NO INSURANCE

For office use only:
Ins Checked ☐
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Date entered in CT: _____
CA initials _____

Great Day
Chiropractic & Rehab

Are you in the right place?
Please read this before proceeding with paperwork:

At **Great Day Chiropractic & Rehab**, we specialize in treating **neuro-musculo-skeletal** (nerve, muscle, bone) conditions from a chiropractic perspective. In other words, we mobilize injured joints that have become fixated or "stuck" due to sudden injury or long-term stresses. There are about 40 conditions that respond well to chiropractic treatment so, with that in mind, the first thing we will do is determine if your problem is indeed **neuro-musculo-skeletal** in nature and if you are a good fit for our care. If you're not a candidate for chiropractic care, we will refer you to a physician or specialist better suited for your condition. Keep in mind that underlying medical problems may exist, and you should always make your primary care provider aware of any symptoms that you are experiencing.

Typically, there is a sequence of events that brings a patient like you into our office. These events can unfold over a period of days or a period of years:

- Your body is subjected to injury, repetitive motion, and/or chronic tension causing pain.
- Your body reacts with muscle tightness, spasms, and inflammation.
- Scar tissue is created, causing your muscles to stiffen and stick together.
- You begin to lose range of motion and feel pain, weakness, and other symptoms.
- Other muscles compensate, and this over-stresses them.
- The body begins to "learn" that all of this dysfunction is normal.

Your symptoms are likely part of a cycle of injury, physical stress, and muscular dysfunction. To decrease pain and restore your body and joints to a full, free, and painless state we will use the following methods and techniques where appropriate in 3 distinct phases of care:

Phase 1: Relief Care – Our goals are to get you out of pain, to stop your condition from worsening and begin to reverse it.

- Chiropractic manipulation or "adjustments" to increase range of motion and break up joint adhesions (joints that are "stuck").
- Electrical muscle stimulation (e-stim) and/or ultrasound therapy to increase blood flow, decrease muscle spasm and inflammation.
- Ice and/or moist heat to increase blood flow, decrease muscle spasm and inflammation.
- Active stretching to increase range of motion and relax the muscles. To be done at home and in our office.
- Nutritional support - a recommendation of dietary changes and nutritional supplements to aid your body in recovery.

Phase 2: Stabilization Care – Our goal is to shift from short-term pain relief to long-term prevention.

- Decrease in the number of office visits.
- Decrease home stretching.
- Begin strengthening exercises to retrain your body in normal movement patterns and to "unlearn" dysfunctional patterns. This helps your muscles to "remember" that full, free, painless motion is normal again. This can also correct poor posture.
- Increase your strength and flexibility. This will prepare your body to better handle whatever stresses you subject it to. (sports, work, etc..).
- Teach you how to prevent the problem from returning.

Phase 3: Wellness Care – Optional

- Some patients return on an "as need" or on a more regular basis to maintain their restored health. This is completely up to each individual.

On average, between 6-12 treatments visits may be required to correct your problem. More serious issues, such as automobile accident injuries, can require additional visits. If your condition does not begin to improve after 4-6 visits, a second opinion from a medical provider or other specialist is appropriate. Also, should your symptoms return after successful treatment, you should contact your primary care provider. We strongly encourage you to see your medical provider regularly. Soreness may be a side effect of your treatment. Please report any worsening of your symptoms to us immediately. Chiropractic adjustments to carry a small risk of injury. If you have any questions about this risk, please feel free to ask.

_____	_____	_____
SIGNATURE	**PRINTED NAME**	**DATE**

PATIENT APPLICATION FOR TREATMENT

Today's Date: _____

Name:_____How would you like to be addressed?_____

Date of Birth:_____ Age:_____ Gender: M F

Your Address:_____City:_____

State:_____ Zip:_____ SS#:_____ Home #:_____

Your Occupation:_____ Work#:_____

Mobile#:_____

Marital Status: S M W D Email Address:_____

How many children do you have? _____ What are their ages?_____

Have they or any other members of your family received chiropractic care? ☐Yes ☐No

Emergency Contact Name and Ph#:_____

Who can we thank for referring you to us?

Reason for seeking services at **Great Day Chiropractic and Wellness Center**?

_____

_____

_____

_____

Is there anything about your NERVE SYSTEM and/or SPINE we should know about (previous surgeries)

_____

_____

_____

_____

What are your health goals?

_____

_____

_____

_____

What is your level of commitment to yourself, your life and well-being?

