Matthew J. McIlrath, D.C., C.M.U.A.

DrMattMcIlrath@Yahoo.com

1201 Philadelphia Pike
Wilmington, DE 19809
Phone: 302-798-7033 Fax: 302-798-7216

526 Kennett Pike
Chadds Ford, PA 19317
Phone: 610-388-0388 Fax: 610-388-0188

PATIENT INFORMATION
(General Insurance)

First Name: _____ MI: _____ Last Name: _____

Address: _____

City: _____State: _____ Zip Code: _____

Primary Phone: ( ) _____-_____ Date of Birth: _____

SS # _____-_____-_____ Sex: M☐ F☐ Marital Status: M☐ S☐ D☐ W☐

Email Address: _____

Employer Information:

☐ Employed Full Time ☐ Employed Part Time ☐ Student ☐ Disabled ☐ Retired

If employed, please complete the following:

Occupation: _____

Employer: _____

Address: _____

Work Phone: ( ) _____-_____ Ext: _____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name: _____

Phone: ( ) _____-_____ Relationship: _____

Patient Signature Date

Authorization and release: I authorize payment of insurance benefits directly to the doctor. I authorize the doctor to release all information necessary to secure the payment benefits. I understand I am responsible for all costs of treatment, regardless of insurance coverage. If the patient has an HMO plan that requires a referral, the patient must call their family doctor to obtain prior to the office visit. If you do not have or obtain the referral, the doctor will see you with the understanding that you will be responsible for the entire amount.

(1) Primary Insurance Information:

Insurance Company: _____

Name of Insured: _____

Ins Co. Address:

_____

_____

Ins Co. Phone Number: _____

Policy #: _____Group #: _____

(2) Secondary Insurance Information:

Insurance Company: _____

Name of Insured: _____

Ins Co. Address:

_____

_____

Ins Co. Phone Number: _____

Policy #: _____ Group #: _____

(3) Physician Information:

Physician Name: _____

Physician Address: _____

Physician Phone Number: _____

Name _____ Date: _____

Review of Systems – (Check box if you have had trouble with any of the following)

Cardiovascular			No	**Respiratory**			No	**Allergic/Immunologic**			No
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								**Ear, Nose and Throat**			No
Jaw Pain				**Eyes**			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				**Psychiatric**			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				**Gastrointestinal**			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				PMS				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				**Hematologic**			No				
Pinched Nerves					Past	Present		**Musculoskeletal**			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
				Sweating				Broken Bones			
Weight Loss/Gain				Varicose Vein				Joints Replaced			
Low Energy Level								Neck Pain			
Difficulty Sleeping								Low Back Pain			
								Upper Back Pain			

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Informed Consent of Chiropractic Treatment

I hereby request and consent to the performance of chiropractic treatment including manipulation and other chiropractic procedures including various modes of physiotherapy, massage therapy, and diagnostic x-rays, if necessary, on me / or on the patient named below, for whom I am legally responsible by the chiropractic physician at Health One Chiropractic and/ or anyone working in this office authorized by the chiropractic physician Dr. Matthew J. McIlrath.

I further understand that such chiropractic services may be performed by the physician at Health One Chiropractic and/or other licensed Physicians of Chiropractic who may treat me now or in the future at this office. I have had an opportunity to discuss with Dr. Matthew J. McIlrath and/or with other office or clinic personnel the nature and purpose of chiropractic treatment and other procedures. I understand that results are not guaranteed.

I understand and am informed that the practice of Chiropractic Medicine, an in all healthcare, carries some risks of treatment which are minimal; including, but not limited to: fractures, disc injuries, strokes (CVA), dislocations, and sprains. I do not expect the physician to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests at the time, based upon the facts then known.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my physician. I intent this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at this facility in the future.

To be completed by the patient:

_____
Print Patientôs Name

_____
Signature of Patient

_____/_____/_____
Date

To be completed by the patientôs Representative, if necessary, (e.g. If the patient is a minor or is Physically or mentally incapacitated)

_____
Print Name of Representative

_____
Signature of Representative

_____/_____/_____
Date

Physician Signature _____ Date _____/_____/_____

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Patient Survey

Dear Patient,

Please complete this survey and return it to the front desk before you leave today.

