Get Moving Chiropractic 3045 Whitman Dr., Suite 102 Evergreen, CO 80439 (303) 670-7777

Whom may we thank for referring you to this office → _____***?***

APPLICATION FOR CARE AT GET MOVING CHIROPRACTIC

Today's Date: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____-_____-_____ Age: _____ ☐ Male ☐ Female

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

E-mail Address: _____ Home Phone: _____Mobile Phone:_____

Marital Status: ❑ Single ❑ Married Do you have Insurance: ❑ Yes ❑ No Work Phone: _____

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Spouse's Name _____Spouse's Employer _____

Number of children and Ages: _____

Name & Number of Emergency Contact: _____ _____Relationship: _____

HISTORY of COMPLAINT

Please identify the condition(s) that brought you to this office: Primarily: _____
Secondarily: _____ Third: _____ Fourth: _____

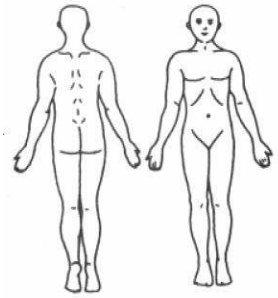
On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by c***ircling the number*****:**
Primary or chief complaint is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Second complaints is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Third complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Fourth complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
When did the problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM
How long does it last? ☐ It is constant **OR** ☐ I experience it on and off during the day **OR** ☐ It comes and goes throughout the week

How did the injury happen?_____

Condition(s) ever been treated by anyone in the past? ☐No ☐ Yes **If yes,** when: _____ by whom? _____

How long were you under care: _____ What were the results? _____

Name of Previous Chiropractor: _____ ☐ **N/A**



***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:
R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/ **S**tabbing **T= T**ingling

What relieves your symptoms? _____

What makes them feel worse? _____

Doctor only LOCQSMAT:

_____

_____

_____

_____

_____

_____

LIST RESTRICTED ACTIVITY:	CURRENT ACTIVITY LEVEL	USUAL ACTIVITY LEVEL
_____:	_____	
_____:	_____	
_____:	_____	
_____:	_____	

Is your problem the result of ANY type of accident? ☐ Yes, ☐ No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about:

_____

_____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ❑ No ❑ Yes **If yes** how many times? _____ When was the last episode? _____ How did the injury happen?_____

Other forms of treatment tried: ☐ No ☐ Yes **If yes,** please state **what** type of treatment: _____, and who provided it: _____ **How long ago? _____**What were the results. ☐ Favorable ☐ Unfavorable→ please explain. _____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past*, C** for ***Currently*** have and **N** for ***Never** have had*:

___ Broken Bone ___Dislocations ___ Tumors ___Rheumatoid Arthritis ___ Fracture ___Disability ___Cancer
___ Heart Attack ___Osteoarthritis ___ Diabetes ___Cerebral Vascular ___ Other serious conditions:

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES→			
ADULT DISEASES →			

SOCIAL HISTORY

1. Smoking: ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
2. Alcoholic Beverage: consumption occurs → ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
3. Recreational Drug use: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

FAMILY HISTORY:

1. Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes
If yes whom: ❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sister's ❑ brother's ❑ son(s) ❑ daughter(s)
Have they ever been treated for their condition? ❑ No ❑ Yes ❑ I don't know
2. Any other hereditary conditions the doctor should be aware of. ❑ No ❑Yes: _____

_____ _____ - _____ - _____
Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____
Doctor's Signature **Date Form Reviewed**

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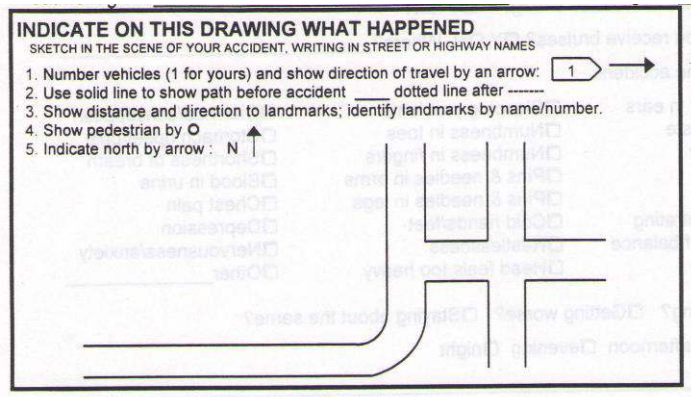
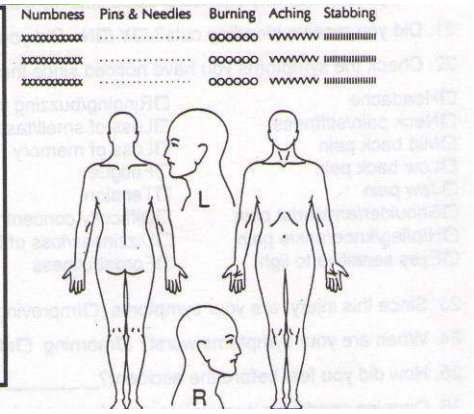
Automobile Accident History Form