High ☐ Medium ☐ Low ☐

Patient:_____

Date:_____

HEALTH HISTORY

Please mark all that apply:

☐ Broken or Fractured Bones	☐ Osteoarthritis	☐ Eating Disorder
☐ Circulatory Problems	☐ Epilepsy	☐ Alcoholism
☐ Rheumatoid Arthritis	☐ Pacemaker	☐ Drug Addiction
☐ Seizures/Convulsions	☐ Strokes	☐ HIV Positive
☐ A Congenital Disease	☐ Cancer	☐ Gall Bladder
☐ Excessive Bleeding	☐ Ulcers	☐ Head Problems
☐ High/Low Blood Pressure	☐ Ruptures	☐ Depression
☐ Diabetes	☐ Coughing Blood	☐ Tumors

Explanation_____

_____

_____

When was your last physical exam?_____

When was the last time you were involved in an accident of any kind and what happened?

_____

_____

_____

_____

Please list any medications/supplements you are taking and the reason you are taking them.

1._____

2._____

3._____

4._____

5._____

Who are your current health care providers and what conditions are they treating?

1._____

2._____

3._____

4._____

5._____

Patient:_____

Date:_____

Please tell us about your health history

C= child T = teenager A = Adult N = not at all

1. PHYSICAL HEALTH

• Birth Trauma (as mother or child)	C	T	A	N	_____
• Slips/Falls	C	T	A	N	_____
• Car Accidents	C	T	A	N	_____
• Sports Injuries	C	T	A	N	_____
• Physical Abuse	C	T	A	N	_____
• Poor Posture	C	T	A	N	_____
• Work Injuries	C	T	A	N	_____
• Extensive Computer Work	C	T	A	N	_____
• Carry Heavy Purse/Bag/Child	C	T	A	N	_____
• Repetitive Lifting/Bending	C	T	A	N	_____
• Driving for many hours	C	T	A	N	_____
• Continuous Hours Standing/Sitting	C	T	A	N	_____
• Bone Fracture/Surgery	C	T	A	N	_____
• Sleeping Position (i.e. stomach, side)	C	T	A	N	_____
•					
• **2. EMOTIONAL HEALTH**					
• Relationship	C	T	A	N	_____
• Career	C	T	A	N	_____
• Children	C	T	A	N	_____
• Money	C	T	A	N	_____
• Fast Paced Life	C	T	A	N	_____
• Holding in Feelings	C	T	A	N	_____
• Quick Tempered	C	T	A	N	_____
• Verbal Abuse	C	T	A	N	_____
• Perfectionist	C	T	A	N	_____
• Sickness or Loss of Loved One	C	T	A	N	_____
•					
• **3. CHEMICAL HEALTH**					
• Environment	C	T	A	N	_____
• Smoker – How much do you smoke?	C	T	A	N	_____
• Poor diet	C	T	A	N	_____
• Caffeine – How much?	C	T	A	N	_____
• Artificial Sweeteners	C	T	A	N	_____
• Prescription Drugs	C	T	A	N	_____
• Over the counter drug (Advil, Tylenol)	C	T	A	N	_____
• Recreational Drugs	C	T	A	N	_____

Patient:_____

Date:_____

PATIENT HISTORY

What is your main complaint? _____

On the scale below, please circle the **severity** of **main complaint.** **(At it's worst)**

None		*Slight*		*Mild*		*Moderate*			*Severe*
1	2	3	4	5	6	7	8	9	10

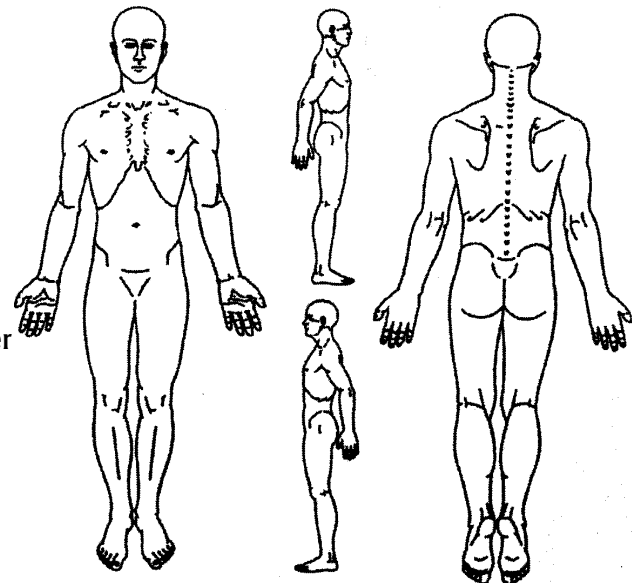
On the scale below please circle the **percentage of time** you experience your **main complaint.**

