About the Patient

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone (_____) _____

Cell Phone (_____) _____

Birthdate _____ Age _____

Gender ❒M ❒F Number of Children _____

Employer _____

Type of Work _____

Marital Status ❒ Married ❒ Single ❒ Divorced
❒ Separated ❒ Widowed

Email Address _____

How you would like to be notified of your appointments?

❒ Email ❒ Text (Carrier_____)

Social Security # _____

Credit Card number to be put on file for outstanding balances. This card WILL NOT be charged before informing you first.

Credit Card# _____

Exp: _____

Reason For This Visit

Describe the purpose of this visit: _____

_____

_____

Is the purpose of this appointment related to:

❒ Sports ❒ Chronic Discomfort ❒ Injury ❒ Other

Please Explain: _____

_____

When did this condition begin? _____

Is it: ❒ getting worse ❒ staying constant ❒ off & on

Does this condition interfere with:

❒ work ❒ sleep ❒ daily routine ❒ other activities

Please Explain _____

Has this condition occurred before? ❒ Yes ❒ No

Explain _____

What level is your pain?

Have you seen other doctors for this? ❒Yes ❒No

Dr.'s Name (s) _____

Type of treatment _____

Results _____

Experience With Chiropractic

Who referred you to this office? _____

Have you been adjusted by a chiropractor before? ❒ Yes ❒ No

Reason for those visits? _____

Doctor's Name _____

Approximate date of last visit? _____

Has any *adult* in your family seen a chiropractor? ❒ Yes ❒ No

Has any *child* in your family seen a chiropractor? ❒ yes ❒ No

Awareness of Chiropractic Principles

Were you aware that .....

Doctors of chiropractic work with the nervous system? ❒ Yes ❒ No

The nervous system controls all bodily functions and systems? ❒ Yes ❒ No

Chiropractic is the largest natural healing profession in the world? ❒ Yes ❒ No

If chiropractic care starts at birth, you can achieve a higher level of health throughout life? ❒ Yes ❒ No

Goals For My Care

People see Chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of their pain, and others for correction of whatever is malfunctioning in their bodies (wellness care). Your doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

❒ **Relief Care:** Symptomatic relief of pain or discomfort

❒ **Corrective Care:** Correcting and relieving the cause of the problem as well as the symptoms.

❒ **Wellness Care:** Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.

❒ I want the doctor to select the type of care appropriate for my condition.

_____

Patient's Signature Date

Medications I Now Take

❒ Nerve Pills
❒ Pain Killers (including Aspirins)
❒ Muscle Relaxers
❒ Blood Pressure Medicine
❒ Insulin
❒ Stimulants
❒ Blood Thinners
❒ _____
❒ _____
❒ _____

Health Habits

	No	Yes
Do you smoke?	❒	❒
Do you drink alcohol?	❒	❒
Do you drink coffee?	❒	❒

Do you exercise regularly? ❒ No ❒ Moderate ❒ Daily

Do you wear ❒ Heel Lifts ❒ Sole lifts ❒ Inner Soles ❒ Arch Supports

HEALTH CONDITIONS

Please check each of the diseases or conditions that you have had now or in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

❒ Severe or Frequent Headaches
❒ Sinus Problems
❒ Dizziness
❒ Cancer
❒ Loss of Sleep
❒ Hepatitis
❒ Pain Between the Shoulders
❒ Frequent Neck Pain
❒ Numbness or Pain in Arms/Legs/Hands
❒ Lower Back Problems
❒ Digestive Problems
❒ Ulcers/Colitis
❒ Heart Attack/Stroke
❒ Thyroid Problems
❒ Kidney Problems
❒ Congenital Heart Defect
❒ Heart Surgery/Pacemaker
❒ High/low Blood Pressure
❒ Psychiatric Problems
❒ Difficulty Breathing
❒ Rheumatic Fever
❒ Asthma
❒ Arthritis
❒ Alcohol/Drug Abuse
❒ Venereal Disease
❒ HIV/AIDS
❒ Diabetes
❒ Tuberculosis
❒ Shingles
❒ Chemotherapy
❒ Anemia

FOR WOMEN ONLY:

Are you pregnant?
❒ Yes ❒ No

Are you nursing?
❒ Yes ❒ No

Are you taking birth control?
❒ Yes ❒ No

Do you experience painful periods?
❒ Yes ❒ No

Do you have irregular cycles?
❒ Yes ❒ No

Do you have breast implants?
❒ Yes ❒ No

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for all payment. I agree that I am responsible for all the bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider of services rendered.

_____ _____

Patient Signature Date Guardian or Spouse/s Signature Date

Who should receive bills for payment on account?

