Rockrimmon Chiropractic Clinic
425 Rockrimmon Blvd. Ste. 100, Colorado Springs, CO. 80919
Phone 719-593-1969 Fax 719-593-0744

Patient Information

Patient Name:_____Date:_____/_____/_____Referred by: _____

Address:_____City:_____State:_____Zip: _____

Telephone: (home)_____(mobile)_____Email:_____

Age:_____Birth Date:_____Social Security #:_____Occupation: _____

Marital Status:_____Spouse's Name:_____Spouse's Occupation:_____# of Children_____

Emergency Contact:_____Contact's Phone: _____

Have you ever been under chiropractic care before? Y N If Yes, Please describe: _____

Gender: M F If Minor please list Parent/Guardian _____

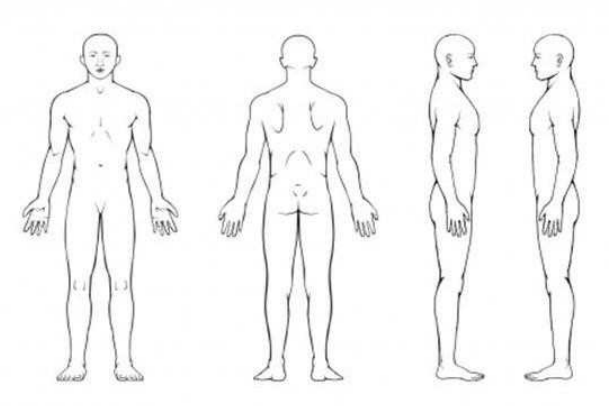
Insurance Information

Do you have health insurance? Y N If yes, name of your insurance company?_____Phone:_____

If so, please provide the front desk with a copy of your card. *(Front Desk: Copy of Card Received_____)*

Current Complaints

Please Use the following letters to indicate TYPE and LOCATION of your symptoms on the human diagram below
A=ACHE **B**=BURNING **N**=NUMBNESS **S**=STABBING **P**=PINS & NEEDLES **O**=OTHER



Please Describe the Nature of your complaint including when and how your symptoms began:_____

_____

Other practitioners seen for this condition? _____

Have you ever had the same condition? Y N If yes, When?_____

Is Your Condition getting worse? Y N Is it constant or do the symptoms come and go?: _____

Does your pain travel/radiate from one area to another? Y N Please describe_____

Does anything make your symptoms better?_____Worse?_____

Medical History

Have you been treated for any condition or allergy in the last year? Y N. If Yes, Please

Describe_____

Please list medications, their dosage, and the condition for which you take

them:_____

_____

Please list vitamins, minerals, herbs, and their dosages _____

Have you ever Please describe if you answered Yes

Broken bones? Y N _____

Been hospitalized? Y N _____

Been in an Auto Accident? Y N _____

Had Sprains/Strains? Y N _____

Been struck unconscious? Y N _____

Had Surgery? Y N _____

Please list any past or recent illnesses, traumas (i.e. car accidents,falls,etc.):_____

Social History

	None	Light	Moderate	Heavy
Alcohol				
Coffee				
Tobacco				
Drugs				
Exercise				
Sleep				
Appetite				
Soft Drinks				
Water				
Salty Foods				
Sugary Foods				
Artificial Sweeteners				

Family History

Immediate Family Member	Present & Past Health Conditions

Please indicate below all conditions you have suffered from or currently suffer from:

☐	Alcoholism	☐	Allergies	☐	Anemia	☐	Arteriosclerosis	☐	Arthritis
☐	Asthma	☐	Neck or Back pain	☐	Breast Lump	☐	Bronchitis	☐	Cancer
☐	Chest pain/problem	☐	Cold extremities	☐	Constipation	☐	Cramps	☐	Depression
☐	Diabetes	☐	Digestion Problems	☐	Dizziness	☐	Ear ringing	☐	Eye pain/problems
☐	Fatigue	☐	Frequent Urination	☐	Headaches	☐	High blood pressure	☐	Irregular heart beat
☐	Menstrual problems	☐	Kidney infection/stone	☐	Memory loss	☐	Loss of balance	☐	Loss of smell or taste
☐	Nosebleeds	☐	Pacemaker	☐	Polio	☐	Prostate trouble	☐	Shortness of breath
☐	Sinus infection	☐	Sleep Problems	☐	Spinal Curvatures	☐	Stroke	☐	Swollen Joints
☐	Thyroid condition	☐	Tuberculosis	☐	Ulcers	☐	Varicose Veins	☐	Venereal Disease
☐	Sciatica	☐	Nervousness	☐	Easily bruise	☐	Other	☐	Other

