Acupuncture Chiropractic Center

2403 27th St. Greeley, CO 80634

Treating Doctor: _____ **Date:** _____

Name _____ **In order to receive text reminders, cell number required.**

The Doctor and/or staff have my permission to send a **text** or leave a **voicemail** regarding my appointment, treatment, or account information at this number:

Please circle: Home - Work - Cell **Phone**_____ Initial_____

Email Address_____

Mailing Address _____ **City/State** _____ **Zip Code** _____

Age _____ **Birth Date** _____ **Marital Status:** M S W D **Number of Children** _____

Ethnicity: _____ **OR** Unspecified

Race: _____ **OR** Unspecified

Gender Identity: Male - Female - Other: _____

Preferred Language: _____

Occupation _____ **Employer** _____

By supplying this information, I acknowledge registration to www.acupuncturechiropracticcenter.com . This information will not be used outside of ACC.

Whom may we thank for referring you to our office? _____

Name of Spouse _____ **Occupation** _____ **Phone** _____

Nearest Relative _____ **Phone** _____ **Relationship** _____

Purpose of this appointment: _____

Have you been to a Chiropractor before? _____ Have you ever been treated with acupuncture? _____

Is this condition due to an accident? _____ Date of accident _____

What operations have you had? _____ When? _____

Do you have any serious illnesses? _____ If yes, please list: _____ Date diagnosed: _____

Other doctors seen for this condition _____

Have you been treated for any health conditions in the last year? Yes No

Please describe _____

Please Circle one (If going through insurance, please present card to the front desk): INSURANCE WC PI Self-Pay

NO SHOW POLICY: <u>For missed massage appointments, a fee of $40 will be billed directly to you, the patient.</u> This fee will not be billed to insurance. There will be a limit of three missed massages before we will no longer be able to schedule you. Please understand that this typically takes an entire HOUR out of our massage therapists' schedules and, unfortunately, they are only paid when a massage is performed. There are many patients waiting to see our therapists and this is simply to decrease the occurrence of missed appointments. ACC requires at least 24 hours cancellation notice.

I understand and agree that health/ accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that Acupuncture Chiropractic Center will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the ACC will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

Patient Signature_____ SS#_____-_____-_____ Date _____

Signature of Parent or Guardian Signature Authorizing care: _____

Do you currently or in the past have: Please mark all that apply

	Current	Past
Sleep Problems	☐	☐
Disabled	☐	☐
Nervous tension	☐	☐
Irritability	☐	☐
Mood Swings / changes	☐	☐

Do you currently or in the past have: Please mark all that apply.

	Current	Past
Growing moles or lumps	☐	☐
Wear glasses or contacts	☐	☐
Glaucoma	☐	☐
Light bothers eyes	☐	☐
Other eye problems	☐	☐

Date of last eye exam: _____

Hearing difficulties	☐	☐
Ringing in ears	☐	☐
Sinus infection	☐	☐
Motion sickness	☐	☐
Dental Problems	☐	☐

Date of last dental exam: _____

Do you currently or in the past have: Please mark all that apply.

	Current	Past
More frequent urination	☐	☐
Pain or blood with urination	☐	☐
Leaking urine	☐	☐
Urinating at night	☐	☐
Kidney or bladder infection	☐	☐
Kidney stones	☐	☐
Recurrent abdominal pain	☐	☐
Ulcers	☐	☐
Heartburn	☐	☐
Swallowing problems	☐	☐
Hernia	☐	☐
Hemorrhoids	☐	☐
Polyps	☐	☐
Loss of smell	☐	☐

Do you currently or in the past have: Please mark all that apply.

	Current	Past
Arthritis or gout	☐	☐
Bursitis	☐	☐
Fractured bones	☐	☐
Seizures	☐	☐
Tremor	☐	☐
Passing out	☐	☐
Speech problems	☐	☐
Trouble concentrating	☐	☐
Diarrhea or constipation	☐	☐
Varicose veins	☐	☐

Do you currently or in the past have: Please mark all that apply.

