HIGHER HEALTH
CHIROPRACTIC & REHABILITATION

12155 Lioness Way #103, Parker CO 80134
www.HigherHealthChiropractic.com
303-925-0808

Name: _____ **Today's Date:** _____

Address: _____ **Employer**: _____

City/State: _____ **Zip Code**: _____ **Type of Work**: _____

Cell Phone:_____ **Home Phone**: _____

Email Address:_____ **Social Security Number** _____-_____-_____

Date of Birth: _____ **Age**: __ **Sex**: □ M □ F

Circle One: Single Married Widowed Divorced Separated **Name Of Spouse** (If applicable): _____

Name of Emergency Contact: _____ **Phone Number of Emergency Contact**: _____

How Did You Hear About Our Office: _____ **Do you have Children** □ – Yes □ - No

How Many Children _____ **Ages of Children** _____

Please Give your Insurance Information to the Front Desk

Please List Health Concerns Below

Concern:	**Severity on 1-10 Scale (10 being the worst)**	**When did it start?**
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____

CIRCLE ALL CURRENT PROBLEMS YOU HAVE

Headache / Migraine	Dizziness	Nervousness	Thyroid Problems
Neck Pain	Vertigo	Anxiety	Fibromyalgia
TMJ / Jaw Pain	Ear Infections	ADD/ADHD	Chronic Fatigue
Shoulder Pain	Sinus Problems	Mental Disorder	Low Immune
Carpel Tunnel	Allergies	Depression	Stomach Problems
Pain in Hands	Asthma	Epilepsy	Acid Reflux
Mid Back Pain	Chest Pain	Seizure Disorder	Ulcers
Low Back Pain	Heart Problems	Menstrual Disorder	Nausea
Disc Problems	High Blood Pressure	Infertility	Throat Issues
Sciatica	Numbness in Arms	Erectile Dysfunction	Irritable Bowl
Hip Pain	Numbness in Hands	Kidney Problems	Liver Disease
Knee/Leg Pain	Numbness in Legs	Bedwetting	
Foot Pain	Numbness in Feet	Bladder Problems	

Major Surgery/Operations: □ Appendectomy □ Tonsillectomy □ Gall Bladder □ Hernia □ Back Surgery □ Broken Bones

Details/Other: _____

Have you been in an Auto Accident: □ Past year □ Past five years □ Over five years □ Never **Quantity**: _____

Details/Severity: _____

Major Accidents or Falls: _____

Hospitalizations: _____

Date of Last: Spinal X-ray _____ **MRI/CT** _____ (region: _____) **Physical Exam** _____

Blood Test _____ **PAP Smear** (women) _____ **Height** _____ **Weight** _____

Previous Chiropractic Care: □ None □ **Approximate Date of Last Visit**: _____

Treated for What:_____ **Results**:_____

Name of Primary Care Physician (PCP):_____ **Date of Last Visit**: _____

PLEASE LIST ALL OVER THE COUNTER & PRESCRIPTION MEDICATIONS YOU ARE ON

NAME OF MEDICATION	RX/OTC	HOW LONG	WHAT FOR

*Add any more on the back

SOCIAL HISTORY:

