, front desk can make a copy)**

_____

_____

_____

Please list anything you may have an allergic reaction from:

_____

_____

I have filled this page out in its entirety to the best of my knowledge. Initial: _____

Circle any services you're interested in!

Dry Needling/Acupuncture **Laser Therapy** **Physical Therapy**

Supplements **Diagnostic Ultrasound** **Balance/Coordination Therapy**

Patients are REQUIRED to complete all the following paperwork below (Total of 8 signatures, 1 OPTIONAL). If you have any questions please ask a team member!

FINANCIAL POLICY AGREEMENT

Thank you for choosing Alvarado Healthcare as your healthcare provider. We are committed to providing excellent care to all of our patients and we will always do our best to achieve this goal!

Most insurance plans allow patients to select their own treating physician even if the physician they prefer is not in their insurance plan's network. To help you understand your responsibilities, we will inquire as to your plan's benefits, and explain what, if any, financial obligations you will have for our services.

Our independence is a hallmark trait of our practice. As a treating provider, the course of **treatment we provide will NOT be limited to what an insurance plan representative will approve,** but will instead be based solely upon the state-of-the-art care that your Physician recommends.

All charges will be submitted to your insurance carrier. You will be responsible for your deductible, co-pay, or coinsurance on allowed payments up to your out-of-pocket maximum according to your insurance policy. In a few cases, however, a particular plan may not provide reasonable and customary payment, in which case you will be responsible for some of the difference between what is billed and what your insurance plan allows for payment.

Initial: _____

BY SIGNING BELOW, YOU ATTEST THAT YOU COMPLETELY UNDERSTAND AND AGREE WITH OUR FINANCIAL POLICY AS DESCRIBED ABOVE FOR THE SERVICES PROVIDED BY ALVARADO HEALTHCARE AND ITS PROFESSIONALS. I ACKNOWLEDGE THAT I HAVE BEEN TOLD IN ADVANCE THAT THE SERVICES AND ITEMS LISTED ABOVE ARE NON-PAYABLE BY MEDICARE/INSURANCE AND I AGREE TO PAY FOR THESE SERVICES AND ITEMS AT THE TIME THE SERVICE OR WHEN ITEM IS PROVIDED. I HAVE HAD AMPLE OPPORTUNITY TO ASK QUESTIONS ABOUT MY FINANCIAL OBLIGATION AND OTHER TREATMENT OPTIONS. I ACKNOWLEDGE THAT I AM SIGNING THIS NOTICE VOLUNTARILY AND THAT IT IS NOT BEING SIGNED AFTER THE PRODUCTS OR SERVICES HAVE BEEN PROVIDED. I UNDERSTAND I HAVE THE RIGHT TO REFUSE CARE AND THAT BY SIGNING THIS FORM I AM FULLY RESPONSIBLE FOR ALL NON-COVERED SERVICES AND PRODUCTS.

Patient Signature: _____ Date: _____

Parent / Guardian Signature: _____ Date: _____

Assignment of Benefits

I irrevocably assign Alvarado Healthcare all my rights and benefits under any insurance contracts for payment for services rendered to me by Alvarado Healthcare. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by Alvarado Healthcare to be released to Alvarado Healthcare. I irrevocably authorize Alvarado healthcare to file insurance claims on behalf of services rendered to me. I irrevocably direct all such payments to go directly to Alvarado Healthcare. I irrevocably authorize Alvarado Healthcare to act on my behalf and report any suspected violation of proper claims practices to the proper regulatory authorities. This assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect.

X_____

Patient Signature

Payment Consent Form

We request all Patients to provide our office with either their **Debit, Credit, or HSA card to be kept on file** unless they are paying with cash or check each visit. This information is stored Safely in our encrypted payment processing system. If a patient wishes to receive a receipt for each visit, speak with the Front Desk Staff and they print or email receipts for you.

Keeping a card on file is for our **patient's convenience**, this will allow a more **sufficient checkout** for you, **reduce** the person-to-person contact, and **prevent a service fee** charged if using a credit/debit card each time. This Account information will be used for any patients that have a Copay, Coinsurance, or Self-Pay charge for each visit. If payment has failed, Alvarado Healthcare at its discretion will attempt to process the charge again within 30 days. I agree to not dispute recurring billing with my bank so long as the transactions correspond to the terms in my financial responsibility form (Discussed on my second visit). **Alvarado Healthcare pays for any credit card fees**. If at any time a refund is to be issued, an added on service fee may be subtracted from the refunded amount.

_____ _____

Printed Name (Patient) PATIENT SIGNATURE or LEGAL REPRESENTATIVE

Alvarado Healthcare Cancellation Policy (Scholarship Fund)

The **Alvarado Healthcare Scholarship** is offered to a Highland Senior planning to pursue a career in Healthcare. The recipient of the award is selected based on their demonstration of excellence in the classroom, self-motivation, and vision of attaining something extraordinary. While we are very eager to get you better and back to normal, the best way to get you better is by **following your recommended treatment plan.** If you ever need to c**ancel an appointment**, we request a **call a day prior**. This allows **us to find a different day or time for you** before the schedule fills up and also gives us the **opportunity to help someone** else during that time. If we receive a **same-day cancellation** or do not receive notice of your canceled appointment, we will **request a $10 donation** towards our scholarship fund. The card on file will **automatically be charged** the day of the cancellation, unless stated otherwise by a team member!

