Welcome to Chiropractic Plus, P.C. Account#:____________

Personal History

Today's Date:__________________ Social Security Number: XXX-XX-_________

Patient's Name:__________________________Address:____

City:______________________State:_____Zip Code:___________ E Mail:__________________________

H #:(_____)__________________W #:(_____)__________________Cell#(____)__________________

OFFICE USE ONLY:
Pulse: _____ Respiration: _____ BP: _____/_____

Age:_______Birthdate: mo._____day_____yr_____Sex: M F Height:________Weight:_________

Circle if you are: Married Single Widowed Divorced Separated Student

Spouse name: _________________________Children name (s) and age (s): ______________________________

Contact in case of emergency:__________________________ Phone: (_____)____________________

Primary Insurance:__________________________ Phone: (_____)____________________

Secondary Insurance:________________________ Phone: (_____)____________________

PLEASE SHOW ALL INSURANCE CARDS TO THE FRONT DESK

How were you referred to our office?____

How has this problem affected your life?____

Patient assigns to Chiropractic Plus, P.C. any and all benefits payable by Patient's/Insured's insurance or health care plan(s) as a result of charges incurred by patient for services rendered by Chiropractic Plus, P.C. Patient hereby directs all insurers and other persons responsible for patient's health care costs to make all payments for health care services rendered by Chiropractic Plus, P.C. directly to Chiropractic Plus, P.C.. I also request payment of government benefits to the party who accepts assignment below. Patient/Guardian hereby authorizes the release of any medical or other information examination and/or copying of any of patient's medical records, x-rays, laboratory reports, and the results of all tests of any type or character to such persons as Chiropractic Plus, P.C. deems appropriate.

When you provide us with your contact information, we may use that information to provide you services. For example, we may use your contact information to send you appointment reminders and any type of payment information via text or email. We may use business partners to provide these services to you. If you do not wish for us to share that information with any third parties, please notify us. But recognize that if you choose not to share the information, we may not be able to provide you with certain services.

INFORMED CONSENT

When a patient seeks chiropractic care & agrees to the care, it is essential for the patient and CP to be working toward the same objective. We do not offer to diagnose or treat any disease or condition other than vertebral subluxation and its associated conditions; however, if during the course of examination we encounter non chiropractic or unusual findings, we will advise you. If you desire treatment of those findings we will recommend that you seek another healthcare provider. Risks & complications due to chiropractic treatment are rare but do exist. Patient does not expect the Dr to be able to anticipate & explain all risks & complications, & does wish to rely on the Dr to exercise judgment during the course of treatment which will be in patient's best interest. There is no guarantee that any illness, injury or disease can be prevented or cured by participation in chiropractic treatment.

Signature of patient ____________________________________

CONSENT TO TREAT A MINOR

I hereby authorize Chiropractic Plus, P.C. and whomever they may designate to administer chiropractic care as necessary to my minor child.
Name of minor/child___________________________Dated this_______day of_________, 20_______.

Signature of patient/guardian ____________________________________

CHIROPRACTIC PLUS
PATIENT CASE HISTORY

Name________________________ Date____________________ PT#__________________

Please mark the following sign or symptom with either C-currently or P-previously. Leave the answer blank if you have never experienced the symptom.

PLEASE LIST BY DATE ANY INJURIES, ACCIDENTS, FALLS, HOSPITALIZATIONS, SURGICAL PROCEDURES IN THE PAST 5 YEARS

___ None
____
____
____
____

CARDIO-VASCULAR

C P High Blood Pressure
C P Low Blood Pressure
C P Pain Over The Heart
C P Poor Circulation
C P Rapid Heart Beat
C P Slow Heart Beat
C P Strokes
C P Swollen Ankles
C P Varicose Veins

RESPIRATORY

C P Chest Pain
C P Chronic Cough
C P Difficulty Breathing
C P Asthma

EYES/EARS/NOSE/THROAT

C P Ear Ache
C P Ear Discharge
C P Ear Noises
C P Enlarged Thyroid
C P Nose Bleeds
C P Poor vision Condition: _______
C P Eye Pains
C P Sinus Infections
C P Sore Throat

