

BrightLife Regenerative Medical Clinics

Patient File # _____

Patient Name _____ Date: _____ Email: _____

SS #/SIN _____ DOB _____ Male Female Home phone _____ Cell Phone _____

Check appropriate Box: Minor Single Married Divorced Widowed Separated Children(s) Name/Age _____

Patient's Address _____ City _____ State _____ Zip _____

Employer Name: _____

Spouse or Patient's Guardian name _____ Spouse's Employer _____

Whom may we thank for referring you? _____

Person to contact in case of an emergency _____ Phone _____

In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

Parent or Guardian _____ Date _____

Responsible Party

Name of The Person responsible for this account _____ Relationship to Patient _____

Address _____ Home Phone _____

E-Mail _____ Cell Phone _____

Driver's License # _____ Date of Birth: _____

Is the person currently a patient at our office? Yes No

Do you have any Medical insurance? Yes No if yes, complete the following:

Name of the insured _____ Relationship to patient _____

Birthdate _____ SS#/SIN _____ Name of Employer _____ Work Phone _____

Address of Employer _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or local # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

**ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE
AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY**

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **BrightLife Regenerative Medical Clinics** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that **have been or will be** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan of this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 ____.

X _____ (SEAL)
(patient signature)

X _____ (SEAL)
(signature of Guardian if applicable)

X _____
(please print patient name)

Health History

Patient Name: _____ DOB: _____ Date: _____

Chief Complaint: _____

History of Present illness:

Location: _____
(Where is the pain/problem?)

Quality: _____
(Example: normal vs abnormal color, activity, etc..)

Severity: _____
(How severe is the pain/problem on a scale of 1-10 with 10 being the most severe?)

Duration: _____
(How long have you had this pain/ problem? When did it start?)

Timing: _____
(Does the pain/problem occur at a specific time?)

Context: _____
(Where were you at the onset of this pain/problem?)

Associated Signs/Symptoms _____

Modifying Factors _____

(What other associated problems have you been having?)

(What makes the pain/problem worse or better? Have you had previous episodes?)

Past Medical History

(Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

Measles.....	NO	YES	Anemia.....	NO	YES	Back Trouble.....	NO	YES	Hepatitis.....	NO	YES
Mumps.....	NO	YES	Bladder Infection.....	NO	YES	High Blood Pressure.....	NO	YES	Ulcer.....	NO	YES
Chicken Pox.....	NO	YES	Epilepsy.....	NO	YES	Low Blood Pressure.....	NO	YES	Kidney Disease.....	NO	YES
Whooping Cough...	NO	YES	Migraine Headaches.	NO	YES	Hemorrhoids.....	NO	YES	Thyroid Disease.....	NO	YES
Scarlet Fever.....	NO	YES	Tuberculosis.....	NO	YES	Date of Last Chest X-Ray	_____		Bleeding Tendency.....	NO	YES
Diphtheria.....	NO	YES	Diabetes.....	NO	YES	Asthma.....	NO	YES	Any Other Disease.....	NO	YES
Small pox.....	NO	YES	Cancer.....	NO	YES	Hives of Eczema.....	NO	YES	(Please List):		
Pneumonia.....	NO	YES	Polio.....	NO	YES	AIDS & HIV.....	NO	YES	_____		
Rheumatic Fever...	NO	YES	Glaucoma.....	NO	YES	Infectious Mono.....	NO	YES	_____		
Arthritis.....	NO	YES	Hernia.....	NO	YES	Bronchitis.....	NO	YES	_____		
Venereal Disease...	NO	YES	Blood or Plasma			Mitral Valve Prolapses...	NO	YES	_____		
			Transfusion.....	NO	YES	Stroke.....	NO	YES			

Previous Hospitalizations/Surgeries/Serious Illnesses **When?** **Hospital, City, State**

Medication: (include nonprescription)

Have you ever taken Fen-Phen/Redux? NO YES
Are you taking any medications (prescription or over the counter) for acid indigestion?
O yes O no if yes what type: _____

Patient Social History:

Marital Status Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____
Use of Alcohol Never: _____ Rarely: _____ Moderate: _____ Daily: _____
Use of Tobacco Never: _____ Rarely: _____ Moderate: _____ Daily: _____
Use of Drugs Never: _____ Type/Frequency: _____
Excessive Exposure
At home or at work to: Fumes: _____ Dust: _____ Solvents: _____ Airborne Particles: _____ Noise: _____

CLINICIAN SIGNATURE: _____ **DATE REVIEWED:** _____

PATIENT NAME: _____ **DATE:** _____

Name: _____ DOB _____ Date: _____

Family Medical History:

	Age	Disease	If Deceased, Cause Of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Spouse:	_____	_____	_____
Children:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Indicate which of the below you have experienced in the last 1-2 months
 1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes/Ears/Nose/Throat/Respiratory

