Wilkinson Clinic of Chiropractic
115 E. Waverly Street, Morris, IL 60450
Phone: (815) 942-5350 Fax: (815) 942-5414

Date_____
Account # _____
X-ray #_____

Patient Demographics

Name_____ Preferred Phone [Home/Cell] ( ) _____

Address_____ City_____ State_____ ZIP_____

Age _____ Birthdate _____/_____/_____ Social Security # _____ Email_____

Gender M / F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Student

Occupation _____ Employer _____ Work Phone ( ) _____

Emergency Contact _____ Phone ( ) _____ Relationship _____

Date of Last Physical Exam _____ Referred By _____

Patient's Primary Care Physician _____ Permission to Contact Yes / No

I consent to receive reminders via text and email. Yes / No

I consent to receive news and promotions via email. Yes / No

Medical Information

Are you taking any medications? Yes / No

If yes, please list name and use:

Are you currently pregnant? Yes / No How far along? Any high-risk factors?

Do you suffer from chronic pain? Yes / No If yes, please explain.

What makes your pain feel better?

What makes your pain feel worse?

Have you had any orthopedic injuries? Yes / No

If yes, please list:

Please indicate if any of the following apply to you:

__ Cancer __ High Blood Pressure __ Kidney Dysfunction

__ Headaches/Migraines __ Neuropathy __ Blood Clots

__ Arthritis __ Fibromyalgia __ Numbness

__ Diabetes __ Stroke __ Sprains or Strains

__ Joint Replacement __ Heart Attack

Explain any conditions you have marked above:

Massage Information

Have you had a professional massage before? Yes / No

What type of massage are you seeking?

__ Relaxation __ Therapeutic/Deep Tissue __ Other

If other, please explain.

What pressure do you prefer?

__ Light __ Medium __ Deep

Do you have any allergies or sensitivities? Yes / No

If yes, please explain.

Are there any areas you do not want massaged? (Ex: Feet, face, abdomen, etc) Yes / No

If yes, please explain.

What are your goals for this treatment session?

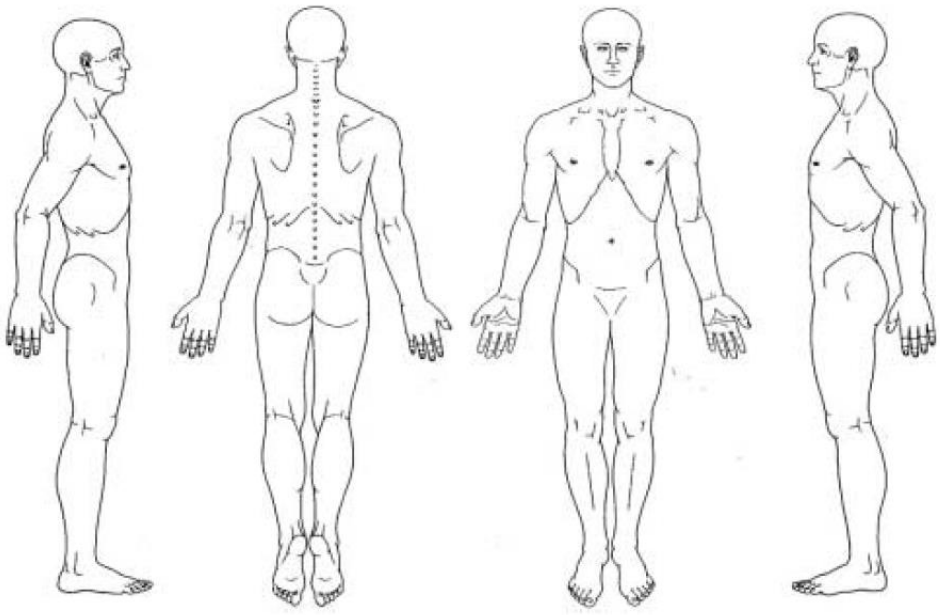
Please list any areas of discomfort (upper back, middle back, low back, shoulders, etc.)

My pain is greater on the: __Right __ Left __Both

Body Chart

Please indicate with an (**X**) any areas you are feeling discomfort.

For each (**X**), indicate the type of discomfort you are feeling with **P** (pain), **M** (muscle spasm), **R** (restriction) and **S** (swelling).



With this signature, I certify the above medication information is correct and complete to my knowledge.

Signature _____ Date _____

Massage Financial Policy of
Wilkinson Clinic of Chiropractic

Explanation of Coverage: Patient insurance is a contract between the patient and their insurance provider, not Wilkinson Clinic of Chiropractic or its employees. This office **WILL NOT FILE ANY MASSAGE SERVICES CLAIMS TO YOUR INSURANCE**. Any massage services performed at Wilkinson Chiropractic are on a cash basis and are the responsibility of the patient when massage services are rendered, unless otherwise agreed upon with the Massage Club authorization. It is the further agreement between the undersigned and Wilkinson Clinic of Chiropractic as follows:

- It is our office policy that payment for services rendered is ultimately the responsibility of the patient, whether you have third party assistance with your financial obligation or are a self-pay patient. We are happy to extend a payment plan to you so that you can follow through with all the care you may require.
- Unless agreed to in writing, all payment for treatments, deductibles, and co-payments are due at the time of service. If we participate in your plan, you will not encounter balance billing above the stated fee schedule. If we do not participate, we will work with you to determine the amount of coverage and help estimate your responsibility.
- For your convenience, this office accepts cash, checks, and the following credit cards: Visa, MasterCard, American Express, and Discover.
- Should payment be refused by your bank for any check written, this office will charge a fee of $25 to offset the charges we will incur as a result of the returned check.
- Should you discontinue care for any reason, other than discharge by the doctor, any and all balances will become due and payable at that time. If you are on a predetermined payment plan, that plan will continue to be in effect until your balance is zero.
- *This office does not turn away any patient due to their ability to pay. If you feel you might qualify for our financial hardship policy, notify the office immediately so we can begin your qualification process.*

