FEMALE

APPLICATION FOR CARE AT IMPACT CHIROPRACTIC

Today's Date: _____ Whom may we thank for referring you to this office → _____

PATIENT DEMOGRAPHICS - Women

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____ Mobile Phone: _____

Marital Status: ☐ Single ☐ Married Do you have Insurance: ☐ Yes ☐ No Work Phone: _____

Height: _____ Weight: _____

Employer: _____ Occupation: _____

Spouse's Name _____ Number of children and Ages: _____

Name & Number of Emergency Contact: _____Relationship: _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primary: _____

Secondary: _____ Tertiary: _____ Quaternary: _____

When did the problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM

How long does it last? ☐ It is constant ☐ I experience it on and off during the day ☐ It comes and goes throughout the week

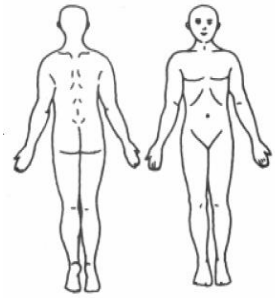
Is your problem the result of ANY type of accident? ☐ Yes, ☐ No

How did the injury happen? _____

Condition(s) ever been treated by anyone in the past? ☐ No☐ Yes If **yes,** when: _____ By whom? _____

How long were you under care: _____ What were the results? _____

Name of Previous Chiropractor: _____ ☐ **N/A**



***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:
R = Radiating **B= B**urning **D =D**ull **A =** Aching **N = N**umbness **S =S**harp/ **S**tabbing **T= T**ingling
What relieves your symptoms? _____

What makes them feel worse? _____

Please list a **goal** you would like to reach if you got rid of this problem:

_____

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	DESCRIBE	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →				
SURGERIES →				
CHILDHOOD DISEASES →				
ADULT DISEASES →				

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ☐No ☐ Yes **If yes** how many times? _____ When was the last episode? _____ How did the injury happen? _____

Other forms of treatment tried: ☐ No ☐ Yes **If yes,** please state **what** type of treatment: _____, and who provided it: _____ **How long ago? _____**What were the results. ☐ Favorable ☐ Unfavorable→ Please explain.

_____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past*, C** for ***Currently*** have and **N** for ***Never** have had*:

___Broken Bone ___Dislocations ___Tumors ___Rheumatoid Arthritis ___Fracture ___Disability ___Cancer
___ Heart Attack ___Osteo Arthritis ___Diabetes ___Cerebral Vascular___ Osteoporosis ___ Other serious conditions: ___

Have you ever suffered from (please check all that apply)?

___ Headache	___ Pregnant (Now)	___ Dizziness	___ Endometriosis	___ Ulcers
___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance	___ Impotence/Sexual Dysfun.	___ Heartburn
___ Jaw Pain, TMJ	___ Convulsions/Epilepsy	___ Fainting	___ Digestive Problems	___ Heart Problem
___ Shoulder Pain	___ Tremors	___ Double Vision	___ Colon Trouble	___ High Blood Pressure
___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Diarrhea/Constipation	___ Low Blood Pressure
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menopausal Problems	___ Asthma
___ Low Back Pain	___ Foot or Knee Problems	___ Hearing Loss	___ Menstrual Problems	___ Difficulty Breathing
___ Hip Pain	___ Sinus/Drainage Problem	___ Depression	___ PMS	___ Lung Problems
___ Back Curvature	___ Swollen/Painful Joints	___ Irritable	___ Bed Wetting	___ Kidney Trouble
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Learning Disability	___ Gall Bladder Trouble
___ Numb/Tingling arms, hands, fingers		___ ADD/ADHD	___ Eating Disorder	___ Liver Trouble
___ Numb/Tingling legs, feet, toes		___ Allergies	___ Trouble Sleeping	___ Hepatitis (A,B,C)

List Prescription & Non-Prescription drugs you take: _____

_____

_____

I hereby authorize payment to be made directly to Impact Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Impact Chiropractic for any and all services I receive at this office.

