



Welcome to Alliance Health Partners and Optima Rehabilitation!

You are scheduled with	<input type="checkbox"/> Chad Abercrombie, DC	on _____ at _____.
	<input type="checkbox"/> Scott Oliphant, DC	
	<input type="checkbox"/> Optima Rehabilitation	

Enclosed is your initial patient paperwork. Please fill it out as completely as you can and sign by the X's. If you cannot finish your paperwork, please arrive **at least 15 – 30 minutes** prior to your scheduled appointment time to complete it before seeing the doctor or physical therapist. If you have any question prior to your appointment regarding your new patient paperwork, please feel free to call us. If possible, you should call your insurance carrier, prior to your scheduled appointment, to verify if you have chiropractic or physical therapy benefits. This will prevent you from acquiring any unnecessary charges. It is very important to obtain and supply us with as much insurance information as you can. We cannot process your claims without it. **Please bring with you to the appointment:**

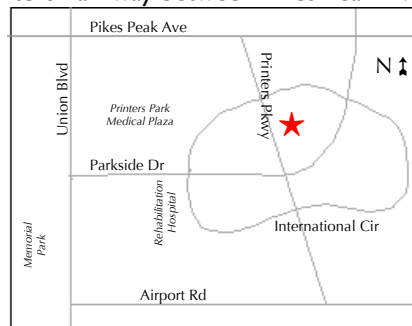
- Your Driver's License or Identification Card
- Insurance Card of the Health Insurance your claims will be sent to
- Insurance Card of the Auto Insurance your claims will be sent to (if applicable)
- We MUST have a copy of these cards in your file.**

In addition, please have the following information with you at your initial appointment, or indicate it on your new patient paperwork:

- Health Insurance Carrier's Name, Address, Phone Number, and Policy Number
- Auto Insurance Carrier's Name, Address, Phone Number, and Claim Number (if applicable)
- Adjuster's Name and Phone Number (if applicable)
- Name and Social Security Number of Insured
- Attorney's Name, Address, and Phone Number (if applicable)

As we only have a limited number of appointments available, **attending your initial evaluation at the scheduled day and time above is extremely important.** With your initial evaluation, the doctors and/or physical therapist will establish an appropriate plan of care, including the initial frequency and duration of your treatment. If we determine that you are a candidate for our care, it may take at least 4 – 12 visits to properly stabilize your condition. The most important factor in your treatment is consistency, thus missed or cancelled appointments are rarely tolerated.

We are located East of Memorial Park, on Printers Parkway between Pikes Peak Avenue and Parkside Drive.



Thank you for your attention to this important matter. We look forward to meeting you and participating in your health care. If you should have any questions, please contact us at: Alliance Health Partners (719) 632-4754 info@ahpchiro.com
Optima Rehabilitation (719) 471-4221 pt@optimarehab.com

**The Doctors and Staff,
Alliance Health Partners and Optima Rehabilitation**

New Patient Checklist

Dear Patient:

Listed below are the items, corresponding to your patient type, which you will need to complete prior to starting care in our office. Thank you for your cooperation in completing all items are to ensure that your care goes as smooth as possible. If you have any questions please call us at 471-4221 or 632-4754.

Please bring the following items to your first appointment:

Personal Pay Patients

- Your paperwork, with all areas filled out and signed
**If you cannot complete the paperwork prior to your visit please arrive 15-30 minutes early.*
- Your Driver's License or Identification Card
- Doctor's Referral/Prescription, if applicable

Health Insurance Patients

- Your paperwork, with all areas filled out and signed
**If you cannot complete the paperwork prior to your visit please arrive 15-30 minutes early.*
- Your Driver's License or Identification Card
- Your Health Insurance Card
- Doctor's Referral/Prescription, if applicable
- Please call our office to verify your benefits for our services, so we can explain what your out of pocket co-pays, co-insurance, deductibles, or other costs will be prior to your first visit.

