



**General Health History**

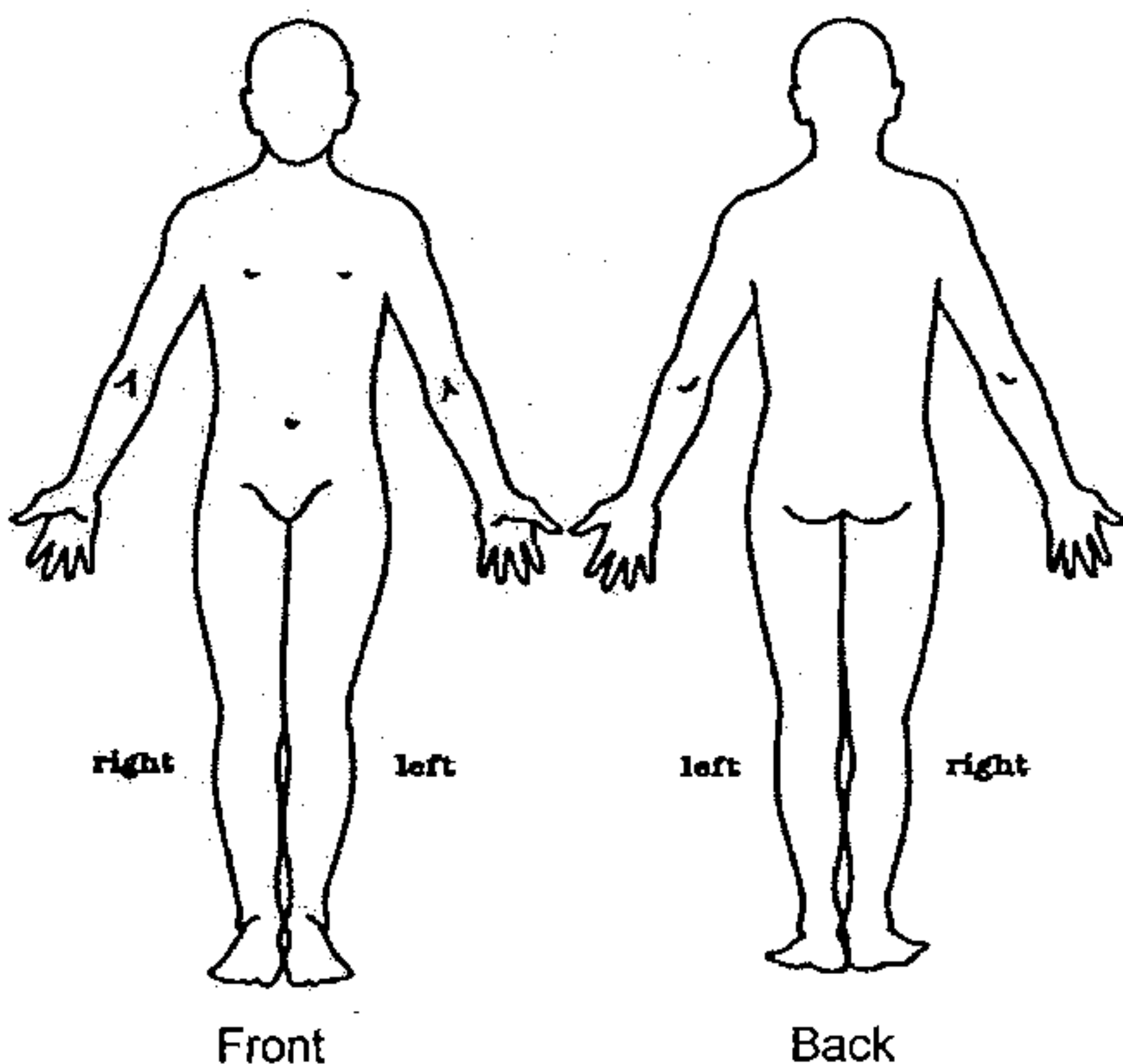
Check symptoms you have or have had in the past.

