Dr. Miravone Dorough, DC, ND

at Estuary Center for Living & Healing Arts

24W788 75th Street
Naperville, IL 60565
Phone: 331. 442. 9912
Fax: 331. 200.3458
info@DrMiravone.com

Welcome!

Dr. Miravone specializes in Naturopathic & Chiropractic medicine and is available to answer any of your questions about how she can serve you to improve your health as much as possible. She will work as your advocate to integrate alternative medicine into your life to optimize your health! She will utilize Naturopathic medicine, lifestyle guidance, clinical and functional nutrition, homeopathy, botanical medicine, emotional wellness, acupuncture, and Chiropractic medicine to provide you with the most well rounded care possible.

Naturopathic physicians are trained to work with the body's natural healing mechanisms as well as using the power of nature to improve your life without harmful side effects, lifelong requirements, and suppression of symptoms. She will dive deep into your health by utilizing a complex first office visit (90 minutes) that will include a detailed comprehensive history, blood work, physical exam, and explanation of every aspect of your treatment plan so you can take charge of your health.

Dr. Miravone maintains her Chiropractic licensure and works under her scope as a Chiropractor in Illinois. Dr. Miravone obtained both doctoral degrees from the fully accredited school, National University of Health Sciences in Lombard, IL and has passed ALL of her medical board exams necessary to obtain licensure. Dr. Miravone is currently licensed as an ND in Vermont & has passed the licensing exams. Since NDs are not currently licensed doctors in IL, it is imperative that board certified NDs maintain a license in a licensable state. Naturopathic physicians are trained as primary health care practitioners and receive doctoral degrees from accredited four-year Naturopathic medical colleges (with a four-year Bachelor's degree requirement). Naturopathic doctors are currently licensed in the following states: Alaska, Arizona, California, Colorado, Connecticut, District of Columbia, Hawaii, Kansas, Maine, Maryland, Minnesota, Montana, New Hampshire, North Dakota, Oregon, Utah, Vermont, Washington, and the U.S territories of Puerto Rico and Virgin Islands. Please visit www.naturopathic.org for more information about licensure and information regarding training of Naturopathic doctors.

General information:

Office visits- The first office visit with Dr. Miravone will be scheduled for 90 minutes and following return office visits will be scheduled for 30 minutes. All patients will be seen on an appointment basis. Patients must cancel their appointment AT LEAST 24 hours **before** the scheduled time or will be charged $250 for new visits and $100 for return office visits/therapies. Appointments that are 15 minutes or MORE late to their appointment will be asked to reschedule or accrue a missed appointment fee. *****CREDIT CARDS ARE REQUIRED TO HOLD YOUR APPOINTMENT AND WILL BE AUTOMATICALLY CHARGED IN THE EVENT OF A LAST MINUTE CANCELLATION*****

Telephone consultations- Patients are free to call and ask questions (email can be an option for clarification of treatment plan or miscellaneous questions). If the phone consultation requires a visit, the patient will be asked to make an appointment right away. Telemedicine visits are also an option for patients. Please inquire for more information.

Payment- ALL payment (co-pay, therapies, etc) is due in FULL at time of visit.

Insurance- Currently accept ***Blue Cross Blue Shield IL-PPO.*** All other networks would be considered "out of network"

Past due amounts- For amounts not paid in full, a finance charge of 1.5% will be added. Past due accounts shown to have zero activity for more than 90 days will be turned over to a collection agency.

Credit cards are **required on file as a convenient method of payment in the event of a last minute cancellation (less than 24 hours) or for portions that your insurance does not cover, which you are liable for.
We keep your credit card on file for the following instances: 1. Your credit card on file will be charged for any outstanding balance owed after two billing cycles (60 days). 2. You arrive for an appointment and there are late cancellation and/or no-show fees owing. These will be charged on the day of that appointment to the card you provide or card on file. 3. Proof of insurance is required at each visit. If you do not provide insurance information by the following day after an appointment, the cost of the visit will be charged to the credit card on file. Your credit card information is kept confidential and HIPAA secure. Payments to your card are processed only after the claim has been filed and processed by your insurer, the insurance portion of the claim has paid and posted to the account, and 60 days have passed since initial bill. You can go to the patient portal and add a credit card to have on file yourself or we are happy to do it for you.