	Current	Past
Asthma	☐	☐
Eczema	☐	☐
Hay Fever	☐	☐
Sinus Problems	☐	☐
Diabetes	☐	☐
High cholesterol or triglycerides	☐	☐
Thyroid trouble	☐	☐
Anemia	☐	☐
Bleeding or bruising tendency	☐	☐

Do you currently or in the past have: Please mark all that apply

	Current	Past
Low blood pressure	☐	☐
Racing, pounding heart	☐	☐
Ankle swelling	☐	☐
Lung or breathing problems	☐	☐
Pneumonia	☐	☐

Please mark all that apply.	Current	Past
History of trauma	☐	☐
Infection	☐	☐
Unexplained weight loss	☐	☐
Unusual fatigue	☐	☐
Depression	☐	☐
Dizziness/Poor balance	☐	☐
Vomited blood	☐	☐
Bloody or black stools	☐	☐
Change in appetite	☐	☐
Fevers	☐	☐
Night Sweats	☐	☐
High blood pressure	☐	☐
Chest Pain	☐	☐
Shortness of breath	☐	☐
Chronic cough	☐	☐
Stroke	☐	☐
Heart disease or murmur	☐	☐
Loss of bowel or bladder control	☐	☐
Headaches	☐	☐
Muscle weakness or paralysis (legs give out)	☐	☐
Memory loss	☐	☐
Severe trauma	☐	☐
Direct head trauma	☐	☐
Lost consciousness	☐	☐
Poor coordination	☐	☐
Night pain	☐	☐
History of osteoporosis	☐	☐
History of cancer	☐	☐
Use of corticosteroids	☐	☐
Use of anticoagulants	☐	☐
Numbness in groin (saddle anesthesia)	☐	☐

Patient Signature_____

TESTS: Please list the most recent date:

☐ Chest X-ray ☐ EKG ☐ MRI/CT Scans ☐ Other X-ray

Date/Location:_____

HABITS:

Smoking Status: ☐ Former ☐Current Daily ☐Casual ☐Never

	Y	N	
Alcohol Consumption	☐	☐	If yes, please describe: # Drinks per day ___Drinks per week___
Coffee or Tea Consumption	☐	☐	Cups per day _____
Other Drug Use (Street Drugs)	☐	☐	_____
Exercise	☐	☐	Daily ☐ Weekly ☐ Monthly ☐ Type _____

Hobbies or Interests: _____

Medication: Please list all currently used medicines: prescription and non-prescription drugs, vitamins, and herbs.

_____

_____

Allergies: Please list all known drug allergies _____

_____

Treatment you are receiving or have received:

☐ Medical care ☐ Chiropractic care ☐ other: _____

Are you: ☐ Right handed ☐ Left handed ☐ Ambidextrous

Do you currently or in the past have: Please mark all that apply

	Currently	Past
Back pain or stiffness	☐	☐
Neck pain or stiffness	☐	☐
Shoulder pain	☐	☐
Hip pain	☐	☐
Foot pain or trouble	☐	☐
Swollen or painful joints	☐	☐
Cold hands or feet	☐	☐
Numbness or pain in the arms, Hands or fingers	☐	☐
Numbness or pain in the legs, Feet or toes	☐	☐

MALES ONLY

Do you have…?

☐ Changes in urine stream ☐ Prostate trouble

☐ Lumps in testicles ☐ Sex concerns

Date of last prostate exam: _____

FEMALES ONLY

Do you have…?