- Asthma 1 2 3 4 5
- Stuffy Nose 1 2 3 4 5
- Hay Fever 1 2 3 4 5
- Sore throat 1 2 3 4 5
- Chronic Cough 1 2 3 4 5
- Chest Congestion 1 2 3 4 5
- Frequent Sneezing 1 2 3 4 5
- Itchy/Watery Eyes 1 2 3 4 5
- Drainage 1 2 3 4 5
- Earache or Ear Infection 1 2 3 4 5
- Itching 1 2 3 4 5
- Hoarseness 1 2 3 4 5
- Shortness of Breath 1 2 3 4 5
- Wheezing 1 2 3 4 5

Muscular/Skeletal

- Muscle Aches 1 2 3 4 5
- Fibromyalgia 1 2 3 4 5
- Arthritis 1 2 3 4 5
- Joint Pain 1 2 3 4 5
- Low Back Pain 1 2 3 4 5
- Neck Pain 1 2 3 4 5
- Wrist/Hand Pain 1 2 3 4 5
- Elbow Pain 1 2 3 4 5
- Shoulder Pain 1 2 3 4 5
- Hip Pain 1 2 3 4 5
- Knee Pain 1 2 3 4 5
- Ankle/Foot Pain 1 2 3 4 5
- Pain b/t shoulder blades 1 2 3 4 5

Neurological

- Headaches 1 2 3 4 5
- Migraines 1 2 3 4 5
- Dizziness 1 2 3 4 5
- Numbness 1 2 3 4 5
- Tingling 1 2 3 4 5
- Pins/needles in hands or feet 1 2 3 4 5

General

- Fatigue 1 2 3 4 5
- Malaise 1 2 3 4 5
- Weakness, tiredness 1 2 3 4 5
- Lightheadedness 1 2 3 4 5
- Irritability 1 2 3 4 5
- Constipation 1 2 3 4 5
- Diarrhea 1 2 3 4 5
- Feeling foggy 1 2 3 4 5
- Forgetfulness 1 2 3 4 5

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

 Signature of the Patient, Parent or Guardian

 Date

 Doctor's Review

 Signature of Doctor

 Date

BrightLife Regenerative Medical Clinics

CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic manipulation and manual therapy techniques and other chiropractic procedures, including various modes of physical therapeutic modalities and procedures and diagnostic X-rays, where warranted, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below.

I have had an opportunity to discuss with the doctor of chiropractic named below the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment and diagnostic services including but not limited to:

Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations and sprains.

Therapeutic Modalities and procedures: additional pain and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.

Radiographs: ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The doctor named below has additionally explained the risks associated with my refusal of treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient/Guardian Signature _____ Date _____

Witness Signature _____ Date _____

NEUROLOGICAL AND VASCULAR PATIENT QUESTIONNAIRE

NAME: _____ DATE: _____

For any YES answer, please notify the Doctor.

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES
Comment: _____
2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES
Comment: _____
3. Do your hands or arms fall asleep regularly? NO YES
Comment: _____
4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
Comment: _____
5. Do you suffer from a loss of handgrip strength? NO YES
Comment: _____
6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
Comment: _____
7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES
Comment: _____
8. Do your legs or feet fall asleep regularly? NO YES
Comment: _____
9. Do you have reduced feeling (sensation) or swellings in your legs, feet? NO YES
Comment: _____
10. Do you suffer from cold hands or feet? NO YES
Comment: _____
11. Do you suffer from headaches, dizziness or memory loss? NO YES
Comment: _____
12. Do you have difficulty maintaining your balance? NO YES
Comment: _____
13. Do you suffer from vertigo or blurred vision? NO YES
Comment: _____
14. Do you suffer from a reduced hearing capacity? NO YES
Comment: _____
15. Do you suffer from ringing in your ears? NO YES
Comment: _____
16. Do you have bladder or bowel control problems on a regular basis? NO YES
Comment: _____

HIPAA
Notices of Privacy Practices
BrightLife Clinic

This notice, effective immediately describes how medical information about you may be used and disclosed and how you can get access to this information, please review carefully. Our office is required by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment – We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations.

Payment – We may disclose your health care information to your insurance company provider for the purpose of payment or health care operations. We have your permission to disclose your health care information to your insurance company for the purpose of appealing claims on your behalf.

We may disclose your health care information as necessary to comply with State Workers' Compensation laws, Public Health Authorities, Emergency situations, Judicial and Administrative proceedings, Law Enforcement, Medical examiners, Researcher that has been approved by an Institutional Review Board, when necessary to prevent a health or safety issue, to military or national security and government benefit purposes, for company approved marketing purposes, showing gratitude and appreciation for referrals, and change of ownership.

We reserve the right to change and amend this Notice of Privacy Practices at any time. Our office is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact our Compliance Officer by calling (847) 490-9090.

Complaints – Complaints about your privacy rights, or how our office has handled your health information should be directed to our Compliance Officer by calling (847) 490-9090. You may make an appointment for a personal conference in person or by telephone. If you are not satisfied with the manner in which this office handles your complaint, please call (847) 490-9090.

I understand and have been provided with a Notices of Privacy Practices, which provides a description of the information uses and disclosures. I understand and had the right to review this notice prior to signing the consent, the right to object the use of my health information for directory purposes and the right to request restriction as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

Patient Name

Date

Patient/Guardians Signature