CHIROPRACTIC CARE - PATIENT ADMITTANCE FORM

FULL NAME _____ DATE _____

APPROVED MAILING ADDRESS _____ APT____ CITY _____ STATE ____ ZIP_____

APPROVED HOME PHONE#_____ WORK PHONE# _____ EXT_____

EMAIL ADDRESS_____ APPROVED CELL PHONE #_____

DATE OF BIRTH_____ SEX_____ MARITAL STATUS _____ SPOUSE'S NAME_____

OCCUPATION_____ CHILDREN (AGES)_____

EMPLOYER_____ EMPLOYER ADDRESS _____

SOCIAL SECURITY # ___ ___ ___ - ___ ___ - ___ ___ ___ ___ *****THIS WILL BE YOUR CHECK IN PIN NUMBER*****

DRIVERS LICENCE # _____ STATE____

HOW DID YOU HEAR ABOUT OUR OFFICE_____

NAME OF PERSONAL PHYSICIAN _____

NEAREST RELATIVE NOT LIVING WITH YOU (EMERGENCY CONTACT)_____

RELATIONSHIP_____ PHONE _____ ADDRESS _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT?_____

ACCIDENT - INJURY INFORMATION

Are your present problems due to an accident or injury? _____ Date of accident/injury: _____

Type of accident/injury (circle): Auto On-The-Job Sports Military Household Slip & Fall Personal Other _____

Name of Attorney handling your case _____ Phone # _____

INSURANCE INFORMATION

Type of insurance you plan to use to help pay your account (circle): Auto Work Comp Group Medicare Other _____

Name of Insurance Company _____ Phone # _____

Insured's Name/Date of Birth_____ ID#: _____ GROUP#_____

If insurance is your spouses please list spouses employer: _____

TREATMENT AUTHORIZATION

I hereby authorize this office and its staff and doctors to examine and treat my or my above mentioned dependents condition as the doctors deem appropriate and I give authority for these procedures to be performed. I clearly understand and agree that all services rendered to me or my dependent are charged directly to me and that I am responsible for payment of services by this office and all outside laboratory or radiology services performed on my or my dependents behalf. Should collection of a past due amount become necessary, I will become responsible for all charges, fees and attorney fees. All charges for services and care given will be charged directly to me and I will be personally responsible for payment of them. I give my permission to be called by telephone concerning my or my dependents appointments or treatment, even if my name and number are on a state or national no call list. Please also be aware we do use audio and video recording throughout this office.

We realize todays free spinal examination includes, but is not limited to a consultation, history of the complaint and examination/palpation of the area involved to determine if there is a need for chiropractic care. However, the free screening does not include x-rays or treatment and is limited to one free exam per individual. If x-rays are indicated it is customary to pay for x-rays when taken unless deposit arrangements are made in advance. We are required by Law to advise you of the fees for our services. They are as follows: X-ray views-8x10 $30 each; 14x17 view $45 each; copies of x-rays CD $10; Spinal Manipulations $60; All therapies and re-exams are $40 each. Please rest assured our staff/manager will go over any costs before doing any charged procedures.

I have received a copy of the "Notice of Privacy Practices" for me to keep for my records.

Patient/Guardian Signature (x) _____ Date _____

PREVIOUS HEALTH PROBLEMS

Fractured bones	Spinal taps	Fainting	Digestive disorders	Knee Pain
Allergies	Scoliosis	Birth defects	Respiratory disorders	Blurred Vision
Joint replacement	Diabetes	Osteoporosis	Eyes	Numbness in Hands/Feet
Metal screws/implants	High Blood Pressure	Cancer	Ears	Difficulty Breathing
Cervical whiplash	Stroke	Tumor	Nose	Plantar Fasciitis
Electronic implant	Aneurysm	Cyst	Throat	
Pacemaker	Convulsions	Ear infections	Endocrine	Are you pregnant? Y N
Ruptured spinal disc	Seizures	Birth complications	Foot Pain or Numbness	
Slipped spinal disc	Memory Lapse	Asthma	Arm Pain	Other serious illness:
Pinched nerve	Dizziness	Bed Wetting	Mid Back Pain	_____
Spinal surgery	Concussion	Heart Disease	Low Back Pain	_____
Spinal injections	Arthritis	Fibromyalgia	Neck Pain	_____
Thyroid problems	Bowel/Bladder Changes	Menstrual problems	Headaches	
Endometriosis	Pelvic Pain	Shoulder Pain	Leg Pain	

Surgeries: _____

_____

_____

SURVEY

In order that we can improve our services to better suit your needs, we ask that you take a few minutes to answer the following questions:

DO YOU...