- ☐ Menstrual problems
- ☐ Abnormal bleeding
- ☐ Breast lumps or pain
- ☐ Problems getting pregnant
- ☐ Vaginal discharge
- ☐ Tubal infections
- ☐ Sex concerns

Age periods began: _____

Number of pregnancies: _____

Number of miscarriages or abortions: _____

Number of Cesarean Sections: _____

Type of birth control: _____

Date of last gynecological exam: _____

Date last period began: _____

Are you currently or possibly pregnant? _____

Are you currently breast-feeding? _____

DOCTOR'S NOTES: _____

_____

_____

_____

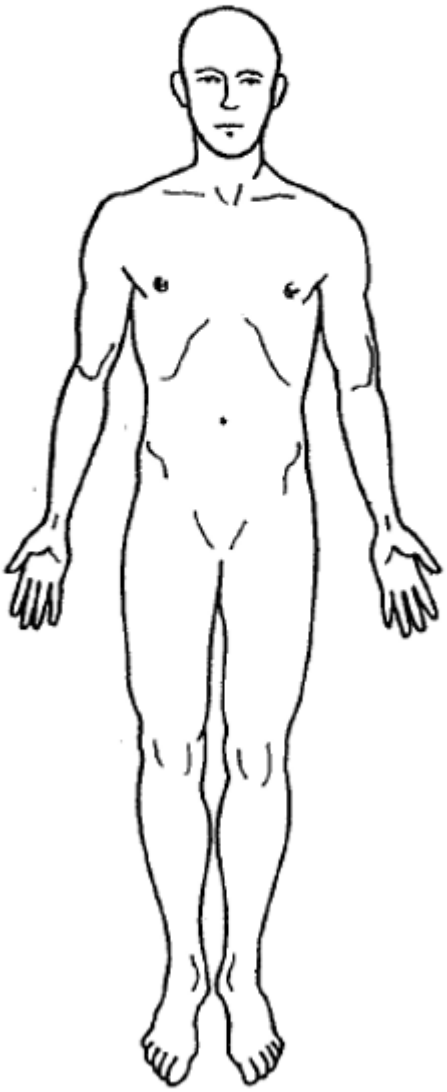
Patient Signature: _____ **Date:** _____

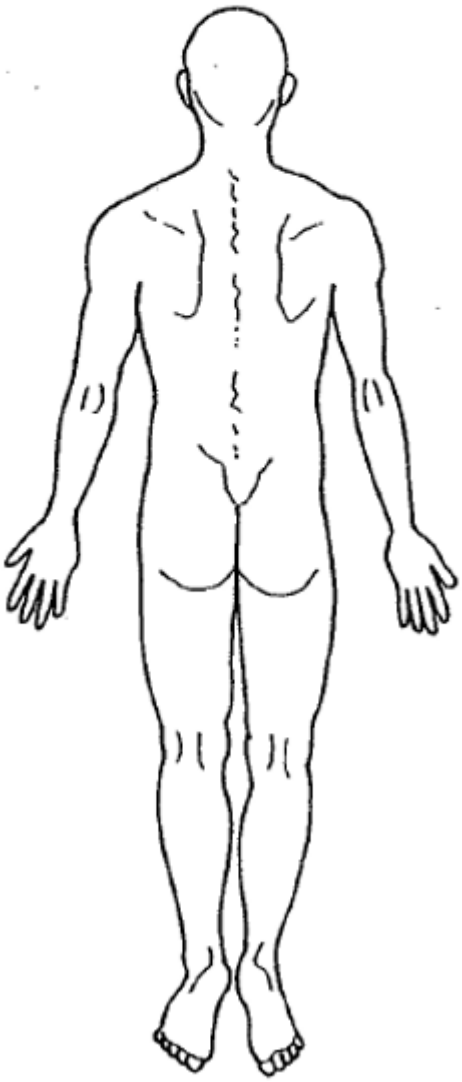
PAIN DRAWING

Name: _____ Date: _____

Mark the areas on your body where you feel your pain. Include all affected areas. If your pain radiates, draw an arrow from where it starts to where it stops.