Patient _____Age _____Date_____
Date and Time of Accident_____
Location of accident (city, state, street)_____
Road condition □ wet □ dry □ snow/ice □ other _____
Were the police notified of the accident? □ Yes □ No Was a report filed? □ Yes □ No
Collision involved: □ 1 vehicle □ 2 vehicles □ 3 + vehicles □ pedestrian □ other _____
Did you go to the hospital afterwards? □ Yes □ No Name _____
How did you get there?_____
Were you examined by a doctor? □ Yes □ No Were x-rays taken? □ Yes □ No
What body parts x-rayed? _____
What did the Dr. say was wrong? _____
Treatment/medications given?_____





Driver of car _____
Where were you seated? □ driver □ front passenger □ rear left □ rear right
Other occupants in the car and their injuries?_____
Were you struck from: □ behind □ front □ left side □ right side □ other _____
Were you aware of the collision prior to impact? □ Yes □ No
Did you brace for impact? □ Yes □ No
How far is the head rest or seat back from your head? □ less than 3“ □ 3 to 6“ □ greater than 6”
Were you wearing? □ seatbelt □ shoulder harness □ none
Did the airbag deploy? □ Yes □ No
Year/make/model of car you were in ? _____
Estimated cost of damage?_____ Was your vehicle drivable? □ Yes □ No
What car parts were damaged?_____
Was your car moving at the time of collision? □ Yes □ No If yes, how fast? _____ Mph
Were you braking? □ Yes □ No If no, was the driver’s foot on the brake? □ Yes □ No
Did your body strike anything in the car? _____
Was your head: □ pointed straight ahead □ turned right □ turned left
Year/make/model of the other car?_____ Damage: □ min □ mod □ severe
Was the other vehicle drivable? □ Yes □ No
Was the other car moving at the time of collision? □ Yes □ No If yes, of fast? ____Mph
If moving, was the other vehicle □ slowing down □ gaining speed □ steady speed
Describe how the accident happened:

_____

_____

Describe where you felt pain or unusual feelings: (location, type, severity)
a: During the accident: _____
_____
b: Immediately after the accident:_____
_____
c: Later that day/night: (and up to now)_____
_____
Did you lose consciousness (black out)? □ Yes □ No If yes, for how long? _____
If no, were you dazed/confused? □ Yes □ No
Did you experience a flash of light or explosion in your head? □ Yes □ No
Did you receive any injuries/bruises/cuts from the seatbelt or airbag? □ Yes □ No
Did you receive any bleeding cuts? □ Yes □ No Did you receive any bruises? □ Yes □ No
Where?_____

Check the symptoms you have noticed since the accident: (P= pain)

□ Headache	□ Ringing in ears	□ Sleeping problems	□ Diarrhea/constipation
□ Neck P	□ Loss of smell/taste	□ Numb toes	□ Stomach upset/pain
□ Mid back P	□ Loss of memory	□ Numb fingers	□ Shortness of breath
□ Low back P	□ Jaw pain	□ Fatigue	□ Pins/needles in arms
□ Cold hands/feet	□ Tension	□ Shoulder/arm/wrist P	□ Eyes sensitive to light
□ Restlessness	□ Dizzy/lose balance	□ hip/leg/knee/ankle P	□ Nervousness/anxiety
□ Forgetfulness	□ Depression	□ Head feels too heavy	□ Pins/needles in legs
□ Chest P	□ Hard to concentrate	□ Blood in urine	□ Other _____

