WholeHealth Chicago
Integrative, Functional, and Alternative Medicine

New Patient Registration

PATIENT INFORMATION

TODAY'S DATE:

Last Name: _____ First Name: _____ Middle Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Telephone: _____ E-Mail: _____ Fax #: _____

Cell Phone: _____ Secondary E-Mail: _____

Birthdate: ____/____/_____ Age: _____ Social Security #: _____- _____- _____ Gender: _____ Married: Y N

Occupation: _____ Student: Y or N Full time: _____ Part time: _____ Work Telephone : _____

Employer Address: _____ City: _____ State: _____ Zip: _____

RESPONSIBLE PARTY INFORMATION

Last Name: _____ First Name: _____ Middle Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Telephone: _____ E-Mail: _____

Birthdate: _____/ _____/ _____ Age: _____ Social Security #: _____- _____- _____ Gender: _____

Occupation: _____ Relationship to Patient: Self _____ Spouse _____ Partner _____ Dependent _____

Employer: _____ Work Telephone: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

Primary Insurance			Secondary Insurance		
Address			Address		
City	State	Zip	City	State	Zip
Insured Name		Date of Birth	Insured Name		Date of Birth
Policy I.D. #	Group #:		Policy I.D. #	Group #:	

OTHER INFORMATION

Illness/Injury is job related: Yes _____ No _____

If yes, Date of Injury: _____

Employer: _____

Employer Contact: _____

Employer Phone # _____

Illness/Injury related to an accident?: Yes _____ No _____

If yes, Date of Accident: _____

Do you have an attorney?: Yes _____ No _____

Attorney Name: _____

Attorney Phone #: _____

How did you hear about our office: Yellow Pages _____ Personal Reference (Name): _____ Other: _____

IN CASE OF EMERGENCY

Name: _____ Relationship: _____ Address: _____

City: _____ State: _____ Zip: _____ Telephone #: _____

PRIMARY HEALTH CONCERN: _____

I HEREBY CERTIFY THAT THE INFORMATION GIVEN ABOVE IS TRUE AND CORRECT.
I UNDERSTAND THAT REGARDLESS OF INSURANCE COVERAGE, I AM ULTIMATELY RESPONSIBLE FOR ALL SERVICES PERFORMED.

PATIENT SIGNATURE OR RESPONSIBLE PARTY SIGNATURE _____ DATE _____

WholeHealth Chicago

Integrative, Functional, and Alternative Medicine

New Patient Intake Form

To our new patients: Welcome to WholeHealth Chicago, Inc! To help us establish you with our practice, please complete the following form. This form has been designed to facilitate our patients' continuity of care at Whole Health Chicago, Inc. This is a confidential record and will be kept in this facility. Information contained here will not be released to anyone without your authorization to do so.

PERSONAL HISTORY FORM

TODAY'S DATE:

Name: _____ Date of Birth: ___/___/____ Age: ____ Gender: _____

Address:_____ City:_____ State: _____ Zip: _____ Phone#: _____

Date of Last Physical Exam: _____ Your Doctor: _____ Referred by: _____

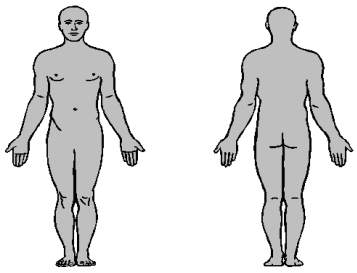
ALLERGIES: _____

_____

MAIN PROBLEMS/ REASONS FOR THIS APPOINTMENT: (if possible, rank in terms of importance to you)

1. _____
2. _____
3. _____
4. _____
5. _____

Please mark your areas of pain/ discomfort on the figures:



Is your condition getting worse? Yes _____ No _____

Is your discomfort Constant _____ or Off and On _____

Have you seen other doctors for these conditions? Yes _____ No _____

(If yes, please list doctor, prior interventions, treatments medication and treatment dates.)

_____

_____

_____

Have you experienced any accidents or falls within the: Past Year _____ Past 5 Years _____ Never _____

(If you have experienced an accident, what type was it? Auto _____ Work _____ Home _____ Sports _____ Other _____

Briefly explain: _____

_____

_____

_____

HEALTH SCREENING HISTORY

List the date of your most recent test or exam.

