Welcome to

Ruof Chiropractic, Inc.

Please fill out front and back of all pages in this packet, with the exception of pages that do not apply to you, such as the *Union Insurance Policies* and *X-ray Questionnaire*.

NAME: First_________________________________ Last____

BIRTHDATE ______/_____/___________ SOCIAL SECURITY #______________________________________

EMAIL ADDRESS:____

MAILING ADDRESS:____

CITY____ STATE __________ ZIP ______________________________

PHONE #s: Cell_____________________________ Home____

OCCUPATION_________________________________ EMPLOYER______________________________________

EMPLOYER ADDRESS____________________________________ City____________________ State___________

EMPLOYER PHONE #:______________________________________

EMERGENCY CONTACT: Name_______________________ Relation_________________________________

PRIMARY PHONE #: _______________________________ This number is their: Cell Home Work

SECONDAY PHONE #: _____________________________ This number is their: Cell Home Work

PLEASE ANSWER THESE QUESTIONS:

How did you hear about our practice? ____

Is this visit due to an accident? Yes ☐ No☐

If yes, what type? Auto ☐ Work☐ Other ____

Has it been reported? Yes ☐ No ☐ If yes, to whom?__________________________________

Do you have health insurance? Yes ☐ No ☐ Name of Carrier__________________________________

Do you have secondary insurance? Yes ☐ No ☐ Name of Carrier__________________________________

Do you have Medicaid insurance? Yes ☐ No ☐ **If YES**, please be advised we are unable to accept Medicaid
You will be responsible for any portion unpaid by Medicare

______________________________ ______________________________ ____________

Patient Signature Print Name Date

Insurance & Billing Policy

YOUR FIRST VISIT will consist of a consultation by Dr. Ruof. A consultation is completely free of charge; however an *exam* which also includes x-rays is $100 ***unless you are using medical insurance***.

YOUR FOLLOW-UP VISIT will consist of a follow-up exam in which the findings of your x-rays will be discussed with you as well as your recommended treatment plan and financial costs based on your insurance. If you do not have insurance, a financial plan will be discussed with you. We offer affordable rates as well as easy automatic monthly payment plans.

- ***If you opt to participate*** in the treatment plan the providers have discussed with you, we will begin treatment during your follow-up visit.
- ***If you opt to not participate*** in the treatment plan the providers have discussed with you, the $100 you paid on your first visit will cover the cost of both visits. If you are using insurance, your insurance will be billed for both days as an exam. Depending on your policy you will be billed or asked to pay a co-payment for both days of service.

WEEKLY VISITS following your first two visits may consist anywhere between 2 to 4 visits per week for the first month depending on your condition. We wish we could work miracles in one visit, but taking a natural, non-invasive approach to healing takes time.

I have read and understand the terms listed above. By signing, I acknowledge our policy and my financial responsibilities as a patient at Ruof Chiropractic, Inc.

______________________________ ______________________

Patient Signature Date

Insurance & Billing Policy

Assignment and Release: I certify that I (or my dependent) have insurance coverage with the above named insurance carrier and I authorize, request and assign my insurance company to pay directly to the physician/ medical practice, insurance benefits otherwise payable to me. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

Billing: Statements are mailed at the end of every month. For patients that are responsible for plan deductibles, copayments, and co-insurance, you may send us a check in the mail, make a payment in the office via credit card, cash, or check, or call our office and pay by credit card over the phone. We require patients to make a minimum of one (1) payment per month towards your account balance of no less than 25% of your balance. A due date will be indicated on patient bills.

Interest: Interest will accrue on any outstanding balances for dates of service that remain unpaid after 180 days.

Medicaid: We do not accept Medicaid as a secondary insurance. If you have Medicare as primary and Medicaid as secondary, you will be responsible for your Medicare co-insurance.

Insurance Disclaimer: “A quote of eligibility and benefits is not a guarantee of payment. All benefits are subject to eligibility, medical necessity, and the terms, conditions, limitations, and exclusions of the patient’s health benefit plan at the time the services are rendered.”

Financial Responsibility: I understand that my health insurance company may deny payment for the services performed at our practice. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for co-payment, deductible, or co-insurance that applies.