Ache	>>>	Numbness	===	Pins/Needles	000
Burning	xxx	Stabbing	///	Throbbing	~~~





Acupuncture Chiropractic Center

Dr. Michael Springfield D.C. Dipl. Ac.
Dr. Eric Walker, D.C., C. Ac.

Payment Options

__ Private Pay
As a courtesy to our patients who do not have chiropractic insurance benefits, we offer a discount for services rendered in this office. Discounted rates do not follow ACC's normal fee schedule. These fees are substantially lower with intent of affording a greater chiropractic/acupuncture benefit to more people. Payment for services and/or supplies is due and payable at the time of service.

__ Insurance
Once your insurance has been verified, your benefits will be explained to you. This verification will determine approximately what your coverage is and co-payments/co-insurance amounts will be collected as dictated by your insurance carrier at each visit. Remember that all charges incurred in this office are ultimately your personal responsibility. ACC will file insurance claims for you in a timely fashion.

__ Personal Injury
Please provide your automobile insurance. Once your insurance coverage has been verified, your benefits will be explained to you. We may be willing to consider your case using a "medical" or "doctor's lien"; and if this applies, a co-payment at each visit will be necessary to carry your case. Remember that all charges incurred in this office are ultimately your personal responsibility.

__ Medicare
As a participating provider for Medicare, ACC will accept assignment for Medicare patients. Medicare will cover chiropractic adjustments ONLY at 80% once the yearly deductible is met. It is the insured's responsibility to pay any applicable deductible and 20% of the charge for the adjustment at the time of service. Should therapy services be rendered, the insured will be required to pay the charges at the time of service unless there is a secondary insurance plan.

__ Worker's Compensation
If you have been involved in a work related accident or injury, you must report this to your supervisor immediately. Once we have received proper authorization to evaluate and treat you for your work related condition your insurance carrier for your employer is financially responsible for all medical bills related to your injury.

NO SHOW POLICY: If you are unable to keep your appointment kindly give **24-hour notice.** Fees for missed appointments will apply. These fees will not be billed to insurance. There will be a limit of three missed massages before we will no longer be able to schedule you.

By my signature below, I understand that I am financially responsible for all charges incurred by me at Acupuncture Chiropractic Center (ACC). I hereby assign my insurance benefits to Dr. Michael Springfield and/or Dr. Eric Walker. Any overpayment on my account will be refunded. Additionally, I authorize ACC to release any protected health information required to secure payment. Should my account become delinquent, I understand that I am responsible for any interest, collection fees, attorney's fees and court costs incurred in collecting any outstanding balance. For any returned checks there will be a $30.00 fee in addition to the outstanding balance on the account. Patient balances that are over 30 days past due are subject to a monthly finance charge of 1.75% (21% APR).

Signature: _____ **Date:** _____

Acupuncture Chiropractic Center

Dr. Michael Springfield D.C. Dipl. Ac.
Dr. Eric Walker, D.C., C. Ac.

NOTICE OF PRIVACY PRACTICE SUMMARY

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) affords individuals certain rights to privacy regarding protected health information. While we've always protected your privacy concerning your personal health information, this summary discloses how your health information may be used. An expanded notice of your privacy rights is available for review upon request. Be aware that the terms of this notice may change from time to time and that you may contact us at any time to obtain the most current copy of this notice.

Acupuncture Chiropractic Center uses your health information for you treatment (including direct to indirect treatment by other healthcare providers), to obtain payment for treatment from third party payers (for example, an insurance company), to evaluate the quality of care that you receive, and for administrative purposes.

Acupuncture Chiropractic Center may disclose your health information in the day- to-day operations of our practice. This may include, but not be limited to daily sign in sheets, sending appointment reminders, phone messages, birthday cards, newsletters, holiday greetings and information about treatment alternatives or other health related issues.