SMOKING: □ CIGARS □ PIPE □ CIGERETTS **HOW OFTEN:** □ DAILY □ WEEKENDS □ OCCASIONALLY

EXERCISE: □ DAILY □ WEEKENDS □ OCCASIONALLY □ NEVER

HOW DO YOUR CURRENT HEALTH CONCERNS AFFECT THE FOLLOWING: HOBBIES, RECREATIONAL ACTIVITIES, EXERCISE

_____

_____

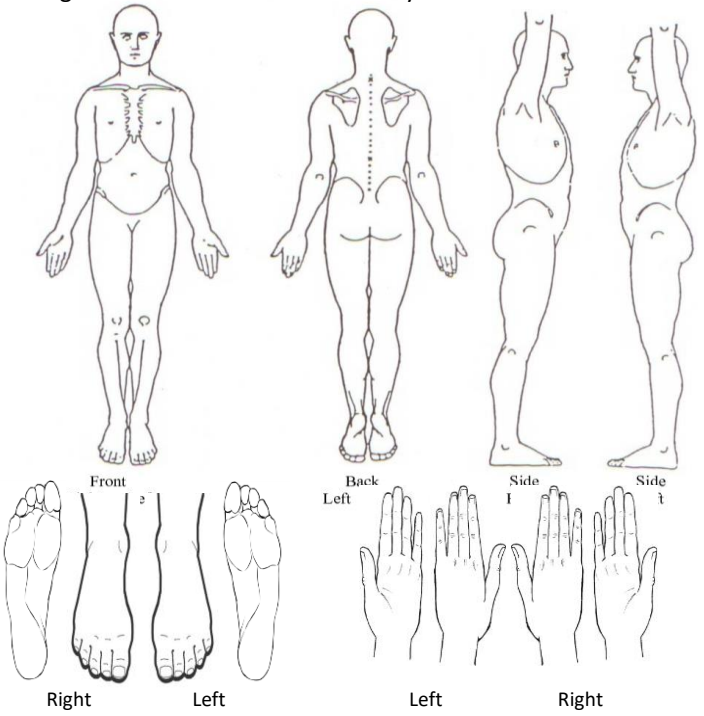
WHAT ACTIVITIES ARE BEING RESTRICTED BY YOUR CURRENT HEALTH PROBLEMS:

Carrying/Lifting Groceries	Driving	Reading/Concentration	Sexual Activities
Extended Computer Work	Sweeping/Vacuuming	Sleep	Sitting to Standing
Climbing Stairs	Garbage	Dressing	Static Sitting
Pet Care	Lifting Children	Shaving	Static Standing
Yard Work	Walking	Bathing	Laundry
Dishes			

Other _____

PLEASE MARK THE AREAS ON THE DIAGRAMS WITH THE FOLLOWING LETTERS:

S = SHARP/STABBING N = NUMBNESS
A = ACHING T = TINGLING
D = DULL B = BURNING
R = RADIATING



What makes the Problem(s) Worse?

□ Sitting □ Laying down □ Walking □ Bowel Movement
□ Standing Sleeping □ Driving □ Sneezing □ Coughing
□ Bending □ Computer work
□ Other: _____

What Relieves your Problem(s):

□ Ice □ Rest □ Exercise □ Pain Meds □Heat
□ Massage □ Stretching
□ Other: _____

MISSED APPOINTMENTS

If you do not show up for your scheduled appointment you will be charged $25.00 as a missed appointment fee that you must pay before you are seen or treated again. As a courtesy for you, we may call you on the telephone when an appointment is missed and/or you have not been in for a while. If you do not wish for us to call you or mail you reminder cards please let us know in writing in your file. Patients are encouraged to leave valuables at home or with an accompanying family member or friend. This facility shall not be liable for the loss of or damage to any personal property including, but not limited to money, credit cards, clothing, jewelry, glasses/contacts, dental devices, hearing aids, furs, documents or any other items.

HEALTHCARE PRIVACY NOTICE/HIPPA

I acknowledge that I have received a copy of the Notice of Privacy Practices for Protected Health Information of Higher Health Chiropractic & Rehabilitation.

INFORMED CONSENT/NO GUARANTEE POLICY

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 doctor's care, a guarantee or promise of improvement or complete recovery cannot be made and it is even possible that no change will occur. I further understand that in the practice of chiropractic, massage therapy, acupuncture, rehabilitation, and nutrition counseling there are some risks including but not limited to fractures, disk injuries, strokes, dislocations, sprains-strains, and/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 procedure(s) which the doctor/provider feels at the time is in my best interest. In addition, because the 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.

I understand that I have the right to refuse treatment, but must be aware of the probable consequences of refusing treatment and/or failing to cooperate with the prescribed treatment. Should you refuse and/or fail to comply with the prescribed treatment your provider will discuss specific consequences with you. The patient agrees to be compliant with the agreed upon treatment recommendations and treatment schedules and to maintain open communication with the doctor in regards to any misunderstandings involved with their care in the office. The Patient understands that lack of cooperation, failure to keep appointments; failure to follow exercise and other recommendations, engaging in activities identified by the office as potentially injurious or traumatic to the body may necessitate additional treatments and therefore result in additional costs. I may discontinue care and terminate the care plan at any time by written notice to that effect delivered in person, by fax, or by mail, to the Office. Such "notice of termination" shall discharge the Office from all further obligations and/or duty to render care.