Explanation of Insurance Benefits: Most of our services will fall under your plan deductible. Once you have fulfilled that deductible to us or other providers, the insurance policy will pay a percentage of the allowed amount. This is usually between 70% and 100%, and is dependent on your policy. If the policy pays less than 100%, you are responsible for the remaining percent co-insurance. *By law, all patients are required to pay plan deductibles to us when opting to use insurance. We cannot make any exceptions to this rule.*

It is important to save the Explanation of Benefits that you receive from your insurance company. If you have any billing questions or concerns, you can consult these EOBs prior to contacting our office. They outline what your insurance has paid to us and what you will owe to our facility. It is important to consult your insurance or these forms prior to contacting our office with billing questions.

I have read and understand the terms listed above. By signing, I acknowledge our policy and my financial responsibilities as a patient at Ruof Chiropractic, Inc.

________________________________ ____________________

Patient Signature Date

Appointment Cancellations & Rescheduling Policy

Our goal is to provide quality individualized medical care in a timely manner. "No-shows" and late cancellations inconvenience those individuals who need access to medical care in a timely manner. Below is our office policy regarding missed appointments. This policy enables us to better utilize available appointments for our patients in need of medical care

In order to be respectful of the medical needs of other patients, please be courteous and call promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Your early cancellation will give another person the possibility to have access to timely medical care.

To cancel appointments, please call 708-423-1440. If you do not reach us, please leave a message on our voicemail. If you would like to reschedule your appointment, please leave your phone number. We will return your call and give you the next available appointment time.

A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. A failure to be present at the time of a scheduled appointment will be recorded in your medical record as a "no-show."

- First missed appointment: there will be no charge
- Subsequent missed appointments: $25 fee will be billed to your account

I have read and understand the policy above.

______________________________ ______________________

Patient Signature Date

For Union Insurance Policy Holders

** Please review and sign if you are a union insurance policy holder **

PLEASE BE ADVISED: Laborer Welfare Funds/ Union policies will send an accident or injury questionnaire and a coordination of benefits form to you, the patient, at your home address. These forms are usually attached to an Explanation of Medical Benefits. This is standard procedure when being treated by a chiropractor. When you receive these forms, please complete and return to your union as soon as possible. If you do not complete these forms in a timely manner, this results in the claim being denied or payment being delayed. If no payment is made to your account by your insurance policy beyond a 60 day period because the union is waiting for information or forms from you, the unpaid balance will default to you. **It is your responsibility as the patient to follow up with your union insurance policy to ensure processing of your claims. It is most ideal that you inquire about your medical claims to your union insurance prior to contacting our office about your balance.**

IMPORTANT NOTICE ABOUT YOUR COVERAGE: In recent years union policies have made modifications to services performed by a chiropractor. When benefits are checked by our office, there is always a "no guarantee of coverage and payment" statement given to us by a union insurance policy with regards to your treatment. This means that you have coverage but that approval of treatment is based on medical necessity. If they determine that your treatment is not medically necessary based on your condition, and you chose to proceed with treatment during your initial visit, the balance will default to you, the patient. If you decided to decline treatment based on these circumstances, we understand. We understand this can be frustrating. If you decide not to use your insurance because of these circumstances, we can offer you our discounted self-pay prices for our services.

I have read and understand the terms listed above. I understand that I am responsible for any balance *unpaid* by my union insurance company beyond 60 days from the date of services that I received by Dr. Nathan Ruof at Ruof Chiropractic, Inc. I understand that I am responsible for following up with my insurance policy prior to contacting this facility with billing questions.

_______________________________________ _______________________

Patient Signature Date

Informed Consent to Care

A patient coming to the doctor/physician's assistant gives him/her permission and authority to care for them in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor/physician's assistant, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

Ruof Chiropractic, Inc., does not perform breast, pelvic, prostate rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care physician.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may be against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

______________________________ ____________________

Patient Signature Date

Informed Consent to Care

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/ strain injuries, irritation of the disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care in our office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider.

I understand and accept that there are risks associated with chiropractic care and give consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported, following Dr. Ruof's assessment.

This notice is effective as of the date it is signed and will expire seven years after the date on which you last received services from us.