Acupuncture Chiropractic Center may disclose your health information for public health activities, research, health and safety, governmental function in order to comply with worker's compensation laws and other pertinent legislative rules and regulations. Acupuncture Chiropractic Center will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so. You have a right to request restrictions on how your health information may be used and disclosed to carry out treatment, reimbursement, and healthcare operations. Acupuncture Chiropractic Center may not be required to agree with these requested restrictions; however if we do agree with these requests then we are bound to comply with them. Further, you have a right to request and retain a copy of your health record, request communication of your information by alternative means at alternative locations when appropriate, revoke your authorization and request an accounting of your healthcare records. However, any use or disclosure that occurred prior to the date of revocation is not affected.

You may talk to the Privacy Officer of Acupuncture Chiropractic Center and/or to the Department of Health and Human Services if you believe your privacy rights have been violated. In the event that a complaint is filed, you will not experience any retaliation.

Acupuncture Chiropractic Center must maintain the privacy of protected health information as provided by this Privacy Practice Summary. We are obligated to obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under current law.

This office is a semi-private facility. If you wish to discuss clinical or financial information privately, please notify a staff member and we will provide a private setting for that discussion.

In the interest of protecting the privacy of your personal health information, there may be instances when you are asked additional questions to verify your identification. Further, you will not be allowed access into areas designated as "authorized personnel only".

By my signature below, I acknowledge that I have reviewed this information and understand its contents.

I HEREBY AUTHORIZE *Acupuncture Chiropractic Clinic & Compcare, Inc.* TO SHARE:
Any of my medical information, **including information about:**

- My appointment times, dates, and reasons for the visits

WITH THE FOLLOWING PEOPLE:

Full Name: _____ Relationship: _____

Full Name: _____ Relationship: _____

SIGNED: _____ DATE: _____

Acupuncture
Chiropractic
Center

Dr. Michael Springfield, D.C., Dipl. Ac.
Dr. Eric Walker, D.C., C. Ac.

Informed Consent to Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as **HOT or COLD PACKS, ELECTRIC MUSCLE STIMULATION, THERAPEUTIC ULTRASOUND, ACUPUNCTURE, MASSAGE, and MANUAL THERAPY or dry hydrotherapy** may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and herby give my full consent to treatment.

_____	_____	_____
Patient Name (Please Print)	**Patient Signature**	**Date**

WITNESS:

_____	_____	_____
Printed Name	**Signature**	**Date**

Acupuncture Chiropractic Center

Dr. Michael Springfield, D.C., Dipl. Ac.
Dr. Eric Walker, D.C., C. Ac.

ASSIGNMENT OF BENEFITS / ERISA AUTHORIZED REPRESENTATIVE FORM

Financial Responsibility

I have requested professional services from **Acupuncture Chiropractic Center, LLC.** on behalf of myself and/or my dependents, and understand that by making this request, I am responsible for all charges incurred during said services. I understand that all fees for said services are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

Assignment of Insurance Benefits

I hereby assign all applicable health and/or auto insurance benefits to which I and/or my dependents are entitled to Provider. I certify that the health and/or auto insurance information that I provided to Provider is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Provider to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided to Provider, in good faith. I also hereby instruct my benefit plan (or its administrator) to pay Provider directly for services rendered to me or my dependents. To the extent that my current policy prohibits direct payment to Provider, I hereby instruct and direct my benefit plan (or its administrator) to provide documentation stating such non-assignment to myself and Provider upon request. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make out the check to me and mail it directly to Provider.

I am fully aware that having health and/or auto insurance does not absolve me of my responsibility to ensure that my bills for professional services from Provider are paid in full. I also understand that I am responsible for all amounts not covered by my health insurance, including co-payments, co-insurance, and deductibles.

Authorization to Release Information

I hereby authorize Provider to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated during examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

ERISA Authorization

I hereby designate, authorize, and convey to Provider to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 *C.F.R.* §2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

A photocopy of this Assignment/Authorization shall be as effective and valid as the original.

_____ _____

Patient Signature Date

_____ _____

Policyholder/Insured Date