CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 PRIVACY INFORMATION

Doctors have always protected the confidentiality of health information by sealing medical records away in file cabinets and refusing to reveal your information. Today, state and federal laws also attempt to ensure the confidentiality of this sensitive information.

The federal government recently published regulations designed to protect the privacy of your health information. The "privacy rule" protects health information that is maintained by physicians, hospitals, other health care providers and health plans. Physicians, doctors and other health care providers have until April 14, 2003, to comply with the privacy rule's standards for protecting the confidentiality of your health information.

This is to notify you that those practices are in place in our office.

This new regulation protects virtually all patients regardless of where they live or where they receive their health care. Every time you see a physician, doctor, are admitted to the hospital, fill a prescription, or send a claim to a health plan, your health care provider will need to consider the privacy rule. All health information including paper records, oral communications, and electronic formats (such as e-mail) are protected by the privacy rule.

The privacy rule also provides you certain rights, such as the right to have access to your medical records. However, there are exceptions, these rights are not absolute. We also take precautions in our office to safeguard your health information such as training you employees and employing computer security measures. Please feel free to ask your doctor or our privacy officer about exercising your rights or how your health information is protected in our office.

Please let us know if you have any questions about or Notice of Privacy Practices. You may contact your Doctor (Privacy Officer) at 719-522-1219, to discuss any questions you may have with him/her.

I have read and understand Alpine Chiropractic Clinic's Privacy Policy.

_____ _____
Signature Print Name

_____
Date

3 PHONE NUMBERS

Cell Phone (_____) _____ Home Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) _____

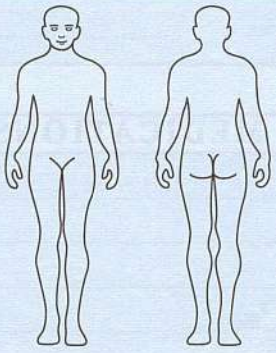
5 PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

6 HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No		
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No	Other _____	
Chicken Pox	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
				Rheumatoid Arthritis	☐ Yes ☐ No		

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

7 MEDICATIONS

Pharmacy Name _____

Pharmacy Phone (____) _____

ALLERGIES

VITAMINS/HERBS/MINERALS

Alpine Chiropractic
X-Ray Consent

Patient Consent to X-Ray

I hereby authorize the performance of diagnostic x-rays. Dr. Haylee has requested the x-rays for further diagnostic purposes. At this time I know of no other condition which the taking of x-rays would further complicate.

Patient Signature: _____ Date: _____

Consent to X-Ray A Minor

I am a parent or legal guardian of _____, who is a minor, _____ years of age. I hereby authorize the performance of diagnostic x-rays of said minor. Dr. Haylee has requested the x-rays for further diagnostic purposes. At this time I know of no other condition which the taking of x-rays would further complicate.

Parent/Legal Guardian Signature: _____Date: _____

Females: Regarding Possibility of Pregnancy

This is to certify that, to the best of my knowledge, I am NOT pregnant. The doctor and certified staff of Alpine Chiropractic have permission to perform diagnostic x-rays. I am aware that taking x-rays, particularly those involving the pelvis, can be hazardous to an unborn child. I have been advised that the 10 days following onset of a menstrual period are generally considered to be safe for x-ray examinations. With these factors in mind I am advising my doctor that:

	Yes	No	Unsure
I am pregnant	_____	_____	_____
I could be pregnant	_____	_____	_____
I am late with my menstrual period	_____	_____	_____
I am taking oral contraceptives	_____	_____	_____
I have an IUD	_____	_____	_____
I have had a tubal ligation	_____	_____	_____
I have had a hysterectomy	_____	_____	_____
I have had irregular menstrual periods	_____	_____	_____

My last period began on: _____

With full understanding of the above and believing that I am not currently at risk, I consent to x-rays.

Patient Signature: _____ Date: _____

Alpine Chiropractic Clinic Financial Agreement

The purpose of this agreement is to clarify the financial aspects of your care. This way we can devote our entire efforts to helping you get the best results in the shortest amount of time.

Services
Our fees are based on the severity of your conditions and the amount of time needed to help you. These are the most common services we provide:

Procedure	Purpose	When performed	Fee
Consultation	Tour office, meet doctor, discuss your problem And health history.	Initial visit.	$45
Evaluation/ Management (Exam)	Accurately determine the nature of your health problem and determine appropriate treatment plan.	First visit, new conditions, exacerbations and progress exams.	$25 - $185
Diagnostic Imaging (X-Rays)	Visualize the location of spinal and extraspinal problems and confirm other examination findings.	If necessary, first visit, reinjuries, and at certain progress examinations.	$30 - $65 per view
Chiropractic Adjustments	Reduce the Vertebral Subluxation Complex and stabilize your spinal or joint problem.	As indicated by examination or evaluation.	$10 - $100
Therapy	Reduce inflammation and swelling, speed the healing process, and help provide relief.	As indicated by examination or evaluation.	$10 - $35
Rehabilitation	Increase strength, stability and joint motion.	As indicated by examination or evaluation.	$15 - $95

Consent for Treatment
I hereby authorize the doctor or designated staff to administer treatment and to perform such procedures he/she may deem necessary in the diagnosis and/or treatment of my condition. I agree not to hold the doctor or his staff responsible for any pre-existing medical condition.

Scheduling
I understand that each appointment I make is set aside specifically for me. If I am more than 10 minutes late, Dr. Henry may be unable to see me as planned. If I absolutely need to change my appointment, I agree to call at least 24 hours in advance if at all possible. I understand that if I do not keep my appointment, or do not change it at least 24 hours in advance, a broken appointment fee of $25 may be assessed

Self Pay
It is my responsibility to notify the staff how I will be paying for services rendered. I understand that, if there is no third party (insurance) involved, I am responsible for full payment at the time of service, and will receive a time-of-service cash discount. If a third party does become involved, I understand it is my responsibility to notify the office staff of this change. I further understand it is not the policy of Alpine Chiropractic Clinic to bill for services previously rendered.

Insurance/Contract-Services/Third Party
It is my responsibility to know my insurance benefits and plan parameters for chiropractic care, and I will be responsible for contacting my insurance company myself, should I have any questions. I authorize and request my insurance company to make payment directly to Alpine Chiropractic Clinic unless other arrangements have been made.

We will not become involved in disputes with your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, “usual and customary” charges, etc., other than to supply factual information. Remember, your insurance contract is between you and your insurance company.

Payment Arrangements:I agree to pay Alpine Chiropractic by way of: _____Credit/Debit Card _____Cash _____Check

Billing
Any outstanding balances are billed monthly and are considered past due 10 days after the invoice date, or when special arrangements are not met. Returned checks are subject to a $25.00 fee. Balances older than 30 days will accrue interest charges of 1.75% per month. I understand that after 30 days, unpaid balances may be assigned to a collection agency, and will be assessed a $25 collection fee, plus any legal fees, collection fees, or court costs incurred.

Questions
Please ask if you have any questions about this agreement. If your ability to comply with its provisions changes, please tell us. We are here to help.

Patient Agreement
I have read, understood and agreed to, and received a copy of this agreement.

_____	_____	_____	_____
Patient/Responsible Party	Date	Clinic Representative	Date