		Occasional		*Intermittent*			*Frequent*			*Constant*
0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

How long have you been experiencing your **main complaint?**_____

On the diagram below, please show **WHERE** you are experiencing **ALL** of your present complaints the following letters:

B=burning pain **St**=stiffness **P**=pain **So**=soreness **A**=ache **O**=other **S**=sharp pain **N**=numbness **T**=tingling **D**=discomfort



When do you notice it most? ☐AM ☐PM

How long does it last? _____

What makes it feel worse?_____

What makes it feel better?_____

Have you ever had the problem in the past?

☐Yes ☐No

I have ☐been hospitalized ☐been treated by another chiropractor ☐been treated by another specialty provider ☐never received care for this problem.

Have you lost time from work because of it?

☐Yes ☐No

Are you pregnant? ☐Yes ☐No ☐N/A

What was the first day of you last menstrual cycle?_____Number of pregnancies?_____

Miscarriages?_____ ☐N/A

Additional Comments:

FINANCIAL POLICY

At **Great Day Chiropractic & Rehab**, we understand that the cost of healthcare is a key concern for our patients. Although patient care is our main priority, we hope that you will assist us by understanding your responsibility as it relates to our Financial Policy. If you have any questions regarding our policy a member of our staff will be glad to assist you.

HEALTH INSURANCE

- As a courtesy to you, when given a copy of your insurance card, we will call and find out your benefits for chiropractic care in our office.
- We do not file claims for **acupuncture, massage, lab work, orthotics, supplements or merchandise** to your insurance.
- If you receive care that we do not file for, you will need to pay for the services rendered. If you would like to submit the charges yourself for reimbursement, we will be happy to make copy of your fee slip. Please remember-the benefits information your insurance company quotes us is not a guarantee of payment from them and any remaining fees are due immediately from you.

MEDICARE

- Medicare covers spinal adjustments only. After your yearly deductible has been met, Medicare should cover 80% of the allowed costs for adjustments. You will be responsible for the remaining 20%, as well as the cost for any non-covered services.
- You will be asked to fill out an advanced beneficiary notice for non-covered services.

SECONDARY INSURANCE

- Please inform us of any secondary insurance you may have. We will be glad to file chiropractic claims to your secondary insurance after your primary insurance has processed the claim(s).

AUTO ACCIDENTS AND MED-PAY

- If you've not already done so, please notify your auto insurance carrier of your accident immediately. We will have you fill out the proper document so we can file claims with your insurance carrier. We will call your adjuster together the information we need to file.
- If you reach the maximum amount payable under your auto insurance, we will file the claim that your health insurance. Although you are ultimately responsible for your Bill, we will do whatever we can to secure reimbursement from your insurance carrier. Once the claim is settled or if you suspend/terminate care against physicians recommendations, any remaining fees are due immediately from you.
- If there is a third party involved (such as an attorney), you'll be asked to make partial payments as care is received. Accepting assignment and/or liens is done so under a pre-qualified understanding between the patient, this office and the third party payor(s). Establishing an honest ethical working relationship allows this office to continue accepting liens and assisting patients in their goals for better health. Any and all changes of the original party's agreement, independent of this office's knowledge or consideration, immediately disqualifies the terms of that agreement and demands immediate payment on the outstanding balance.

PATIENTS WITHOUT INSURANCE

- We request that 100% of all visits be paid at the time of service.
- We gladly accept cash, checks, credit cards, HSA, and flex-pay cards.
- Our office has established a single-fee schedule that applies to all patients for each service provided based allowable limits determined to be reasonable and customary for the state of Colorado. We cannot offer "cash" or time of service discounts greater than 10% below these rates, however, we do offer discounts for members of discount groups such as ChiroHealthUSA. Discount members are entitled to discounts similar to insured patients. Membership is $49.00 per year and covers you and your dependents. Ask a staff member for details if you are interested.

Changes to any appointment should be made 24 hours in advance to avoid a $25 service fee. Reschedules should be confirmed and done directly with the front desk. The Doctor is the only one qualified to change your treatment schedule.

When you pay by check you expressly authorize this office, if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check, plus a processing fee of $25 and any applicable sales tax. The use of a check for payment is your acknowledgment and acceptance of this policy and it's terms.

