



NAME: _____ DATE: _____

Address: _____

City: _____ COLORADO Zip: _____

Home Phone: _____ Work phone: _____

Cell Phone: _____ Email: _____

Date of Birth: _____ Age: _____ SS#: _____

Marital Status: _____

Family Members:			Chiropractic Care?
Spouse:	_____	Age: _____	Yes No
Child:	_____	Age: _____	Yes No
Child:	_____	Age: _____	Yes No
Child:	_____	Age: _____	Yes No

Employer: _____ Occupation: _____

Hobbies: _____

What are you goals in relation to your Chiropractic treatment? _____

How did you hear of Dr. Anderson? Referred by _____ We want to thank them.

Internet Yellow Pages Drive By Other: _____

Have you had Chiropractic care in the past? YES NO If yes, please let us know how long ago and who was your doctor. _____

How will you be paying for your care? Self -Pay Health Insurance Personal Injury

Insurance Company: _____ Policy # _____

Policy Holder's SS# _____ Insured's Birthday: _____

If we will be billing your insurance, please give your insurance card to the front desk so we can make a copy and please sign the insurance assignment below.

INSURANCE ASSIGNMENT

I hereby authorize and instruct my insurance carrier to issue payment check (s) directly to Dr. JT Anderson. Any sum of money under this assignment shall be credited to my account with the below referenced Doctor. I shall be personally liable for any unpaid balance to the doctor for services rendered as well as unpaid hospital, diagnostic testing, and consultant services.

J.T. Anderson, D.C.
6726 S. Revere Parkway #110
Centennial, CO 80112
303/649-9950

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

HEALTH HISTORY

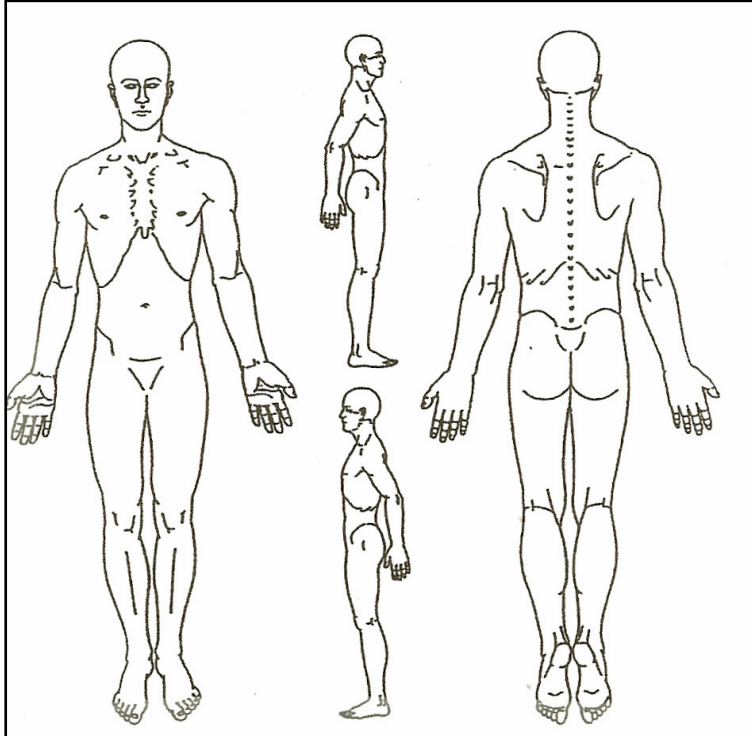
Patient Name: _____ Date: _____

What is the reason for your visit? _____

Describe your current problem and how it began. _____

Use the below listed key to mark areas and type of pain.

A = ACHE N = NUMBNESS S = STABBING
B = BURNING P = PINS AND NEEDLES



PAIN SCALE

Circle the number that best describes your pain.

0 1 2 3 4 5 6 7 8 9 10

None Little Medium Severe

•Are you presently under another doctor's care for this complaint? Y/N Dr's name: _____

•Does anything make the complaint worse?

•Does anything make the complaint better?

•Can you perform daily activities? Yes / No

Describe: _____

•What have you done in the past to treat this issue?