Workers Compensation Patients

- Your paperwork, with all areas filled out and signed
**If you cannot complete the paperwork prior to your visit please arrive 15-30 minutes early.*
- Your Driver's License or Identification Card
- Your Workers Compensation Insurance information, including:
 - Insurance Company Name
 - Adjuster's Name
 - Address
 - Phone Number
 - Fax Number
 - Claim Number
- Doctor's Referral/Prescription, if applicable

Auto Accident and Personal Injury Patients

- Your paperwork, with all areas filled out and signed
**If you cannot complete the paperwork prior to your visit please arrive 15-30 minutes early.*
- Your Driver's License or Identification Card
- Your Auto Insurance Card
- Your Auto Insurance information, including:
 - Insurance Company Name
 - Adjuster's Name
 - Address
 - Phone Number
 - Fax Number
 - Claim Number
- Liability Limits of at-fault policy
- Doctor's Referral/Prescription, if applicable
- A copy of the accident report, if available.
- The At-Fault party's insurance information, including:
 - Insurance Company Name
 - Adjuster's Name
 - Address
 - Phone Number
 - Fax Number
 - Claim Number
 - Liability Limits of at-fault policy

PATIENT INFORMATION

Name: _____ Date: _____

Education: # of years completed: _____ Full-time student Part-time student Non-student

Employed: Full-time Part-time Retired
 Work Status: Working without restrictions
 Working with restrictions, please list: _____
 Not working/off work since _____

Job Description: _____ Years Employed: _____

Work Requirements:

- Bend Stoop Stand Walk Climb Sit Crawl Reach Push Pull Kneel
- Computer Work Phone Work Fine hand skills

Lifting requirement: Max _____ lbs Repetitive _____ lbs

Please provide the following information:		For Office Use Only	
<input checked="" type="checkbox"/>	Copy of your Driver's License or Identification Card		
<input checked="" type="checkbox"/>	Copy of your Health Insurance Card		

PATIENT'S HEALTH INSURANCE INFORMATION	
Insurance Company: _____	Group/Policy #: _____

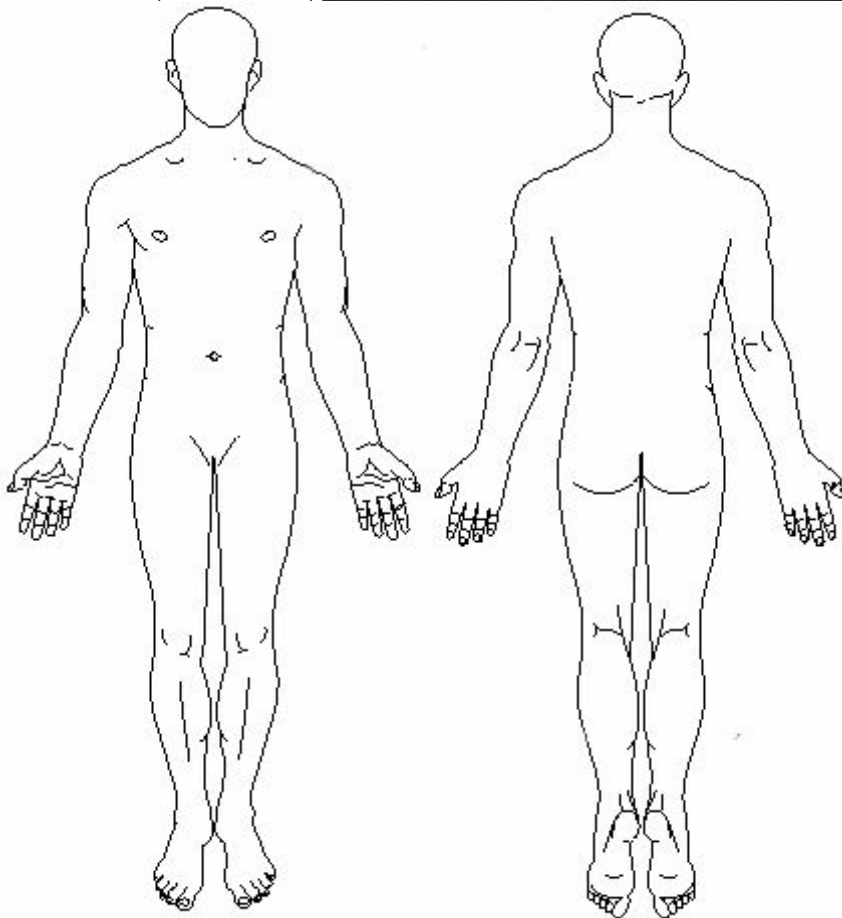
PATIENT PAIN PROFILE

Patient Name: _____

Date: _____

On the following illustration, use the letter keys below to mark the areas on your body where you feel the described sensation:

- KEY
- A = ACHE N = NUMBNESS P = PINS & NEEDLES B = BURNING S = STABBING
 O = OTHER (Please describe): _____



What percent of the time is your pain present? *If your pain is there all the time, in varying degrees, that would indicate 100%.* _____%

Rate the intensity level of your pain. *Refer to the color chart we have provided to rate your pain intensity. 10/10 is considered "Emergency Room" pain.*

Average day: _____/10 Good day: _____/10 Bad day: _____/10 Today: _____/10

Rate the level of functional deficit you experience due to your pain. _____/10

A rating of 10/10 would indicate severe disability where you are bedridden or should be in the emergency room.