_____ _____

Printed Name (Patient) PATIENT SIGNATURE or LEGAL REPRESENTATIVE

INFORMED CONSENT TO CARE

You are the decision maker for your health care. Part of our 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:_____

Notice of Non-Payable Services
(Services not covered by your insurance)

Some insurance companies do not cover all services or therapies rendered in our office. Medicare plans only cover spinal adjustments (Treatment from Neck to Lower back), any other services rendered outside of medicare guidelines are left to patient responsibility. Insurance companies we are Out-Of-Network with (Cigna, Tricare, Aetna Better Health, Medicaid, Meridian, BCBS with the member Id that starts with QM). The services listed below are services you could end up paying out of pocket for.

Services usually not covered through insurance:

Laser Therapy:
$50 Single Session or $276 for 6 Treatments
Dry Needling:
$50-$75
Diagnostic Ultrasound
$130-$180

Non-Covered Medicare/Essence

New Patient Evaluation
$85
Laser Therapy:
$50
Dry Needling:
$50-$75
Electric Stimulation
$10
Re-Exams:
$64
Soft Tissue & Muscle work:
$35
Extremity Adjustments:
$35

Patient Acknowledgement:

I acknowledge that I have been told in advance that the services and items listed above are non-payable by Medicare/Insurance and I agree to pay for these services and items at the time the service or when the item is provided. I have had ample opportunity to ask questions about my financial obligation and other treatment options. I also acknowledge that at any time I can ask Alvarado Healthcare for my cost estimates before services are rendered, I acknowledge that I am signing this notice voluntarily and that it is not being signed after the products or services have been provided. I understand I have the right to refuse care and that by signing this form I am fully responsible for all non-covered services and products.

_____ _____

PRINTED NAME (PATIENT) PATIENT SIGNATURE OR LEGAL REPRESENTATIVE

_____ _____

IF LEGAL REPRESENTATIVE, STATE RELATIONSHIP DATE

Notice of Privacy Practice

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record:

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable fee.

Request confidential communications:

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share:

You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for service or health care items out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information:

You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why. We will include all disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice:

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically, we will provide you with a paper copy promptly.

Choose someone to act for you:

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated:

You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gove/ocr/privacy/hippa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

Share information with your family, close friends, or others involved in your care. Share information in a disaster relief situation. Include your information in a hospital directory. Contact you for fundraising efforts. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

Marketing purposes. Sale of your information. Most sharing of psychotherapy notes.

In the case of fundraising:

We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways:

Treat you:

We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization:

We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

Bill for your services:

We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues:

We can share health information about you for certain situations such as preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, preventing or reducing a serious threat to anyone's health or safety.

Do research:

We can use or share your information for health research.

Comply with the law:

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests:

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director:

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests:

We can use or share health information about you for worker's compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, for special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions:

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of This Notice:

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request.

Contact Person:

All questions concerning this notice, or requests made pursuant to it, should be addressed to:
Alvarado Healthcare (compliance officer), EMAIL- alvaradohealthcare@gmail.com

Patient Acknowledgment:

I acknowledge that I have reviewed this office's Notice of Privacy Practices, acknowledge that I may refuse to sign this acknowledgment if I wish, and agree to the liability limitations explained therein. I have the right to obtain a paper copy of this notice.

_____ _____

Printed Name (Patient) PATIENT SIGNATURE or LEGAL REPRESENTATIVE

For Treatment of a Minor

I hereby request and authorize the medical providers of Alvarado Healthcare and whomever he/she may designate as his/her assistant or authorized representative, to administer chiropractic and related care as he/she deems necessary to my dependent minor child. This authorization also extends to include diagnostic imaging, laboratory and other testing at the doctor's discretion. This consent is effective as of the date executed below and will continue in effect until revoked by the guardian or when the minor becomes of legal age. Also gives this office the right to treat the minor for Chiropractic care and related care as he/she deems necessary if a guardian is not present.

MINOR/CHILD'S NAME: _____

YOUR RELATIONSHIP TO MINOR/CHILD: _____

As of today's date, I have the legal right to select and authorize health care service for the minor child named above. If applicable, under the terms and conditions of a divorce/separation or other legal authorization, the consent of a spouse, former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

I certify by my signature that I understand the nature of this consent and voluntarily agree to its provisions**.** I understand I can withdraw my permission in writing at any time.

PRINTED NAME OF PARENT/GUARDIAN: _____

ADDRESS: _____

PHONE: _____

SIGNATURE PARENT/GUARDIAN: _____

TODAY'S DATE: _____

WITNESS: _____

Social Media Consent (Optional Signature)

I, hereby grant and authorize ***Alvarado Healthcare*** the right to take, alter, copy, exhibit, publish, distribute the **pictures, video or my name** to be used in and/or for any lawful promotional materials including, but not limited to, newsletters, flyers, posters, brochures, advertisements, fundraising letters, annual reports, press kits and submissions to journalists, websites, social networking sites and other print and digital communications, without compensation or payment. This authorization shall continue indefinitely, unless I otherwise revoke this authorization in writing. This authorization extends to all languages, media, formats and markets now known or later discovered.

(Initial Below)

- **I,** Agree to the following photos/videos to be taken and used for ***Alvarado Healthcare*** usage (Initial Ones that Apply)

  _____ Procedures being performed such as: Dry Needling, Laser, Vibration Plate ,Exercises, Adjustments

  _____ Participation in Fundraisers/ Charity events or any other Events in office

_____ I waive the right to inspect or approve any finished product in which my likeness appears, including written or electronic copy.

_____ I waive any right to royalties or other compensation arising or related to the use of the photograph

_____ I understand and agree that these materials shall become the property of *Alvarado Healthcare* and will not be returned.

I hereby hold harmless and release **Alvarado Healthcare** from all liability, petitions, and causes of action which I, my heirs, representative, executors, administrators, or any other persons may make while acting on my behalf or on behalf of my estate.

Printed Name: _____ **Signature:** _____

Date: _____

You Finished!