Mammogram: _____ Pap Smear: _____ Self Breast Exam: _____ Breast Exam by Doctor: _____

Blood test for Anemia: _____ Blood test for Cholesterol: _____ Other Blood Tests: _____

Immunizations: Polio: _____ Tetanus: _____ Hepatitis: _____ Pneumonia: _____ Flu Shot: _____

Test for Blood in stool: _____ Rectal Exam: _____ Feeling the Prostate: _____ Scope Lower Bowel: _____

Self Exam Testicle: _____ Testicle Exam by Professional: _____ P: _____ G: _____

WholeHealth Chicago
Integrative, Functional, and Alternative Medicine

New Patient Intake Form

Patient Name: _____

CURRENT MEDICATIONS	DOSE	TIMES / DAY

CURRENT HERBS/VITAMINS/SUPPLEMENTS	DOSE	TIMES / DAY

PAST MEDICAL HISTORY (Prior Illness, Injury, Hospitalization, Surgery, Trauma)

Date: _____ Reason: _____

PERSONAL AND FAMILY HISTORY: (check all those that apply)

	YOURSELF	MOTHER	FATHER	GRANDPARENTS	SIBLING	SPOUSE	CHILDREN
AIDS							
ALCOHOLISM							
ALLERGIES							
ALZHEIMER'S							
ANEMIA							
ARTHRITIS							
ASTHMA							
BREAST CANCER							
CANCER							
COLON CANCER							
DEPRESSION							
DRUG ABUSE							
EMPHYSEMA							
EPILEPSY							
GLAUCOMA							
HEART ATTACK							
HEART TROUBLE							
HIGH BLOOD PRESSURE							
IRRITABLE BOWEL SYNDROME							
KIDNEY DISEASE							
LIVER DISEASE							
MENTAL ILLNESS							
MIGRAINE HEADACHES							
PNEUMONIA							
PROSTATE CANCER							
SICKLE CELL ANEMIA							
STROKE							
SUICIDE							
TUBERCULOSIS							
ULCERS							

WholeHealth Chicago

Integrative, Functional, and Alternative Medicine

New Patient Intake Form

Patient Name: _____

PATIENT REPORTS (Symptoms that Currently Apply to You)

CONSTITUTIONAL	EAR, NOSE, MOUTH & THROAT	MUSCLES, BONES & JOINTS	DIGESTION & INTESTINE	EYES	IMMUNE SYSTEM	BLOOD SYSTEM
Poor Appetite _____	Headaches _____	Neck Pain _____	Indigestion _____	Blurred Vision _____	Too Many Infections _____	Anemia _____
Fevers _____	Jaw Clicks _____	Back Pain _____	Belching _____	Eye Pain _____	Allergies to Food _____	Easy Bruising _____
Chills _____	Grinding Teeth _____	Muscle Pain _____	Heartburn _____	Poor Vision: Day _____ Night _____	Allergies to Environment _____	Chest Pain _____
Food Cravings _____	Trouble Chewing _____	Painful Joints: Right _____ Left _____	Difficulty Swallowing _____	Wear Corrective Lenses _____	Lymph Gland Swelling _____	Lightheaded _____
Weight Loss _____	Facial Pain _____	Shoulder _____	Nausea _____	Nearsighted _____	Other _____	Palpitations _____
Weight Gain _____	Sore Throat _____	Elbow _____	Liver Trouble _____	Farsighted _____		Cold Hands or Feet _____
Fatigue _____	Mouth Sores _____	Hip _____	Vomiting _____	Other _____		Fainting _____
	Bad Breath _____	Knee _____	Diarrhea _____			Swelling Feet _____
	Ringing Ears _____	Ankle _____	Cramping Bowels _____			Blood Clots
	Nosebleed _____	Wrist _____	Gassy Gut _____			Varicose Veins _____
	Postnasal Drip _____	Finger _____	Constipation _____			
	Sinus Problems _____	Joint Swelling _____	Abdominal Pain _____			
	Trouble with Taste/Smell _____	Muscle Weakness _____	Rectal Pain/Itching _____			
	Poor Hearing _____	Muscle Cramps _____	Hemorrhoids/ Piles _____			
	Earaches _____		Blood in Stool _____			