________________________________ ____________________

Patient Signature Date

X-Ray Questionnaire: For Women Only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: ____

- ☐ There is a possibility that I may be pregnant at this time
- ☐ Yes, I am definitely pregnant
- ☐ No, I am definitely not pregnant at this time
- ☐ I request that x-ray films not be taken at this time because:

  ____

  ____

  ____

Date of last menstrual period: ____________________

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

____ ________________________

Patient Signature Date

Health History

Who is your Primary Care Physician (PCP)? ____
(Please list the Doctor and/or Practice)

Please check to indicate if you are currently experiencing any of the following conditions:

☐ Neck Pain/Stiffness	☐ Pins/Needles in Arms	☐ Light Bothers Eyes	☐ Sudden Weight Loss	☐ Nausea
☐ Back Pain/Stiffness	☐ Pins/Needles in Legs	☐ Depression	☐ Loss of Taste	☐ Cold Feet
☐ Arm/Hand Pain	☐ Fatigue	☐ Nervousness	☐ Loss of Memory	☐ Chest Pain
☐ Leg/Knee Pain	☐ Sleeping Difficulties	☐ Tension	☐ Jaw Problems	☐ Fever
☐ Headaches	☐ Loss of Smell	☐ Cold Sweats	☐ Constipation	☐ Fainting
☐ Dizziness	☐ Allergies	☐ Stomach Problems	☐ Shortness of Breath	
☐ Asthma	☐ Blurred Vision	☐ Night Pain	☐ Bowel/Bladder Changes	

Please check to indicate if you have ever had any of the following:

☐ AIDS/HIV	☐ Cancer	☐ Hepatitis	☐ Osteoporosis	☐ Stroke
☐ Alcoholism	☐ Cataracts	☐ Hernia	☐ Pacemaker	☐ Suicide Attempt
☐ Allergy Shots	☐ Chemical Dependency	☐ Herniated Disc	☐ Parkinson's Disease	☐ Thyroid Problems
☐ Anemia	☐ Chicken Pox	☐ Herpes	☐ Pinched Nerve	☐ Tonsillitis
☐ Anorexia	☐ Diabetes	☐ High Cholesterol	☐ Pneumonia	☐ Tuberculosis
☐ Appendicitis	☐ Emphysema	☐ Kidney Disease	☐ Polio	☐ Tumors/Growths
☐ Arthritis	☐ Epilepsy	☐ Liver Disease	☐ Prostate Problems	☐ Typhoid Fever
☐ Asthma	☐ Fractures	☐ Measles	☐ Prosthesis	☐ Ulcers
☐ Bleeding Disorders	☐ Glaucoma	☐ Migraines	☐ Psychiatric Care	☐ Vaginal Infections
☐ Breast Lump	☐ Goiter	☐ Miscarriage	☐ Rheumatoid Arthritis	☐ Venereal Disease
☐ Bronchitis	☐ Gonorrhea	☐ Mononucleosis	☐ Rheumatic Fever	☐ Whooping Cough
☐ Bulimia	☐ Gout	☐ Multiple Sclerosis	☐ Scarlet Fever	
	☐ Heart Disease	☐ Mumps	☐ Other ______________________	

Are you currently under drug and/or medical care? ☐ Yes ☐ No

If yes, please explain: ____

Please list any medications you are currently taking (Be sure to include dosage and frequency):

____

____

Health History (Continued)

Please lit any surgeries you have had (include type and date):

____

____

Please list any allergies: ______________________________

____

Please list an supplements you are currently taking (vitamins/herbs/minerals):

____

____

Is there a family history of any of the following conditions? (Indicate family member including parents, grandparents, and siblings)

☐ Heart Disease ____________ ☐ Diabetes ____________ ☐ Cancer ____________

☐ Cancer ____________ ☐ Arthritis ____________ ☐ Other ____________

Do you exercise? If Yes, please indicate frequency and type.