GENERAL NEUROLOGIC	CARDIOVASCULAR	EYE, EAR, NOSE, THROAT	WOMEN ONLY
Abrupt Onset Weakness <input type="checkbox"/>	Chest Discomfort/ Pain <input type="checkbox"/>	Intermittent Loss of Vision <input type="checkbox"/>	Breast Lump <input type="checkbox"/>
Dizziness/ Fainting <input type="checkbox"/>	Irregular Heart Beat <input type="checkbox"/>	Double Vision <input type="checkbox"/>	Abnormal Pap Smear <input type="checkbox"/>
Hallucinations <input type="checkbox"/>	Shortness of Breath <input type="checkbox"/>	Blurry Vision <input type="checkbox"/>	Nipple Discharge <input type="checkbox"/>
Gait Abnormalities <input type="checkbox"/>	Rapid Heart Beat <input type="checkbox"/>	Persistent Cough <input type="checkbox"/>	Bleeding Between Periods <input type="checkbox"/>
Numbness / Tingling <input type="checkbox"/>	Exertional Leg Pain <input type="checkbox"/>	Difficulty Swallowing <input type="checkbox"/>	Vaginal Discharge <input type="checkbox"/>
Muscle Twitching <input type="checkbox"/>	Swelling of Ankles <input type="checkbox"/>	Loss of Hearing <input type="checkbox"/>	Extreme Menstrual Pain <input type="checkbox"/>
Short Term Memory <input type="checkbox"/>	High Blood Pressure <input type="checkbox"/>	Vision Flashes or Halos <input type="checkbox"/>	Hot Flashes <input type="checkbox"/>
Long Term Memory <input type="checkbox"/>	Low Blood Pressure <input type="checkbox"/>	Ringing in the Ears <input type="checkbox"/>	Painful Intercourse <input type="checkbox"/>
Headaches <input type="checkbox"/>	Varicose Veins <input type="checkbox"/>	Hoarseness <input type="checkbox"/>	Date of last menstrual period: _____
Sweats <input type="checkbox"/>			
Tiredness <input type="checkbox"/>	GENITO-URINARY	MEN ONLY	Date of last pap? _____
Difficulty Sleeping <input type="checkbox"/>	Lack of Bladder Control <input type="checkbox"/>	Lump in Testicle <input type="checkbox"/>	Have you had a mammogram? Yes No
Nervousness <input type="checkbox"/>	Difficulty Voiding Bladder <input type="checkbox"/>	Impotence <input type="checkbox"/>	Are you pregnant? Yes No
Difficulty w/Word Retrieval <input type="checkbox"/>	Blood in Urine <input type="checkbox"/>	Last PSA Blood Test Date _____	Number of Children _____
Weight Gain <input type="checkbox"/>	Painful Urination <input type="checkbox"/>	Reduce Urinary Output <input type="checkbox"/>	

**Symptom Chart**

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols shown below.

<u>Numbness</u>	<u>Pins + Needles</u>	<u>Pain</u>	<u>Weakness</u>
NNNNNNN	OOOOOOO	PPPPPPP	WWWWW
NNNNNNN	OOOOOOO	PPPPPPP	WWWWW



**Chief Complaint Information**

Primary Reason for Visit:

\_\_\_\_\_

\_\_\_\_\_

When did your symptoms begin?

Was it \_\_\_ sudden or \_\_\_ gradual?

**Current Medication (with Dosage)**

**Condition**

_____	_____
_____	_____
_____	_____

**Vitamins**

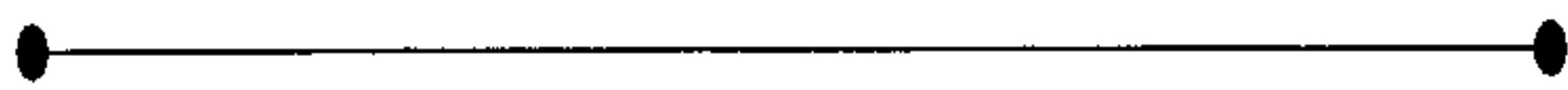
**Surgery**

**Date**

_____	_____
_____	_____

**Visual Analog Scale**

Please place an (X) along the line below which represents your current level of pain involving your major area of complaint.