BREATHING & LUNGS	SEXUAL ORGANS	SKIN, HAIR, BREAST	NERVES, BRAIN, & MOVEMENT	WOMEN	URINE, KIDNEY & BLADDER	REPRODUCTIVE
Shortness of Breath _____	Sores on Genitals _____	Breast Lumps or Pain _____	Seizures _____	Pelvic Pain _____	Painful Urination _____	Age Period Started _____
Wheezing or Asthma _____	Lumps or Swelling _____	Breast Leaks Fluid _____	Nerve Pain _____	Vaginal Discharge _____	Wake up to Urinate_____	Number of Pregnancies _____
Repeated Colds or Flu _____	Erection Problems _____	Rashes _____	Poor Balance _____	Painful Periods _____	Kidney Stones _____	Prengancies Lost _____
Cough, Dry/ Irritating _____	Poor Sexual Response _____	Itching/Hives _____	Poor Coordination _____	Premenstrual Syndrome _____	Loss of Bladder Control _____	Past Fertility Problems _____
	Infertility _____	Hair Loss _____	Tremors or Shaking _____	Hot Flashes _____	Frequent Urination _____	Number of Live Births _____
	Repeated Infections _____	Dry Skin, Eczema _____		Itching or Soreness _____	Sudden Urge to Urinate _____	Children, Currently Living _____
					Blood/Puss in Urine _____	Age Menopause _____

WholeHealth Chicago

Integrative, Functional, and Alternative Medicine

New Patient Intake Form

Patient Name: _____

SOCIAL HISTORY (Check those that apply)

MARITAL STATUS: Single _____ Married _____ Divorced _____ Other _____

EDUCATION LEVEL COMPLETED: High School _____ College _____ Professional School _____ Other _____

MEMORIES OF YOUR CHILDHOOD: Mostly Happy _____ Mostly Painful _____ Normal _____ Don't Recall _____

DO YOU FIND YOUR LIFE: Generally Unsatisfactory _____ Too Demanding _____ Boring _____ Satisfactory _____

LIVING ARRANGEMENT: Alone _____ Family _____ Roommate _____ Other _____

CHILDREN (list ages): _____

MAJOR STRESSES IN LAST SIX MONTHS: Money _____ Job _____ Marriage _____ Home Life _____ Children _____

Other _____

LIFESTYLE / SELF CARE ISSUES

Do you smoke cigarettes?	Yes _____	No _____	If yes, how many? _____ Packs per day
Did you ever smoke?	Yes _____	No _____	If yes, when did you quit? _____
Do you drink alcohol?	Yes _____	No _____	If yes, how much? _____ Drinks per week
Do you drink caffeinated beverages?	Yes _____	No _____	If yes, which? _____
Do you use recreational drugs?	Yes _____	No _____	If yes, which? _____
Do you manage stress well?	Yes _____	No _____	Not Sure _____ Need Help _____
Do you excercise regularly?	Yes _____	No _____	If no, why? _____
Do you enjoy your job?	Yes _____	No _____	If no, why? _____
Do you allow time to unwind and relax?	Yes _____	No _____	If no, why? _____
Do you sleep soundly?	Yes _____	No _____	If no, why? _____
Are you satisfied with your sex life?	Yes _____	No _____	If no, why? _____
Are you satisfied with your social life?	Yes _____	No _____	If no, why? _____
Are you satisfied with your spiritual life?	Yes _____	No _____	If no, why? _____
Is your diet healthy enough?	Yes _____	No _____	Not Sure _____ Need Help _____

TYPICAL BREAKFAST: _____

TYPICAL LUNCH: _____

TYPICAL DINNER: _____

TYPICAL SNACKS: _____

DEVICES

Do You Use:	Eyeglasses _____	Contact Lenses_____	Hearing Aid_____	Dentures _____
	Brace (Neck, Back) _____	Pacemaker _____	IUD, Dlaphragm_____	Artificial Limbs _____

YOUR PRIMARY CARE DOCTOR'S NAME _____ DR's PHONE #_____

YOUR PRIMARY CARE DOCTOR'S ADDRESS _____

May we contact your regular or referring doctor? _____

☐ I HAVE REVIEWED AND CONFIRMED THE INFORMATION WITH THE PATIENT.

