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

Medicare Insurance Information

Do you have a Medicare Part B Policy? Yes____ No___
If yes, Policy #_____

Do you have a Medicare Part B Supplement (Replacement) Policy? Yes____No____
Insurance Company _____ Policy or Contract #_____

Do you have a Secondary to Medicare? Yes____ No_____
Insurance company_____ 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

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

Are you taking any prescription or non-prescription medication? Yes No

What kind?_____

Are you allergic to any prescription medication? Yes No, what kind?_____

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

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

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 Medicare or a Medicare Supplement policy. 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.

Spinal Adjustment (1 to 5 areas)	**$25-$40**
Chiropractic X-ray studies	**$49 - $365**

Explanation of professional Fees

Chiropractic Adjustment: $25-$40

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.

Chiropractic X-ray Studies: $49-$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.

MEDICARE

We accept assignment for Medicare Patients. We bill Medicare according to the published fee-schedule. You will be responsible for your deductible and co-pay. Please let us know if you have Secondary Insurance which covers chiropractic care.

I authorize the release of any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement. I also authorize any and all payments of benefits to be made directly to Carefree Chiropractic. Should I, in error receive any payments myself, I will bring them to this office. I am responsible for payment of the services which I receive.

Signature _____Date _____

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 purposed, 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 you r 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 of 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: _____