NO PAIN

WORST PAIN

**Family History**

Please place an X for all that apply

Family Member	Age	Alive	Deceased	Cancer	Heart disease	Diabetes	Stroke	Neurologic Disease	Back or neck problems (spine surgery)
Father	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sibling (M/F)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sibling (M/F)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sibling (M/F)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Conditions**

Check conditions you have, or have had in the past or condition for which you have been treated

Alcoholism <input type="checkbox"/>	Chicken pox <input type="checkbox"/>	Head Injury/ Concussion <input type="checkbox"/>	Prostate Problem <input type="checkbox"/>
Anemia <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Herniated Disc <input type="checkbox"/>	Psychiatric Care <input type="checkbox"/>
Appendicitis <input checked="" type="checkbox"/>	Emphysema <input type="checkbox"/>	High Cholesterol <input type="checkbox"/>	Rheumatoid Arthritis <input type="checkbox"/>
Arthritis <input type="checkbox"/>	Epilepsy <input type="checkbox"/>	HIV Positive <input type="checkbox"/>	Rheumatic Fever <input type="checkbox"/>
ALS <input type="checkbox"/>	Facial Weakness <input type="checkbox"/>	Kidney Disease <input type="checkbox"/>	Scarlet Fever <input type="checkbox"/>
Atrial Fibrillation <input type="checkbox"/>	Fractures <input type="checkbox"/>	Liver Disease <input type="checkbox"/>	Spinal Stenosis <input type="checkbox"/>
Asthma <input type="checkbox"/>	Glaucoma <input type="checkbox"/>	Measles <input type="checkbox"/>	Stroke <input type="checkbox"/>
Bells palsy <input type="checkbox"/>	Emphysema <input type="checkbox"/>	Migraine Headaches <input type="checkbox"/>	Suicide Attempt <input type="checkbox"/>
Bleeding Disorders <input type="checkbox"/>	Goiter <input type="checkbox"/>	Mononucleosis <input type="checkbox"/>	Thyroid Problems <input type="checkbox"/>
Breast lump <input type="checkbox"/>	Gout <input type="checkbox"/>	Multiple Sclerosis <input type="checkbox"/>	TMJ Disorders <input type="checkbox"/>
Bronchitis <input type="checkbox"/>	Heart Disease <input type="checkbox"/>	Mumps <input type="checkbox"/>	Tuberculosis <input type="checkbox"/>
Cancer <input type="checkbox"/>	Heart Murmur <input type="checkbox"/>	Osteoporosis <input type="checkbox"/>	Tumor <input type="checkbox"/>
Carpal Tunnel Syndrome <input type="checkbox"/>	Heart Arrhythmia <input type="checkbox"/>	Pacemaker <input type="checkbox"/>	Ulcers <input type="checkbox"/>
Cataracts <input type="checkbox"/>	Heart Problems <input type="checkbox"/>	Polyneuropathy <input type="checkbox"/>	Venereal Disease <input type="checkbox"/>

**Test History:**

	Last Test Date	Normal	Abnormal
EKG	_____	_____	_____
Blood Test	_____	_____	_____
Heart Ultrasound	_____	_____	_____
Carotid Ultrasound	_____	_____	_____
Nerve Study	_____	_____	_____

**Allergies:**

Substance

Reaction

\_\_\_\_\_

**Health / Habits:**

Do you smoke?      Yes                      No                      \_\_\_ # Pks./da y      <10yrs or > 10 yrs

Did you quit smoking?      \_\_\_ years ago      Smoked for \_\_\_ years      \_\_\_ #Pks / day

Alcohol Use?      None      < 5      >10      PER / Day      PER Week      PER Month      PER Year

Exercise?      None      Mild      Occasional      (vigorous)      <4X/per week      Frequent (vigorous)      4 X per week

**Prior Symptom History**

<p><b>Prior Similar Symptoms</b></p> <p><input type="checkbox"/> I have NOT had prior symptoms similar to my current complaints.</p> <p><input type="checkbox"/> My current complaints DID exist before, but have not been bothering me.</p> <p><input type="checkbox"/> My current complaints ALREADY existed and were worsened.</p>	<p><b>Has your History Contributed to your Current Symptoms?</b></p> <p><input type="checkbox"/> My history HAS contributed to my current symptoms.</p> <p><input type="checkbox"/> My history HAS NOT contributed to my current symptoms.</p> <p><input type="checkbox"/> I'm NOT SURE if my history has contributed to my current symptoms.</p>
<p>My most recent prior similar symptoms (if applicable) occurred..... ___ months ago / ___ years ago Or on Date: ___ / ___ / ___</p>	