❒ Patient ❒ Spouse ❒ Parent ❒ Worker's Comp.

❒ Medicare ❒ Personal Health Insurance ❒ Auto Insurance

Ownership of X-Ray Films

It is understood and agreed that the payments to the Doctor for X-Rays is for examination of X-Rays only. The X-Ray negatives will remain the property of this office. They are kept on file where they may be seen at any time while I am a patient of this office.

Emergency Contact

Name _____

Relationship _____

Work Phone _____

Home Phone _____

My Health Insurance

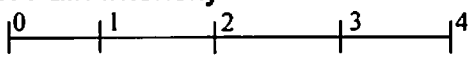
I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will provide any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt.

Signature:_____ Date:_____

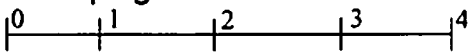
Patient Name_____ Date_____

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. Please complete the following questions regarding how you currently feel. Zero being none and four being severe.

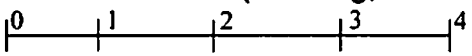
1. Pain Intensity



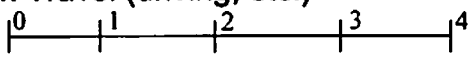
2. Sleeping



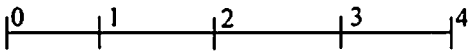
3. Personal Care (washing, dressing)



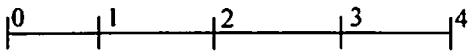
4. Travel (driving, etc.)



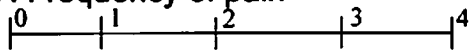
5. Work



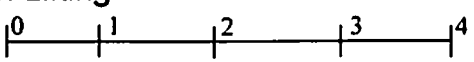
6. Recreation



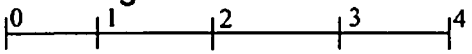
7. Frequency of pain



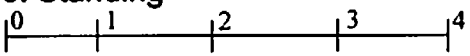
8. Lifting



9. Walking



10. Standing



Total Score _____

Current Condition(s)/Complaint(s)

1._____

2_____

3_____

Office Fee Schedule and Financial Policy

We are committed to providing you with best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time of service is rendered unless you arrange a Chiropractic Active Life Plan in advance. These plans are designed to be the most cost effective way to keep you and your family as healthy as possible . They include Corrective Adjustment Plans (CAP) and Continued Corrective Adjustment Plans (CCAP). Details of these plans will be discussed with you during your chiropractic report.

Insurance

If you have health insurance that covers chiropractic care and choose to use it, the fees will be based on the insurance policy guidelines. We will file the insurance claim for you, but please remember that in the event of a dispute, your agreement with your insurance company is between you and them. Quoted benefits are not a guarantee of payment until the actual claim has been processed. Any unpaid balances remaining after your insurance claim has been processed will be billed to you. *Please note that based on your individual insurance policy preventative chiropractic services may or may not be covered.*

Time of Service Fees

If you do not have health insurance or choose not to use it, you will be eligible for the time of service fees below. You may request a receipt for tax purposes or a health savings account (HSA) indicating the total amount you have paid for chiropractic care during the year. There is no insurance documentation given with these receipts.

Service	Fee
Consultation	No charge
X-rays (per region)	$50.00
Exam	$50.00
Adjustment Adult	$50.00
Decompression session	$50.00

I, (name) _____have read and I understand the above policies.

_____

Patient Signature Date

Kabel Chiropractic 2209 W Wildcat Reserve Pkwy E-3 Phone: 720-489-1450 Fax : 720-489-1890

Kabel Chiropractic Informed Consent to Care

You are a decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendation as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological function and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravation and /or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fracture (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is rare but serious condition known as cervical arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fits.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complications to care. I have also had an opportunity to ask questions about its content, and by singing below, I agree with the current or future recommendations to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name:_____ Signature_____ Date_____

Witness Name:_____ Signature_____ Date_____

HEALTH CARE PRIVACY NOTICE

Our staff is committed to maintaining the privacy of your "protected health information" known as (PHI). PHI is information about you, including demographic information, that may identify you and that may relate to your present, future and past physical or mental health or condition and the care and treatment you receive from our practice. This Notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read this Notice and address any questions, misunderstandings or concerns to the Compliance Officer of this office.

This office is required by law to abide by the terms of this Health Care Privacy Notice as well as all other applicable federal and state laws governing privacy practices in health care. Our office may change and/or modify the terms of this Notice at anytime without additional notice to you except to publicly post in our office and/or make available to patients any updated notices. A photocopy of this Notice is available to you upon request.