How often are symptoms present? _____

Other Symptoms:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Ringing in the Ears | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> High blood Pressure | <input type="checkbox"/> Jaw/TMJ Problems | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Stroke | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Painful urination |
| <input type="checkbox"/> Extremity Issues | <input type="checkbox"/> Cancer | <input type="checkbox"/> Light Sensitivity | <input type="checkbox"/> Weight loss/Gain |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Allergies | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Loss of Smell or Taste |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Asthma | <input type="checkbox"/> Painful Menstruation |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Cold Feet | <input type="checkbox"/> Allergies | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Stomach Upset | | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Heartburn/Reflux | | <input type="checkbox"/> Are you pregnant?
YES NO |

Are you under medical care for any condition(s)? _____

What medications are you taking and why? _____

List prior surgeries and dates: _____

Please list any other health problems past or present: _____

Have you had any accidents or trauma? When? _____

Patient Name: _____ Date: _____

Family Health History: *Please list any conditions you know about*

Father: _____

Mother: _____

Brother: _____

Sister: _____

Other: _____

Lifestyle:

List any nutritional supplements you are taking and why: _____

Do you exercise regularly? If yes, describe activity and frequency: _____

Approximately, how much water do you drink daily? _____ TAP or BOTTLED

Do you smoke: YES NO Do you drink alcohol: YES NO How often? _____

Do you eat healthy foods? _____

Rate your stress level: 1 2 3 4 5 6 7 8 9 10 Comments: _____

Do you sleep well? _____ How many hours a night? _____

Is there any other comment you would like to add? _____

Acknowledgement and Consent For Treatment

I acknowledge and affirm that I have accurately answered the above information and certify it to be true and correct to the best of my knowledge.

I, _____, hereby authorize Dr. J.T. Anderson and whomever has been designated as his assistant(s) to administer chiropractic treatment as deemed necessary. I authorize Dr. J.T. Anderson and whomever he has designated as his assistant(s) to perform treatment, therapies and additional procedures including but not limited to spinal decompression, cold laser, graston technique, as therapeutically necessary on the basis of findings during the course of said treatment and according to the applicable standard of care. I understand and agree that if I have questions regarding my care or therapies, that it is my responsibility to ask for additional clarification on any and all treatments recommended.

I certify that I have read and fully understand the above authorization for Chiropractic treatment. I understand that options exist for treatment, and that all treatments are choices between risks and benefits. If I am unclear as to the risks and benefits associated with my treatment, I understand that further information may be requested from Dr. Anderson. I certify that no guarantee or assurance has been made to me as to the results that may be obtained.

WOMEN: To the best of my knowledge, I am NOT pregnant at this time. I give full consent to any and all suggested radiographic studies and I acknowledge a willingness for these tests to be considered.

Patient Signature: _____ Date: _____

Printed Name: _____

Staff Signature: _____ Date: _____



Office Policy Overview

Thank you for choosing Dr. Anderson as your chiropractic care provider. It is our goal to provide you with the best care possible, as well as exceed your expectations regarding the logistical handling of your account. As such, it is important that you understand the policies of our office. We have combined many items in this single form and encourage you to read it carefully and completely. We are happy to answer any questions you have regarding our policies at any time.

Cancellation Policy - *Please initial next to each line*

_____ **If you need to cancel your appointment, we request a 24 hour notification.**
_____ **Appointments canceled or missed with less than a 24 hour notice will be assessed a \$40.00 cancellation fee.**

We realize there are times when you cannot make an appointment for a variety of reasons outside of your control. These occasions will be reviewed individually on a case by case basis.

Financial Policy

If you do not have insurance: All payments are due and payable at the time services are rendered. We do have package plans available so that patients may receive chiropractic care without undue financial difficulty.

Co-Payment/Co-Insurance Policies: We are obligated by law to collect your carrier designated fees. We will verify your insurance benefits to the best of our ability. Please understand that this does not guarantee benefits. You, the patient, are ultimately financially responsible for the care you receive in this office. We will do our best to communicate with you in a timely manor regarding any issue with your insurance policy and will work on your behalf to resolve these issues.

Policies with a Deductible: Deductibles can be difficult at best. If you have a deductible, it may be in your best interest to choose our self pay program rather than submit to your insurance company for payment. We are happy to provide you with a statement you can submit personally so that any charges from this office can be applied to your deductible. Please discuss this with our front desk staff to determine the best course of action.