**Description of Symptoms** (Describe your symptoms in the sections below, in the order of severity, if possible.)

**I. First Current Symptom:** (Please check off the boxes below to describe your first symptom. Describe only ONE symptom per Section)

**1. Check only one body location below**

Headaches L  R  B

Front of Head  
 Top of Head  
 Back of Head

Jaw L  R  B

Eye L  R  B

Neck L  R  B

Upper Back L  R  B

Mid Back L  R  B

Low Back L  R  B

Chest L  R  B

Abdomen L  R  B

Ribs L  R  B

Buttocks L  R  B

Shoulder L  R  B

Upper Arm L  R  B

Forearm L  R  B

Hand L  R  B

Hip L  R  B

Leg L  R  B

Foot L  R  B

Other locations: \_\_\_\_\_

**2. Types of pain** Other types of pain: \_\_\_\_\_

Dull  Sharp  Aching  Cutting  
 Throbbing  Burning  Numbing  Tingling  Cramping  
 Spasm  Stinging  Shooting  Pounding  Constricting

**3. Pain Frequency**

Up to 1/4 of awake time  1/4 to 1/2 of time  
 1/2 to 3/4 of awake time  Most all the time

**4. Pain Intensity (How it affects your daily activities)**

Doesn't affect  Somewhat affects  
 Seriously affects  Prevents activities

**5. Does this pain radiate into other body parts?**

	Left	Right	Both
<input type="checkbox"/> Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other locations of radiation: \_\_\_\_\_

**6. Actions affecting this pain**

	Brings On	Aggravates	Relieves
<input type="checkbox"/> In the A.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> In the P.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Twisting left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Twisting right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Straining	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Actions:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**II. Second Current Symptom:**

(Please check off the boxes below to describe your next symptom).

**1. Check only one body location below**

Headaches L  R  B

Front of Head  
 Top of Head  
 Back of Head

Jaw L  R  B

Eye L  R  B

Neck L  R  B

Upper Back L  R  B

Mid Back L  R  B

Low Back L  R  B

Chest L  R  B

Abdomen L  R  B

Ribs L  R  B

Buttocks L  R  B

Shoulder L  R  B

Upper Arm L  R  B

Forearm L  R  B

Hand L  R  B

Hip L  R  B

Leg L  R  B

Foot L  R  B

Other locations: \_\_\_\_\_

**2. Types of pain** Other types of pain: \_\_\_\_\_

Dull  Sharp  Aching  Cutting  
 Throbbing  Burning  Numbing  Tingling  Cramping  
 Spasm  Stinging  Shooting  Pounding  Constricting

**3. Pain Frequency**

Up to 1/4 of awake time  1/4 to 1/2 of time  
 1/2 to 3/4 of awake time  Most all the time

**4. Pain Intensity (How it affects your daily activities)**

Doesn't affect  Somewhat affects  
 Seriously affects  Prevents activities

**5. Does this pain radiate into other body parts?**

	Left	Right	Both
<input type="checkbox"/> Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other locations of radiation: \_\_\_\_\_

**6. Actions affecting this pain**

	Brings On	Aggravates	Relieves
<input type="checkbox"/> In the A.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> In the P.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Twisting left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Twisting right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Straining	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Actions:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**III. Third Current Symptom:**

(Please check off the boxes below to describe your 3rd symptom).

**1. Check only one body location below**

Headaches L  R  B

Front of Head  
 Top of Head  
 Back of Head

Jaw L  R  B

Eye L  R  B

Neck L  R  B

Upper Back L  R  B

Mid Back L  R  B

Low Back L  R  B

Chest L  R  B

Abdomen L  R  B

Ribs L  R  B

Buttocks L  R  B

Shoulder L  R  B

Upper Arm L  R  B

Forearm L  R  B

Hand L  R  B

Hip L  R  B

Leg L  R  B

Foot L  R  B

Other locations: \_\_\_\_\_

**2. Types of pain** Other types of pain: \_\_\_\_\_

Dull  Sharp  Aching  Cutting  
 Throbbing  Burning  Numbing  Tingling  Cramping  
 Spasm  Stinging  Shooting  Pounding  Constricting

