INAPC
INTEGRATIVE NEUROLOGY & ATHLETIC PERFORMANCE CLINIC

3805 E. Main St. Suite G
St. Charles, IL 60174
Phone: 331-222-9667

Patient Information

Patient Name_____ Today's Date_____
First (preferred name) Last

Email_____ Cell Phone_____ Home Phone_____

Street Address_____ City_____ State_____ Zip_____

Date of Birth_____ Age_____ Gender: M / F Marital Status: S / M / W / D

Occupation_____ Employer_____ Work Phone_____

Emergency Contact_____ Relationship_____ Phone #_____

Have you ever had Chiropractic Care? Y / N When?_____ Reason?_____

How did you hear about us?_____

Subscriber Name, Relationship & Date of Birth:

Patient Medical Information

Do you have/experience any of the following?	**Yes**	**No**
Vertigo (dizziness)?	☐	☐
Passing out easily (faint or lose consciousness)?	☐	☐
Double vision or have you lost sight in one eye?	☐	☐
Slurred speech or difficulty with speech?	☐	☐
Indigestion or difficulty swallowing?	☐	☐
Difficulty walking with coordination or falling to one side?	☐	☐
Nausea or vomiting?	☐	☐
Numbness on one side of your face or body?	☐	☐
Difficulty in arranging words properly?	☐	☐
Headaches or head pain that is unlike any you had before?	☐	☐
Headaches for hours or days?	☐	☐
Chest Pain?	☐	☐
A sore that does not heal?	☐	☐
Any unusual bleeding or discharge?	☐	☐
Any thickening in your breasts or elsewhere?	☐	☐
Recent change in any wart or mole?	☐	☐
Nagging cough or hoarseness?	☐	☐
Night sweats?	☐	☐
Pain in your neck, jaw or face?	☐	☐
A drooping eyelid or change in your pupils?	☐	☐
Ringing in your ears?	☐	☐
Pain that wakes you from a sound sleep?	☐	☐
Losing weight now without trying?	☐	☐

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	Yes	No
Coughing up blood or noticing it in your stool or urine?	☐	☐
Any recent changes in bowel or bladder habits?	☐	☐
Any loss of bladder or bowel control?	☐	☐
Lost consciousness or had double vision recently?	☐	☐
Seeing any other doctor now for any reason?	☐	☐

If yes, please explain_____

Patient Health History

Date of last: Physical Exam:_____ MRI/CT/Bone scan:_____
Spinal X-ray:_____ Blood/Urine test:_____

Mark with an X to indicate if you have/had any of the following. Please also mark any that apply to immdiate family, and indicate the relationship to you.

( ) AIDS/HIV	( ) Goiter	( ) Pneumonia
( ) Alcoholism	( ) Gonorrhea	( ) Polio
( ) Allergy Shots	( ) Gout	( ) Prostate problems
( ) Anemia	( ) Heart Disease	( ) Prosthesis
( ) Anorexia	( ) Hepatitis	( ) Psychiatric Care
( ) Appendicitis	( ) Hernia	( ) Rheumatoid Arthritis
( ) Arthritis	( ) Herniated Disc	( ) Rheumatic Fever
( ) Asthma	( ) Herpes	( ) Scarlet Fever
( ) Bleeding disorders	( ) High Blood Pressure	( ) Stroke
( ) Breast lump	( ) High Cholesterol	( ) STD
( ) Bronchitis	( ) Kidney Disease	( ) Suicide attempts
( ) Bulimia	( ) Liver Disease	( ) Thyroid problem
( ) Cancer	( ) Measles	( ) Tonsillitis
( ) Cataracts	( ) Migraines	( ) Tuberculosis
( ) Chemical Dependency	( ) Mononucleosis	( ) Tumors
( ) Chicken Pox	( ) Multiple Sclerosis	( ) Typhoid Fever
( ) Diabetes	( ) Mumps	( ) Ulcers
( ) Emphysema	( ) Osteoporosis	( ) Vaginal Infections
( ) Epilepsy	( ) Pacemaker	( ) Whooping Cough
( ) Fractures	( ) Parkinson's	( ) Other:
( ) Glaucoma	( ) Pinched Nerve	

Exercise:	**Working Habits:**	**Other Habits:**	
( ) None	( ) Sitting	( ) Smoking	Packs/Day_____
( ) Mild	( ) Standing	( ) Drinking	Drinks/Week_____
( ) Moderate	( ) Light labor	( ) Coffee/Caffeine	Cups/Day_____
( ) Heavy	( ) Heavy labor	( ) Stress	Reason_____