1. Are you presently taking any type of nutritional supplements (such as vitamins, minerals, herbs, amino acids, fish oils, etc.)? ____Yes ____ No
2. If you answered yes to question 1, please check the types of supplements you are taking.

   ____ Multivitamin ____ Minerals ____ Vitamin C

   ____Omega Oils (Fish Oils) ____ Calcium ____ Beta Carotene

   ____Vitamin B Complex ____ Antioxidants (Vitamins A & E)

   ____ Prostate Formula ____ Womenôs Formula

3. Please list any supplements that you are taking that are not listed above.

4. Who recommended that you take these supplements?
   ____ Advertisement ____ Family or Friend ____ Store Clerk
   ____ Health Professional ____ Other

5. Are your supplements physician grade? ____ Yes ____ No
6. If this office offered group nutrition seminars designed to help improve your dietary habits, would you consider attending? ____ Yes ____ No
7. Are you interested in a comprehensive weight management program?

   ____ Yes ____ No

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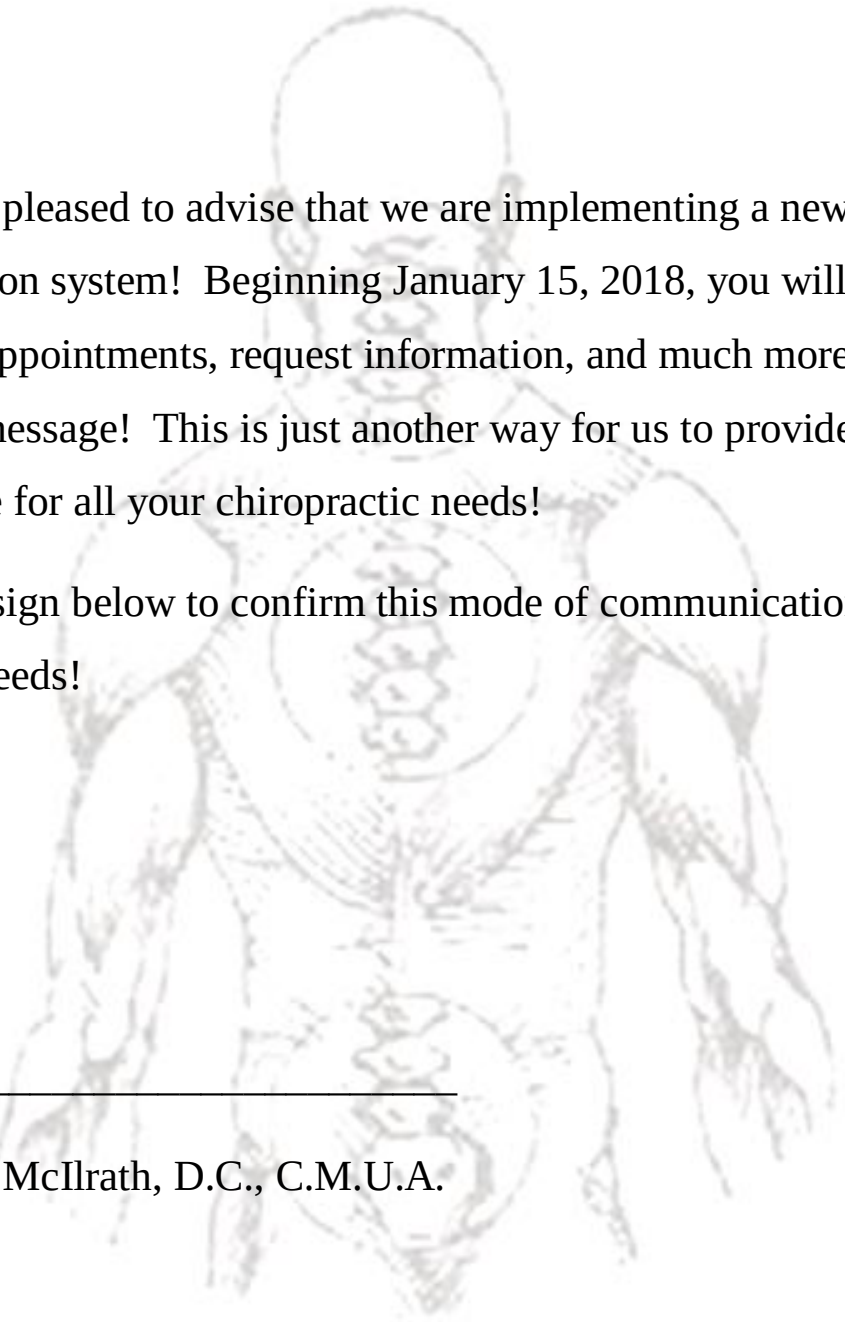