**3. Pain Frequency**

Up to 1/4 of awake time  1/4 to 1/2 of time  
 1/2 to 3/4 of awake time  Most all the time

**4. Pain Intensity (How it affects your daily activities)**

Doesn't affect  Somewhat affects  
 Seriously affects  Prevents activities

**5. Does this pain radiate into other body parts?**

	Left	Right	Both
<input type="checkbox"/> Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other locations of radiation: \_\_\_\_\_

**6. Actions affecting this pain**

	Brings On	Aggravates	Relieves
<input type="checkbox"/> In the A.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> In the P.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Twisting left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Twisting right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Straining	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Actions:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

# Rominski Active Healthcare

2410 Aft Lane, Ste 100  
Elgin, IL 60124

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

For use and/or disclosure of Protected Health Information (PHI)  
To carry out Treatment, Payment and Healthcare Operations

\_\_\_\_\_, hereby states that by signing this Consent,  
(Patient Name)

I acknowledge and agree as follows:

The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my Protected Health Information (PHI) necessary for the Practice to provide treatment to me and also, necessary for the Practice to obtain payment for that treatment and to carry out health care operations. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

The practice reserves the right to change its privacy practices that are described in its Privacy Notice in accordance with the applicable law.

The Practice's Privacy Notice is provided at the time of the patient's first visit and is always available with the staff at the reception desk. I may also request a copy from this office at any time via US Mail.

This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my Protected Health (PHI).

I have read and understand the forgoing notice and all of my questions have been answered to my complete satisfaction in a way that I can understand.

Name of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

# Rominski Active Healthcare

Thank you for choosing Rominski Active Healthcare as your healthcare provider. Please understand that payment of your bill is considered part of your care. The following is a statement of our Financial Policy which we require you to read and sign prior to the provision of services.

## FINANCIAL POLICY

All patients must complete our patient information packet in full prior to seeing a physician  
**PAYMENT IS DUE AT THE TIME OF SERVICE**

We accept cash, check, and insurance, Visa or MasterCard  
\*\*\*Financial assistance is available to those who qualify\*\*\*

### Regarding Commercial Health Insurance:

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will accept assignment of insurance benefits with confirmed commercial insurance coverage with an insurance company who has maintained good credit with Rominski Active Healthcare. Rominski Active Healthcare submits claims to insurance carriers as a courtesy to our patients. It is the patient's responsibility to make sure that all services rendered are covered benefits. You are required to pay your co-pay, deductible and co-insurance portion at the time of each visit.

### Workers Compensation:

If your condition is the result of a work related injury, we require that you have an authorization number and the name of the insurance adjuster; otherwise you will be required to pay for the initial visit in full at the time of service. If your workers compensation case is contested, we require payment in full at the time of services, or confirmation of commercial health insurance coverage or other liable 3<sup>rd</sup> party coverage. See above regarding commercial health insurance.

### Automobile (Personal) Injuries:

If your condition is the result of an automobile accident, we will bill your automobile med pay insurance. If med pay is not available, we may submit the claims to your personal health carrier. If third party liability cannot be confirmed, we will require payment in full at the time the services are rendered.

### Minors:

Parents and/or legal guardians are required to accompany a minor at the time services are rendered. For unaccompanied minors, non-emergency treatment will be denied.

### Missed Appointments:

Scheduled appointments should be canceled at least 24 hours in advance. Our policy is to charge for missed appointments at the rate of \$25. Please help us serve you and others by keeping scheduled appointments.

### Regarding Billings:

I understand that I will receive a monthly bill reflecting the balance due. I also understand that I am responsible to pay any and all remaining balances within 60 days from the date services are rendered. Rominski Active Healthcare follows the current guidelines of HIPAA and of the Illinois Hospital Association regarding the setting of fees for health care handling and copying of patient's records. If my records are requested by a third party we will follow the guidelines set by HIPAA and the Illinois Hospital Association to determine our charges. I also understand that if legal and/or collection services are required on past due balance(s), after sixty (60) days from date of service, all costs including reasonable attorney's fees are my responsibility or that of the legal guardian in the case of a minor.