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Printed Name:_____

Signature:_____Date:_____

Adult Patient ☐ Parent or Guardian ☐ Spouse ☐

Terms of Acceptance

Chiropractic has only one goal: Eliminate misalignments within the spinal column which interfere with the expression of the body's innate wisdom. These interferences are known as the vertebral subluxation complex or VSC
Adjustment: The specific, high velocity, low amplitude application of force to facilitate the body's correction of the VSC.
Health: A state of optimal physical, mental, and social well-being, not merely the absence of symptom or disease.
Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae or pelvis in the spinal column which causes alteration of nerve functioning and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.
We do not offer to treat any disease or condition other than vertebral subluxation. However, if during the course of chiropractic examination we encounter non-chiropractic or unusual findings, we will recommend that you seek the services of a health care provider who specializes in that area.

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREAMENT, PAYMENT, AND HEALTHCARE OPERATIONS.

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:
1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out it's health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing the Consent, and has encouraged me to read the Privacy Notice carefully prior to signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to the following: The Practice may telephone my home and leave messages on the answering machine or with the individual answering the phone concerning scheduling.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment, and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this Consent at any time, the Practice has the right to refuse me treatment.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.
By signing below, I agree that; I have read and fully understand the above statements, all questions regarding the doctor's objectives pertaining to my care in this office have been answered to mycomplete satisfaction, I accept chiropractic care on this basis.

Signature Printed Name Date

X-ray Consent/ Pregnancy Release

The purpose of the x-ray exam to be performed is to analyze the spine for vertebral subluxation, spinal degeneration, and to determine the appropriateness of spinal adjustments and discover any non-chiropractic findings, as mentioned above.
Women: I certify that to the best of my knowledge I am not pregnant. I have been advised that x-rays can be hazardous to an unborn child. Date of last menstrual cycle_____.

I fully understand the above and give consent to spinal x-rays. Sign:_____Date:_____

Consent to evaluate and adjust a minor child

I,_____being the parent or legal guardian of_____have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Signature Printed Name Date

Financial Policy

Financial Policy: We are willing to discuss our financial policy and fees with you at any time as your clear understanding of our financial policy is important to us. Please ask if you have any questions.

Coupon Policy: If you are using a coupon that includes a discounted fee for the following services: consultation, exam, report of findings and adjustment, we are legally prohibited from submitting bills to a third party for these same services. There are no hidden costs. The doctor will inform you of any additional fees prior to any service(s) being performed.

If you have insurance, we will help you to receive the maximum benefits. Insurance is a contract between you and your insurance company. You are responsible for timely payment on your account. After 90 days, if your account has not been paid by your insurance, and you have a balance due with us, you are responsible to pay the balance in full to us. Your insurance benefits will be explained to you at the time of your report.

If you Do Not have insurance or your insurance does not cover your care, we offer flexible and affordable payment options to insure that you receive the care that you need at a cost that you can afford. One of your doctors or a member of our staff will go over all of your payment options with you at the time of your report and you will be provided with an explanation of our fees upon request.

Interruption of Care: In the unlikely event that it is necessary to discontinue your care for any reason, all outstanding fees for services rendered become immediately due and payable. Remember that healing and spinal correction take time. Chiropractic and lifestyle changes are not quick fixes. If at any time during your care you do not feel that you are responding as well as expected, please schedule a consultation with the doctor.

Pre-payment fees are made more affordable by reducing the standard fee for the chiropractic adjustments recommended in your care plan. The fees for exams, consultations, exercise training, supports & devices are not reduced in pre-payment plans. What this means is that if you are seeking a refund for care that has not yet been rendered, your refund will be based on our normal fees. For example, if the rate for each adjustment in your personalized care plan comes out to $55 per adjustment, your refund will be the number of adjustments you have remaining in your care plan, multiplied by $55.

If you decide not to follow the recommended treatment plan and choose to visit this office on a “pay-per-visit” basis, then the rate per adjustment you received in your care plan becomes null and void and you will be charged the standard fees for services rendered.

My signature below means that I have read and understand the above financial policies, I have no further questions regarding them, and that I agree to abide by them.

Patient, Parent or Guardian Signature Printed Name Date