Complete the following chart to assess your present symptoms, which resulted from your injuries:

	<u>Symptom Description</u> <i>Describe each symptom, including area, as clearly as possible.</i>	<u>Frequency</u> <i>Enter the amount of time, on a percentage basis, that the symptom is present during your waking hours</i>	<u>Intensity Range</u> <i>Using a scale of 0-10, where 10 is the <u>worst</u> pain imaginable, rate the pain intensity level for each symptom.</i>
1		%	/10
2		%	/10
3		%	/10
4		%	/10
5		%	/10

FUNCTIONAL RATING INDEX – FOR USE WITH NECK AND/OR BACK PROBLEMS ONLY

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.

For each item below, **please mark the number that most closely describes your condition right now.**

SECTION 1 - Pain Intensity

- ⓪ No pain
- ① Mild pain
- ② Moderate pain
- ③ Severe pain
- ④ Worst possible pain

SECTION 2 - Sleeping

- ⓪ Perfect sleep
- ① Mildly disturbed sleep
- ② Moderately disturbed sleep
- ③ Greatly disturbed sleep
- ④ Totally disturbed sleep

SECTION 3 - Personal Care (washing, dressing, etc.)

- ⓪ No pain; no restrictions
- ① Mild pain; no restrictions
- ② Moderate pain; need to go slowly
- ③ Moderate pain; need some assistance
- ④ Severe pain; need 100% assistance

SECTION 4 - Travel (driving, etc.)

- ⓪ No pain on long trips
- ① Mild pain on long trips
- ② Moderate pain on long trips
- ③ Moderate pain on short trips
- ④ Severe pain on short trips

SECTION 5 - Work

- ⓪ Can do usual work plus unlimited extra work
- ① Can do usual work; no extra work
- ② Can do 50% of usual work
- ③ Can do 25% of usual work
- ④ Cannot work

SECTION 6 - Recreation

- ⓪ Can do activities
- ① Can do most activities
- ② Can do some activities
- ③ Can do a few activities
- ④ Cannot do any activities

SECTION 7 - Frequency of Pain

- ⓪ No pain
- ① Occasional pain; 25% of the day
- ② Intermittent pain; 50% of the day
- ③ Frequent pain; 75% of the day
- ④ Constant pain; 100% of the day

SECTION 8 - Lifting

- ⓪ No pain with heavy weight
- ① Increased pain with heavy weight
- ② Increased pain with moderate weight
- ③ Increased pain with light weight
- ④ Increased pain with any weight

SECTION 9 - Walking

- ⓪ No pain; any distance
- ① Increased pain after 1 mile
- ② Increased pain after 1/2 mile
- ③ Increased pain after 1/4 mile
- ④ Increased pain with all walking

SECTION 10 - Standing

- ⓪ No pain after several hours
- ① Increased pain after several hours
- ② Increased pain after 1 hour
- ③ Increased pain after 1/2 hour
- ④ Increased pain with any standing