If there is an outstanding balance on your account, you will receive a statement from Physicians Billing Source. Please feel free to contact the billing agent on the statement should you have any questions.

- We accept cash, check, or credit card for your payments. If needed, a payment plan contract can be established through the front office.
- Any returned checks will be charged a \$25.00 fee in addition to the amount of the check.
- I certify that I have read and understand the information listed above. I understand that it is my responsibility to ask questions regarding these policies if my understanding is unclear.

Patient Signature: _____
Staff Witness: _____

Date: _____
Date: _____



NOTICE OF PRIVACY PRACTICE

We, at JT Anderson Chiropractic, respect your privacy. We are required by law to maintain the privacy of protected health information about you, to notify you of our legal duties and you legal rights, and to follow the privacy policies described in this notice. “Protected Health Information” (PHI) means any information that we create or receive that identifies you and relates to your health or payment for services to you.

Use and Disclosure of Information about You.

We may use and disclose your protected health information as needed in the following categories:

Treatment: - Our staff will have access to your PHI throughout the course of your care for administrative purposes as well as to assist us the development and execution of your treatment plan. Your PHI may be used to coordinate a referral or evaluate the quality of care you receive as well as obtain payment for treatment provided to you. We may use your PHI for appointment reminders, or to contact you about additional treatment options that may prove beneficial to you. Your PHI may be disclosed to a family member or friend who is involved in your care as needed. If you would prefer your information be kept confidential in this case, we will respect your wishes.

Dr. J.T. Anderson may disclose your information as required by state or federal law to public health oversight agencies, to child protective agencies, coroners, medical examiners, or funeral director, tissue and organ donation agencies. Your PHI may also be disclosed to researchers for approved projects, to care for you in a psychiatric emergency, or for governmental function in order to comply with workers compensation laws.

It is our policy to obtain specific written permission for every disclosure of protected health information to third parties. You will be asked to sign a general consent for disclosure for treatment, payment and health care operations. For all other third parties, except as required by state of federal law, you will be asked to sign a specific authorization form for each person or organization requesting information about you.

Your rights:

You have the right to request communication regarding appointment reminders, bills, and any treatment information be made in a confidential manner. You must provide us with alternative means and alternative locations for us to do so. You may request that we restrict disclosure of PHI for particular purposes or to certain third parties. We are not obligated to agree to such a restriction, but will consider your request. You may revoke a consent or authorization to share PHI. This revocation will not affect any previous use or disclosure of your information. However, revocation of consent for sharing information with your insurance or managed care company may result in termination of our services. You have the right to review and attain a copy your medical record. At your request we will make a copy of your record for you . We will charge \$.75 per page for this service. If you believe your medical record contains an error, you may ask us to amend it. Any mistake will be noted, however if no mistake is found, you will be allowed the opportunity to add a short statement to the record explaining why you believe the record to be incorrect. This information will be included as part of the total record.

Complaints

Questions regarding about our policies and procedures, requests to exercise individual rights, and complaints should be directed to our Privacy Officer: Bethany Anderson- (by mail) 6726 S. Revere Parkway #110, Centennial, CO 80112, (by phone) 303-649-9950.

You can also submit a complaint to the United States Department of Health and Human Services at: Office for Civil Rights, US Department of Health and Human Services, 200 Independence Ave., S.W., Rm. 509F, Washington, DC 20201 , or at 1-800-368-1019.

You will not be retaliated against for filing a complaint.

Dr. J.T. Anderson must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information. We must abide by the terms of this notice, notify you if we are unable to agree to any requested restriction regarding how your information is used or disclosed, accommodate reasonable requests you may make to communicate your health information by alternative means or to alternative locations. Dr. J.T. Anderson will not disclose your information to others unless you authorize us to do so, or unless the law authorizes or requires us to do so. We will obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted by law.

By my signature below, I acknowledge receipt of this Notice of Privacy Practices and give consent for my PHI to be disclosed in accordance with the above listed means.

(This form will be retained in your health record.)

Printed Name _____

Signature _____

Date _____

Witness _____

Date _____