_____ _____ - _____ - _____

Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____

Doctor's Signature **Date Form Reviewed**

Patient's Name: _____ **Date___/___/___**

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Impact Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____  *Witness Initials*

Patient or Authorized Person's Signature Date **REGARDING:** X-rays/Imaging Studies

Please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

☐ The first day of my last menstrual cycle was on ____-____-____ Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____  *Witness Initials*

Patient or Authorized Person's Signature Date

Impact Chiropractic NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition, we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -**we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Martin Rigney at (970) 690-9899. If he is unavailable, you may make an appointment with our receptionist to see him within 72 hours or 3 working days. If you are still not satisfied with the way this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Patient initials: _____

Impact Chiropractic's NOTICE REGARDING YOUR RIGHT TO PRIVACY continued….

I have received a copy of Impact Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____ _____

Patient's Name DOB

_____ _____

Patient signature Date

_____ _____

Witness Date

IMPACT CHIROPRACTIC
family health center

1730 S. College Ave
Fort Collins, CO 80526
www.impact-chiropractic.com
970.223.5501

FINANCIAL & APPOINTMENT POLICIES

As outlined in our mission statement, we are committed to providing the very best care for you or your child. Part of the process of providing this care involves a financial relationship between you, and us, the Chiropractic provider. In an effort to make your visit with us as comfortable as possible, we have provided for you, prior to your first visit, a description of our financial policy. Please take the time to review our financial policy below and gain an understanding of your financial obligation for your Chiropractic care. If you should have any questions, please ask the front office team member.

As a condition of providing care for you by this office, all fees must be paid at the time the care is provided. Payment for our services may be in the form of cash, check, MasterCard, Visa or Discover. We also accept CareCredit (a medical/dental credit card).

For our patients with insurance, we will be happy to file a claim for you if we have received all of your insurance information on the day of the appointment. On your first visit to our office, please bring your insurance card or other insurance information. You must be familiar with your insurance benefits, as any amount not covered by your insurance company is payable at the time services are rendered and these fees may include deductibles, co-payments or certain procedures not covered by your insurance policy. As your insurance plan is a contract between you, your employer, and the insurance company, some carriers will not reimburse our office. In this instance, you will be responsible for the full cost of each visit at the time services are provided and your insurance company will send you the reimbursement check directly.

Please understand that we file insurance as a courtesy to our patients. We do not have a contract with your insurance company, only you do. We are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim. We can only assist you in estimating your portion of the cost of treatment. We at no time guarantee what your insurance will or will not do with each claim. Your employer chooses your particular policy and if you are unhappy with its coverage, you should speak with your Human Resources Department. Only your employer can adjust benefits.

Your insurance company is required by the Colorado Insurance Commissioner to process, pay or reject all insurance claims within thirty (30) days. We file all insurance electronically, so your insurance company will receive each claim within days of the appointment. You are responsible for any balance on your account after 30 days, whether insurance has paid or not. Any account balance exceeding (60) days in age may be forwarded to a collection agency and/or attorney. All costs incurred in collecting unpaid fees will be charged to your account. These fees often exceed 50% of the unpaid balance.
We will do our best to maximize the insurance benefits that you are eligible to receive and will check your insurance to determine what your out-of-pocket portion will be.

You are responsible for payment for your care.

Dr. Rigney, Dr. Osterhaus, and Dr. Conner's treatment recommendations are based upon what they believe is in your best interest rather than on what your insurance covers.

A $35.00 fee will be assessed for any "returned check."
No call/No shows will be subjected to a $25 fee.

Please note: For those insurance carriers that Impact Chiropractic does not participate with, the claim check may be mailed directly to you. In these cases, you agree to and are responsible for signing and forwarding the check to our office.

I have read the above financial policy and understand my financial options and obligations as described.

_____ _____

Signature of Parent/Responsible Party Date