Score

Patient Name: _____

Date: _____

<p style="text-align: center;">CARDIOVASCULAR</p> <p><i>Do you currently or in the past have:</i></p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:30%;"></td> <td style="width:10%; text-align: center;"><i>Current</i></td> <td style="width:10%; text-align: center;"><i>Past</i></td> <td style="width:10%; text-align: center;"><i>Never</i></td> </tr> <tr> <td>Fast or slow heart rate</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Extremity swelling</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>High or low blood pressure</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Artery plaque-hardening</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> <p style="text-align: center;">RESPIRATORY</p> <p><i>Do you currently or in the past have:</i></p> <table style="width:100%; 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text-align: center;"><i>Current</i></td> <td style="width:10%; text-align: center;"><i>Past</i></td> <td style="width:10%; text-align: center;"><i>Never</i></td> </tr> <tr> <td>Street drugs</td> <td style="border-bottom: 1px solid black;"></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Marijuana card</td> <td style="border-bottom: 1px solid black;"></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Coffee/tea consumption</td> <td style="border-bottom: 1px solid black;"></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> <p style="text-align: center;">EXERCISE HABITS</p> <p><input type="checkbox"/> Aerobic Frequency _____ /week Type _____</p> <p><input type="checkbox"/> Other Frequency _____ /week Type _____</p> <p style="text-align: center;">GENERAL</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%;">Dominant hand</td> <td style="width:15%;"><input type="checkbox"/> Left</td> <td style="width:15%;"><input type="checkbox"/> Right</td> </tr> <tr> <td>Education completed</td> <td><input type="checkbox"/> High school</td> <td><input type="checkbox"/> College <input type="checkbox"/> Other</td> </tr> <tr> <td>Wear corrective glasses</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> <tr> <td>Implants or devices</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> </tr> </table>		<i>Current</i>	<i>Past</i>	<i>Never</i>	Fast or slow heart rate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremity swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Artery plaque-hardening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<i>Current</i>	<i>Past</i>	<i>Never</i>	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coughing up, other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain with step or walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Circulation problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<i>Current</i>	<i>Past</i>	<i>Never</i>	Frequent gas or belching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain with eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual pain or cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lumps in breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin lesions or bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Changing moles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<i>Never</i>	<i>Yes, Year</i>	<i>Body Area(s)</i>	<i>Resolved</i>	<i>Persisted</i>	Pain syndromes	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<i>Currently or in the past:</i>	<i>Amount/Day</i>	<i>Current</i>	<i>Past</i>	<i>Never</i>	Street drugs		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Marijuana card		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coffee/tea consumption		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dominant hand	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Education completed	<input type="checkbox"/> High school	<input type="checkbox"/> College <input type="checkbox"/> Other	Wear corrective glasses	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Implants or devices	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<p style="text-align: center;">CONSTITUTIONAL</p> <p><i>Do you currently or in the past have:</i></p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:30%;"></td> <td style="width:10%; text-align: center;"><i>Current</i></td> <td style="width:10%; text-align: center;"><i>Past</i></td> <td style="width:10%; text-align: center;"><i>Never</i></td> </tr> <tr> <td>Unexplained weight loss</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Blood in urine</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Blood in stools</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Blood in sputum</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Bore through pain</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Pain that awakens you</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Drop attacks</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Lip or face numbness</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Speech problems</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Body chills or convulsions</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Serious infections</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Diffuse itchiness</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Nose bleeds</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Frequent bruising</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Double or altered vision</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>One-sided weakness</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> <p style="text-align: center;">FAMILY HISTORY</p> <p><i>Please list the age at diagnosis of each individual's condition, when applicable:</i></p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:60%;"></th> <th style="width:10%; text-align: center;"><i>Self</i></th> <th style="width:10%; text-align: center;"><i>Mother</i></th> <th style="width:10%; text-align: center;"><i>Father</i></th> <th style="width:10%; text-align: center;"><i>Sibling</i></th> </tr> </thead> <tbody> <tr><td>Breast/brain cancer</td><td></td><td></td><td></td><td></td></tr> <tr><td>Liver/pancreatic canc.</td><td></td><td></td><td></td><td></td></tr> <tr><td>Cancer of GI system</td><td></td><td></td><td></td><td></td></tr> <tr><td>Blood cancer</td><td></td><td></td><td></td><td></td></tr> <tr><td>Bone cancer</td><td></td><td></td><td></td><td></td></tr> <tr><td>Other cancer</td><td></td><td></td><td></td><td></td></tr> <tr><td>Rheumatoid arthritis</td><td></td><td></td><td></td><td></td></tr> <tr><td>Other arthritis</td><td></td><td></td><td></td><td></td></tr> <tr><td>Alcoholism</td><td></td><td></td><td></td><td></td></tr> <tr><td>Diabetes</td><td></td><td></td><td></td><td></td></tr> <tr><td>Hyper/hypo thyroid</td><td></td><td></td><td></td><td></td></tr> <tr><td>Heart disease</td><td></td><td></td><td></td><td></td></tr> <tr><td>High blood pressure</td><td></td><td></td><td></td><td></td></tr> <tr><td>Chronic pain</td><td></td><td></td><td></td><td></td></tr> <tr><td>Kidney disease</td><td></td><td></td><td></td><td></td></tr> <tr><td>Liver disease</td><td></td><td></td><td></td><td></td></tr> <tr><td>Spinal operations</td><td></td><td></td><td></td><td></td></tr> <tr><td>Psychiatric issues</td><td></td><td></td><td></td><td></td></tr> <tr><td>Headaches</td><td></td><td></td><td></td><td></td></tr> <tr><td>Migraine</td><td></td><td></td><td></td><td></td></tr> <tr><td>Vascular disease</td><td></td><td></td><td></td><td></td></tr> <tr><td>Peripheral vascular</td><td></td><td></td><td></td><td></td></tr> <tr><td>Clots or occlusions</td><td></td><td></td><td></td><td></td></tr> <tr><td>Stroke</td><td></td><td></td><td></td><td></td></tr> <tr><td>Blood disorder</td><td></td><td></td><td></td><td></td></tr> <tr><td>Bleeding disorder</td><td></td><td></td><td></td><td></td></tr> <tr><td>Palsy or seizures</td><td></td><td></td><td></td><td></td></tr> <tr><td>Nerve disorders</td><td></td><td></td><td></td><td></td></tr> </tbody> </table>		<i>Current</i>	<i>Past</i>	<i>Never</i>	Unexplained weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood in stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood in sputum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bore through pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain that awakens you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drop attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lip or face numbness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Speech problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Body chills or convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Serious infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diffuse itchiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent bruising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Double or altered vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	One-sided weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<i>Self</i>	<i>Mother</i>	<i>Father</i>	<i>Sibling</i>	Breast/brain cancer					Liver/pancreatic canc.					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Patient Name: _____

