APPLICATION FOR CARE AT IMPACT CHIROPRACTIC

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

PATIENT DEMOGRAPHICS

Name: ____ Birth Date: ________-________-________ Age: _________

Address: _______________________________________ City: ________________________________ State: _____ Zip: ___________

E-mail Address: ______________________________ Home Phone: _______________________ Mobile Phone: _________________

Marital Status: ☐ Single ☐ Married ☐ Other __________________ Do you have Insurance: ☐ Yes ☐ No

Height: ___________ Weight: __________ Gender: _________________ Pronoun(s): he/him she/her they/them other:_________

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

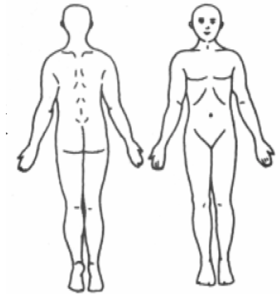
Is your problem the result of ANY type of accident? ☐ Yes, ☐ No

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 = **R**adiating **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 ___ Osteoporosis ___Cancer
___ Heart Attack ___Osteoarthritis ___Diabetes ___Cerebral Vascular ___Disability ___ Other conditions: __________

Have you ever experienced (please check all that apply)?

__ Headaches	__ Frequent Sickness	__ Dizziness	__ Fertility Concerns
__ Migraines	__ Sinus/Allergies	__ Fainting	__ Endometriosis
__ Neck Pain	__ Convulsions/Epilepsy	__ Blurred Vision	__ Menstrual Problems
__ Jaw Pain, TMJ	__ Tremors	__ Ringing in Ears	__ PMS
__ Shoulder Pain	__ Chest Pain	__ Hearing Loss	__ PCOS
__ Upper Back Pain	__ Swollen/Painful Joints	__ Depression	__ Menopausal Issues
__ Mid Back Pain	__ Skin Problems	__ Anxiety	__ Prostate Concerns
__ Low Back Pain	__ Trouble Gaining Weight	__ Irritability	__ Impotence/Sexual Dysfunc.
__ Hip Pain	__ Trouble Losing Weight	__ Mood Changes	__ Colon Trouble
__ Knee Pain	__ Eating Disorder	__ ADD/ADHD	__ Diarrhea/Constipation
__ Foot/Ankle Pain	__ Difficulty Sleeping	__ Sensory Processing	__ Heart Burn
__ Numbness	__ Asthma/Lung Problems	__ Learning Disability	__ Heart Problem
__ Tingling	__ Thyroid Condition	__ Bed Wetting	__ High / Low Blood Pressure
__ Scoliosis	__ Liver Trouble	__ Kidney Trouble	__ Auto-immune Disorder

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**

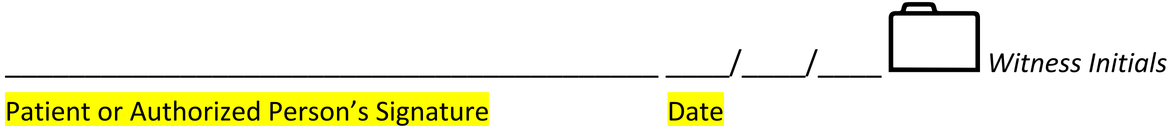
Patient's Name: ______________________ **Date**___/___/___

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.



Patient or Authorized Person's Signature Date

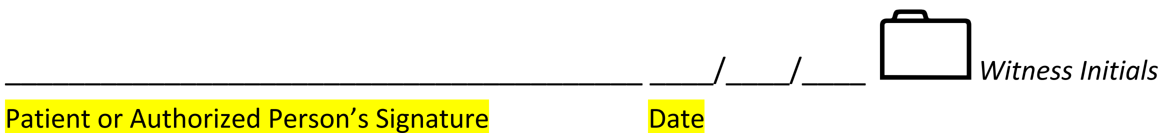
REGARDING: X-rays/Imaging Studies

If applicable, please read carefully and check the boxes below. Please include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation. If not applicable, please skip to signature section below.

☐ 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.



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.

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

FINANCIAL & APPOINTMENT POLICIES

As outlined in our mission statement, we are committed to providing the very best care for you and/or your family. 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 check your benefits 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. We are happy to provide a super bill for you to submit to our insurance for reimbursement.

Please understand that 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.

You are responsible for any balance on your account after 30 days, whether insurance has paid or not. Any account balance exceeding (90) 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.

You are responsible for payment for your care.
In the case extra adjustments are needed outside of your recommended frequency, you will be assessed an adjustment fee the day the service is rendered. Please be prepared to pay this fee on the day of service.

The doctors' 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

OFFICE POLICIES

___ (initial) **Appointment Scheduling**:, We ask that you **pre-schedule** your future appointments. To keep your progress on schedule, rescheduled appointments must be made up **within 24 hours**. Pre-scheduling your appointments in advance will help ensure that you get the appointment time you need. You MUST have an appointment scheduled before seeing the doctors. **No Call No Show appointments will be charged a $25 fee. Please call at least 1 hour before your scheduled appointment to avoid this charge.**

___ (initial) **Children/Family Wellness:** We offer family corrective care and wellness plans at a discounted rate. If your family members have not had their spines checked, please schedule their appointments ASAP. Our doctors have over 300 post-doctoral classroom hours in family wellness. This is the premier center to have your family's spines checked. *Removing interference in the nervous system with adjustments helps with ear infections, colic, allergies, asthma, ADHD, autism, digestive problems, immune system function, athletics, prevention, and wellness.* Help your children avoid health concerns that many people deal with as adults.

___ (initial) **Pet Policy:** We love your furry children, but out of advisement from our attorney and insurance agent – we sadly ask that you leave them at home. *If they do come in for a visit, your signature on this form states that **you take full responsibility** for any accident, incident, damage, loss, or bite that may occur on Impact Chiropractic's premise.* Service animals are allowed.

___ (initial) **Solicitation:** We realize that there are several good products on the market; however, solicitation of goods or services to our patients or staff is unacceptable. We desire to create a comfortable, healing, and non-pressure environment in our office.

___ (initial) **Guarantees:** We do not guarantee that we can prevent or cure any illness, injury, or disease. In this office we find and remove spinal subluxation, so that your nervous system will function optimally and so that your spine does not degenerate prematurely.

____ (initial) **Photography Release:** We frequently take photos/videos for our social media accounts. By initialing here, you authorize Impact Chiropractic, LLC and those acting under its permission to copyright, use and publish the video/photo/audio taken in our office. You agree that Impact Chiropractic has the unrestricted right to use this video/photo/audio in whole or in part, commercially or non-commercially, for all online/internet purposes, including the rights to publish and display for advertising and publicity, and to edit and make derivative works, all without additional review or compensation. You are of legal and have read this Authorization and Release, prior to its execution, and are fully familiar with its contents.
In the event that video/photo participant is a minor, his/her parent has read, understood, completed, and signed this Authorization and Release for his/her minor child. *We will always ask your permission before taking any photos/videos.*

____ I DO NOT wish to have photos/videos taken at any time.

___ (initial) **Guest Speaker:** Our doctors are also available to come to your work or social gathering to educate employees/friends on several different health topics – managing stress, health essentials, nutrition, pediatrics, to name a few! *We will provide a FREE, healthy lunch to everyone attending!* There is no fee for this service; however, there is a minimum of 5 people required to attend. Please 'check' if interested: □

Contact for setting up an event (Name): ______________________________ Phone: ______________________________

I have read and understand the above policies and agree to abide by them.

PATIENT NAME(S) ____

PATIENT SIGNATURE(S) ____ DATE: ________________