Since this injury, are your symptoms? □ Improving □ Getting worse □ About the same
When are your symptoms worst? □ Morning □ Afternoon □ Evening □ Night
How did you feel before the accident?_____
Ongoing conditions/complaints experienced before the accident?_____
_____
Are your work activities restricted because of your injuries? □ Yes □ No If, yes, explain:
_____
Describe your work duties:_____
_____
Have you injured this area of your body before? □ Yes □ No Explain: _____
_____
If you have been in other auto or work accidents, list year and describe briefly:
1._____
2._____
3._____
Have you seen any other doctors as a result of this accident? □ Yes □ No Who?_____
What was the treatment (if any)?_____
Are you pregnant? □ Yes □ No Date of last menstrual period?_____
Have you consulted an attorney? □ Yes □ No Name _____

Patient/Guardian's Signature_____

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Activities of Daily Living/Symptoms/Medications

Patient Name: _____ Date: _____

Daily Activities: Effects of Current conditions On Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing computer Work	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Gardening	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Playing Sports	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Recreation Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Shoveling	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dancing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Rolling Over	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Working	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Climbing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Performing Sexual Activity	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting to Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform

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Patient Name: _____ Date: _____

Please mark P for in the **Past, C** for **Currently** have and **N** for **Never**

___ Headache	___ Pregnant (Now)	___ Dizziness	___ Prostate Problems	___ Ulcers
___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance	___ Impotence/Sexual Dysfun.	___ Heartburn
___ Jaw Pain, TMJ	___ Convulsions/Epilepsy	___ Fainting	___ Digestive Problems	___ Heart Problem
___ Shoulder Pain	___ Tremors	___ Double Vision	___ Colon Trouble	___ High Blood Pressure
___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Diarrhea/Constipation	___ Low Blood Pressure
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menopausal Problems	___ Asthma
___ Low Back Pain	___ Foot or Knee Problems	___ Hearing Loss	___ Menstrual Problem	___ Difficulty Breathing
___ Hip Pain	___ Sinus/Drainage Problem	___ Depression	___ PMS	___ Lung Problems
___ Back Curvature	___ Swollen/Painful Joints	___ Irritable	___ Bed Wetting	___ Kidney Trouble
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Learning Disability	___ Gall Bladder Trouble
___ Numb/Tingling arms, hands, fingers		___ ADD/ADHD	___ Eating Disorder	___ Liver Trouble
___ Numb/Tingling legs, feet, toes		___ Allergies	___ Trouble Sleeping	___ Hepatitis (A,B,C)

List Prescription & Non-Prescription drugs you take:_____

_____

_____

Get Moving Chiropractic Clinic

30772 Southview Dr. #140 Evergreen, CO 80439
P: 303-670-7777 F: 855-515-0842

Irrevocable Lien, Assignment of Benefits, and Security Interest

Patient/Guardian: _____ (hereafter "patient")

Date of Injury: _____

Provider: _____

Patient, in order to receive care, treatment, products, and services from Get Moving Chiropractic Clinic LLC (hereafter "Provider") (collectively referred to hereafter as "Services"), hereby executes this Irrevocable Lien, Assignment of Benefits, and Security Interest (hereafter "Document") in favor of Provider. Patient agrees as follows:

- Provider shall have an irrevocable lien against, and a security interest in, any settlement, award, judgment, verdict, or recovery arising out of the injury sustained by patient on the above-referenced Date of Injury. Patient assigns, to Provider, the proceeds from any such settlement, award, judgment, verdict, or recovery in an amount equivalent to Patient's outstanding balance with Provider.

- Patient assigns to Provider, in an amount equivalent to Services provided, any benefits available, or to which Patient may be entitled, and any legal or contractual rights patient may have under health insurance, uninsured/underinsured motorist coverage, and medical payment coverage. On Patient's behalf, Patient authorizes Provider to receive a complete copy of Patient's, or any third-party's insurance policy, including declarations sheets, endorsements, conditions, limitations, benefits, exclusions, and policy limits.

- Patient understands and agrees that this Document is valid, secured, and enforceable upon execution. Patient further agrees that Provider may file this, and any other Document, with the appropriate court, any insurance carrier, with Patient's attorney, or the Colorado Secretary of State, as Provider so desires. Patient further authorizes Provider to provide copies of Patient's medical records to Patient's attorney and any insurance carrier who may be responsible for payment of Services, either through contract or due to a third-party's liability.