USE AND DISCLOSURE OF PHI

Our office may use and disclose your PHI for health care delivery purposes. Your PHI may be used by doctors/providers and staff of this office for the purposes of your care and treatment; for collection of compensation that you owe our office; and to support the operation of this practice. Your doctor and our staff will take all reasonable measures to maintain the confidentiality of your PHI.

Following is a list of situations where your PHI may be disclosed *without your written authorization*:

- **Business Associate**: Your PHI may be used or disclosed to a business associate of our office from whom we have obtained assurances that they will safeguard your PHI and use it only for the purposes for which it was intended.
- **Emergency Situations**: For your care, in an emergency situation, where written acknowledgment from you is not practical until after the emergency situation has ended.
- **Health Care Operations**: For certain administrative, financial, legal, and quality control activities that are necessary to run this office and to support the core functions of treatment and collection of compensation due our office.
- **Legal Proceedings**: If requested in judicial or administrative proceedings by court order, subpoena or by law enforcement personnel in an emergency.
- **Payment**: The provider may disclose your PHI to a third party in order to obtain reimbursement for your health care services.
- **Your Personal Representative**: Your PHI may be disclosed to a person who is authorized by state law to act on your behalf in making your health care decisions.
- **Public Health Purposes**: Your PHI may be disclosed to legally authorized public health authorities for the purpose of the prevention, control, investigations, intervention, and reporting of disease, injury, disability and vital events such as births or deaths. Your PHI may be disclosed for public health activities such as child abuse, neglect, safety and effectiveness of a product regulated by the FDA, and persons at risk of contracting and spreading disease.
- **Research Purposes**: Your PHI may be disclosed for research purposes, either with your written permission, or without any identifying characteristics.
- **Treatment**: For the coordination or management of your health care services, your health care services, your health care provider may consult with another health care provider, a third party, or for the referral to another health care provider.
- **Worker's Compensation**: State laws may permit disclosure of your PHI to comply with worker's compensation laws without your authorization, and where no minimum necessary standard is required.

MISCELLANEOUS

- **Normal Operation**: We may use or disclose your PHI in the normal course of operations, notifying you of appointments, services, and clinic news. We also send welcome cards to our new patients and thank you cards to those that refer others for services.
- **Employee Limitations**: Disclosure of your PHI will be limited to the members of the clinic and its workforce who may need access for treatment, payment or health care operations.
- **"Minimum Necessary" Standard**: The disclosure of your PHI will be the minimum required to accomplish the intended purpose.

Your Rights: The Privacy Rule allows you the right to review and receive copies of your records as it relates to your health care. The request must be in writing, allowing your doctor/provider 30 days to respond. Your doctor/provider may deny your request if it will cause harm to you or to another person. Your doctor/provider may charge a copy fee, which will not exceed the amount permitted by State Law. The Privacy Rule also allows you the right to request limits on the disclosure of your PHI by your doctor/provider regarding treatment, payment and health care operations. Your doctor/provider may not agree to your restrictions, but would be bound by any restrictions you place in writing to the doctor/provider.

Your doctor/provider must comply with any reasonable request to have confidential information transmitted by alternative means, or to an alternative location if this will not endanger you.

You may request to have an amendment placed in your record if you disagree with something in your record. This does not mean that anything will be removed or changed; and, the doctor/provider has the right to respond with a rebuttal statement if he/she feels it is necessary.

You may revoke authorization, in writing, at any time, except in the event that the doctor/provider has acted as indicated in the doctor's/provider's Authorization Notice.

You have the right to file a written complaint with our Privacy Officer if you believe that any of your privacy rights have been violated. You can obtain a complaint form from the Privacy Officer. It must be completed and filed within 180 days of when you knew or should have known that the violation occurred. You may also send a written complaint, either on paper or electronically, to the Office of Civil Rights (OCR). The Privacy law prohibits our office from taking any retaliatory actions against anyone who files a complaint.

Semi-Private Adjusting

It is the practice of this office to provide chiropractic care in a "semi-private" environment. Patients are within earshot of other patients and staff. We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an "incidental disclosure" of health information. It is our view that the kinds of matters related in a "semi-private" environment are incidental matters, in the event you or someone else would not agree with us we are providing this disclosure. If you choose not to be adjusted in a "semi-private" environment, other arrangements will be made for you. Your decision will have no adverse effect on your care from Dr. Kabel or on your relationship with our staff. Your signature indicates your authorization of this activity.

I, _____, (patient's name) acknowledge that I have read and fully understand and have had all my questions answered to my satisfaction.

_____ _____

Printed Name of Individual/Child Signature of Individual/Guardian

_____ _____

Date Signed Witness