

Welcome to Carefree Chiropractic! Please take your time completing the following information so we can serve you to the best of our ability.

Patient Information

Title: Mr. Mrs. Miss Ms. Dr. (circle one) DATE _____

Last Name _____ First _____ Middle Initial _____

EMAIL _____

Address _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Cell _____

Gender: MALE FEMALE Birthdate _____ Social Security # _____

Status: Married Single Widowed Divorced Child Other Spouse's Name _____

Children's names _____

How were you referred to this office? (circle all that apply) Yellow pages Newspaper Flyer Radio TV Friend/

Relative (Name _____) Other _____

Your occupation _____ Employer _____

Employer's address _____ City _____ State _____ Zip _____

Nearest Relative not living with you _____ Relative's phone _____

Address _____ City _____ State _____ Zip _____

Other doctors seen for this condition? MD DC DO DDS Doctor's name _____

Diagnosis _____ X-rays? YES NO Length of time under care _____

Off work? YES NO If yes, how long? _____ Have you returned to the same job? YES NO

Treatment received: Medication Physiotherapy Adjustments Surgery Other _____

Results _____

Ever seen another chiropractor/DC? YES NO Name _____ Date(s) _____

Height _____ Weight _____ Blood pressure _____

Smoking status: (circle one) Current every day, current some days, former smoker, never smoker

Race: (Circle one) African American, American Indian, Asian, Black, Native Hawaiian, Pacific Islander, White, decline, Unknown

Ethnicity: (Circle one) Hispanic/Latino, Not Hispanic/Latino

Insurance Information

Are you covered under any group, union, or personal health and accident insurance? YES NO

Insurance company _____ Major policy holder _____

Relation to policy holder _____ Policy or contract # _____

PLEASE ANSWER THOROUGHLY FOR BEST EVALUATION

Primary area of discomfort

How long have you had this condition? _____ Days _____ Weeks _____ Months _____ Years

As far as you know, the cause was

If condition is due to any injury, what day did the injury occur?

Place injury occurred: () Home () Work () Other

Intensity of discomfort: () Mild () Moderate () Severe

Frequency of discomfort: () Constant () Daily () Intermittent ___times per Day / Week

How would you describe the pain: () Sharp () Dull () Achy () Stiff () Throbbing

() Tingling Other

Pain is getting: () Better () Worse () Staying the same

What aggravates the discomfort: () Lifting () Bending () Lying () Sitting () Walking

() Standing Other

Time of day discomfort is most noticeable: () Morning () Afternoon () Evening () Increases during day

Discomfort decreased when/with: () Resting () Lying () Sitting () Standing () Ice () Heat () Other

Names of other doctors seen for this condition?

I have tried: () Aspirin () Muscle Relaxers () Pain Medication () Cortisone () Other

Results

Have you had any surgical operations? () Yes () No What kind?

Are you taking any prescription medication? What kind? _____

Are you **allergic** to any prescription medication? _____

PLEASE NOTE THE LOCATION OF YOUR DISCOMFORT

Headaches

- ___ Back of head
- ___ Top of head
- ___ Side(s) of head
- ___ Front of head
- ___ Behind the eyes
- ___ Other _____

Neck Pain

___ Left side ___ Right Side ___ Both sides

Pain travels to:

- Upper back ___ Left ___ Right
- Shoulders ___ Left ___ Right
- Arms ___ Left ___ Right
- Hands ___ Left ___ Right
- Fingers ___ Left ___ Right
- Other

Low Back Pain

___ Left side ___ Right side ___ Both sides

Pain travels to:

- Legs ___ Left ___ Right
- Buttocks ___ Left ___ Right
- Thighs ___ Left ___ Right
- ___ Left ___ Right
- Knees ___ Left ___ Right
- Ankles ___ Left ___ Right
- Feet ___ Left ___ Right
- Other

Mid Back Pain

___ Left side ___ Right side ___ Both sides

Pain travels to:

- Neck ___ Left ___ Right
- Shoulders ___ Left ___ Right
- Arms ___ Left ___ Right
- Around Rib Cage ___ Left ___ Right
- Through chest ___ Left ___ Right
- Other

Other areas of discomfort:

Other health issues:

I hereby authorize the Doctor to care for me as he deems appropriate. I will not hold him responsible for any pre-existing medically diagnosed condition(s), nor any medical diagnosis. The information I have given is accurate and true.

SIGNATURE _____ DATE _____

Professional fee Schedule

Our experience has shown that it is wise to have an understanding with our patients regarding our office policies and fees. We offer several methods of payment for your chiropractic care and you have chosen to bill your health insurance. The information you provide will enable us to best serve you and to help avoid misunderstandings in the future. Our main concern is your health and well-being. The fees that follow are general. Your specific plan will dictate your individual charges.