Pregnancy history: # of pregnancies_____# of live births_____
# of miscarriages_____Vaginal/C-section?_____Are you pregnant now?_____If yes, due date?_____

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Patient Health Questionnaire

Purpose or reason for this appointment:_____

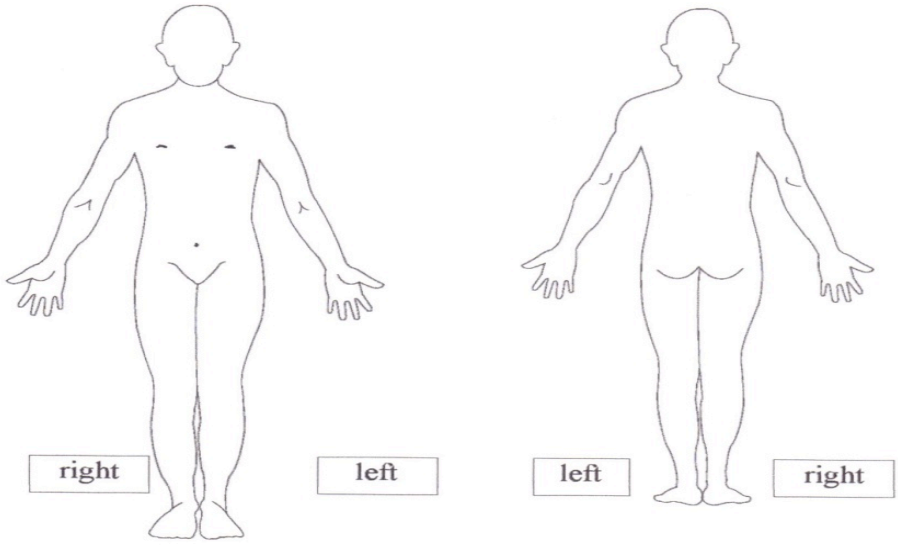
Have you ever experienced this before? Y / N If yes, when?_____

When did your symptoms begin?_____

How did they start?_____

Please use the symbols to indicate the type of pain on the pictures

- Sharp IIII
- Dull ache ****
- Numb 0 0 0 0
- Shooting ////
- Pins and needles + + + +
- Burning x x x x



How often do you experience your symptoms? (Please circle)

- Constantly (76-100% of the day)
- Frequently (51-75% of the day)
- Occasionally (26-50% of the day)
- Intermittently (0-25% of the day)

None **Unbearable**

Please circle the average intensity of your symptoms: 0 1 2 3 4 5 6 7 8 9 10

How much have your symptoms interfered with your work/social activities?

Not at all A little bit Moderately Quite a bit Extremely

Who have you seen for your current symptoms?

No one Physical Therapist Chiropractor Medical Doctor Other

Past Injuries/Surgeries	**Description**	**Date**
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

Medications	**Allergies**	**Vitamins/Herbs**
1._____	1._____	1._____
2._____	2._____	2._____
3._____	3._____	3._____
4._____	4._____	4._____

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CONSENT FOR CARE/TREATMENT

1. I hereby authorize and voluntarily consent to care/treatment for my condition(s) at the Integrative Neurology and Athletic Performance Clinic (INAPC)/Runyan Chiropractic (RC), which may include the performance of diagnostic procedures, interpretation of diagnostic studies including imaging, nutritional supplementation, chiropractic care, joint and soft tissue manipulation, acupuncture, electroacupuncture, cupping and physical therapy 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, minor bleeding, fainting, infection, 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 I wish to rely on the doctor to exercise judgment during the course of any procedure that the doctor believes, at the time, based on the facts as then known, is in my best interest.

3. Realizing that outpatient care/treatment requires the cooperation of physicians and support health care personnel, including nurses, therapists, technicians and office staff, 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 INAPC/RC.

4. I am aware that the practice of medicine and chiropractic is not an exact science, and I acknowledge that no guarantees have been made to me as a result of examinations, treatments or recommendations.

5. I have been advised that only pre-sterilized needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

6. I fully understand that in the case of pregnancy, a risk of causing fetal distress with acupuncture treatment(s) is possible.

7. I hereby authorize INAPC/RC to retain, preserve and use for scientific or teaching purposes or to dispose of at their convenience, any specimens or tissue taken, if applicable, from my body during my care at INAPC/RC.

8. I hereby understand that I or the responsible third party 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 or clinical correlation.