_____ _____

PHYSICIAN SIGNATURE DATE

2265 NORTH CLYBOURN AVENUE • CHICAGO, IL 60614 • P: 773.296.6700 • F: 773.296.1131 • WWW.WHOLEHEALTHCHICAGO.COM

WholeHealth Chicago
Integrative, Functional, and Alternative Medicine

Our Financial Policy

WHOLEHEALTH CHICAGO 3, SC
OUR FINANCIAL POLICY

Thank you for choosing WholeHealth Chicago as your health care center. We are committed to your successful treatment. Please understand that full payment of your account is considered part of your treatment. The following is provided to avoid misunderstandings concerning payment for professional services.

We accept cash, personal checks, Visa, MasterCard, American Express and Discover as forms of payment.

REGARDING INSURANCE

- It is your responsibility to understand the benefit and reimbursement policies of your insurance company. We do not verify your insurance benefits; call the number on the back of your insurance card for all inquiries.
- It is your responsibility to provide us with accurate and current insurance information.
- All charges become your responsibility 60 days after the insurance claims have been submitted.
- We are only **IN-NETWORK** with Blue Cross/Blue Shield PPO and Blue Choice Select PPO Plans.
- We are **OUT-OF-NETWORK** with Blue Cross HMO's and all other insurance plans.
- We do not accept Medicaid. We do not submit claims to UMR or Cigna (State of IL) insurances. Payment will be due at the time of service.

"In-Network" Insurance Plans. All co-payments, co-insurance, deductibles, and non-covered services are due at the time of service. You are responsible for payment of all services your insurance company may deny.

"Out-of-Network" Insurance Plans. For your convenience, we will submit claims to most insurance companies. We require a payment equal to 40% of the visit charges to be made at the time of services for all out of network plans. WholeHealth Chicago will wait 60 days for your insurance company to process the claim. After 60 days, any remaining balance will become your responsibility and will be charged or billed according to the Credit Card Agreement.

NON-COVERED SERVICES

Please be aware that some or all of the services provided may be non-covered services and not considered "reasonable and necessary" under the Medicare Program or other medical insurance. Therefore, it is our policy not to bill for certain services including acupuncture, massage, homeopathic consultations, vitamin therapy, intravenous therapy, or any other services considered ineligible by your insurance company.

MISSED APPOINTMENT

Our policy is to charge for missed appointments unless cancelled at least 24 hours in advance. The fee charged is the amount you would have paid at your appointment. Fees vary, but a one hour new patient visit with one of our medical physicians is $300; a two hour new patient visit is $600. Health insurance does not cover late cancelled or missed appointments.

LATE FEES

We depend on timely payment from our patients in order to keep our fees at their current level. To minimize the risk of a late fee, your credit card can be charged when a patient balance is due. Our Payment Agreement Form has an option to allow for a statement to be mailed to you so you may pay by check. If payment is not received within three (3) weeks of the statement date, the balance due will be charged to your credit card. If we are unable to charge the balance, there will be a $10.00 late fee charged to balance.

If payment is not received within six (6) weeks of the first statement date, you will be referred to collections and will be charged a $25 collection fee. If you require payment arrangements, you must contact the office within three (3) weeks of the first statement date. Other financial charges include a $25 returned check fee and a $10 rebilling fee. Patients whose accounts are not in good standing will be asked to pay their balance prior to receiving additional services.

I have read, understand, and agree to this Financial Policy.

_____ _____

SIGNATURE DATE

Relationship to patient (if minor) _____

WholeHealth Chicago
Integrative, Functional, and Alternative Medicine

Our Privacy Policy

With patient consent, WholeHealth Chicago may use and disclose protected health information to carry out treatment, payment, and healthcare operations only. Please refer to WholeHealth Chicago's Notice of Privacy Practices for a complete description of such uses and disclosures, available at the front desk.

WholeHealth Chicago will do its best to protect your private health information while allowing you access to your records.

- WholeHealth Chicago will not sell your information to any third parties for marketing purposes
- WholeHealth Chicago will not release your information for any purposes without your signed consent.
- You have the right to review your medical records and make amendments to those records. Records may be obtained by submitting a written request.
- You have the right to submit a written request that WholeHealth Chicago restrict how it uses or discloses your protected health information.
- You may revoke this consent in writing except to the extent that the practice has already made disclosures with this prior consent.

Please initial where you consent to the following:

_____ WholeHealth Chicago may call my home, or another designated number and leave a message, recorded or with a person, regarding items that assist the practice in carrying out treatment, payment, and operations.

