



Schulte Family Chiropractic

440 S 3rd St, Ste 204, St. Charles, IL 60174

Patient Name: _____	Chief Complaint: _____
Address: _____ _____	Home Phone: _____
Email: _____	Cell: _____ Work: _____
Date of Birth: _____ Age _____	SSN# _____ - _____ - _____
Marital Status: M S W D Spouse Name _____	Gender _____ # Children _____
Occupation: _____	Employer: _____
Referred by: _____	

Family Physician: _____ (Note: We may send your health information to this provider)

Person to contact in case of emergency (Name and Phone): _____

Surgeries past 5 years? _____ When? _____
_____ When? _____

Serious Illness: _____ When? _____

Accidents/Injuries: _____ When? _____
_____ When? _____
_____ When? _____

History of Cancer(s): _____ When? _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to Schulte Family Chiropractic all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature of Insured / Guardian

Date



Schulte Family Chiropractic

Welcome to our office! It is our goal to provide you with the best possible chiropractic health care. We strive to operate on a prompt and timely schedule. We make every effort to accommodate your need for care on a same day basis. Please feel free to ask us any questions you may have.

Terms of Acceptance

Informed Consent:

A patient, in coming to the chiropractic physician, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he is aware that such care may be contra-indicated. Also, it is the responsibility of the patient to make it known, or to learn through healthcare procedures whatever he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic physician provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient of Schulte Family Chiropractic, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Missed Appointments:

There is a possible \$25 fee charged for all appointments that are not canceled prior to scheduled visit. We want to respect your time, and we appreciate your respect of our time. We understand that emergencies may arise, so please let us know if you are unable to make an appointment as soon as possible.

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

In the event that we would need to communicate your healthcare information to your friends and family, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

May we mail postcards or leave messages on any answering device, i.e. home answering machines or voicemails? Yes No

May we send text messages to your cellular phone for special circumstances or appointment notification? Yes No

Acknowledgement:

I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

I, _____, have read and fully understand the above statements.

Signature: _____ Date: _____ Witness: _____