Collection Notice: A penalty of 50% of the unpaid balance will be assessed against undersigned in addition to any balance due and owing if full payment is not received within 90 days of notice of balance due.
Waiver: That no assent, express or implied, by Wilkinson Clinic of Chiropractic, to any breach of any of the agreed upon terms, shall be deemed to be a waiver of any succeeding breach of the same covenant.
Default: If your account is more than 90 days past due, this office reserves the right to pursue any legal remedies at law or in equity and the prevailing party shall be entitled to collect reasonable attorney's fees and costs from the losing party.

Cancellation Policy: Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapist's day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or change to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, will be charged a cancellation fee. Fees are as follows: ***30 minute = $35, 60 minute = $55, 90 minute = $80, 120 minute = $95*** Initial_____

Patient Name (Print): _____ Patient Signature: _____

Date: _____

Guardian Name (Print): _____ Guardian Signature: _____

CHIROPRACTIC INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physio therapy, diagnostic x-rays, massage and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by Dr Phillip H Wilkinson or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working for, or serving as back-up for Dr Phillip H Wilkinson, including those working at the clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of the office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, 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 the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment like massage, is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure.

I further understand that there are treatment options available for my condition other than chiropractic or massage procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Name of Patient:_____ Date:_____

Patient Signature:_____ OR Guardian Signature:_____

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Morris, Il 60450
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www.drphilwilkinson.com

Patient Acknowledgements

For use and/or disclosure of Protected Health Information (PHI)
To carry out Treatment, Payment and Healthcare Operations

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been offered to me prior to my signing this Consent, and is readily available both in the clinic and if I ask. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice would be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice.
3. The practices "NOPP" is provided at the clinic, may also request a copy via fax, email, or mail.
4. The "NOPP" also describes my rights and the duties of this office with respect to my PHI.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand. _____INITIAL

RELEASE OF INFORMATION

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, adjuster or any other person necessary for you to process any claim for reimbursement of charges incurred by me at your health care facility _____ INITIAL

RIGHT TO RECEIVE PAYMENT

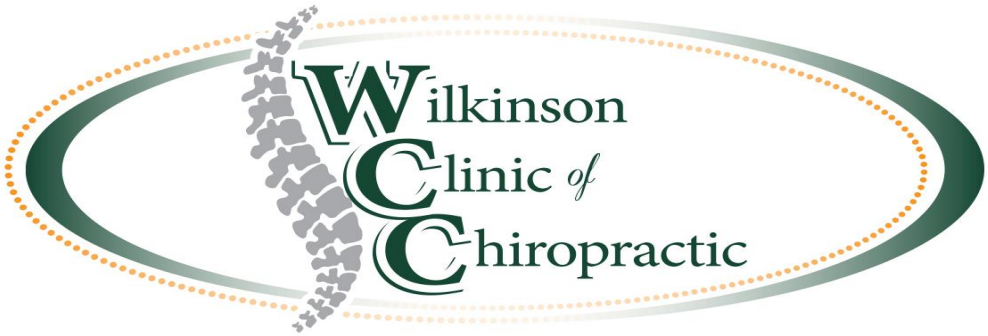
I authorize and sign to you, Dr. Wilkinson, to receive direct payment from my attorney, insurance company or any other party who may become obligated to pay me any sums. I further authorize endorsements of my name to any draft containing my name to which you are legally entitled. If your insurance carrier sends you payment for services incurred in this office, you shall send or bring full payment to our office immediately upon receipt. _____ INITIAL

VOLUNTARY TERMINATION OF CARE

I understand that if I suspend or terminate my care at any time, prior to Dr Wilkinson's recommended care, that my portion of all charges for professional services are immediately due and payable to Dr Wilkinson. All services performed by Dr Wilkinson will be directly charged to me, and ultimately I will be responsible for payment regardless of insurance coverage. _____INITIAL

_____ _____
Name of Individual (Printed) Signature of Individual

_____ _____ _____
Signature of Legal Representative Date Signed Relationship



PLEASE FILL THIS OUT IF MAY UTILIZE BOTH MASSAGE AND CHIROPRACTIC.

I, _____ both understand, and acknowledge the following.

Dr. Phillip Wilkinson and Wilkinson Clinic of Chiropractic were the host via a rental agreement for massages services performed by Patty Dinovo. As of 8/1/24 there is no longer a rental agreement and Patty Dinovo is now an employee of Wilkinson Clinic of Chiropractic. With my signature below I acknowledge there is no longer any financial tie to Comprehensive Pain and Wellness and any services provided are that of an employee of Wilkinson Clinic of Chiropractic and therefore billable by Wilkinson Clinic of Chiropractic only.

As such, I understand that a recommendation for massage by Dr Wilkinson does not mean I have to choose Patty DiNovo and can choose any LMT I wish.

Furthermore, I understand that a recommendation from Patty Dinovo to receive chiropractic does not mean that I have to see Dr Wilkinson and can choose any chiropractor I would like.

I acknowledge that I am voluntarily choosing to utilize both entities at 115 E. and can change one or both services at any time.

Patient/Client Signature:_____ Date:_____