DENVER CHIROPRACTIC CENTER

BACKGROUND INFORMATION:

Name: _____ Date: _____

Address: _____ Home Phone: _____

City: _____ State: ____ Zip: _____ Cell Phone: _____

Birth date: _____ Gender: M F Marital Status: M S Height: _____ Weight: _____

No. Children: _____

Please provide us with your email address so that we can communicate with you about your appointments and treatment program, including possibly emailing your rehab exercises to you.

Email: _____

Occupation: _____ Years There: _____

Employer: _____

How did you hear about us? _____

Describe your major complaint: _____

When did this start? _____ Is it: □ getting better □ getting worse □ the same

How did it start? _____

Other complaints? _____

_____

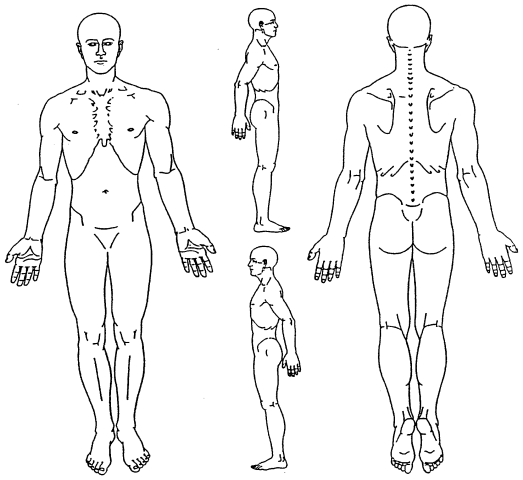
We offer two types of treatment programs in our office, please choose the one that is more appropriate for you:

_____ACUTE SYMPTOM CARE: I am only concerned about relief of symptoms at this time.

_____CORRECTIVE /PREVENTATIVE CARE: I am concerned about symptom relief AND finding the underlying causes in order to prevent the return of symptoms in the future.

Denver Chiropractic Center.
Glenn D. Hyman, D.C., C.S.C.S. 1780 South Bellaire Street, Suite 710. Denver, CO 80222
Voice 303.300.0424 Fax 303.648.5456 www.denverback.com

Please mark the areas of your symptoms below.



Use letters below to indicate type and location of discomfort		
A = ACHE	**B = BURNING**	**C = STABBING**
N = NUMBING	**P = PINS & NEEDLES**	**O = OTHER**

INSTRUCTIONS: Please circle the number that best describes the question being asked.
NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your average pain levels and pain at minimum / maximum using the last 3 months as your reference. If you have completed this form before, indicate your average pain level since the last time you completed this form.

EXAMPLE:

headache **neck** **low back**

no pain _____ **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

##

1. What is your pain RIGHT NOW?

no pain _____

0 1 2 3 4 5 6 7 8 9 10

2. What is your TYPICAL or AVERAGE pain?

no pain _____

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

no pain _____

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its best? _____%

4. What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

no pain _____

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its worst? _____%

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LIFESTYLE QUESTIONNAIRE

Please answer all questions frankly, to the best of your knowledge.

Blood Pressure (if known) _____ % Body Fat (if known) _____

1. Any surgeries, hospitalizations, recent illnesses?

   _____

   _____

2. Any medications or supplements? _____
3. How would you describe your diet: ☐ good ☐ okay ☐ bad
4. Describe your caffeine intake: Coffee: cups/day _____

   Other sources? _____

   Do you smoke? Y / N

   Do you use alcohol? Y / N
5. List what kinds of exercise do you do and how often you do them:

   _____

   _____

6. Rate your energy level: ☐ Very Low ☐ Low ☐ Average ☐ Excellent ☐ Highs and Lows
7. Have you been having any problems with :

Eyes.	☐ Yes	☐ No
Ears.	☐ Yes	☐ No
Nose.	☐ Yes	☐ No
Teeth / Mouth / Throat.	☐ Yes	☐ No
Skin.	☐ Yes	☐ No
Heart / Cardiovascular system.	☐ Yes	☐ No
Lungs / Respiratory system.	☐ Yes	☐ No
Digestive system.	☐ Yes	☐ No
Reproductive system.	☐ Yes	☐ No

If yes, please explain:

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PAYMENT POLICY*

We offer 2 options regarding payment in this office.
Please mark an **X** next to the one you choose:

____ 1. **Check here if you have Anthem Blue Cross / Blue Shield, United Healthcare, Aetna, Humana, or an auto insurance case (If your plan is not listed here, please ask).**

Policy # _____ Group # _____

This office is under contract with these companies, and must bill them. The fee schedule is determined by each carrier, not by us. **You are responsible for your co-pays at the time of service and any deductibles on your policy.** We are contractually bound by their fee schedules, but you are still ultimately responsible for your account.