If we accept assignment from your insurance company, or any liable third party, we maintain the right to demand payment from you, the patient, if for any reason your balance has not been paid in full within sixty (60) days from the date of service.

I understand and agree to the terms of this Financial Policy:

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Legal Guardian

\_\_\_\_\_  
Date

# Rominski Active Healthcare

## Consent for Care/Treatment

1. I hereby authorize and voluntarily consent to care/treatment for my condition(s) at Rominski Active Healthcare (hereinafter referred to as RAH), which may include the performance of diagnostic procedures, interpretation of diagnostic studies including imaging, the administration of medication, nutritional supplementation, chiropractic care, joint and soft tissue manipulation, physical therapy and procedures requiring the use of needles as deemed necessary by my physician(s), his or her assistants, consultants, or designees for the diagnosis or treatment of my disorder(s)/illness(es).
2. I understand and am informed that in the practice of medicine and chiropractic, as in other forms of health care delivery, there are some risks associated with some diagnostic tests and therapeutic procedures, including but not limited to bruises, pain, fractures, allergic reactions, disc injury, stroke, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts as then known, and is in my best interest.
3. Realizing that outpatient care/treatment requires the cooperation of physicians and support healthcare personnel to include nurses, therapist and technicians, I hereby give consent for their communication and all procedures provided to me by qualified physicians and other personnel working under the supervision and direction of my attending physician at RAH.
4. I am aware that the practice of medicine and chiropractic is not an exact science and I hereby acknowledge that no guarantees have been made to me as to the result of examinations, treatments or recommendations.
5. I hereby authorize RAH to retain, preserve and use for scientific or teaching purposes, or dispose of at their convenience, any specimens or tissue taken from my body during my care at RAH.
6. I hereby understand that the responsible third party or I may be billed for the review of any outside medical records or imaging studies. This includes record reviews for the purpose of a second opinion and clinical correlation.
7. I understand that a specialized diagnostic or focused therapeutic approach to neurological or related orthopedic conditions at RAH is not to take the place of my general healthcare. I understand that I should consult with my personal/family medical physician/medical internist for general care and for the coordination of my healthcare with other specialists. It is the policy of RAH to recommend that each patient receive at a minimum semi-annual comprehensive examinations from their attending medical internist/medical family physician unless deemed otherwise. This approach helps facilitate timely diagnosis and intervention.
8. I understand that if I am seeking or limited to a diagnostic opinion at RAH I am responsible to follow up with the recommended physician(s) for review of therapeutic options and/or intervention. If I do not follow through with the recommended course of care including diagnostic follow-up, I understand that it could lead to an unwanted outcome including but not limited to chronic pain, physical disability, loss of limb, cognitive impairment or death.
9. I understand that RAH provides facilities, equipment and clerical support services for the use of physicians in rendering diagnostic and therapeutic services to their patients. I recognize with the exception of designated "staff RAH physicians", the physicians rendering services to me, including but not limited to, attending physicians, consultants, pathologists, radiologists and neurosurgeons are independent practitioners and are not employees or agents of RAH and may not be covered by RAH managed care plans. In some cases I can expect to receive separate bill from the independent physicians providing services at RAH.
10. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about the content, and by signing below I certify that I understand its contents. I intend this consent form to cover the entire course of evaluation and care for my present condition, complications related to my condition and for any future condition(s) for which I seek treatment.

Signature of Patient/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**Rominski Active Healthcare  
Motor Vehicle Accident**

1. Description of Accident: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Your Vehicle Type:  Car  Van  Station Wagon  Pickup truck  
 Large Truck  Bus

3. Your Position in vehicle:  Driver  Passenger  Left rear Passenger  
 Right Rear Passenger

4. What was your vehicle doing at the time of accident?  Stopped at intersection  
 Parking  Stopped in traffic  Stopped at light  Making a right turn  
 making a left turn  Accelerating  Slowing down  Other \_\_\_\_\_