- Patient directs any attorney representing Patient to acknowledge and honor this Document, even if not signed by the attorney, and to make payment to Provider pursuant to the same. This document is intended to be valid and enforceable, even if not signed by Patient's attorney. Patient's attorney is advised, that by execution of this Document, that Patient recognizes that Provider is a third party with an undisputed interest in Patient's claim/case as anticipated by Colorado Formal Ethics Opinion 94.

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- Patient authorizes and directs Patient's attorney, Patient's insurance company, or any third-party insurance company to disclose all insurance benefits, offers, status of negotiations, and any final settlement or judgment amount, along with date of settlement, all provider or insurer lien reductions, and disbursement amounts to others (actual or proposed).

- Provider shall not be responsible, either in part or in whole, for payment of attorney's fees, expenses, or costs which Patient may incur for the collection of funds due from third parties or insurance benefits. Patient understands that Provider is not subject to either the "made-whole rule" or the "common fund doctrine."

- This agreement does not create a continuing obligation to provide Services for Patient. Should Patient or Patient's representative request that Provider bill services to health or other insurance, such request shall be made in writing. In the event Provider is asked to bill health or other insurance, Patient shall be responsible for payment of all co-payments or deductibles at the time of service, unless another method of payment is agreed to between Patient and Provider, in writing.

- This Document applies to amounts currently owed by Patient to Provider and to amounts which may be incurred in the future. Patient agrees that this Document shall apply to any balances owed by patient for past or future treatment, whether or not such Services are related to the Date of Injury as set forth above.

- Patient agrees that this document shall be governed by the laws of Colorado and any dispute under this document, or for Services provided, shall be brought in the county where Patient received Services.

- In the event patient has made any misrepresentations or committed fraud, Patient shall be responsible for Provider's reasonable attorney's fees and costs should collection efforts be undertaken by Provider, whether or not a lawsuit is undertaken.

- If any provision of this agreement is deemed to be unenforceable for any reason, the remaining portions shall still be enforceable and have binding effect.

Dated this ____ day of _____, 20____.

_____

Signature of Patient/Guardian Printed Name

Address_____

City, State, Zip _____

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ACKNOWLEDGEMENT

I, the undersigned attorney, am the attorney of record for Patient named above. I hereby acknowledge receipt of the foregoing Irrevocable Lien, Assignment of Benefits, and Security Interest and hereby agreed to honor and observe the terms herein. **I provide this acknowledgement with the understanding that attorneys' fees and costs shall be deducted BEFORE payment of any Services pursuant to this Lien**.

_____ _____

Attorney Signature Attorney Printed Name

_____

Firm Name

Get Moving Chiropractic Clinic
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REQUIRED DISCLOSURES PURSUANT TO C.R.S. §38-27.5-104

Patient/Guardian: _____

Health-care provider: _____

Date of Injury: _____

Pursuant to Colorado law, Patient/injured person is provided with the following disclosures and advisements:

- Before a health-care provider lien is created, a health-care provider or its assignee must make the following disclosures and advisements to the injured person:
    - The following are potential methods for payment of a health-care provider's billed charges:
        - The creation of a health-care provider lien;
        - The use of benefits available from any payer of benefits as defined in section 38-27-101(9) to which the injured person is a beneficiary, including that the injured party can obtain information about the payer of benefits' network from the payer of benefits or the health-care provider;
        - Any other payment method or arrangement agreed to in writing by both the health-care provider or its assignee and the injured person; or
        - A combination of the payment methods specified in subsections (1)(a)(I) to (1)(a)(III) of C.R.S. 28-27.5-104, as set forth above.
    - That the health-care provider or its assignee is not a heath insurer or payer of benefits;
    - That, except in the event of fraud or misrepresentation by the injured person:
        - If the injured person does not receive a judgment, settlement, or payment on the injured person's claim against third parties or under an uninsured or underinsured motorist policy, the injured person is not liable to the holder of the health-care provider lien for any portion of the health-care provider lien;
        - If the injured person receives a net judgment, settlement, or payment that is less than the full amount of the health-care provider lien, the injured person is not liable to the holder of the health-care provider lien for any amount beyond the net judgment, settlement, or payment, and the holder of the health-care provider lien may not file a complaint or counterclaim

against the injured person directly to be reimbursed for any amount beyond the net judgment, settlement, or payment. Nothing in this section prevents a health-care provider or its assignee from initiating a declaratory judgment action or participating in an interpleader action or claim pursuant to the Colorado Rules of Civil Procedure, or any other similar action or claim, to determine the health-care provider's or its assignee's share of the injured person's net judgment, settlement, or payment;

- The health-care provider or its assignee may not assign a heath-care provider lien to a collection agency or debt collector.