Financial arrangements are valid under your present condition. They are subject to renewal by the start of each New Year. Should changes arise in your medical or financial situation that would affect your current financial agreement, you must notify this office prior to your care. Should you discontinue care or be released from further service, at this office, all outstanding balances are due upon notification.

Any past due balance not paid **within 90 days** will be reported to the credit bureau and turned over to an attorney, small claims court, or agency for collections. You will be responsible for all charges related to this collection process. Please keep your account current to avoid any action or blemish on your credit history.

Thank you for your understanding of our Financial Policy. Please let us know if you have any questions.

I have read, understand and agree to this Financial Policy in its entirety.

Printed Name:_____

Signature: _____ **Date:** _____

PATIENT PRIVACY

This practice is committed to maintaining the privacy of your protected health information (PHI), which includes information about your health condition and the care you receive from the practice. This notice details how this information may be used in this office. With consent from you, it is the policy of this office to use the your PHI in the following manners:

1. Treatment: Your PHI will be given to those professionals that require it to provide care.
2. Appointment reminders: Our staff may call from time to time to remind you of appointments
3. Sign-in Log: We maintain a log of incoming patients for our own statistical use
4. Referral board: We keep a board to thank member of our practice who have referred others
5. Medical Doctors: It is the policy of this office to share our findings with your regular medical doctor. This helps build a better understanding of how we may work together to improve your health.

In special circumstances, your PHI may be disclosed as in the following:

1. Personal Representative: In accordance with applicable law that may represent you.
2. Emergency situations
3. Abuse, Neglect, or Domestic Violence
4. Law Enforcement issues
5. Worker's Compensation claim
6. Avert a health threat

Your rights regarding your health information:

1. Right to inspect and copy your records: A written request must be submitted and cost of copying may be applied to such a request
2. Amend your PHI by submitting a written request with an explicit reason.
3. Request restrictions on your PHI. However, this practice is not obligated to agree to any such restrictions.
4. Revoke consent at any time
5. Complain to the practice

Printed Name:_____

Signature: _____ **Date:** _____

CONSENT TO TREAT

The primary treatment used by doctors of chiropractic is the spinal adjustment.
•We will use that procedure to treat you.

• The nature of the chiropractic adjustment.
We will use our hands or a mechanical device upon your body in such a way as to move your joints. That may cause an audible “pop” or “click,” much as you have experienced when you “crack” your knuckles. You may feel or sense movement.

• The material risks inherent in chiropractic adjustment.
As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include: fractures, disc injuries, dislocations, and muscle strain, Horner’s syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

• The probability of those risks occurring.
Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and x-ray. Stroke has been the subject if tremendous disagreement within and without the profession with one prominent authority1 saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The other complications are also generally described as “rare.”

• The availability and nature of other treatment options.
Other treatment options for your condition include:
• Self-administered, over-the-counter analgesics and rest
• Medical care with prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
• Hospitalization with traction
• Surgery

The material risks inherent in such options and the probability of such risks occurring include:

• Overuse of over-the-counter medications produces undesirable side-effects. If complete rest is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient’s general health, severity of the patient’s discomfort, his pain tolerance and self-discipline in not abusing the medicine. Professional literature describes highly undesirable effects from long term use of over-the-counter medicines.
• Prescription muscle relaxants and pain-killers can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient’s general health, severity of the patient’s discomfort, his pain tolerance, self-discipline in not abusing the medicine and proper professional supervision. Such medications generally entail very significant risks — some with rather high probabilities. • Hospitalization in conjunction with other care bears the additional risk of exposure to communicable disease, iatrogenic (doctor induced) mishap and expense. The probability if iatrogenic mishap is remote, expense is certain, exposure to communicable disease is likely with adverse result from such exposure dependent upon variables.
1 Haldeman, Scott, D.C. M.D.
• The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic (doctor caused) mishap, all those of hospitalization and an extended convalescent period. The probability of those risks occurring varies to many factors.

• The risks and dangers attendant to remaining untreated.
Remaining untreated allows the formation of adhesions and reduces mobility which sets up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

Do Not Sign Until You Have Read And Understand The Above.

Please Check The Appropriate Block and Sign Below:

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with my Doctor of Chiropractic and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.
Dated: _____ _____
Printed Name

_____
Signature

Witnesses: _____
Signature of Parent or Guardian (if a minor)

_____
Printed Name

_____
Signature