Chiropractic Associates of Kankakee, Inc.
Dr. Brent W. Adams, Chiropractor
535 E North St Ste A, Bradley IL 60915
(815) 614-3073

Staff use	
Account #	______________
Date:	________________

Confidential Patient Questionnaire

→ PLEASE NOTIFY US IF CONDITION IS DUE TO WORK OR ACCIDENT ←

PERSONAL DATA		
Patient Name: *(Last, First, M.I.):*		❑ **Male** ❑ **Female**
Called Name:	**Date of Birth:**	**Age:**
Address: *(Street):*	**Social Security #**	
(City, State, ZIP):	**Marital status:** ❑ **S** ❑ **M** ❑ **D** ❑ **W**	
Best Phone:	**Email:**	
Additional Phone:	**Emergency Contact Name:**	
Employment Status: Employed Retired Student Unemployed	**Emergency Contact #**	
How Did You Hear About Us?		

CONTRACT FOR SERVICES

Print Patient Name:____

By signing below:

- I understand that I am responsible for all fees for services performed in this office, and I agree to pay all fees for services provided to me at the time of visit. I understand that any insurance benefits, which I have, are a contracted arrangement between that insurance company and me. This office will be responsible for preparing notes, billing receipts, and informational reports as needed to aid in insurance payment/reimbursement. This office is required by law to file all Medicare claims for its patients.
- I understand and agree to the terms of this contract for professional services with Chiropractic Associates of Kankakee and I consent to diagnosis and treatment. I realize there is no guarantee of results, and have been informed that some risks of treatment do exist. While I do expect my doctor to use his/her best judgment to choose the most appropriate care for my condition. I agree that the doctor cannot foresee every possible complication/risk, which could arise in my treatment.
- (For **Females only**) To the best of my knowledge I am **Pregnant** or **Not Pregnant (please circle one).**
- I hereby give permission to the Doctor to release any information requested by my insurance company acquired in the course of my examination and treatment. I authorize insurance benefits to be paid directly to Chiropractic Associates of Kankakee.
- Under the Health Insurance Portability and Accountability Act (HIPAA), I authorize the release of any information necessary to process my insurance or other benefits.
- I give the physicians and staff of Chiropractic Associates of Kankakee, Inc. permission to treat the minor child that I have guardianship of and will abide by the above stated contract for services rendered to the above mentioned minor child.

Signature of Person Responsible for Payment:_______________________________________ **Date:**_____________

For Minor: Guardian Signature____**Date:**_____________

Witness: _______________________________________