COLORADO CHIROPRACTIC AND REHABILITATION CENTER, LLC

2460 W. 26th Ave. Suite C-40
Denver, Colorado 80211 (no mail here)

New Patient/Injury Form

Thank you for choosing Colorado Chiropractic and Rehabilitation Center, LLC to serve your health care needs. Please complete this Consent Form and provide documentation of insurance in order to receive treatment services. Our team looks forward to working with you toward your full recovery.

Patient Name: _____ **Date:** _____

Address: _____ City: _____ State: _____ Zip: _____

Auto and Work Comp Patients please give full Social Security #: _____

Phone Number: _____ (H) _____ (C) Email: _____

How did you hear about us? _____

❑ Male ❑ Female Date of Birth: ___/___/_____ Age: _____ Height: ____'_____" Weight: _____#

Emergency Contact: _____ Phone: _____ Relation: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Other

Your Household: ❑ Alone ❑ Roommate(s) #___ ❑ Spouse/Partner ❑ Children #_____

Education: ❑ F/T ❑ P/T ❑ Non-Student Years completed _____ highest level completed _____

Employer: _____ Job Title: _____

Job Description: _____ Years Employed: _____

Employer Address: _____ Phone: _____

Employment: ❑ Full-Time ❑ Part-Time Job Satisfaction: Unsatisfied Satisfied Very Satisfied

Status: ❑ F/T ❑ P/T ❑ Not Working since _____ Restrictions: ❑ Yes ❑ No

Current Restrictions: _____

What type of injury are we seeing you for? _____

❑ Work ❑ Sports ❑ Third-Party/Liability ❑ Auto Accident Date of Loss/Accident/Injury: ____/____/_____

What happened? _____

Insurance/ Payment Information:

❑ None, I will be paying for services myself. ❑ Workers Compensation Claim ❑ Auto Claim

Attorney Name: _____ Firm Name: _____

Phone: _____ Date Retained: ____/____/_____ ❑ I have not retained an attorney

I understand it is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages.

Patient Signature _____ Date: _____

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Consent for Treatment:

I hereby give my informed consent to receive health care services, evaluation, and treatment rendered according to the applicable standards of care at Colorado Chiropractic and Rehabilitation Center, LLC (hereinafter "CCRC"). I understand that options exist for treatment and all treatments are choices with risks and benefits. If the risks and benefits of a proposed treatment are not clear to me, I understand that I am responsible to request further information from CCRC. The information within my Patient Chart is confidential. I understand that all requests for release of my records, or any portion of my records, must be made in writing to CCRC. Protected health information will only be released with a written authorization, signed by me, and only the minimum disclosure related to my care necessary to fulfill such written request will be provided. I have been provided a copy of CCRC's Privacy Policy Practices and agree to comply with all of CCRC's policies and practices. I understand that I have a responsibility to communicate honestly with my health professionals working at CCRC and to notify them at the earliest time possible of any changes to my condition, health status, re-injury, and/or new injuries and accidents.

I further authorize any health professional working at CCRC to provide tests, procedures, and treatments that are necessary or advisable for the evaluation and management of my health care at CCC and within the scope of CCRC's practice whether rendered by Dr. Walker personally or by another health care provider or staff member under the orders or direction of Dr. Walker.

Patient Signature: _____ **Date:** __/__/____

Financial Responsibility Agreement:

CCRC explained and I understand that CCRC offers a "Time of Service Discount" off the normal fees charged for services rendered if payment in full is made at the time services are rendered. By signing below, I choose not to take advantage of the discounted rates. Instead, I authorize CCRC to bill my insurance company (including workers compensation) the normal fees for service.

I also realize that there is a possibility that my insurance company may not pay some or part of fees for certain services rendered by CCRC. CCRC does not promise or guarantee that services rendered to me will be paid by my insurance company. I agree to pay for all charges for services rendered to me if my insurance company reduces or denies payment for any services provided to me by CCRC. Workers Compensation patients with an open claim are not responsible for charges and services rendered if they have an open and accepted Workers Compensation Claim. CCRC will not balance bill services provided to an accepted claim for a Workers Compensation patient who has been provided services by CCRC. Any services provided after a denial of my claim or closure of my claim (without authorized maintenance services) will be my responsibility to pay in full. I am required to notify CCRC if my claim is denied for any reason and contact them to cancel all services immediately. I am responsible to pay any services provided to me after denial of my Workers Compensation Claim.