☐ Never ☐ Daily ☐ Weekly

☐ Walking ☐Running ☐ Swimming ☐ Other ____________________

Do your work activities mostly involve: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

What is your daily/weekly intake of the following (please indicate amount and frequency:

Caffeine ____ cups/ day week Alcohol ____ drinks/ day week Cigarettes ____ packs/ day week

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

______________________________ ____________________

Patient Signature Date

Review of Systems

Please mark if you have experienced any of these symptoms within the last month:

Y	N	**Neurological**
____	____	Migraines
____	____	Headaches
____	____	Slurring of Speech
____	____	Ringing in Ear
		Ear/Nose/Throat
____	____	Altered Taste/Smell
____	____	Night Blindness
____	____	Sore Throat
____	____	Gingivitis
____	____	Nose Bleeds
		Cardiovascular
____	____	Chest Pain
____	____	Palpitations-Racing Heart Beat
____	____	Swelling in hands/feet
____	____	Anemia
		Respiratory
____	____	Recurrent Respiratory Infection
____	____	Asthma
____	____	Chest Congestion
____	____	Wheezing
____	____	Frequent Sneezing
		GI
____	____	Stomach Pains or Cramping
____	____	Constipation
____	____	Reflux or Heartburn
____	____	Bloating
____	____	Gas
____	____	Nausea or Vomiting
		Musculoskeletal
____	____	Joint Pain
____	____	Arthritis
____	____	Chronic Pain
____	____	Muscle Ache

Y	N	**Skin**
____	____	Eczema
____	____	Dermatitis
____	____	Excessive Sweating
____	____	Rashes
____	____	Brittle Nails
____	____	Hair Loss
____	____	Easy Bruising
____	____	Increased Bleeding
____	____	Numbness/Tingling
Y	**N**	**Genitourinary**
____	____	Uterine Fibroids
____	____	Ovarian Cysts
____	____	Cancer (breast, ovarian, prostate, uterine)
____	____	Prostate Problems
Y	**N**	**Emotional/Mental**
____	____	Depression
____	____	Anxiety
____	____	Mood Swings
____	____	Irritability
____	____	Memory Loss
____	____	Confusion
Y	**N**	**Energy**
____	____	Fatigue
____	____	Hyperactivity
____	____	Restlessness
____	____	Insomnia
____	____	Decreased Libido
____	____	Stress
Y	**N**	**Weight**
____	____	Decreased Appetite
____	____	Weight Gain
____	____	Inability to Lose Weight
____	____	Food Cravings
____	____	Binge Eating
____	____	Water Retention

____

Patient Signature

____

Date

Neurological/MRI/Vascular Patient Questionnaire

For any YES answer, please include details.

1. Do you suffer from neck pain with pain in your shoulder, arms, or hands? YES NO

   Comment: ____________________

2. Do you have weakness, numbness, or burning in your shoulder, arms, or hands? YES NO

   Comment: ____________________

3. Do your hands or arms fall asleep regularly? YES NO

   Comment: ____________________

4. Do you have reduced feeling (sensation) or swelling in your hands or arms? YES NO

   Comment: ____________________

5. Do you suffer from a loss of handgrip strength? YES NO

   Comment: ____________________

6. Do you suffer from back pain with pain in your buttocks, legs, or feet? YES NO

   Comment: ____________________

7. Do you have weakness, numbness, or burning in your buttocks, legs, or feet? YES NO

   Comment: ____________________

8. Do your legs or feet fall asleep regularly? YES NO

   Comment: ____________________

9. Do you have reduced feeling (sensation) or swelling in your legs or feet? YES NO

   Comment: ____________________

10: Do you suffer from cold hands or feet? YES NO

   Comment: ____________________

11. Do you have frequent falls or find that you trip over your feet while walking? YES NO

   Comment: ____________________

12. Do you suffer from frequent headaches? If yes, how often? YES NO

   Comment: ____________________

13. Have you ever been diagnosed by any physician with having peripheral neuropathy? YES NO

   If yes, when and what treatment has been tried?

   ____

14. Have you tried any medications for your pain such as anti-inflammatory? YES NO

   If yes, what kind of medication (Aleve, Motrin, Tylenol, Advil, steroids, flexeril)?

   ____

15. Have you tried any physical therapy or chiropractic treatments before? YES NO

   If yes, When? For how long? What kind?

   ____

16. Have you had an MRI? YES NO

   If yes, when? Who ordered it? What was it ordered for?

   ____

17. Have you used any splint or braces or other prescribed treatment by an MD? YES NO

   If yes, when? What kind? Who ordered it?

   ____

____________________ ____________________

Patient Signature Date