- That a health-care provider's assignee's compensation from the injured person is based on the difference between the health-care provider's usual and customary billed charge and the amount that the assignee pays to purchase the health-care provider lien;

- Of any common ownership interest between the holder of the health-care provider lien and the injured person's legal counsel. No such relationship exists;

- Of any common ownership interest between the assignee of a health-care provider lien and any health-care provider who is providing treatment or who may provide treatment to the injured person under the terms of the health-care provider lien; and

- That if the injured person has obtained health insurance even after a health-care provider lien has been created, and the injured person or the injured person's legal counsel so informs the holder of the health-care provider lien, all future care may be billed to the health insurance carrier at the injured person's discretion.

- Nothing in C.R.S. 38-27.5-101, *et. seq.* changes any obligation of the health-care provider or its agents under the "Colorado Medical Assistant Act", Articles 4 to 6 of Title 25.5

- Upon request by the injured person or the injured person's legal counsel, the holder of a health-care provider lien shall provide in writing to the injured person an itemized statement of all the billed charges for treatment comprising the total value of the health-care provider lien as the billed charges are accrued, to the extent practicable, and when the health-care provider lien is final. The final itemized statement must include a summary of all treatments provided, the total amounts billed for each treatment, and the total amount of the health-care provider lien due and owning.

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I acknowledge receipt of the foregoing disclosures and advisements as required by Colorado law.

Dated this ____ day of _____, 20____.

_____ _____

Signature of Patient/Guardian Printed Name

Get Moving Chiropractic 30772 Southview Dr., Suite 140 Evergreen, CO 80439 (303) 670- 7777

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Get Moving Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____  *Witness Initials*

Patient or Authorized person's Signature Date

REGARDING: Services Received

I hereby authorize payment to be made directly to Get Moving Chiropractic, for all benefits which may be payable under a health care plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Get Moving Chiropractic for any and all services I receive at this office.

_____ ____/____/____  *Witness Initials*

Patient or Authorized person's Signature Date

JDD,DC 5/2011

Notice of Privacy Practices Acknowledgement
Get Moving Chiropractic

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date_____ Attempt_____

Staff Name_____

OUR OFFICE POLICIES

Welcome to GET MOVING CHIROPRACTIC!

As a potential new patient, we feel it is important that you understand our office policies regarding, how patients of this practice are cared for, and the various methods we offer to facilitate payment for that care. Please read each policy carefully so there is no misunderstanding as to what you can expect as a patient of this practice, and what we expect in return. Once you have read "Our Office Policies", if you have any questions or any of these policies are unclear to you, and you would like further explanation before submitting your ***Application for Care*****,** please let our front desk know and a member of our staff will be happy to discuss them with you further. We believe it is in everyone's best interests to provide potential new patients as much information as possible about how the doctors at this office practice chiropractic so that an informed decision can be made as to whether they wish to become a patient.

Over time, individuals who are accepted, as patients at this office, gain a greater understanding as to the purpose of chiropractic. Since the majority of patient care occurs in an open bay area, patients have a unique opportunity to observe firsthand the positive results that are achieved and the benefits derived from being under chiropractic care. This knowledge and awareness reaps a positive environment that promotes healing and encourages families to maintain good health. We want your experience with us to be an exceptional one, so help us to help you and together we can make affirmative changes in your life and the lives of those you care about.

☐ **PATIENT PRIVACY** – Since the majority of patient care takes place in an open bay area it is important to understand that any conversations you have with the doctor can be overheard by other patients. In order to maintain patient privacy it is the policy of this practice to refrain from discussing any confidential matters with patients during treating hours while patients are being adjusted. If you have a confidential matter you wish to discuss please let us know and we will schedule time for you to speak to the doctor in a private consultation room. These consultations must be scheduled in advance.