The care the Patient is to receive will be outlined in a treatment plan and will be determined based upon the Patient's present condition. If a new injury or condition arises during the course of treatment provided for hereby, then, and in that event, care to be provided under the current treatment plan will be suspended until such time as the subsequent problem has resolved, or maximum medical improvement has been obtained. In the event that there is some type of insurance coverage available for the subsequent event such as a Worker's Compensation, Homeowner's, Automobile Medical- Payments or other insurance benefits relating to personal injury, then, and in that event, the Office shall have the option to bill said insurances for the care related to the subsequent injury or condition.

ASSIGNMENT OF BENEFITS/AUTHORIZATION & LIEN

I, the assignee, being the patient or the legal guardian for 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(s), attorney, and any third party payer to pay 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 & 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 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 any insurance company, adjuster, attorney, or legal service bureau to facilitate collections under the terms of this document. Assignee grants this Facility a full power of attorney to endorse &/or sign my name on any & all checks for payments of any indebtedness owed to this office & assignee.

INSURANCE BENEFITS/CREDIT POLICIES/DISCOUNTS/PAYMENT TERMS/REFUND TERMS

As a courtesy, the Facility will obtain a verification of applicable insurance benefits as they are quoted to us, but some third party payers misquote benefits, coverage, and liability. Our Facility & staff are not responsible for what a third party payer and/or a 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. Our Facility will file initial insurance claims for you.

Co pays, deductibles, and all non-covered service charges are due the day the service is rendered. For your convenience we accept cash, check, MasterCard and Visa debit and credit cards. Patients are responsible for charges on all service(s) and/or product(s) which may exceed the maximum allowable and/or insurance carrier does not reimburse this Facility enough to meet our cost. Returned checks, debits & credit charges made payable to this Facility for insufficient funds, stop payments, or other of non-payment will be assessed a $30.00 charge.

All account balances, including automobile and or work injury claims must be paid in full within 90 days of the release of treatment. Patients are fully responsible for all money owed this office and such payment is not contingent on any settlement, claim, judgment, or verdict by which they may eventually recover the 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 and all treatment, products, and services rendered to the patient or minor shown below. This office requires a credit card to be kept in our secure files. If charges are over 90 days past due or in the unlikely event insurance does not cover services rendered, Healthcare Complete will contact the assignee to utilize the credit card on file to pay for balances owed.

A non-discriminatory "Time of Service Discount" is offered to anyone who pays for services the day they are rendered or before they are rendered. The "TOS" is only offered on the day of service or before the day of service. This discount does not apply to supports, orthotics, physical therapy equipment, vitamins, supplements, ointments, and weight loss or detoxification programs.

Patients shall be entitled to a refund if he/she has made a lump sum payment, or payments, rather than having paid for each service as rendered. The refund shall equal the lump-sum amount(s) paid less any and all sums due for the services actually performed, including adjustments or other treatments, and examinations, reexaminations and consultations. However, the amounts due for the services actually rendered shall be computed at non-discounted rates and as would have otherwise been charged for the services if paid for as rendered. That is, if the "non-discounted" amount due for the services actually rendered equals the lump sum paid there will be no refund owed to the Patient. If it is less than the amount paid, the balance will be refunded. If the sum calculated at non-discounted rates exceeds the lump sum(s) paid, the balance will be immediately due and payable by the Patient to the Office. Refund requests must be made in writing to the office and funds will be paid to the patient within 30 days of the termination by either party.

Your signature on this document fully authorizes our staff & doctors to perform any examinations, diagnostic tests &/or treatment as we may consider medically necessary & to release all information pertinent to your health, insurance or benefits to any & all applicable parties on your behalf. Your signature on this document confirms that you have read, understand and agree to comply with all of the terms & conditions of the Health Care Privacy Notice and all policies, consents, terms & conditions regarding your responsibilities to this Facility and that you grant the physicians, therapists and/or staff of this Facility to use and share your confidential health information with others in order to treat you and/or to arrange for payment of your bill and/or for issues that concern this Facility operations and responsibilities.

Patient Signature: _____ Printed Name: _____Date: _____

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name_____ Date_____
Print Patient's Name

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20___

By_____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By_____
Signature of Parent/Guardian (circle one)