We are pleased to advise that we are implementing a new communication system! Beginning January 15, 2018, you will be able to schedule appointments, request information, and much more with a simple text message! This is just another way for us to provide you with better service for all your chiropractic needs!

Please sign below to confirm this mode of communication for your health care needs!

Thank you,

_____

Dr. Matthew McIlrath, D.C., C.M.U.A.

_____ _____

Patient Name (Print) Patient Signature

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PROMISE TO PAY AGREEMENT

This agreement made and entered on this day, _____, between Health One P.A. and _____, for services rendered by Dr. Matthew McIlrath and or his associates of Health One P.A. I promise to pay Health One P.A. co-pays and deductibles applied by said insurance.

I agree to be responsible for any balance not covered by said insurances.

The payment will be effective after the final payment from said insurance.

You will be expected to pay the balance until paid in full and failure to comply may result in legal ramifications of this promissory note. You will be responsible to pay all legal fees from this point forward if your balance goes into default.

You may be offered a payment plan to make a payment agreement to pay the balance in full over an agreeable period of time.

Upon signing this promissory note you are agreeing to pay any balance owed to Health One P.A. and you understand the term and conditions to the promissory note.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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CONSENT AND AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Name (Print Name): _____

Consent: Federal regulations allow us to use or disclose protected health information from your record in order to provide treatment to you, to obtain payment for the services we provide, and for other professional activities known as ñhealth care operationsò (for example, quality improvement activities).

With this consent form, we are asking you make this permission explicit. By signing this consent, you are giving us permission to use or disclose your protected health information for these activities.

Authorization: This information is for the use or disclosure of your personal health information to: 1) Any insurance company or insurance adjuster involved in this case to receive payment for services provided. This will expire when paid in full for services rendered, 2) Any current or future attorney(s) representing you for this case to assist in the settlement of the case and to acquire payment for treatment when necessary. This will expire upon settlement of the case, 3) This authorization is also for adding your picture to our ñWall of Fameò. This will expire when the ñWall of Fameò is disassembled.

I hereby authorize the use or disclosure of my protected health information as specified above. I understand that this is a consent and authorization that is voluntary and that I may refuse to sign it. I understand that I may revoke this consent and authorization by giving written notification to my provider or any other member of the office staff. A revocation will not affect any action taken in reliance on the consent and authorization prior to revocation. Other limitations on my right to revoke this consent and authorization may be found in my providerôs Notice of Privacy Practices. I understand that, if the recipient is not a health care provider or health plan, the information disclosed under this consent and authorization may no longer be protected by federal privacy regulations and may be redisclosed by the recipient. I understand that I should receive a copy of this consent and authorization, even if I do not ask for it.

I understand that, I may ask you to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment, payment, or health care operations. However, you do not have to agree to these restrictions. If you do agree to a restriction, the agreement is binding.

I understand that treatment may not be denied if I refuse to sign this consent and authorization, except: 1) If the authorization is the very reason for seeking the healthcare. (e.g., a pre-employment physical), that health care may be denied; or 2) If the authorization is for disclosure to research study, I may be denied the treatment that is part of the study. In addition, the following consequences might occur if I refuse to sign this authorization; (1) If the authorization is to demonstrate to a health plan that a service should be paid eligibility, the insurer may deny me the coverage I am seeking.

_____ _____

Signature of Patient (or personal representative) Date