☐ **YOUR CARE** - When a patient seeks chiropractic health care and we agree to provide that care, it is essential for the patient and the doctor to be working toward the same objective. Chiropractic care at **Get Moving Chiropractic** is rendered primarily to minimize and reduce subluxations, which are a major interference to the expression of the body's innate wisdom. The doctors use 1) diversified adjustments OR 2) a variety of techniques to accomplish this goal, including but not limited to therapeutic exercises. It is important that you understand both the objective and the method(s) so there is no confusion or disappointment. Tremendous progress has been made in the rehabilitating and correction of spinal problems. Where in the past, chronic spinal structural problems could not be reversed or corrected, today they can. Your doctor will outline a course of treatment that will take you beyond simple pain relief, through two distinct phases of care to make a structural correction to your spine that will enable your central nervous system to function optimally, thereby improving you overall health.

☐ **FIRST THINGS FIRST**- Prior to receiving chiropractic care at this office, a health history and examination will be completed. Imaging studies as well as any other necessary diagnostics may also be ordered, to confirm the true nature of your condition and exact location of subluxations. The results of these procedures will aid in assessing your presenting problem, your overall health and, in particular, the condition of your spine. They will also assist the doctor in determining the type and amount of care you will need. All relevant findings will be reported to you along with care plan recommendations so that you can make the best possible decision regarding your health care needs. Our gold standard for care is to ensure the reduction of subluxation while teaching patients what they need to do in addition to being adjusted to maintain their health for a lifetime.

☐ **PATIENT'S REPORT OF FINDINGS** – To enhance your understanding of the chiropractic approach that will be used to manage your health, immediately following your first adjustment, you will be scheduled for a 'Doctors Report of Findings'. The information you receive at this appointment will be both informative and clinically relevant to your case, therefore attendance is required for individuals who wish to become new patients of this practice. Because the results of your x-rays and all examinations as well as the doctors' recommendations for care, will be discussed at that time, we strongly urge new patients to invite their spouse or significant other to attend. We know from experience that when a patient's family understands the goals and objectives of chiropractic care and how restoring and maintaining good health can affect their lives as well, they become infinitely supportive and helpful in making important decisions concerning treatment options.

Get Moving Chiropractic Dr. Katy R. Mooberry DC, CACCP

30772 Southview Dr. #140 Evergreen, CO 80439 Phone: 303-670-7777 Fax: 303-482-1946

New Patient Consent Form

*Please read the following carefully and initial each statement on the line provided.

____ Financial Policy and Agreement: Payment is required for all office services on the day of service and may be paid by cash, check or credit card. There is a $30 fee for all returned checks. Payment on the day of service is eligible for a cash discount if you have a zero balance. If you have insurance that pays for chiropractic care, we will be glad to bill them for you. You must pay deductibles and co-payments, if applicable, at the time of service. If you need assistance or need to make special arrangements please talk with us. I understand that I am financially responsible for all charges whether or not paid by insurance and if I terminate or suspend my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I will be responsible for any costs of collections, attorney's fees or court costs required to collect my bill. If my bill is turned over to collection, I will pay for the charge added to my account. **Insurance is billed by code; payment varies by plan.**

____ Patient Release and Agreement: I authorize the release of any information including diagnosis and the records of any treatment rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to Get Moving Chiropractic all medical benefits otherwise payable for medical services. I authorize the use of this signature on all my insurance submissions and to obtain medical records.

_____ Consent and Agreement: Chiropractic examination and therapeutic procedures (including chiropractic manipulation, ultrasound, heat and cold application, electrotherapy and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to soreness, inflammation, soft tissue injury, dizziness, burns, temporary worsening of symptoms, broken bones and strokes. The more serious complications are extremely rare. Additional information on side effects and complications is available upon request. It is also our policy to inform you of the procedure being performed and the risks and alternative treatments available. If your physician does not explain to your satisfaction, please ask for more information.

I have read and understand the above statements regarding treatment side effects and I also understand that there is no guarantee for a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel can assist you further.

THERE IS A 24 HOUR CANCELLATION POLICY OR YOUR ACCOUNT WILL BE CHARGED $25.00.

I have read all three of the above agreements and I accept these terms and conditions.

_____ _____

Patient signature or Guardian if patient is under 18 years of age Date