Date: _____

PATIENT TREATMENT HISTORY

LIST ALL DOCTORS, TESTS, AND TREATMENT YOU HAVE RECEIVED SINCE YOUR INJURY

Start with the first doctor/healthcare provider/hospital you saw after your injury and check all tests/treatments that apply

1. Name of hospital/doctor/therapist/medical center: _____
 Date of visit: _____
 Indicate what was done by checking the appropriate boxes:

<input type="checkbox"/> Exam Consultation	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Spinal manipulation/adjustments
<input type="checkbox"/> X-ray of neck	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Muscle massage/myotherapy
<input type="checkbox"/> X-ray of lower back	<input type="checkbox"/> Exercise recommended	<input type="checkbox"/> Heat packs
<input type="checkbox"/> Other x-rays	<input type="checkbox"/> Medication prescribed	<input type="checkbox"/> Cold/ice packs
<input type="checkbox"/> MRI/CT scan	<input type="checkbox"/> Neck collar	<input type="checkbox"/> Ultrasound/Electrical muscle stimulation
<input type="checkbox"/> Other diagnostic test	<input type="checkbox"/> Low back brace	<input type="checkbox"/> Other, describe below:

Indicate if treatment:

Made condition worse
 Did not help
 Helped

2. Name of hospital/doctor/therapist/medical center: _____
 Date of visit: _____
 Indicate what was done by checking the appropriate boxes:

<input type="checkbox"/> Exam Consultation	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Spinal manipulation/adjustments
<input type="checkbox"/> X-ray of neck	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Muscle massage/myotherapy
<input type="checkbox"/> X-ray of lower back	<input type="checkbox"/> Exercise recommended	<input type="checkbox"/> Heat packs
<input type="checkbox"/> Other x-rays	<input type="checkbox"/> Medication prescribed	<input type="checkbox"/> Cold/ice packs
<input type="checkbox"/> MRI/CT scan	<input type="checkbox"/> Neck collar	<input type="checkbox"/> Ultrasound/Electrical muscle stimulation
<input type="checkbox"/> Other diagnostic test	<input type="checkbox"/> Low back brace	<input type="checkbox"/> Other, describe below:

Indicate if treatment:

Made condition worse
 Did not help
 Helped

3. Name of hospital/doctor/therapist/medical center: _____
 Date of visit: _____
 Indicate what was done by checking the appropriate boxes:

<input type="checkbox"/> Exam Consultation	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Spinal manipulation/adjustments
<input type="checkbox"/> X-ray of neck	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Muscle massage/myotherapy
<input type="checkbox"/> X-ray of lower back	<input type="checkbox"/> Exercise recommended	<input type="checkbox"/> Heat packs
<input type="checkbox"/> Other x-rays	<input type="checkbox"/> Medication prescribed	<input type="checkbox"/> Cold/ice packs
<input type="checkbox"/> MRI/CT scan	<input type="checkbox"/> Neck collar	<input type="checkbox"/> Ultrasound/Electrical muscle stimulation
<input type="checkbox"/> Other diagnostic test	<input type="checkbox"/> Low back brace	<input type="checkbox"/> Other, describe below:

Indicate if treatment:

Made condition worse
 Did not help
 Helped

4. Name of hospital/doctor/therapist/medical center: _____
 Date of visit: _____
 Indicate what was done by checking the appropriate boxes:

<input type="checkbox"/> Exam Consultation	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Spinal manipulation/adjustments
<input type="checkbox"/> X-ray of neck	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Muscle massage/myotherapy
<input type="checkbox"/> X-ray of lower back	<input type="checkbox"/> Exercise recommended	<input type="checkbox"/> Heat packs
<input type="checkbox"/> Other x-rays	<input type="checkbox"/> Medication prescribed	<input type="checkbox"/> Cold/ice packs
<input type="checkbox"/> MRI/CT scan	<input type="checkbox"/> Neck collar	<input type="checkbox"/> Ultrasound/Electrical muscle stimulation
<input type="checkbox"/> Other diagnostic test	<input type="checkbox"/> Low back brace	<input type="checkbox"/> Other, describe below:

Indicate if treatment:

Made condition worse
 Did not help
 Helped

FINANCIAL POLICY

Welcome to our office! We are pleased that you have chosen Alliance Health Partners/Optima Rehabilitation to provide your care and services. We would like to take a moment to inform you of our policies, regarding payment with the office. We accept cash, personal checks and credit card (VISA, MasterCard, American Express or Discover) for payment on your account.

**INSURANCE PATIENTS WHO NEGLECT TO SUPPLY THIS OFFICE
WITH THE NECESSARY INFORMATION/FORMS
WITHIN A REASONABLE AMOUNT OF TIME
WILL BE RESPONSIBLE FOR PAYMENT IN FULL.**

AUTO/PERSONAL INJURY INSURANCE (PIP, Med-Pay, 3rd Party, Lien): You will be required to complete specific forms pertaining to your situation. If this information is not provided within a reasonable amount of time, you will be responsible for payment in full. If we are required to send your account to collections, the balance due on that date will be doubled and interest at the rate of 1.5% per month will also be added to the balance due, plus collection fees and reasonable attorney fees. If you have scheduled an appointment and do not cancel 24 hours prior to your appointment, you will be charged a \$50.00 no show fee. **Auto insurance/personal injury claims will not be billed under a general health or contracted insurance plan.**

WORKER'S COMPENSATION: You will be required to complete specific forms pertaining to your situation. If this information is not provided within a reasonable amount of time, you will be responsible for payment in full.

CONTRACTED HEALTH INSURANCE (HMO, PPO, EPO, POS): If you have insurance we are contracted with, we will submit your insurance claims for you, if you supply us with the necessary information. This includes a copy of your card, and address to submit claims to and a telephone number to allow us to verify coverage. You are still responsible for payment of your co-payment at the time of service, and any amounts not covered by your insurance, including co-insurance and deductibles. If your coverage is denied for any reason including but not limited to denials for not medically necessary, you are responsible for payment of the entire balance due, based on our normal fee schedule. **You are responsible for obtaining your referral or authorization to be seen in our office. If you do not have a current referral or authorization, we ask that you reschedule or sign a waiver for no referral or authorization thus holding you financially responsible.**

PRIVATE INSURANCE: As a courtesy, we are happy to file your insurance for you. You will be required to provide all the necessary billing information. **If you owe on your deductible or a co-insurance, we will need to collect at the time of service.** All insurance payments that are paid directly to you should be endorsed and paid to Alliance Health Partners/Optima Rehabilitation. It is your responsibility to contact your insurance in the event of non-payment.

MEDICARE: We are participating with the Medicare program. *We will submit your claim/services to Medicare. Medicare will process payment to us.* You will be responsible for your deductible and any co-insurance, if you do not have secondary/supplemental insurance. If the payment from your secondary/supplemental is directed to you, we will expect you to forward payment to us.

CASH ONLY PLAN/NO INSURANCE: *Payment in full is due the day services are rendered* by all patients on a cash only plan. *Prompt payment is expected.* Unless prior arrangements are made, overdue accounts will incur a 1.5% interest rate per month, plus collection fees and reasonable attorney fees.