9. I understand that a specialized diagnostic or focused therapeutic approach to neurological or related orthopedic conditions at INAPC/RC is not to take the place of my general health care. I understand that I should consult with my personal medical physician or internist for general care and for the coordination of my health care with other specialists. It is the policy of INAPC/RC to recommend that each patient receive, at a minimum, a semiannual comprehensive examination from their attending medical physician or internist, unless deemed otherwise. This approach helps facilitate timely diagnosis and intervention.

10. I understand that if I am seeking or limited to a diagnostic opinion at INAPC/RC, 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.

11. I understand that INAPC/RC may provide 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 INAPC/RC physicians," the physicians rendering services to me, including, but not limited to, attending physicians, consultants, pathologies, radiologists and neurosurgeons, are independent practitioners and are not employees or agents of INAPC/RC and may not by covered by INAPC/RC managed care plans. In some cases, I can expect to receive a separate bill from the independent physicians providing services at INAPC/RC.

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.

Patient or Guardian Signature_____ Date_____

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OUR FINANCIAL POLICY

We would like to thank you for choosing the Integrative Neurology & Athletic Performance Clinic (INAPC)/Runyan Chiropractic (RC) as your healthcare provider. INAPC/RC is committed to providing you with the best possible medical care. The following information outlines your financial responsibilities related to payment for your medical care. INAPC/RC reserves the right to revise this policy at any time.

INAPC/RC is a private institution that operates for the benefit of people who seek our services. We provide quality care at a fair and reasonable fee, and it is our policy that the responsibility of paying for care will be placed upon those who receive it; therefore, all accounts will be under the following guidelines:

- Cost of Service(s): The cost of service(s) rendered varies based on the extent, focus and testing required at your visit. The patient or guardian is responsible for costs at the time of the patient's visit or upon processing of your insurance claim. Co-pays (if applicable) are collected at time of service. Prices listed below are self-pay prices and collected as time of service.

DR. JOSEPH BALDINO

- Initial Neurology Examination: $500
- Initial Chiropractic Examination: $200
- Neurological Rehab Therapy: $150
- Chiropractic Treatment: $100

DR. KIMBRA RUNYAN

- Initial Examination: $165
- Treatment Session: $110
- Acupuncture: $85
- Chiropractic Adjustment: $65

- Payment Options: We accept cash, personal check, Visa, Mastercard, American Express, Discover, money order, traveler's check and certified check.
- INAPC/RC will not waive, fail to collect or discount patient financial responsibility in accordance with state and federal law, as well as participating agreements with payers.
- Transaction ledgers are available upon request at the front desk.

- **Missed Appointment(s)**: If you are unable to keep a scheduled appointment, it is expected that you call at least 24 hours before your appointment to cancel or reschedule. Please note that cancelations within 24 hours of your appointment are subject to a cancelation fee equal to the cost of the visit.

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NOTICE OF PRIVACY PRACTICES

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

Your Rights

You may:

- Ask to see or get an electronic or paper copy of your medical record and other health information we have about you. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Ask us to correct health information about you that you think is incorrect or incomplete. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- 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 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.
- 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 the disclosures except for those about treatment, payment and health care operations and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but may charge a reasonable, cost-based fee if you ask for another one within 12 months.
- 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.
- Complain if you feel we have violated your rights by contacting the office manager. 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 Ave., S.W., Washington, D.C., 20201; calling 1-877-696-6775; or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

If you:

- Pay for a service or health care item 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.
- 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.

Your Choices

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

If you are not able to tell us your preference, for example, if you are unconscious, we may 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.

Unless you give us written permission, we never share:

- Your information for marketing purposes or sale
- Your psychotherapy notes, in most situations

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

Notice of Privacy Practices continued on next page

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NOTICE OF PRIVACY PRACTICES *(Continued)*

Our Uses and Disclosures

We can use and/or share your health information:

- With other professionals who are treating you
- To run our practice, improve your care and contact you when necessary
- To manage your treatment and services
- To bill and get payment from health plans or other entities
- 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
- For health research
- 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
- With organ procurement organizations
- With a coroner, medical examiner or funeral director when an individual dies
- For workers' 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
- In response to a court or administrative order or a subpoena

For more information, please visit www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Our Responsibilities

We:

- Are required by law to maintain the privacy and security of your protected health information
- Will let you know promptly if a breach occurs that may have compromised the privacy or security of your information
- Must follow the duties and privacy practices described in this notice and give you a copy of it
- 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, please visit 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. Any new notice will be available upon request in our office.

Please list below any individuals you grant access to your health information, e.g., family member, referring physician, etc.

Name:_____Relation:_____Phone Number:_____

Name:_____Relation:_____Phone Number:_____

Name:_____Relation:_____Phone Number:_____

Patient or Guardian Signature_____ Date_____