Credit Card Number

_____

Exp Date _____ **CVC** _____
Billing Address: _____

Please initial below:
___I understand
___I, the undersigned, authorize and request Dr. Miravone Dorough to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility or that were non covered services. This authorization relates to all payments not covered by my insurance company for services provided to me by Dr. Miravone Dorough. This authorization will remain in effect until I cancel this authorization. To cancel, I must give a 60 day notification to Dr. Miravone Dorough in writing and the account must be in good standing.*

PATIENT (OR LEGAL GUARDIAN) SIGNATURE* _____

If Legal Guardian, please type name here: _____Date _____

Please arrive 15 minutes early for your FIRST office visit to check in and finish any additional paper work.
Please sign here to signify that you read the content of this letter _____
Date _____

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Personal Information

Name _____ **Today's Date** _____

Address **City** **State** **Zip**

_____ _____ _____ _____

Home Phone _____ **Cell Phone** _____

Email **Date of Birth** _____ **Age** _____

_____

Height _____ **Weight** _____

Marital Status _____**S** _____**M** _____**D** _____**W** **Spouse/Partner** _____

Occupation _____ **Employer**_____

Emergency Contact _____- **Relationship** _____ **Phone** _____

Health Insurance Company **Member ID**

_____ _____

Name of Insured _____ **Insured's Date of Birth** _____

Whom may we thank for referring you to our office?

_____

Current Condition

Primary Health Concerns/Date the symptoms/conditions began

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

Have you seen anyone for this condition(s)? **Have you had it before? _____Y_____N**
_____

Is this condition getting worse? ____Y_____N

How do you rate your physical health.

_____

How is this issue affecting your life?

_____

_____

_____

Health Information

Supplements currently taking (brand and dosage preferred)

_____

_____

_____

_____

_____

Medications currently taking (dosage preferred)

_____

_____

_____

_____

_____

Do you exercise regularly? If so, how often? _____

Have you ever received Chiropractic, Naturopathic, or acupuncture medicine? _____Y _____N

Doctor: _____

Approximately how long were you under care? _____ **Date of last visit?** _____

Why did you stop?

_____

How many cigarettes/packs per day?
_____

How many alcoholic drinks per day?
_____

Do you have any allergies to foods? _____ Y _____ N

If yes, please list

_____

Date of last physical exam/doctor visit:

_____

Results of exam:

_____

Date of last cholesterol test:

_____

Results of exam:

_____

History of Past Injuries

List any surgeries you have had

_____

List any accidents/injuries/broken bones

_____

Have you ever injured your spine, head, neck ribs, chest back, pelvis or hips?
_____Y _____N

If yes, state type of injury and year

_____

Have you ever injured, broken, fractured or sprained any bones or joints? _____Y _____N

If yes, state type of injury and year

_____

Have you ever been hospitalized? _____Y _____N

If yes, state reason and year

_____

For Women

Are you pregnant? _____Y _____N Date of last menstrual period _____

Date of last Pap Smear/Pelvic Exam: _____

Date of last Mammogram: _____

History of abnormal Pap Smear/Pelvic Exam? _____Y _____N

If x-rays are recommended, your signature is required to indicate you are NOT pregnant.

Signature:
_____ **Date:** _____

If pregnant, due date _____

For Men (over 35 years old)

What was the date of your last digital rectal exam (prostate exam)?

_____

Results:

_____

When was your last PSA (Prostate Specific Antigen) blood test? **Results:**

_____ _____

Confidential Health History

The following items may relate to your current condition. In the space in front of each item, place a P if you PRESENTLY have the problem and an H if you previously HAD the problem. Leave space blank if you NEVER had the problem.