Consultation	No Charge
Chiropractic Examinations	\$40 - \$140
Spinal Adjustment (1 to 5 areas)	\$60 - \$70
Extremity Adjustment	\$40
Manual Therapies	\$40 - \$115
Chiropractic X-ray studies	\$65 - \$365
Patient / Doctor Conference	\$40 - \$70

Plan # 4 – GENERAL HEALTH INSURANCE

If you have insurance which covers chiropractic care, we will bill your insurance company directly and handle requests for information and documentation. We will make a copy of your insurance card and verify coverage for you. You will be responsible for your deductible and co-pay or the monthly co-pay arranged for you.

Signature _____ Date _____

9/23/09

Explanation of professional Fees

Consultation: No charge

The consultation takes place subsequent to the New Patient Examination. The Doctor will discuss with the patient any current complaints. The Doctor will also give the patient a brief explanation of Chiropractic and the care they will be receiving.

New Patient Examination: \$50-\$140

The Doctor will review the Patient History form describing the patient's chief complaints. At that time, a postural exam, range of motion study, and any necessary orthopedic tests will be performed.

Established Patient Examination: \$40-\$60

Periodically the Doctor will monitor percent improvement and will obtain additional information on a visit related to progress or aggravation from initial findings.

Chiropractic Adjustment: \$60-\$70

Generally an adjustment will be performed each visit to address the individual's subluxation patterns. There are up to four areas of the spine that may be involved.

Extremity Chiropractic Appointment: \$40

Additional areas outside the spine such as knees, wrists, etc. that may require care.

Manual Therapies: \$40-115

Manual therapies consist of services such as, but not limited to, lymphatic drainage, manual traction, and myofascial trigger point.

Chiropractic X-ray Studies: \$65-\$360

Subsequent to the consultation, and after careful review of the patient's complaints. The Doctor will determine if x-rays are necessary for the proper care of the patient.

Patient/Doctor Conference: \$40-\$70

The patient/Doctor conference is a specific office visit at which time the Doctor reviews with the patient their examination finding, including physical examination and X-ray examination study, lending itself to aid the patient in understanding and participating in the health findings and care.

Signature _____ Date _____
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**Carefree Chiropractic
3365 N. Academy Blvd.
Colorado Springs, CO 80917**

FORM: NOTICE OF PRIVACY PRACTICE SUMMARY

This summary discloses how health information about you may be used. A full notice of your privacy rights has also been provided to you.

Carefree Chiropractic uses health information about you for treatment, to obtain payment for treatment with your authorization as required (check your state laws.), for administrative purposes, and to evaluate the quality of care that you receive,

Carefree Chiropractic will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Carefree Chiropractic may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

Carefree Chiropractic may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, governmental function in order to comply with workers compensation laws and regulations, a right to request restriction, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health records.

You may complain to Dr Johnson and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Carefree Chiropractic must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information by alternative means or by alternative locations and obtain your written authorization to

use or disclose your health information for reasons other than those listed above and permitted under law.

If you have any questions or complaints please contact Dr. Doug Johnson at (719) 572-0211.

Patient Signature

Date

TERMS OF ACCEPTANCE

When a patient seeks chiropractic healthcare, and when a chiropractor accepts a patient for such care, it is essential that both are seeking and working for the same goals. Chiropractic does NOT diagnose or treat disease. Chiropractic has only one Goal:

TO LOCATE, ANALYZE, AND CORRECT SPINAL INTERFERENCE TO THE NERVOUS SYSTEM

The purpose of the nervous system is to control and coordinate all bodily function. Interference to this master system automatically produces improper function of the body. The SUBLUXATION (spinal misalignment producing nerve interference), in and of itself, is a detriment to life and health. Correction of the subluxation through a specific chiropractic adjustment allows the body to function at its optimum level. This allows the innate healing power of the body to work at maximum efficiency to restore, maintain, and promote natural health.

WE DO NOT DIAGNOSE CONDITION(S) OR DISEASE(S) OTHER THAN VERTEBRAL SUBLUXATIONS.

WE OFFER NO TREATMENT OF CONDITION(S) OR DISEASE(S) OTHER THAN VERTEBRAL SUBLUXATIONS.

WE PROMISE NO CURE FROM ANY CONDITION(S) OR DISEASE(S).

THE CHIROPRACTIC ADJUSTMENT RESTORES LIFE AND HEALTH TO ITS FULLEST POTENTIAL!

I, _____, having read the above statements, and understanding them fully, do undertake chiropractic health care on this basis.

Date: _____

Signature: _____