GENERAL CONSTITUTION

C P Night Sweats
C P Headaches (circle all that apply)
Migraine w/aura w/o aura
Cluster Headache
Tension Headache
Face Pain
C P Dizziness

C P Chills

C P Difficulty maintaining weight
C P Difficulty with weight loss
C P Nerve Pains
C P Numbness/Tingling
Where: ____________

FOR WOMEN ONLY

C P Pregnant
C P Cramps
C P Excessive Flow
C P Hot Flashes
C P Irregular Cycles

MUSCLE AND JOINTS

C P Backaches Where: _______
C P Foot pains
C P Hernia
C P Shoulder Pains
C P Painful Tailbone
C P Stiff Neck
C P Spinal Curves
C P Swollen Joints
Where: ______________

GASTRO-INTESTINAL

C P Diarrhea
C P Constipation
C P Gall Bladder Troubles
C P Jaundice
C P Liver Problems
C P Nausea

SKIN OR ALLERGIES

C P Boils
C P Bruises Easily
C P Dryness
C P Eczema
C P Allergies
C P Hay Fever

GENITOURINARY

C P Bed Wetting
C P Blood in the Urine
C P Erectile Dysfunction
C P Frequent Urination
C P Kidney Infection
C P Painful Urination
C P Prostate Troubles

FORMAL EXERCISE
(Do not include work)

None

Medium

High

FAMILY HISTORY
Mother Father Brother Sister

______diabetes
______Heart troubles
______Kidney Troubles
______Cancer
______Back Trouble

PLEASE CHECK IF YOU HAVE OR HAD ANY OF THE FOLLOWING:

_______Pneumonia
_______Polio
_______Anemia
_______Seizures
_______Lower Back Pain
_______Goiter
_______Cancer (Type __________)
_______Diabetes
_______Heart Disease
_______Alcoholism
_______ Reflux or Ulcer
_______ Depression or Anxiety

Primary Care Physician:
____

Prior Treatment for this condition:
Type of Doctor/Provider seen:
____

Treatment Rendered:
____

Treatment Effectiveness:
Ineffective Poor Medium Good

EMPLOYMENT

Current Employer: ____

Title & Brief description of Work: ___________________________________

Body Position (Circle all that apply) Sitting / Standing /Bending / Lifting
# of lifts per day _________ Pounds_____________
Level of Stress (Circle one: Low / Medium / High

GENERAL PAIN DISABILITY INDEX QUESTIONNAIRE

NAME (please print):____________________ Date________ PT#________________

Age:_______ Date of Birth:___________ Occupation______________

How Long Have You Had This Pain? _____ Years _____Months_____ Weeks

Is This Your First Episode of Pain? ___Yes ___No

Please List In Order Of Importance:

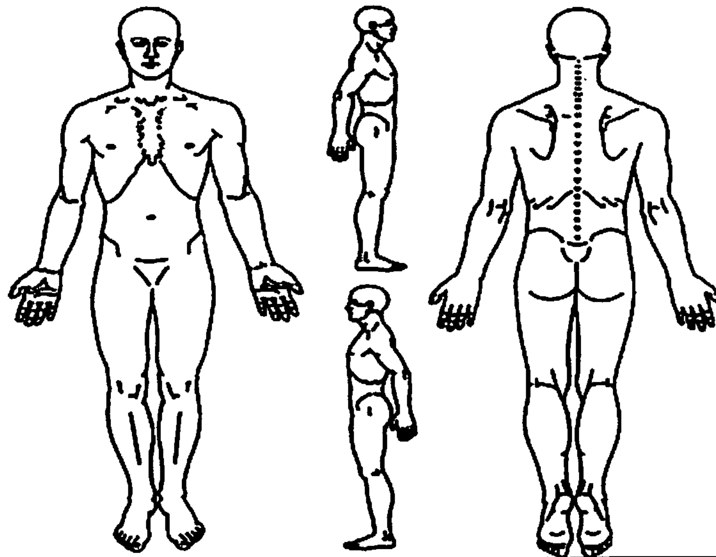
3 Health Challenges:
(i.e. diabetes, heart troubles, digestive issues, anxiety):
1.____________________________________
2.____________________________________
3.____________________________________

