DENVER | HEADACHE
AND SPINE CENTER P.C.

Confidential Patient Information Date: _____

Please allow staff to copy your driver's license and insurance card

Name: _____ M / F SSN: _____

Address: _____ City: _____

State: _____ Zip: _____ DOB: _____ Age: _____ Marital Status: M S D W

Home #: _____ Mobile #: _____ Work #: _____

E-mail: _____ Occupation: _____ Employer: _____

Spouse: _____ Children & ages: _____

Health Insurance: _____ **Ins. Phone #:** _____

Address: _____ **ID #:** _____ **Group #:** _____

Denver Headache & Spine Center is an out of network provider. We are happy to bill all major medical insurance companies. In some cases the policy holder (you) will be sent payment along with an explanation of benefit (EOB). It is your responsibility to supply us with this payment and EOB so we can accurately reconcile your account.

Have you ever been under Chiropractic Care: Y N Year: _____ Doctor: _____

Referred by: _____ Preferred appointment time: AM PM

Terms of Acceptance

Denver Headache & Spine Center does not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is we do not offer to treat, nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our method is specific adjusting to correct vertebral subluxations.

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 my complete satisfaction.

I therefore accept care on this basis.

Signature: _____ Date: _____

List your complaints in order of severity:

1. _____ How long?: _____

2. _____ How long?: _____

3. _____ How long?: _____

What activities aggravate your condition?: _____

Is this condition getting progressively worse?: Yes No Constant Intermittent

Is this condition interfering with your: Work Sleep Daily Routine Other: _____

Does the pain radiate to any part of your body?: Yes No If so, where?: _____

How did your condition start?: _____

Have you had a similar condition before?: Yes No If yes, where and what were the results?: _____

_____

Is your condition due to injury or sickness that is work related?: Yes No Reported to employer? Yes No

Is your condition due to a motor vehicle accident?: Yes No If yes, date of accident: _____

Have you lost any days from work?: Yes No If yes, explain: _____

Females: Are you pregnant? Yes No

What surgeries have you had?: _____

What medications are you currently taking? _____

Serious Illnesses (circle all that apply): Measles Mumps Chicken Pox Other: _____

Have you ever suffered from (check all that apply):

[ ] Allergies	[ ] Nervousness	[ ] Nausea	[ ] Poor circulation	[ ] Enlarged thyroid
[ ] Dizziness	[ ] Neck pain	[ ] Asthma	[ ] Tachycardia	[ ] Bruise easily
[ ] Fatigue	[ ] Neck stiffness	[ ] Colds	[ ] Bradycardia	[ ] Cancer
[ ] Headache	[ ] Poor posture	[ ] Deafness	[ ] Stroke	[ ] Irregular cycle
[ ] Sleep issues	[ ] Swollen joints	[ ] Ear noises	[ ] Chest pain	[ ] Hot flashes
[ ] Ulcers	[ ] Colon issues	[ ] Ear infections	[ ] Difficulty breathing	[ ] Breast lumps
[ ] Arthritis	[ ] Diarrhea	[ ] Eye pain	[ ] Pleurisy	[ ] Varicose veins
[ ] Bursitis	[ ] Difficult digestion	[ ] Failing vision	[ ] High blood pressure	[ ] Excessive flow
[ ] Depression	[ ] Hemorrhoids	[ ] Sinus infection	[ ] Low blood pressure	[ ] Cramps
[ ] Irritability	[ ] Low back pain	[ ] Nosebleeds	[ ] Pain over heart	[ ] Frequent urination
[ ] Foot trouble	[ ] Venereal disease	[ ] Hayfever	[ ] Anemia	[ ] Prostate issues
[ ] Anxiety	[ ] Sciatica	[ ] Itching	[ ] Alcoholism	[ ] Bed wetting
[ ] Diabetes	[ ] Kidney stones	[ ] Swollen ankles	[ ] Other _____	

Tingling or numbness: [ ] Shoulders [ ] Hand [ ] Knees [ ] Arms [ ] Hips
[ ] Elbows [ ] Legs [ ] Fingers [ ] Feet

Notes: _____

Family History (check all that apply):