I UNDERSTAND THAT I AM PERSONALLY FINANCIALLY RESPONSIBLE and obligated to pay, in full, THE ENTIRE BILLED AMOUNT, for any and all health care and/or professional services rendered to me WHETHER OR NOT MY INSURANCE PAYS any portion of the charges incurred by me. I understand that I am personally responsible for any charges, and unpaid portions of charges, not covered by insurance. I understand that amounts unpaid for over 90 days from the date services were rendered are past-due and subject to a monthly finance charge of 1.5% and an annual finance charge of 18%.

I understand and agree that if I fail to make any payments in a timely manner (including but not limited to the balances after insurance benefits and/or settlement proceeds have been received), after such default and upon referral to a collection agency, attorney, or small claims court by CCRC, I will be responsible for all costs of collection, including, but not limited to, collection agency fees up to 50% collection fees, court costs, and CCRC's attorney fees.

Patient Signature:_____ **Date:** ___/___/_____

COLORADO CHIROPRACTIC AND REHABILITATION CENTER, LLC
2460 W. 26th Ave, Suite 40-C
Denver, Colorado 80211 (no mail here)

Office Policy

- **Fees**
  - I understand that Colorado Chiropractic and Rehabilitation Center, LLC is an independent clinic and sets its own fees for all services to conform to reasonable and customary fees for the services provided through this facility (this includes services provided by Dr. Walker, or any other member of the clinic staff or coverage staff). I understand that fees are subject to change without notice. I understand that a complete list of services and fees are available for my review upon written request.

- **Cancelation, Missed Appointment and Rescheduling Policy.**
  - **I agree that I may be charged a fee for any no-show, late cancelation, or rescheduling made less than 24-hours before my scheduled appointment. If you are a Workers Compensation patient, please note that missed appointments, no show or late cancellations (less than 24 hours' notice) are not billed to you but may seriously affect your claim and your ability to continue to treat under your claim with our office.**

- **Late Fees and Monthly Finance Charges.**
  - I agree that I may be charged late fees and/or a monthly finance charge if there is any outstanding balance owning on my account for over 30 days.

- **Time of Service Discount Option.**
  - I agree that, at the sole option and discretion of Colorado Chiropractic and Rehabilitation Center, LLC, I may be offered a Time of Service Discount on services rendered and that this is a reduction from the customary fees for services at Colorado Chiropractic and Rehabilitation Center, LLC. This requires that I pay in full at the time of service (the same day of my service or before my service). If I do not pay in full at or before the time of service, I will be charged the full customary fee for services with no reduction, and I agree that I am personally and solely responsible for the full-billed amount of the services rendered.

- **Other Accidents, Injuries, and Claims.**
  - I understand that if I am involved in a Workers Compensation, Auto Accident, Personal Injury Claim, or Third-Party Claim of any kind after beginning treatment with Colorado Chiropractic and Rehabilitation Center, LLC, any existing financial agreement(s) or Time of Service Discount are suspended and terminate. I understand that I am required to notify Colorado Chiropractic and Rehabilitation Center, LLC. I further understand and agree that Colorado Chiropractic and Rehabilitation Center, LLC, may unilaterally terminate any financial agreement(s) or Time of Service Discount at any time for any reason with written notice.

My signature below confirms I read, understand, and expressly to adhere with and agree to be bound by Colorado Chiropractic and Rehabilitation Center, LLC's Office Policy and all terms and conditions herein.

Patient Name (Print) _____

Patient Signature: _____ **Date:** _____

COLORADO CHIROPRACTIC AND REHABILITATION CENTER, LLC

2460 W. 26th Ave – Suite C-40
Denver, Colorado 80211 (no mail here)
www.cccwalker.com

Family History:

Please list your relative's health issues, current age or age at time of death with cause of death.