Please List In Order of Priority

3 Health Goals:
(i.e. get off medication, reduce weight, sleep better)
1.____________________________________
2.____________________________________
3.____________________________________

Please label areas of concern:

S= stabbing
N= numbness
P= pins and needles
B= burning
A= aching
Other: ___________



OFFICE USE ONLY
____
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OFFICE USE ONLY: D1__________ D2__________ D3__________

Office Use Only

Complaints: L/R/B HA BPL/SA/C L S
1: Neck/UB/MB/LB/PEL/UX/LX/Rib/Nerv(U/L)
FX Loss: ____________ Goal________
I:______P1:______P2:______P3:

C1 Category:
ache/pound/sharp/shoot/stab/throb
****
burn/tender/spasm/tight
****
dull/pain/sore/stiff
****
dizzy/numb/pins&needles/tingle
dull/pain/sore

Frequency
I: C F O I
P1: C F O I
P2: C F O I
P3: C F O I

Intensity
I: S M S M
P1: S M S M
P2: S M S M
P3: S M S M

OATS:
I:______
P1:______
P2:______
P3:______

% Imp S-O
P1:____/____
P2:____/____
P3:____/____

Complaints: L/R/B HA BPL/SA/C L S
2: Neck/UB/MB/LB/PEL/UX/LX/Rib/Nerv(U/L)
FX Loss: ____________ Goal________
I:______P1:______P2:______P3:

C1 Category:
ache/pound/sharp/shoot/stab/throb
****
burn/tender/spasm/tight
****
dull/pain/sore/stiff
****
dizzy/numb/pins&needles/tingle
dull/pain/sore

Frequency
I: C F O I
P1: C F O I
P2: C F O I
P3: C F O I

Intensity
I: S M S M
P1: S M S M
P2: S M S M
P3: S M S M

C: I:____P1____P2____P3:____ **L:** I:____P1:____P2:____P3:____ **Other** I:____P1:____P2:____P3:____

CF: **Lifestyle:** Alcohol, Delayed, Exercise, Prior trauma, Prior injuries, Prior surgery, Smoking, Stress, Sleeping, ADL, Inactive, Obesity, Medication
Health Challenges: Cancer, Diabetes, Cardiovascular, RA, Depression, Anxiety, Reflux, GI, Bladder, Asthma, Arthritis, Allergies, Menstrual, Caffeine
Postural Biomechanics: Chronic posture, DDD, DJD, Old Injury, Laxity, Instability, Kyphosis, Lordosis, Scoliosis, Spondylolisthesis, Lifting

Why Imp/Slow 1:______________________2:______________________3:______________________

Aggravations: Circle to add: if appropriate and use in report scratch off
Bending Chronic posture Degeneration Inactivity Increase ADL Stress No exercise Slowing healing Lifting Laxity Sleeping wrong

Name ______________________ Date ______________ Account:__________

Please Read: Questionnaire is designed to enable us to understand how much your condition has affected your ability to manage everyday activities. Please answer each section by circling the **ONE CHOICE** that applies to you. We realize that you may feel that more than one statement may relate to you, but please **just circle the one choice which closely describes you problem right now.**

SECTION 1-Pain intensity

A. The pain comes and goes and is very mild
B. The pain is mild and does not vary much
C. The pain comes and goes and is moderate
D. The pain is moderate and does not vary much
E. The pain is severe and comes and goes
F. The pain is severe and does not vary much

SECTION 2- Personal Care

A. I can look after myself normally without causing extra pain
B. I can look after myself normally, but it causes pain
C. It is painful to look after myself and I am slow and careful
D. I need some help but manage most of my personal care
E. I need help every day in most aspects of self-care
F. I do not get dressed, wash with difficulty and stay in bed

SECTION 3- Lifting Bending and Carrying

A. I can lift heavy weights without extra pain
B. I can lift heavy weights but it gives me extra pain
C. Pain prevents me from lifting heavy weights off the floor but I can if they are in convenient places
D. Pain prevents me from lifting heavy weights but I can manage light to medium weights
E. I can lift only light weights
F. I cannot lift or carry anything

