



WELCOME

Date: _____

Patient Information

Name: _____
Last First MI

Email address: _____

Mailing Address: _____

Phone # (H) _____ (W) _____ (Cell) _____

Would you like to receive confirmations via text message? yes or no Cell Phone Provider: _____

Can we add your email to our e-newsletter to inform you of clinic news? Yes or no

Can we call you at work? Yes No

Date of Birth: _____ Sex: Male Female SS#: _____

Marital Status: Single Married Divorced Widowed Separated Minor

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

How did you hear about our practice? _____

Emergency contact: Name: _____ Relation: _____ Phone #: _____

Phone #: (H) _____ (W) _____

Accident Information

Is this visit due to an accident? Yes No If yes, what type? Auto Work Other _____

Has it been reported? Yes No If yes, to whom? _____

Financial Information

Name of person responsible for this account: _____

Relationship to patient (if other than self): _____ Phone # _____

Do you have health insurance? Yes No Name of Carrier: _____

Do you have secondary insurance? Yes No Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, Physical Medicine Center of the Rockies, PLLC dba Spine Correction Center of the Rockies, LLC, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.



SIGNATURE (X) _____ **DATE** _____

Form 2

Health History

Who is your primary care physician? (doctor and/or practice) _____

Please check to indicate if you are currently experiencing any of the following conditions:

- | | | | | |
|----------------------------------------------|------------------------------------------------|---------------------------------------------|------------------------------------------------|-------------------------------------|
| <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Arms | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Sudden Weight Loss | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Back Pain/Stiffness | <input type="checkbox"/> Pins/Needles in Legs | <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Arm/Hand Pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Leg/Knee Pain | <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Tension | <input type="checkbox"/> Jaw Problems | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Allergies | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Shortness of Breath | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Night Pain | <input type="checkbox"/> Bowel/Bladder Changes | |

Please check to indicate if you have ever had any of the following:

- | | | | | |
|---------------------------------------------|----------------------------------------------|---------------------------------------------|----------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Tumors/Growths |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fractures | <input type="checkbox"/> Measles | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraines | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Rheumatoid Arthritis | |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Severe allergy to chicken | <input type="checkbox"/> Whooping Cough |
| | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Other _____ | |

Are you currently under drug and/or medical care? Yes No If yes, explain _____

Please list any medications you are currently taking: _____

Please list any surgeries and/or hospitalizations you have had (type & date): _____

Please list any allergies: _____

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

Is there a family history of any of the following conditions? (indicate family member including parents, grandparents & siblings)

- | | |
|----------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Arthritis _____ |
| | <input type="checkbox"/> Other _____ |

Do you exercise: Frequently Moderately Occasionally None

Do your work activities mostly involve: Sitting Standing Light Labor Heavy Labor

Do you sleep on your: Back Side Stomach Do you use a cervical pillow? Yes No

What is your daily/weekly intake of the following:

Caffeine _____ cups/day Alcohol _____ drinks/week Cigarettes _____ packs/day

- I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.



SIGNATURE (X) _____ **DATE** _____

NEUROLOGICAL/ MRI/ VASCULAR PATIENT QUESTIONNAIRE

NAME _____ **DATE** _____

For any YES answer, please explain under comment and notify the Doctor:

- | | | |
|----------------------------------------------------------------------------------------------------------------------------------|----|-----|
| 1. Do you suffer from neck pain with pain in your shoulder, arms or hands?
Comment: _____ | NO | YES |
| 2. Do you have weakness, numbness or burning in your shoulder, arms or hands?
Comment: _____ | NO | YES |
| 3. Do your hands or arms fall asleep regularly?
Comment: _____ | NO | YES |
| 4. Do you have reduced feeling (sensation) or swelling in your hands or arms?
Comment: _____ | NO | YES |
| 5. Do you suffer from a loss of handgrip strength?
Comment: _____ | NO | YES |
| 6. Do you suffer from back pain with pain in your buttocks, legs or feet?
Comment: _____ | NO | YES |
| 7. Do you have weakness, numbness or burning in your buttocks, legs or feet?
Comment: _____ | NO | YES |
| 8. Do your legs or feet fall asleep regularly?
Comment: _____ | NO | YES |
| 9. Do you have reduced feeling (sensation) or swelling in your legs, feet?
Comment: _____ | NO | YES |
| 10. Do you suffer from cold hands or feet?
Comment: _____ | NO | YES |
| 11. Have you tried any medications such as anti-inflammatory?
If yes, what kind of medication? _____
1 | NO | YES |
| 12. Have you tried any Physical Therapy or Chiropractic treatments before?
If yes: When? For how long? What kind? _____ | NO | YES |
| 13. Have you had an MRI?
If yes: When? Who ordered it? What was it ordered for? _____ | NO | YES |
| 14. Have you used any splint or braces or other prescribed treatment by an MD?
If yes: When? What kind? Who ordered it? _____ | NO | YES |
| 15. If you have tried any treatment or medications, did this make your problem better? | NO | YES |



NOTE: Your health information will be kept strictly confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

I hereby authorize the providers to treat my case as they deem appropriate through the use of physical therapy, rehabilitation, manual therapy, chiropractic manipulation of the spine, nutritional support, trigger point injections and diagnostic testing. I realize the goal of holistic healthcare is to strengthen the patient's body in order to heal themselves.

A patient coming to the doctor gives him/ her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/ she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/ she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

It is understood and agreed the amount paid the clinic for x-rays is for interpretation and only the x-ray negatives will remain the property of this office, being on file. The patient also agrees that he/she is responsible for all bills incurred at this office.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

*"National Supplier Clearinghouse
Medicare DMEPOS Supplier Statement*

*DMEPOS suppliers have the option to disclose the following statement in order to satisfy the requirement outlined in Supplier Standard 16 in lieu of providing a copy of the standards to the beneficiary.
The products and/or services provided to you by supplier legal business name or DBA are subject to the supplier standards contained in the Federal regulations shown at 42 Code of Federal Regulations Section 424.57(c). These standards concern business professional and operational matters (e.g., honoring warranties and hours of operation). The full text of these standards can be obtained at <http://ecfr.gpoaccess.gov>. Upon request we will furnish you a written copy of the standards.*

I have read and understand the foregoing.

Patient's Signature

Date

X-ray Questionnaire: For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

There is a possibility that I may be pregnant at this time.

Yes, I am definitely pregnant

No, I am definitely not pregnant at this time

I request that x-ray films not be taken because: _____

Date of last menstrual period: _____



Spine Group, LLC dba:
Mile High Spine & Pain Center
2205 W. 136th Ave # 112
Broomfield, CO
303-457-0123 Fax: 303-252-4065

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ DOB: _____

I acknowledge that I have reviewed the Notice of Privacy Practices of Spine Correction Center of the Rockies.

(Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I wish to receive an electronic copy of Privacy Notice.

My email address is: _____@_____

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please initial below:

_____ I acknowledge that it is the policy of Spine Correction Center of the Rockies to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

_____ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Privacy Officer, Mandy Stone, about my concerns.

Signature of Patient/Guardian

Date

Witness (Office Staff)

Date



Spine Group, LLC dba:
Mile High Spine & Pain Center
2205 W. 136th Ave # 112
Broomfield, CO
303-457-0123 Fax: 303-252-4065

OPEN ADJUSTING DISCLOSURE

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an incidental disclosure of health information.

It is the practice of this office to provide chiropractic care in an open adjusting environment. Open adjusting involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment other arrangements will be made for you. Your decision will have no adverse effect on your care from the doctors or on your relationship with our staff.

Your signature indicates your authorization of this activity.

Signature of Patient/Guardian

Date

Witness (Office Staff)

Date