- Maternal Grandmother/ father _____
- Paternal Grandmother/father _____
- Mother _____
- Father _____
- Brothers & Sisters _____
- Children _____

Hospitalizations, Operations, Serious Illnesses, Auto Accidents or Prior Work Injuries:

Please list dates and body areas involved, type of accident, dates of occurrence and any treatment received:

_____

_____

_____

_____

_____

Hobbies, Habits and Interests:

Do you smoke? **Y/N** If so, how much? _____
Do you drink? **Y/N** If so, how much and how often? _____
Do you consume caffeine? **Y/N** If so, how much per day? _____
Do you exercise? **Y/N** If so, how often and what type of exercise? _____

Are you right handed, left handed or Ambidextrous? _____
Rate your health? **Excellent Average Poor** **Since your injury**, do you feel depressed, have trouble falling asleep, have a poor appetite, have relationship problems or a lack of interest in normally enjoyable activities? _____

Medications, Allergies, Prior Tests/Imaging and Prior Treatment:

Please list your current medications and drugs: _____

Please list any vitamins or herbs you currently take: _____

Please list any allergies: _____
Please list your most recent imaging and the date completed: _____

Please list any prior treatment and the dates treated for your current complaint? _____

Circle any of the following problems that you are currently experiencing:

Back pain or stiffness, Neck pain or stiffness, shoulder pain, hip pain, foot pain, swollen or painful joints, cold hands or feet, numbness or pain in the arms, hands or fingers, feet or toes.

Men: Changes in urine stream, lumps in testicles, prostate trouble, sex concerns.
Women: menstrual problems, abnormal bleeding, breast lumps or pain, problems getting pregnant, vaginal discharge, tubal infections, sex concerns. Are you currently pregnant? **Y/N.**

Patient Name (Print) _____ **Date:** _____

QUADRUPLE VISUAL ANALOGUE SCALE

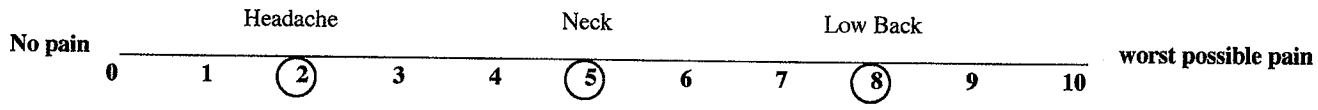
Patient Name _____ Date _____

Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:



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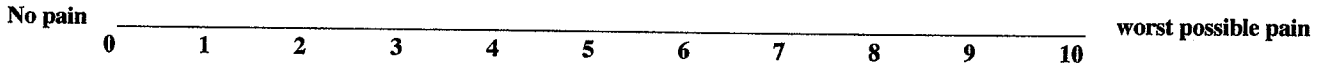
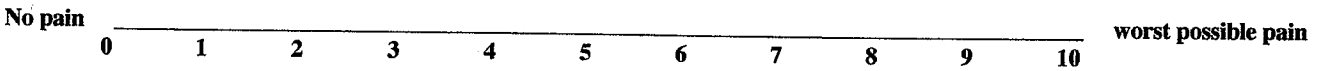
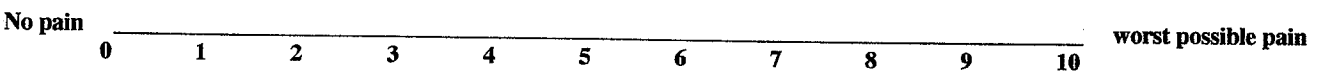
1 – What is your pain RIGHT NOW?



2 – What is your TYPICAL or AVERAGE pain?



3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?



4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

OTHER COMMENTS:

_____

_____

_____

Examiner

Reprinted from *Spine*, 18, Von Korff M, Deyo RA, Cherkin D, Barlow SF, Back pain in primary care: Outcomes at 1 year, 855-862, 1993, with permission from Elsevier Science.

Pain Disability Questionnaire (PDQ)

NAME: _____ **DATE:** _____

Please read:

This survey asks for your views about how your pain now affects how you function in everyday activities. This information will help you and your doctor know how you feel and how well you are able to do your daily tasks at this time.

Please answer every question by making an "X" along the line to show how much your pain problem has affected you (from having no problems at all to having the most severe problems you can imagine).