SECTION 4- Walking

A. Pain does not prevent me from walking any distance
B. Pain prevents me from walking more than one mile
C. Pain prevents me from walking more than ½ mile
D. Pain prevents me from walking more than ¼ mile
E. I can only walk using a cane or crutches
F. I am in bed most of the time and have to crawl to the toilet

SECTION 5-Sitting and or Computer work

A. I can sit in a chair as long as I like
B. I can sit on my favorite chair as long as I like
C. Pain prevents me from sitting for more than 1 hour
D. Pain prevents me from sitting for more than 30 minutes
E. Pain prevents me from sitting for more than 10 minutes
F. Pain prevents me from sitting at all

SECTION 6-Standing

A. I can stand as long as I want without extra pain
B. I can stand as long as I want but gives me extra pain
C. Pain prevents me from standing for more than 1 hour
D. Pain prevents me from standing for more than 30 minutes
E. Pain prevents me from standing for more than 10 minutes
F. Pain prevents me from standing at all.

SECTION 7-Sleeping

A. My sleep is never disturbed by pain
B. My sleep is occasionally disturbed by pain
C. Because of my pain I have less than 6 hours sleep a night
D. Because of my pain I have less than 4 hours sleep a night
E. Because of my pain I have less than 2 hours sleep a night
F. Pain prevents me from sleeping at all

SECTION 8-Social Life

A. My social life is normal and gives me no extra pain
B. My social life is normal but increases the degree of pain
C. Pain has no significant effect on my social life apart from limiting my more energetic interests
D. Pain has restricted my social life and I don't go out as often
E. Pain has restricted my social life to my home
F. I have no social life because of pain

SECTION 9 –Traveling and Driving

A. I can travel anywhere without pain
B. I can travel anywhere but it gives me extra pain
C. Pain is bad but I manage journeys over 2 hours
D. Pain restricts me to journeys of less than 1 hour
E. Pain restricts me to short necessary journeys under 30 minutes
F. Pain prevents me from traveling except to receive treatments

SECTION 10 –Employment/Homemaking/Chores/Yard work

A. My normal homemaking/job activities do not cause pain
B. My normal homemaking/job activities increase my pains, but I still perform these tasks
C. I can perform most homemaking/job activities, except for more physical/stressful activities
D. Pain prevents me from doing anything but light duties
E. Pain prevents me from doing even light duties
F. Pain prevents me from performing any job or homemaking chores

SCORING: OFFICE USE ONLY

0-8: No disability	10-28: Mild disability
30-48: Moderate disability	50-69: Severe disability
Above 70: Complete disability`	DISABITY INDEX SCORE ________

Case History Chiropractic Plus, P.C (Continued)

Account#:____________

First Name ______________________ Last Name __________________________

Preferred method of communication for reminders (Circle one or more):

E-mail / Phone / Mail / Text (Circle or Write Provider: Verizon T-Mobil Sprint Other: ________)

Preferred Language: __________________

Pertinent Social History:

Smoking Status (Circle One): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Alcohol: (Circle One): Every Day Drinker / Occasional Drinker / Former Drinker / Never Drank

Caffeine: ______ Caffeine Drinks per day

CMS law requires providers to report on both race and ethnicity

Race (Circle One): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Hawaiian or Pacific Islander / Other / Decline to Answer

Ethnicity: Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

Are you currently on any Medications? (Please include regular used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day)

Do you have any allergies to medication?

Medication Name	Reaction	Onset Date	Additional Comments

☐ I chose to receive receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and the frequency of chiropractic care.)

Patient Signature ____ Date ________________

Chiropractic Plus, PC Account # ___________

Financial Policy Name ______________

In an effort to maintain compliance with various state & federal regulations, managed care and preferred provider agreements, as well as billing and coding guidelines, we have adopted the following.