_____ WholeHealth Chicago may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment, and operations.

_____ WholeHealth Chicago may e-mail to my home or other designated location any items that assist the practice in carrying out treatment, payment, and operations.

CONSENT TO TREATMENT
The undersigned acknowledges that he/she has requested healthcare services. The doctors and practitioners of WholeHealth Chicago are authorized to perform any healthcare service deemed necessary. Many of the therapies offered at the center are considered unconventional and may be deemed "unproven" by the Food and Drug Administration. There is no obligation to accept or complete any therapeutic recommendations.

PERTAINING TO ACUPUNCTURE TREATMENT
I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks or acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I hereby assign all benefit payments for services rendered under the terms of my insurance policy to be paid to WholeHealth Chicago.

I have read the WholeHealth Chicago Privacy Policy and Consent to Treatment and thoroughly acknowledge, understand and agree to all of the above information.

Printed name _____

_____ _____
SIGNATURE DATE

Relationship to patient (if minor) _____

WholeHealth Chicago
Integrative, Functional, and Alternative Medicine

E-mail Correspondence Policy when Utilizing the Patient Portal

Due to the ever-increasing number of e-mails received by Drs. Edelberg, Kelley, and Donigan. WholeHealth Chicago will now be charging a nominal fee ($25.00) for some e-mail communications.

Most insurance companies do not yet reimburse for e-mail correspondence, therefore, you will be responsible for this fee. A valid credit card must be on file with the office in order to utilize this service. Drs. Edelberg, Kelley, and Donigan will determine those inquiries to be charged and, as a rule, will be limited to more complex issues. For example, “What time do i take my medicine?” or “Can you refer me to a dermatologist?” will not be charged. However, inquires describing symptoms, asking for treatment advice, and/ or a prescription will be charged the $25.00 fee.

_____ _____

SIGNATURE DATE

WholeHealth Chicago
Integrative, Functional, and Alternative Medicine

Credit Card Agreement

I agree to the following:

CHARGES BILLED TO INSURANCE

1. WholeHealth Chicago will charge the credit card below for services not reimbursed by my insurance company after sixty (60) days.

2. WholeHealth Chicago will collect my outstanding balances including co-pays, co-insurance, deductibles and non-covered services on the credit card below.

3. WholeHealth Chicago will refund any over payment to the credit card below.

4. If I receive direct reimbursement from my insurance company for services not paid to WholeHealth Chicago, I will endorse that check and submit it to WholeHealth Chicago within five (5) business days. Otherwise, I authorize WholeHealth Chicago to collect the full amount of my account balance on the credit card below.

CHARGES NOT BILLED TO INSURANCE

1. If I cancel an appointment with less than 24 hours notice, WholeHealth Chicago will collect the normal office visit fee on my credit card below.

2. If I make a payment by check that has insufficient funds, I authorize WholeHealth Chicago to collect the non-payment plus ($25.00) returned check fee on the credit card below.

3. If I require Pre-Authorization ($25.00), letters ($25.00), insurance forms ($25.00), mailed prescriptions ($25.00), or e-mail medical assistance ($25.00), WholeHealth Chicago will automatically charge my credit card on file.

Check one: ☐ CHARGE or ☐ MAIL statements to me before charging my credit card so that I have the opportunity to pay by check. I understand that if payment is not received within three weeks of the statement date, the balance due will be charged to the credit card listed above. If no box is checked, my credit card will be charged for the full balance due. *All balances $25.00 or less will be charged to this credit card without notice.*

Printed Name _____

CREDIT CARD _____ **DEBIT CARD** _____ **HSA** _____

MASTERCARD _____ VISA _____ DISCOVER _____ AMEX _____

CARD NUMBER_____ EXP_____ CVN_____

_____ _____
SIGNATURE DATE

Relationship to patient (if minor) _____

If the card number provided is invalid or does not accept charges, I understand that I may be subject to late fees and further collections.

_____ _____
WITNESS SIGNATURE DATE

WholeHealth Chicago
Integrative, Functional, and Alternative Medicine

Location Information

WholeHealth Chicago is located at 2265 N. Clybourn Ave., (773) 296-6700

Street parking is available on Clybourn Avenue and adjacent streets.

Routes highlighted in GREEN are currently unregulated street parking within 2 blocks of WholeHealth Chicago.