____ 2. **Pay for services when they are rendered, $60, and, if you have insurance, seek reimbursement from your insurance company yourself.**

You will get a receipt for payment if you request one. You may then submit this receipt to your insurance company and seek reimbursement directly from them. Please be aware that we will **not** communicate with your insurance company on your behalf. Nor will we return their phone calls or respond to their letters. **You must deal with them directly.** We will, however, communicate with you if needed.

Cancellation policy:

If you must cancel an appointment, please do so at least 24 hours before the scheduled time. Without 24 hour notice, there will be a $60 fee. Weather-related exceptions will be considered, as well as legitimate emergencies.

I understand this disclosure. I agree that a copy of this document shall serve as original. I understand that my health insurance is a contract between myself and my health insurer, and ultimately I am responsible for my account at Denver Chiropractic Center.

Signed: _____ Date _____

Print Name:_____

*This policy is based on recommendations by the CO State Board.

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HEALTH CARE PRIVACY NOTICE-INFORMED CONSENT-ASSIGNMENT OF BENEFITS-AUTHORIZATION & LIEN

This office is committed to providing patients with quality healthcare services with dignity and concern. Fulfilling this commitment requires the efforts of the doctors, therapists, staff, and patient working together as a team to obtain the maximum results. Patient satisfaction is a vital interest to our staff.

This facility is required by law to abide by the terms of this Health Care Privacy Notice as well as other applicable federal and state laws governing privacy practices in health care. Our facility may change and/or modify the terms of this Notice at any time without additional notice to you except to publicly post in our Facility and/or make available to patients any updated notices. Photocopy of this Notice is available to you upon request. The term Facility refers to this office or clinic. The term Provider refers to doctors and/or licensed professionals in this Facility.

Our Facility & staff are committed to maintaining the privacy of your protected health information (PHI). PHI is information about you, including demographic information that may identify you and that may be related to your present, future, and past physical or mental health condition and the care and treatment you receive from our practice. This Notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read this Notice and direct questions, misunderstandings, or concerns to the Compliance Officer of this Facility.

Our Facility may use & disclose your PHI for health care delivery purposes. Your PHI may be used and/or disclosed without your written authorization by the doctors and staff of this Facility for the purposes of your care and treatment; paying your health care bills; and to support the operations of this practice. Your doctor and the staff will take all reasonable measures to maintain the confidentiality of your PHI.

The Privacy Rule allows you the right to review and receive copies of your health records as it relates to your health care. The request must be in writing, allowing your provider 30 days to respond. Your provider may deny your request if it will cause harm to you or another person. Your provider may charge a copy fee, which will be in compliance with State law. Your provider will comply with any reasonable request to have confidential communication by alternative means or at an alternative location if not doing so endangers you.

You may request to have an amendment placed in your record if you disagree with anything in your record. This does not mean that anything will be removed or changed and the provider has the right to respond with a rebuttal statement if he/she feels it is necessary. You may revoke authorization, in writing, at any time, except in the event that the provider has acted as indicated in the doctor's Authorization Notice.

You have the right to file a written complaint with our Compliance Officer if you believe that any of your privacy rights have been violated. You can obtain a complaint form from the Compliance Officer and/or the Office of the Civil Rights. All complaints must be filed within 180 days of when you knew or should have known that the violation occurred. The Privacy Law prohibits our Facility from taking any retaliatory actions against anyone who files a complaint. A more detailed, updated, & comprehensive Health Care Privacy Notice is available for your review in this Facility.

I understand that this Facility, its doctors & staff are accepting my case based on examination findings & believe the outlined treatment should produce change and/or improvement. However as with any diagnostic test, procedure, examination or doctors care a guarantee of improvement or complete recovery cannot be made and it is even possible that no change will occur.

I further understand that in practice of medicine, chiropractic, psychological counseling, massage therapy, & physical therapy there are some risks including but not limited to fractures, disk injuries, strokes, dislocations, sprains-strains, drug interactions & reactions, and/or other injuries or side effects which cannot be predetermined.

I do not expect the doctor/provider to be able to anticipate and explain all risks and/or complications, and I wish to rely on the doctor/provider to exercise judgment during the course of the procedure(s) which the doctor/provider feels at the time is in my best interest.