- Our clinic has adopted a single fee schedule that applies to all patients for each service provided.
- You may be entitled to a network or contractual discount under the following circumstances:
    - We are a participating provider in your health plan.
    - You are covered by a State or Federal program with a mandated fee schedule.
    - You are a member of ChiroHealthUSA, or any other Discount Medical Plan we may join. Patients who are uninsured, or underinsured (limited benefits for chiropractic care), may join ChiroHealthUSA in our office and will be entitled to network discounts similar to our insured patients. Membership is $49.00/year and covers you and your dependents. Ask our staff for more information.
    - Patients who meet state and/or federal poverty guidelines or other special circumstances outlined in our "Hardship Policy" may be offered a discount for a period of time as determined by the clinic.
- Cash Accounts
    - Services must be paid in full at the time of services are rendered unless other arrangements are made.
- Medicare Insurance
    - We will file claims to Medicare with benefits being paid directly to Chiropractic Plus, according to reimbursement guidelines. Medicare limits chiropractic reimbursement to manual manipulation only and reimbursement is based on medical necessity. Patients will be responsible for deductible amounts, non-covered, and any denied visits which exceed Medicare guidelines.
- Major Medical/Auto Insurance and PPO Benefit Plans
    - Our staff will try to verify your insurance coverage & benefits for you, and will rely on information regarding benefits & limitations of your insurance as we are told by your carrier. However, we cannot guarantee payment and coverage to be completely accurate and true as told by your insurance carrier. Payment for co-pays, deductibles and any amount not covered by your insurance is to be paid at the time services are rendered, unless other arrangements are made with our staff.
- Worker/Industrial Industry
    - Treatment costs must be pre-authorized for full payment by employer or workers compensation insurance carrier. Fees will be charged at the State mandated fee schedule.
- Orthopedic supports/Vitamins/Supplements and supplies
    - To be paid in full at the time of service is rendered or dispensed unless prior arrangements are made as part of a treatment/care plan.
- Payments accepted by the following method:
    - Visa, MasterCard, Discover, American Express, Care Credit, Electronic Funds Transfer (ACH) set up automatically from a checking or savings account or credit card.
    - In the case of a transaction being rejected for Non-Sufficient Funds, I understand that Chiropractic Plus, may at its discretion, attempt to process the charge again within 30 days, and agree to an additional $25 charge for each attempt returned/rejected NSF which will be initiated as a separate transaction.
    - Payment plans available when pre-approved by staff.
- We do not want misunderstandings regarding your bill, obligations to pay or terms of when payment is due. All balances owed past 90 days will be sent to a collections agency for which you are responsible for any and all collection, court and attorney fees charges.

SIGNED ________________________________ DATE ____________________

CHIROPRACTIC PLUS, PC
550 E THORNTON PARKWAY, SUITE 178
THORNTON, CO 80229
303-254-8430

(Consent to use PHI) Notice of Privacy Practices - Acknowledgement & Consent

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Chiropractic Plus, PC or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature ______________________ Date ________

Print Patient's Full Name ______________________ Time ________

Witness Signature ______________ Pt Account Number ______________ Date ________

RELEASE OF PROTECTED HEALTH INFORMATION RECORDS

CHIROROPRACTIC PLUS, PC
550 E THORNTON PARKWAY, SUITE 178
THORNTON, CO 80229
303-254-8430

Release From: ______________________
Phone: ______________________
Fax: ______________________

Release To: Chiropractic Plus, PC
Phone: 303-254-8430
Fax: 303-254-8235

Patient Name: ______________________
S.S. No: ______________________
Fax: ______________________

Release The Following Protected Health Information:

I, the undersigned, request and consent to the release of the following Protected Health Information:

☐ X-Rays ☐ History ☐ Diagnosis ☐ Treatment ☐ Reports
☐ Other: ______________________

Send The Protected Health Information To:

CHIROPRACTIC PLUS, PC
550 E THORNTON PARKWAY, SUITE 178
THORNTON, CO 80229
303-254-8430
303-254-8235-FAX

Purpose Of Release:

☐ For the purpose of treatment at the above health care facility.
☐ Other: ______________________

Patient: ______________________ ______________
Patient or Legal Representative Date

Witness: ______________________ ______________
Privacy Officer Date

The Protected Health Information of the above referenced patient will be used solely for the purposes of treatment, payment and operations. This facility complies with all applicable federal and state privacy statutes.