5. Time of accident: \_\_\_\_\_

6. Your vehicle speed: \_\_\_\_\_ Their vehicle speed: \_\_\_\_\_

7. Damage to your vehicle:  Mild  Moderate  Totaled Est. damage? \_\_\_\_\_

8. Damage to their vehicle:  Mild  Moderate  Totaled Est. damage? \_\_\_\_\_

9. Visibility at time of accident:  Poor  Fair  Good

10. Road condition at time of accident?  Icy  Wet  Sandy  Dark  Clean/Dry

11. Did you hit other vehicle?  Yes  No

12. Did other vehicle hit you?  Yes  No

13. Did you hit another object?  Yes \_\_\_\_\_  No

14. Point of Impact:  Head-On  Left Front  Right Front  Rear-End  
 Left Rear  Right Rear

15. Did you see the accident coming?  Yes  No

16. Were you braced for the impact?  Yes  No

17. Did you have a seat belt on?  Yes  No

18. Did you have a shoulder harness on?  Yes  No

19. Does your vehicle have headrests?  Yes  No

20. What was the position of your headrest at the time of impact?

Even with top of head  Even with bottom of head  Middle of neck

21. What was the position of your head during the impact?  Facing straight forward

Turned Right  Turned Left

**During the Accident . . .**

22. Did your body strike the inside of your vehicle?  Yes \_\_\_\_\_  No

23. Did you lose consciousness?  Yes (How long?) \_\_\_\_\_  No

24. Did the police show up at the scene?  Yes  No

25. Was an accident report filled out?  Yes  No

# ACCIDENTAL INJURY FORM

NAME \_\_\_\_\_

DATE \_\_\_\_\_

Date of Accident \_\_\_\_\_ Time: \_\_\_ am \_\_\_ pm Location of Accident \_\_\_\_\_

## AUTO INJURY

Were You: ( ) Driver ( ) Passenger ( ) Pedestrian

Were you struck from: ( ) Behind ( ) Right Side ( ) Left Side ( ) Front ( ) Parked

Did your car strike the others involved: ( ) Yes ( ) No ( ) Undetermined

Did the other car strike yours: ( ) Yes ( ) No ( ) Undetermined

As a result of the Accident, were traffic citations issued to you? ( ) Yes ( ) No

## ON-THE-JOB INJURY

How did the injury occur? \_\_\_\_\_

Did you report the injury to your foreman or employer: ( ) Yes ( ) No

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

## OTHER

Describe the circumstances of the accident (Be Specific): \_\_\_\_\_

\*\*\*\*\*

## CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

- |                  |                            |                        |                   |
|------------------|----------------------------|------------------------|-------------------|
| ( ) Headache     | ( ) Sleeping Problems      | ( ) Lights Bother Eyes | ( ) Diarrhea      |
| ( ) Neck Pain    | ( ) Head Too Heavy         | ( ) Loss of Memory     | ( ) Feet Cold     |
| ( ) Stiff Neck   | ( ) Pins & Needles in      | ( ) Ears Ringing       | ( ) Hands Cold    |
| ( ) Dizziness    | Arms                       | ( ) Face Flushed       | ( ) Stomach Upset |
| ( ) Back Pain    | ( ) Pins & Needles in Legs | ( ) Buzzing in Ears    | ( ) Constipation  |
| ( ) Nervousness  | ( ) Numbness in Fingers    | ( ) Loss of Balance    | ( ) Cold Sweats   |
| ( ) Tension      | ( ) Numbness in Toes       | ( ) Fainting           | ( ) Fever         |
| ( ) Irritability | ( ) Shortness of Breath    | ( ) Loss of Smell      | ( ) Other         |
| ( ) Chest Pain   | ( ) Fatigue                | ( ) Loss of Taste      |                   |

Did you require post-accident hospitalization? ( ) Yes ( ) No

Have you lost any days of work? ( ) Yes ( ) No If Yes, \_\_\_\_\_ through \_\_\_\_\_

## INSURANCE INFORMATION

Your Insurance Company \_\_\_\_\_ Address \_\_\_\_\_

Other Party's Name \_\_\_\_\_ Address \_\_\_\_\_

Other Party's Ins. Co. \_\_\_\_\_ Address \_\_\_\_\_

Have you been contacted by an insurance adjuster regarding this claim: ( ) Yes ( ) No

If yes, name of adjuster \_\_\_\_\_ Company \_\_\_\_\_

Do you have an attorney that has advised you in this case: ( ) Yes ( ) No

If yes, attorney's name \_\_\_\_\_ Address \_\_\_\_\_

Signature \_\_\_\_\_