Entrance Application

We are honored you chose us to evaluate your health. To better serve you, please fill out the personal information below. If you need assistance, please inform our front desk team member.
Thank you and welcome to HealthSource!

Patient Information

First Name: _____ Middle _____ Last _____ Gender: __M __ F

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Social Security Number: _____

Email Address: _____ Birthdate: _____ Age: _____

Marital Status: __S __M __W __D Job Title: _____ Work Phone: _____

Spouse Name: _____ Birthdate: _____ Social Security Number: _____

Children: Names and Ages: _____

Insurance Information

Name of person on the insurance card: _____ DOB: _____

Name of employer: _____

Employer phone number: _____ City: _____

Person responsible for this account: _____

Additional Information

In case of emergency, whom should we contact? _____

Relation to patient: _____ Phone Number: _____

Family Physician: _____

May we send your Family Physician updates on your progress? _____Yes _____ No

What is your primary complaint? _____

_____

Is this worker's compensation? _____ Is this personal injury? _____

Office use only **Account Number** **Date**

Acknowledgement of Notice of Privacy Practices

I acknowledge that a copy of this clinic's Notice of Privacy Practice's has been made available to me. I also understand that this Notice is available by request.

_____

Name of Patient or Legal Representative *Date*

_____

Signature of Patient or Legal Representative *Date*

Facility Use Only

○ Patient has been provided Acknowledgement of Notice of Privacy Practices and has refused to sign.

_____ _____

Authorized Staff Signature *Date*

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature:_____ Date:

Witness Name: _____ Signature:_____ Date:

Financial Agreement

Please remember that insurance is considered a method of reimbursing the patient for fees put to the doctor and is NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE, IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE AND DEDUCTIBLE AT TIME OF SERVICE.

If this account is assigned to an attorney/outside agency for collection and/or suit, HealthSource shall be entitled to reasonable attorney's fees and for cost of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

_____ _____

PATIENT'S / GUARDIAN'S SIGNATURE INSURED'S SIGNATURE

_____

DATE

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

I assign, authorize, transfer and convey to [PROVIDER/CLINIC NAME] all of my rights, title and interest to all of the insurance benefits to which I may be entitled according to my insurance policy with the companies noted to the extent necessary to provide for payment of my bill. I hereby designate, authorize, and convey to [PROVIDER/CLINIC NAME], to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan: (1) the right and ability to act as my Authorized Representative in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan, including but not limited to with respect to internal appeals or litigation; and (2) the right and ability to act as my Authorized Representative to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right and ability to act as my Authorized Representative with respect to a benefit plan governed by the provisions of the Employee Retirement Income Security Act of 1974 ("ERISA"), as provided in 29 *C.F.R.* §2560.5031(b)(4)), with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines or injunctive relief. By signing this form, I understand that [PROVIDER/CLINIC NAME] is not assuming any obligation or duty to assert such rights and I agree to release any claim I might have relating to Provider's exercise of such rights or the decision not to exercise such rights.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

_____ _____

Patient Date

_____ _____

Policyholder/Insured Date

_____ _____

PATIENT'S / GUARDIAN'S SIGNATURE DATE

DRY NEEDLING CONSENT TO TREAT FORM

Dry Needling (DN) involves inserting a tiny monofilament needle into symptomatic tissue with the intent to reduce pain, increase circulation and improve function of the neuromusculoskeletal system. DN is not traditional Chinese Acupuncture, but instead is based on neurology, physiology and western medical principles. DN is a valuable treatment for musculoskeletal pain; however, like any treatment there are possible complications. While these complications are rare in occurrence, they are real and must be considered prior to giving your consent for dry needling treatment.

Risks of the procedure:

The most serious risk associated with DN is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely only require a chest x-ray and no further treatment. The symptoms of shortness of breath may last for several days to weeks. A more severe lung puncture can require hospitalization. This is a rare complication and in skilled hands should not be a concern.

Other risks may include bruising, infection and/or nerve injury. It should be noted that bruising is a common occurrence and should not be a concern. The monofilament needles are very small and do not have a cutting edge; the likelihood of any significant tissue trauma from DN is unlikely. There are other conditions that require consideration so please answer the following questions:

- Are you taking blood thinners? **Yes / No**
- Are you or is there a chance you could be pregnant? **Yes / No**
- Are you aware of any problems or have any concerns with your immune system? **Yes / No**
- Do you have any known disease or infection that can be transmitted through bodily fluids? **Yes / No**

Patient's Consent:

I have read and fully understand this consent form and attest that no guarantees have been made on the success of this procedure related to my condition. I am aware that multiple treatment sessions may be required, thus this consent will cover this treatment as well as subsequent treatments by this facility. All of my questions, related to the procedure and possible risks, were answered to my satisfaction.

My signature below represents my consent to the performance of dry needling and my consent to any measures necessary to correct complications, which may result. I am aware I can withdraw my consent at any time.

I, _____authorize the performance of Dry Needling.

_____ _____

Patient or Authorized Representative Date

_____ _____

Relationship to patient (if other than patient) Date

☐ I was offered a copy of this consent and refused.

To:

Dr. Ryan Woods
Premier Pain Pain Management
8671 S Quebec St
Ste 150
Highlands Ranch, CO
80130

I, the undersigned hereby attest and warrant to the above named, that I am the legal guardian of:

_____ D.O.B _____
Name of minor patient

_____
Social Security or I.D. number

A minor child as described by law. Further I warrant that my authority to act on the child's behalf is by virtue of

[ ] Being the child's natural parent

[ ] Having been duly appointed legal guardian by a Court of Competent Jurisdiction
(A copy of the order is attached hereto)

And that I hereby give my consent to such medical examinations, diagnostic procedures and treatments as may be deemed necessary by the physician for the evaluation and treatment of the condition for which this minor child has been presented.

Signed in the presence of this witness on _____
Date

_____ _____
Signature Parent/Guardian Social Security Number

_____ _____
Witness Date

Patient	ID#