



Continued from previous page

Describe what caused the pain: \_\_\_\_\_

Describe the quality of the complaint/pain:  sharp  dull/ache  throbbing  tingling/numbness  other: \_\_\_\_\_

Does any of the following make the pain worse:  lifting  bending  pushing  pulling  cough  sneeze  bowel movement  
 driving  riding  sitting  walking  running  standing  
 other: \_\_\_\_\_

Describe if pain is in a single spot or does it spread out:  radiating dull  deep ache  pin point  burning  sharp  stabbing  
 tingling  numb  other: \_\_\_\_\_

Does any of the following make it better:  rest  laying down  sitting  walking  exercise  other: \_\_\_\_\_

How often are you aware of the pain:  intermittent (less than 25% of time when awake)  occasional (25-50% of time when awake)  
 frequent (50-75% of time when awake)  constant (75-100% of time when awake)

Does it interfere with your daily activities:  minimal (annoyance, no impairment)  slight (tolerated, some impairment)  
 moderate (marked impairment)  marked (precludes any activity)

Have you detected any possible relationship of your current complaint with any of the following?

muscle weakness  bowel/bladder problems  digestion  cardiac/respiratory  other: \_\_\_\_\_

Have you tried any self-treatment or taken any medication (over the counter or prescription):  Yes  No

If yes, explain: \_\_\_\_\_ Results: \_\_\_\_\_

## 5 Past Health and Social History:

1. Is this the first time you have experienced this problem?  Yes  No If no, when: \_\_\_\_\_

2. Was treatment provided?  Yes  No If yes, by whom: \_\_\_\_\_ Outcome: \_\_\_\_\_

3. Have you ever had any major illnesses, injuries, broken bones, hospitalizations or surgeries? If yes, please list below:

Date	Injury / Fracture / Illness	Treatment	Results

4. What is your approximate height? \_\_\_\_\_ What is your approximate weight? \_\_\_\_\_

5. Do you regularly exercise?  Yes  No If yes, how many hours a week and what activities: \_\_\_\_\_

6. Do you drink alcohol?  None  Light  Moderate  Heavy How many glasses per week? \_\_\_\_\_

7. Check any conditions you have had:

- |   |  |  |   |  |
|---|--|--|---|--|
| <input type="checkbox"/> AIDS/HIV           | <input type="checkbox"/> Deafness            | <input type="checkbox"/> Herniated Disc      | <input type="checkbox"/> Poor Circulation     | <input type="checkbox"/> TMJ               |
| <input type="checkbox"/> Allergies          | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Prostrate Problems   | <input type="checkbox"/> Venereal Disease  |
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Digestion Problems  | <input type="checkbox"/> Insomnia            | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Vertigo/Dizziness |
| <input type="checkbox"/> Arm/Shoulder Pain  | <input type="checkbox"/> Earache             | <input type="checkbox"/> Irregular Cycle     | <input type="checkbox"/> Sciatica             | <input type="checkbox"/> Other: _____      |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Ear Ringing         | <input type="checkbox"/> Kidney Problems     | <input type="checkbox"/> Shingles             | _____                                      |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Leg Pain            | <input type="checkbox"/> Sinus Infections     | _____                                      |
| <input type="checkbox"/> Bladder Problems   | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Low Back Pain       | <input type="checkbox"/> Smoking              | _____                                      |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Headache – Migraine | <input type="checkbox"/> Neck Pain           | <input type="checkbox"/> Stroke               | _____                                      |
| <input type="checkbox"/> Chronic Fatigue    | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> Thyroid Problems     | _____                                      |

**Office Use Only** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

## 6 **Consent & Treatment:**

*Please read & sign this form below before exam & treatment.*



### **INFORMED CONSENT:**

Medical doctors, chiropractic doctors and physical therapists that perform procedures are required by law to obtain your informed consent before beginning treatment.

I \_\_\_\_\_, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used. Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures. Some risks and complications associated with therapy are as follows:

**Soreness/Bruising:** I am aware that like exercise it is common to experience muscle soreness and occasionally bruising in the first few treatments.

**Dizziness:** Temporary symptoms like dizziness and nausea can occur but are relatively rare.

**Fractures/Joint Injury:** I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.

**Stroke:** Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

**Physical Therapy Burns:** Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor. Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

**Trigger Point Dry Needling (TDN):** is a valuable treatment for musculoskeletal pain. Like any treatment, there are possible complications. While these complications are rare in occurrence, they are real and must be considered prior to giving consent to treatment. The most serious risk associated with TDN is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely only require a chest x-ray and no further treatment. The symptoms of shortness of breath may last for several days to weeks. A more severe lung puncture can require hospitalization and re-inflation of the lung. This is a rare complication and in skilled hands should not be a concern. Other risks may include excessive bleeding (causing a bruise), infection and nerve injury. Bruising is a common occurrence and should not be a concern unless you are taking a blood thinner. As the needles are very small and do not have a cutting edge, the likelihood of any significant tissue trauma from TDN is unlikely. As required by the IDFPR and the ICS, James E. Johnson DC, DIANM, CCEP, ART, FDN/IMS, is qualified to perform trigger point dry needling.

### **TREATMENT RESULTS**

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic and physical therapy, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other person of the doctor's choosing.

### **ALTERNATIVE TREATMENTS AVAILABLE**

Reasonable alternatives to these procedures have been explained to me including, rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.