GENERAL
_____ Anemia
_____ Allergies
_____ Bleeding Problem
_____ Cancer/Tumors
_____ Diabetes
_____ Epilepsy
_____ Fainting or Seizures
_____ Fibromyalgia
_____ Gout
_____ Hepatitis
_____ High Cholesterol
_____ Loss of Sleep
_____ Multiple Sclerosis
_____ Night Sweats
_____ Osteoporosis
_____ Tiredness
_____ Thyroid Problems
_____ Weight Loss or Gain

GASTROINTESTINAL
_____ Poor Appetite
_____ Black or Bloody Stools
_____ Bloating/Gas
_____ Colitis/IBS
_____ Constipation
_____ Diarrhea
_____ Excessive Hunger or Thirst
_____ Hemorrhoids
_____ Hernia
_____ Indigestion
_____ Liver Disease
_____ Loss of Bowel Control
_____ Nausea
_____ Reflux
_____ Stomach Pain
_____ Liver Problems
_____ Ulcer
_____ Vomiting

CARDIOVASCULAR
_____ Chest Pain
_____ Heart Disease
_____ High Blood Pressure
_____ Irregular Heartbeat
_____ Low Blood Pressure
_____ Pacemaker
_____ Poor Circulation
_____ Stroke
_____ Swelling of Ankles
_____ Varicose Veins
_____ Heart/Lung Defect

WOMEN ONLY
_____ Abnormal Periods
_____ Dysmenorrhea
_____ Endometriosis
_____ Extreme Cramps
_____ Hot Flashes
Date of Last Period _____
Last Mammogram _____
Last Pap Smear _____

MEN ONLY
_____ Prostate Problems
Last Physical _____

RESPIRATORY
_____ Asthma
_____ Difficult Breathing
_____ Chronic Cough
_____ COPD
_____ Emphysema
_____ Pneumonia
_____ Tuberculosis
_____ Wheezing

NEUROLOGIC/MENTAL
_____ Anxiety
_____ Anger/Aggression
_____ Attention Deficit
_____ Psychotic episodes
_____ Tremors
_____ Mental Disorder

MUSCULOSKELETAL
_____ Spinal Curvature
_____ Arthritis

GENITO-URINARY
_____ Bladder Trouble
_____ Difficulty Starting/Stopping Flow
_____ Frequent Urination
_____ Painful Urination

FAMILY HISTORY
_____ Cancer
_____ Diabetes
_____ Heart Disease
_____ High Blood Pressure
_____ Kidney Disease
_____ Muscle, Bone or Nerve Disease
_____ Thyroid Disease/Goiter
_____ Tuberculosis
_____ Other

Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s) and physical therapy techniques, on myself (or on the patient named below for which I am legally responsible) which are recommended by the Doctor(s) of Chiropractic (Dr. Miravone Dorough).

I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with Dr. Miravone Dorough and/or with office personnel, the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read ( ) or have had read to me ( ) the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

Signature of Patient/Guardian: _____

Date: _____

Signature of Insured (If Different): _____

Date: _____

Privacy Policy (HIPAA)

We are required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information. If applicable, we may disclose your health information, as deemed necessary by law, to comply with state Workers' Compensation Laws,

in cases of medical emergencies, to aid public health agencies such as the CDC and FDA, Governmental agencies as required by law, law enforcement officials and to comply with a court order, pre-approved agencies for purposes of organ donation or research, or to proper authorities as recognized by the state in order to assure public safety. Your rights include the ability to request (only) restriction on certain uses and disclosures, to receive protected information by alternate means or at an alternate location, to have your physician amend your protected health information or file a statement of disagreement with your physician, and to receive an accounting of certain disclosures your physicians have made (if any). A more detailed explanation of these rights and responsibilities is readily available upon request, or at www.hfa.gov/medicaid/hippa.

Signature of Patient/Guardian: _____

Date: _____

Signature of Insured (If Different): _____

Date: _____

Thank you for choosing Dr. Miravone Dorough @ Estuary Center for Living & Healing Arts!

I look forward to improving your health!