I have read and understand the payment policies set forth and have been given the opportunity to ask questions about this policy. I understand my responsibility for payment with Alliance Health Partners/Optima Rehabilitation.

Patient's Signature (Responsible party over 18 years old)

Date

NOTICE TO INSURANCE COMPANY ASSIGNMENT

PLEASE SIGN, DATE AND ADDRESS AT THE "X" ONLY

Patient Name: _____

Pay to: Alliance Health Partners
155 Printers Parkway Suite 200
Colorado Springs, CO 80910
Phone: (719) 632-4754
Fax: (719) 471-3734
E-mail: info@ahpchiro.com

You are instructed to pay directly to the doctor/therapist at the doctor's/therapist's office, for all professional services rendered to me. This instruction to you is an assignment of my rights under medical coverage to the extent of this bill. Any sum of money paid under this assignment shall be credited to my account, and I shall be personally liable for any unpaid balance to the doctor/therapist. Also I am personally liable for any unpaid accounts for hospital diagnostic, and consultant services.

In the event you should make payment directly to me, I agree that I will become personally liable for all charges submitted to you for payment, including all costs, attorney fees and collections fees.

I hereby authorize the doctor/therapist listed above to furnish you the information and evidence in the doctor's possession regarding my history and physical condition.

Signature: **X** _____

Date: _____

Address: _____

Witness: _____

NOTICE TO INSURANCE COMPANY ASSIGNMENT

PLEASE SIGN, DATE AND ADDRESS AT THE "X" ONLY

Patient Name: _____

Pay to: *Optima Rehabilitation
155 Printers Parkway Suite 200
Colorado Springs, CO 80910
Phone: (719) 471-4221
Fax: (719) 471-3734
E-mail: pt@optimarehab.com*

You are instructed to pay directly to the doctor/therapist at the doctor’s/therapist’s office, for all professional services rendered to me. This instruction to you is an assignment of my rights under medical coverage to the extent of this bill. Any sum of money paid under this assignment shall be credited to my account, and I shall be personally liable for any unpaid balance to the doctor/therapist. Also I am personally liable for any unpaid accounts for hospital diagnostic, and consultant services.

In the event you should make payment directly to me, I agree that I will become personally liable for all charges submitted to you for payment, including all costs, attorney fees and collections fees.

I hereby authorize the doctor/therapist listed above to furnish you the information and evidence in the doctor’s possession regarding my history and physical condition.

Signature: **X** _____

Date: _____

Address: _____

Witness: _____

COLORADO INTEGRATED CARE NETWORK/SOUTHERN COLORADOPHYSICAL MEDICINE*

We are in-network with nearly all major insurance companies.

As a member of CICN/SCPM we are now in-network with most policies provided by: Cigna, United Health Care, UMR, Humana, Aetna, Anthem Blue Cross/Blue Shield, Rocky Mountain Health Plans, and each of their subsidiaries.

A greater range of covered services means more comprehensive care.

Nearly all of the services offered in our clinic can be billed to your insurance company. Ask us for details.

VERY IMPORTANT:

Your insurance’s explanation of benefits (EOB) will list Colorado Integrated Care Network or Southern Colorado Physical Medicine and the name of our assigned Medical Director/Billing Provider, Eric Mehlberg, MD or Kenneth Finn, MD.

For more information about CICN please visit www.cointegratedcare.com.

***THE CICN NETWORK APPLIES ONLY TO THE FOLLOWING INSURANCE COMPANIES:**

- AETNA**
- ANTHEM BLUE CROSS/BLUE SHIELD**
- CIGNA**
- HUMANA**
- ROCKY MOUNTAIN HEALTH PLANS**

***THE SCPM NETWORK APPLIES ONLY TO THE FOLLOWING INSURANCE COMPANIES:**

- GOLDEN RULE**
- UMR**
- UNITED HEALTH CARE**

I, _____ (please print), understand that my insurance company’s explanation of benefits (EOB) will list Colorado Integrated Care Network or Southern Colorado Physical Medicine and the name of Alliance Health Partners’ Medical Director/Billing Provider, Eric Mehlberg, MD or Kenneth Finn, MD in reference to the services received at Alliance Health Partners.

Patient’s Signature (Responsible party over 18 years old)

Date

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out.

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company).
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date: _____

Patient Name (print): _____

Relationship to patient: _____

Signature: _____