**Medications:** Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.

**Rest/Exercise:** It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.

**Surgery:** Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.

**Non-treatment:** I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

**I have read or had read to me the above explanation of treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.**

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

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

Parent/Guardian (if a minor) Signature \_\_\_\_\_

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

Witness Signature \_\_\_\_\_

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

## 7 Provisions:



### ASSIGNMENT OF BENEFITS:

Your signature is necessary for us to process any insurance claims and to ensure payment of services rendered. I authorize release of all medical information necessary to process my insurance, workman's compensation or personal injury claims or that is pertinent to my medical care. I assign all medical benefits to which I am entitled to the above named physician or clinic. This agreement will remain in effect until all money owed to the above named physician or clinic is paid in full. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this state of Illinois.

### CANCELLATION AND NO-SHOW POLICY:

We take this subject very seriously as this can make a difference between responding to treatment or not. **We require a 24 hour notice in the event of a cancellation. THERE IS A \$20 CHARGE FOR CANCELLATION OR NO-SHOW WITHOUT PROPER NOTICE.** For worker's compensation and personal injury cases, documentation of any missed appointment is forwarded to your case manager and/or primary physician. This charge will not be covered by your insurance, worker's compensation or personal injury cases, and **IS YOUR RESPONSIBILITY.**

### STATEMENT OF FINANCIAL LIABILITY:

I understand that I am fully responsible for the payment of this account, and hereby assume and guarantee prompt payment of all expenses incurred. I understand that I am responsible for payment of office charges AT THE TIME OF SERVICE. I understand that unless otherwise indicated below, I hereby request and authorize AEC (Active Edge Chiropractic) to bill my insurance policy/policies for all services provided to me. I authorize payment to AEC for all such services. I acknowledge that the fees charged by AEC are considered to fall within the "usual, customary and reasonable" range by most insurance companies. Since your policy is an agreement between you and your insurer, AEC will not enter into any dispute between you and your insurance company. When you begin treatment with AEC, our billing department will call your insurance company to verify that you do have valid insurance coverage. However, that verification is only a confirmation of a valid policy and not a guarantee of coverage. AEC recommends that each patient call and verify their own insurance coverage and benefits by calling member services with their insurance.

### NOTICE OF LIABILITY FOR "NON-COVERED" SERVICES:

I understand that my insurance carrier or Medicare may deny payment or consider some or all services performed by AEC to be "non-covered" and I am fully responsible for payment of all such "non-covered" services.

### ALTERNATE BILLING / PAYMENT INSTRUCTIONS:

By checking the box to the left, I hereby direct AEC TO NOT bill my insurance company for services provided to me and instead I agree to pay all fees for services furnished to me. I further understand and agree that I will be required to provide a down payment prior to receiving the services based on my estimated financial responsibility. AEC does offer assistance with paying for services through an HFA loan. Please ask the front desk for more information.

### PERMISSION TO RELEASE MEDICAL INFORMATION (HIPPA ACKNOWLEDGEMENT):

I authorize AEC to release information from my medical record or from the person for whom I am legally responsible, to my/their insurance company, other third party payers or their reviewing agencies, as reasonably necessary to expedite claim processing. This authorization is valid for every visit to AEC until written notice revoking it is provided. I release AEC of all responsibility or liability for loss of confidentiality through access and/or copies of records release, or other information disclosed in compliance with this authorization.

**I have read or had read to me all of the above and understand/agree to all provisions therein regarding responsibility for payments and release of information.**

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

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

Parent/Guardian (if a minor) Signature \_\_\_\_\_

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

Witness Signature \_\_\_\_\_

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



There is a \$25 fee to use the dispute process. If the Selected Dispute Resolution (SDR) entity reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate, reduced by the \$25 fee. If the SDR entity disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to [www.cms.gov/nosurprises/consumers](http://www.cms.gov/nosurprises/consumers) or call 1-800-985-3059.

**For questions or more information** about your right to a Good Faith Estimate or the dispute process, visit [www.cms.gov/nosurprises/consumers](http://www.cms.gov/nosurprises/consumers), email [FederalPPDRQuestions@cms.hhs.gov](mailto:FederalPPDRQuestions@cms.hhs.gov), or call 1-800-985-3059.

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.
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**PRIVACY ACT STATEMENT:** CMS is authorized to collect the information on this form and any supporting documentation under section 2799B-7 of the Public Health Service Act, as added by section 112 of the No Surprises Act, title I of Division BB of the Consolidated Appropriations Act, 2021 (Pub. L. 116-260). We need the information on the form to process your request to initiate a payment dispute, verify the eligibility of your dispute for the PPDR process, and to determine whether any conflict of interest exists with the independent dispute resolution entity selected to decide your dispute. The information may also be used to: (1) support a decision on your dispute; (2) support the ongoing operation and oversight of the PPDR program; (3) evaluate selected IDR entity's compliance with program rules. Providing the requested information is voluntary. But failing to provide it may delay or prevent processing of your dispute, or it could cause your dispute to be decided in favor of the provider or facility.

**Disclaimer**

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, and your bill is \$400 or more for any provider or facility than your Good Faith Estimate for that provider or facility, federal law allows you to dispute the bill.

The Good Faith Estimate is not a contract and does not require the uninsured (or self-pay) individual to obtain the items or services from any of the providers or facilities identified in the Good Faith Estimate.

**If you are billed for more than this Good Faith Estimate, you may have the right to dispute the bill.**

You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

If you dispute your bill, the provider or facility cannot move the bill for the disputed item or service into collection or threaten to do so, or if the bill has already moved into collection, the provider or facility has to cease collection efforts. The provider or facility must also suspend the accrual of any late fees on unpaid bill amounts until after the dispute resolution process has concluded. The provider or facility cannot take or threaten to take any retributive action against you for disputing your bill.