Appointment Date/time_____

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_____
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

Accident Information

What type of accident did you experience? AUTOMOBILE WORK OTHER
Date & Time of accident_____ Reported to police? YES NO To employer? YES NO
Were you unconscious? YES NO Did you receive FRACTURES CUTS ABRASIONS BRUISES
Where you hospitalized? YES NO Length of stay? Days____ Hours____ Hospital name_____
Where did you feel pain immediately after the injury?_____
Have you had any other personal or related injuries or accidents? YES NO Please describe_____
_____
Were you disabled? YES NO until what date?_____ Have you injured the area before? YES NO
If so, when?_____

CIRCLE ONE

Vehicle driven by you:	bus, sport car, coupe, sedan, sport utility, station wagon, pickup
Vehicle Size:	compact full size, light, midsize, mini, subcompact, semi
Your position in vehicle:	driver, front middle, front right, back left, back middle, back right, pedestrian hit.
What happened?	Hit head on, hit left front, right front, right rear, rear ended, sideswiped
Damage:	complete, extensive, minimal, moderate, extensive outside-moderate inside, moderate outside-minimal inside, minimal outside-moderate inside
Describe other vehicle:	midsized, semitrailer, subcompact, light truck, pickup truck, sport utility, fall sized van, minivan
Damage to other vehicle:	complete, extensive, minimal, extensive outside- moderate inside, moderate outside-minimal inside, minimal outside-moderate inside

Approximate speed of YOUR vehicle: _____
Approximate speed of OTHER vehicle: _____

Driving conditions:	Clear, cloudy, drizzling, rainy, snowing, stormy
Visibility:	Fair, good, poor
Road conditions:	damp, dry, dry with icy patches, iced over,, snowed over, wet

PLEASE CHECK SYMPTOMS YOU HAVE NOTICED SINCE YOUR INJURY

__Fever	__Constipation	__ Loss of balance	
__Head seems heavy	__Change in urination	__Cold sweats	
__Stiff neck	__Dizziness	__irritability	
__sleeping problems	__Pins/needles in arms	__chest pains	
__Pins/needles in legs	__Numbness in toes	__Change in vision	Symptoms other than listed:_____
__nervousness	__numbness in fingers	__Fatigue	_____
__tension	__Diarrhea	__Depression	_____
__Fainting spells	__Cold feet	__Loss of memory	Since this injury are your symptoms:
__loss of smell	__Cold hands	__ringing in ears	__improved __worse__staying the same
__Loss of taste	__shortness of breath	__face flushed	
__Upset stomach	__Light bothers eyes	__Buzzing in ears	

If your condition is painful, would you describe it as severe, moderate or mild and then, on the illustration below, draw a line from the area of pain or injury to the word or phrase that most accurately describes what you are feeling:

Sharp pain,
Dull pain/ache
Stabbing pain
Nagging pain
Spasm
Tingling sensation
Burning sensation
Numbness

Dr. Notes Only

_____

_____

_____

Headaches__mild__mod__severe
____ Back of head
____ Top of head
____ Side(s) of head
____ Front of head
____ Behind the eyes
____ Other _____

Neck Pain__mild__mod__severe
____ 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

Low Back Pain__mild__mod__severe
___ 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__mild__mod__severe
___ 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 health issues:_____

Frequency of discomfort: ( ) Constant ( ) Daily ( ) Intermittent ___times per Day / Week
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
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? Please list:_____
_____
What **prescription** medication are you actively allergic to? Please list:_____

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:_____

Dr. Notes Only

Name of your insurance company_____
Address:_____
Phone:_____Contact:_____
Name of insured:_____Claim#_____

Name of insurance company of person responsible for injuries:_____
Address_____Phone:_____Contact:_____
Name of insured:_____Claim#_____

Have you retained an attorney? Yes No, If yes, Name of
Attorney:_____
Address_____Phone_____Fax_____

Other important information you wish to
express_____
_____

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 may choose the plan which best suit your needs. Please read your options carefully. 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.

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**

AUTO ACCIDENT / PERSONAL INJURY
You need to supply us with the accident report, the name if you auto insurer, health insurance, names of any attorneys involved. We will bill directly for you.

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 _____

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:_____

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: _____

NOTICE OF DOCTOR'S LIEN

Patient: _____
Date of Accident: _____

I do hereby authorize **Carefree Chiropractic** (Douglas S. Johnson, D.C.) to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for chiropractic service rendered to me both by reason of this accident and by reason of any other bills that are due this office and to withhold such sums from any settlement, judgment, or verdict as may be necessary as to adequately protect and fully compensate said doctor. And I hereby further give Lien on my case to said doctor against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all chiropractic bills submitted by him for service rendered me and that this agreement is made solely for said doctor's additional protection and in consideration awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable.

Dated _____ Patient signature _____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate doctor above-named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

Dated _____ Attorney signature _____

Please date, sign, and return the original copy to doctor's office. Also keep one copy for your records.

Carefree Chiropractic
3365 N Academy Blvd.
Colorado Springs, CO 80917

3rd PARTY MEDICAL LIEN & ASSIGNMENT

Patient: _____
Claim #: _____
Date of Injury: _____

I hereby authorize and direct _____ Insurance Company, to pay to **Carefree Chiropractic** (Douglas S. Johnson, D.C.) such sums as may be due and owing him for chiropractic services rendered me by reason of the accident and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further request that payment be made directly to said doctor which would otherwise be paid to myself, as the result of the treatment charges incurred for injuries in connection therewith. This is a direct assignment of my rights and benefits under this claim.

I fully understand that I am directly and fully responsible to said doctor for all chiropractic bills submitted by him for services rendered me and that this agreement is made solely for said doctor's protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover.

Please acknowledge your agreement to this request by signing below and returning to the doctor's office below. I have been advised that if you do not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but may declare the entire balance due and payable by me.

Date _____ Patient signature _____

The undersigned insurance company does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate said doctor and make payment payable directly to Carefree Chiropractic.

Date _____

_____
Signature of Insurance Company Representative

_____
Print First and Last Name

_____
Insurance Company Name

Please date, sign, and return the original copy to the doctor's office below. Also, keep on copy for your records.

Carefree Chiropractic
3365 N Academy Blvd.
Colorado Springs, CO 80917