Have tired, achy feet/legs?	Y	N	Have a "high arch"?	Y	N
Have heel pain?	Y	N	Have toe pain/numbness?	Y	N
Have pain at the ball of your foot?	Y	N	Have knee pain?	Y	N
Have uneven footwear?	Y	N	Have hip pain?	Y	N
Have "flat feet"?	Y	N	Lower back pain?	Y	N

If you have answered YES to one or more of the above questions, we recommend that you take this opportunity to have a free knee/foot care consult with one of our Doctors! You may be a candidate for Orthotics or Orthopedic footwear!

We here at Heuser Chiropractic believe strongly in maintaining and improving the health of your feet!

PATIENT HISTORY OF NEUROLOGICAL PROBLEMS

1. Have you been diagnosed with any neurological disorders? _____
2. Do you have problems with remembering people, events, dates, etc.? _____
3. Do you experience shaking/tremors? _____
4. Do you have difficulty with balance or dizziness? _____
5. Do you or your child have trouble focusing on activities? _____
6. Do you or your child experience rapid mood swings? _____
7. Have you suffered from a loss in communication skills? _____
8. Do you or your child suffer from hyperactivity? _____
9. What are the conditions you or your child are experiencing difficulty with: i.e. schoolwork, attention, balance, speech: _____

_____

10. What kind of outcome would you like to see from this treatment: _____

Patient Initials _____

HEUSER CHIROPRACTIC 245 S. ACADEMY BLVD. COLORADO SPRINGS, CO 80910

ELECTRONIC HEALTH RECORDS INTAKE FORM

In compliance with Medicare requirements for the government EHR incentive program.

First Name: _____ Last Name: _____

Email address: _____@_____

Preferred method of communication for patient reminders: (Circle One): Email / Phone / Mail

DOB: ___/___/___ Gender (Circle One): Male / Female Preferred Language: English / Other: _____

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

CMS requires providers to report both race and ethnicity.

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

Ethnicity (Circle One): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are You currently taking any medications: (Please include regularly used over the counter medications)

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

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

Would you like a Clinical Summary of your visit upon checkout everytime you come into the clinic: Yes / No

Patient Signature: _____ Date: _____

For Office Use Only:

Height: _____ Weight: _____ Blood Pressure: _____/_____

If your injuries could be due to an auto accident, please fill out this page.

ACCIDENT PATIENT HISTORY

Date of Accident: _____ Time: _____

Were you: ___ Driver ____ Passenger ___ Front Seat ___Back Seat

Were you wearing a seat belt? Yes No Shoulder Harness: Yes No

Were there any other persons in the accident with you: Yes No

DESCRIPTION OF ACCIDENT:

Were you struck: ___ From Behind ___ In Front ___ Right Front ___ Right Middle
___ Right Rear ___ Left Front ___Left Middle ___ Left Rear

Were you: ___ Moving ___ Stopped ___ Turning Right ___ Turning Left

Approximate speed of automobiles at time of impact: _____

Did you see the accident coming? Yes No

Which way were you looking at time of impact? _____

Upon impact which way was your body thrown? ___ Forward ___ Backward ___ Right ___ Left

Did you hit your head on anything: Yes No What? _____

Lose consciousness? Yes No How Long? _____

Amount of damage to vehicle? _____
Type of vehicle? _____
Police report filed? Yes No
Citation Issued? Yes No To Whom? _____

When did the pain begin? _____

Since MVA - pain is: ___ Less ___ Same ___ Worse
Transported to Hospital? Yes No
X-rays Taken? Yes No What X-rays? _____
Have you seen another Dr. since MVA? Yes No Name: _____
What treatment did you receive?

HEUSER CHIROPRACTIC, P.C.
245 S. ACADEMY BLVD.
COLORADO SPRINGS CO 80918
719-574-6006

(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 HEUSER CHIROPRACTIC, SOUTH, P.C. 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	Date

© HIPAA Acknowledgement & Consent

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electrical muscle stimulation, therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocation of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

***Over-the-counter analgesics**. The risks of these medications include irritation to stomach, liver, and kidneys, and other side effects in a significant number of cases.

***Medical care**, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.

***Hospitalization** in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.

***Surgery** in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to treatment.

I have read or have had read to me the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I may seek treatment.

_____	_____	_____
Patients Name	Signature	Date
_____	_____	_____
Witness Name	Signature	Date