	Mother	Father	Sister	Brother	Grandparents
Diabetes:	[ ]	[ ]	[ ]	[ ]	[ ]
Cancer:	[ ]	[ ]	[ ]	[ ]	[ ]
Heart Disease:	[ ]	[ ]	[ ]	[ ]	[ ]
Headache:	[ ]	[ ]	[ ]	[ ]	[ ]
Back Pain:	[ ]	[ ]	[ ]	[ ]	[ ]

Habits (circle all that apply):

Exercise	Tobacco	Alcohol	Drugs	Sleep	Coffee	Appetite
None	None	None	None	None	None	None
Light	Light	Light	Light	Light	Light	Light
Moderate	Moderate	Moderate	Moderate	Moderate	Moderate	Moderate
Heavy	Heavy	Heavy	Heavy	Heavy	Heavy	Heavy

Doctors Notes:

_____

_____

_____

_____

_____

_____

_____

Financial Policy

Payment is due at time of visit.

Name of person responsible for payment: _____

It is our office policy to have your consultation, initial examination and x-rays paid for at the time these services are rendered. For your convenience we have several payment options below from which to choose. Please circle payment form...

CASH CHECK VISA MASTERCARD DISCOVER AMERICAN EXPRESS OTHER

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that Denver Headache and Spine Center will prepare any necessary reports and forms assisting me in making collections from the insurance company, and that any amount authorized to be paid directly to this office will be credited to my account receipt. I also give this office power of attorney to endorse checks made out to me, to be credited to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment any fees for professional services rendered me will be immediately due and payable.

****Denver Headache and Spine Center kindly asks for 24 hours notice on appointment cancellations or reschedules. We allow 2 "no call, no show" missed appointments per year. The fee for additional missed appointments is $55.00 and is not covered by any insurance carrier. This fee applies to massage appointments as well.****

Signature: _____ **Date:** _____

Guardian or Spouse Authorizing Care: _____

DENVER | HEADACHE
AND SPINE CENTER P.C.

Notice of Privacy Practices

This notices describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Right to Notice

As a patient, you have the right to adequate notice of the users and disclosures of your protected health information. Under the Health Insurance Portability and Accessibility Act (HIPPA), Denver Headache and Spine Center can use your protected health information for treatment, payment and health care operations.

a) Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you .
b) Payment: We may use or disclose your health information to obtain payment for services we provided to you.
c) Healthcare Options: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competency or qualifications of healthcare professionals, evaluating provider performance, conducting trainings programs, accreditation, licensing, certification, or credentialing activities.

Your Authorization

Most uses and disclosures that do not fall under treatment, payment, healthcare operations will require written authorization. Upon signing, you may revoke your authorization (in writing) through our practice at any time.

Emergency Situations

In the event of your incapacity of an emergency situation, we will disclose health information to a family member or another person responsible for your care, using our professional judgment. We will only disclose health information that is directly relevant to the person's involvement in your healthcare.

Marketing

We will not use your health information for marketing communications without your written authorization.

Abuse or Neglect

We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to you or other people's health or safety.

National Security

We may disclose the health information of Armed Forces personnel to military authorities under certain circumstances. We may disclose health information to authorized federal official required for lawful intelligence, counterintelligence and other national security activities. We may disclose health information of inmates or patients to the appropriate authorities under certain circumstances.

Appointment Reminders

We may use or disclose your health information to provide you with appointment reminders via phone, e-mail or text.

Your Rights As A Patient

You have the right to restrict the disclosure of your protected health information (in writing). The request for restriction may be denied if the information is required for treatment, payment or healthcare operations.

* You have the right to receive confidential communications regarding your protected health information.
* You have the right to inspect and copy your protected health information.
* You have the right to amend your protected health information.
* You have the right to receive an account of disclosure of our protected health information.
* You have the right to a paper copy of this notice of privacy practices.

Legal Requirements

Denver Headache and Spine Center is required by law to maintain the privacy of your protected health information. We are required to abide by the terms of this notice as it is currently stated, and reserve the right to change this notice.

Complaints

If you have complaints regarding the way your protected health information was handled, you may submit a complaint in writing to our office. You will not be retaliated against in any manner for a complaint.

Sharing Information

If and when we believe it is necessary to share your protected information in any situation that is not included in the above paragraphs, we will first seek special written permission.

Privacy Policy Acknowledgement:

I have received and read the Notice of Privacy Practices.

Patient Name (Print): _____

Signature: _____

Date: _____