In addition, because psycho-social, spiritual, and cultural values affect a patient's response to care, patients are allowed to express and follow spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of treatment.

Patients have the right to refuse treatment, but must be aware of the possible consequences of refusing treatment and/or failing to cooperate with the prescribed treatment. Should you refuse and/or fail to comply with prescribed treatment your provider will discuss specific consequences with you.

Therefore I give my full consent to the doctor/provider to render treatment on me or the minor for whom I am legally responsible by a health care provider of this Facility.

I, the assignee, being the patient or legal guardian of said minor listed below, do hereby irrevocably authorize, direct, assign, and give a full lien to the office named above and listed below, hereinafter referred to as the "Facility" against any & all insurance benefits, proceeds of any settlement, judgment, or verdict which may be paid to the undersigned as a result of the injuries or illness for which I have been treated by the Facility.

I, the assignee further authorizes any and all insurance company, attorney, and any & all third party payer to pay directly to the Facility all sums of money due them for any & all services rendered to me or minor by whom I am responsible for by reason of accident, illness, and by any and all reason of any other bills that are due or may become due, and to withhold such sums from any health & accident, workers compensation, and/or including all insurance or third party benefits.

Assignee agrees that this Facility & staff may deliver medical records, consultations, depositions, and/or court appearances which must be paid in full in advance and authorizes this Facility to release any information pertinent to said health care to insurance company, adjuster, attorney or legal service bureau to facilitate collections under the terms of this document. Assignee grants the Facility a full power of attorney to endorse and/or sign my name on any & all checks for payment of any indebtedness owed this office & assignee.

INSURANCE BENEFITS-CREDIT POLICIES-PAYMENT TERMS & CONDITIONS

As a courtesy, Denver Chiropractic Center will obtain a verification of applicable insurance benefits as they are quoted to us but some third party payers misquote benefits, coverage, and liability. Denver Chiropractic Center is not responsible for what a third party payer and/or representative may tell us. Any contractual, written, verbal, or other obligations or arrangements between you and an attorney, insurance company, liable or third party payer are between you and said person.

1. Our Facility will file initial insurance claims for you. Secondary claim submission and/or additional reports or documents sent for your benefit may result in additional filing or medical report charges, which you are responsible to pay.
2. Co-pays, deductibles, and all non-covered services are due the day the service is rendered.
3. Patients are responsible for charges on all service(s) and/or product(s) which may exceed the maximum allowable and/or when a third party and/or insurance carrier does not reimburse this Facility enough to meet our cost of service.
4. All account balances, including automobile and work injury claims must be paid in full within 90 days of treatment. Patients are fully responsible for all money owed this office and such payment in not contingent on any settlement, claim, judgment, or verdict by which they may eventually recover said fee and it is also regardless of any attorney liens or pending settlement(s). If a third party payer fails to pay said balance in full within the 90-day period, the patient must pay the balance in full. Assignee is fully responsible for all money owed this Facility for any & all treatment, products, & services rendered to the patient or minor shown below.
5. A non-discriminatory "Time of Service Discount" is offered to anyone who pays for services the day they are rendered. The "TOS" is only offered on the day the service is rendered. This discount does not apply to orthopedic supports, orthotics, physical therapy equipment rentals or purchases, vitamins, supplements, ointments, acupuncture treatments, weight loss programs, psychological counseling services, & massage therapy.
6. A service charge is computed by a 'periodic rate' of 1 ½% per month-18% per annum & is added to all balances owed 60+ days. Any balance past due 90 days or more may be submitted to an attorney and/or agency for legal collection for which the undersigned agrees to be 100% responsible for all monthly service charges, interests, costs related to but not limited to all collection related expenses, attorney fees, court &filing fees. Returned checks, debit & credit charges made payable to this Facility for insufficient funds, stop payments, or other reasons on non-payment will be assessed a $30.00 charge.
7. Patients are eligible for a maximum $250.00 personal credit limit when approved. For your convenience we accept most major credit & debit cards.

PATIENT CONSENT & SIGNATURE

By my signature below I acknowledge that I have read or have had read to me and have received a photocopy upon my request of this document including the Health Care Privacy Notice, Facility terms & conditions, credit policies, & Informed Consent and fully understand and have had all of my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valid as an original.

_____

Print Name of Patient

_____ _____

Signature (if minor, parent must sign) **Date**