BE SURE TO ANSWER *ALL* QUESTIONS.

1. Does your pain interfere with your normal work inside and outside the home?
   Work normally — Unable to work at all
2. Does your pain interfere with personal care (such as washing, dressing, etc.)?
   Take care of myself completely — Need help with all my personal care
3. Does your pain interfere with your traveling?
   Travel anywhere I like — Only travel to see doctors
4. Does your pain affect your ability to sit or stand?
   No problems — Cannot sit/stand at all
5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
   No problems — Cannot do at all
6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
   No problems — Cannot do at all
7. Does your pain affect your ability to walk or run?
   No problems — Cannot walk/run at all
8. Has your income declined since your pain began?
   No decline — Lost all income
9. Do you have to take pain medication every day to control your pain?
   No medication needed — On pain medication throughout the day
10. Does your pain force you to see doctors much more often than before your pain began?
    Never see doctors — See doctors weekly
11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
    No problem — Never see them
12. Does your pain interfere with recreational activities and hobbies that are important to you?
    Normal activity — No recreation/hobbies at all
13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?
    Never need help — Need help all the time
14. Do you now feel more depressed, tense, or anxious than before your pain began?
    No depression/tension — Severe depression/tension
15. Are there emotional problems caused by your pain that interfere with your family, social, or work activities?
    No problems — Severe problems

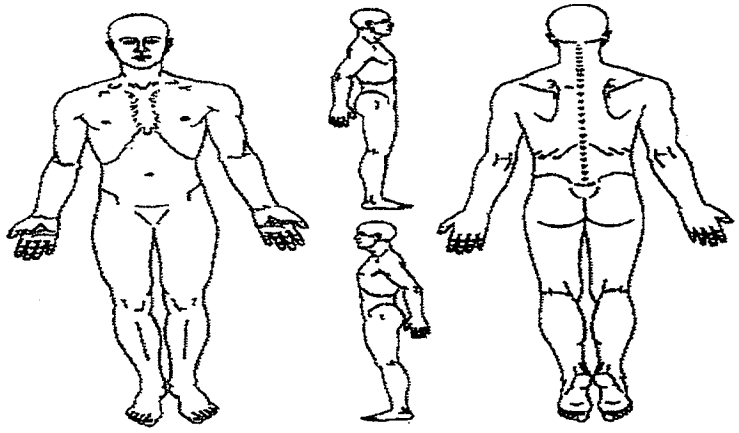
Reproduced with Permission from: Anagnostis C, Gatchel RJ Mayer TG, The Pain Disability Questionaire. Spine 2004, 29:2290-2302.

COLORADO CHIROPRACTIC CENTER PATIENT PAIN DIAGRAM

PLEASE USE THE LETTERS TO INDICATE TYPE AND LOCATION OF PAIN

A= Ache B= Burning C= Cramping S= Stabbing T= Tightness/Tension N= Numbness/Tingling

R L L R



*Please **CIRLCLE** and **EXPLAIN** if you have pain or difficulty doing any of the following:

Bending Squatting Lifting Carrying Walking Reaching Sitting Standing Sleeping

PAIN Performing the following **Duties at Work and/or Activities of Daily Living (please list)**:

_____

List any **functional improvements** with your current treatment: _____

* **(CIRCLE) RATE YOUR PAIN: No pain (1-----x-----x-----x-----5-----x-----x-----x-----x-----10) Severe pain**

*Is your pain worse during the day or at night? **Please explain** _____

_____

*What **increases** your pain? _____

*What gives you the **greatest relief**/control of pain? _____

*Please list the **current medication** you are taking: _____

*Did your symptoms/pain improve since your last treatment? **YES / NO**

*Are you performing your stretches / exercises daily as prescribed? **YES / NO**

*Do you have a NEW injury, accident, or complaint? **YES / NO** If yes, explain_____

I have read and understand the Office Policy for Colorado Chiropractic Center, which states **I must give at least 24-hours' notice for cancellation of ANY appointment or I may be charged a FEE.** This could also result in **termination of my treatment for non-compliancy** and this may affect my workers compensation claim.

Patient Signature: _____ **Date:** _____

Print Name: _____