ALLIANCE HEALTH PARTNERS

OPTIMA PHYSICAL THERAPY & REHABILITATION

Welcome to Alliance Health Partners and Optima Rehabilitation!

You are scheduled with	❑ Chad Abercrombie, DC ❑ Scott Oliphant, DC ❑ Optima Rehabilitation	on _____ at _____.

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***:

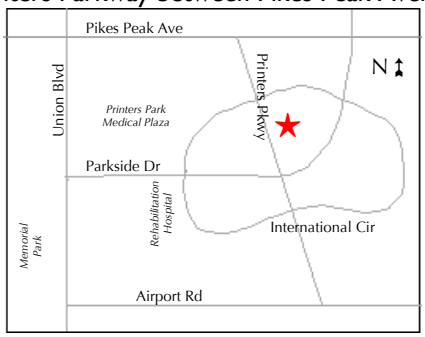
Your Driver's License or Identification Card
Insurance Card of the Health Insurance your claims will be sent to
Insurance Card of the Auto Insurance your claims will be sent to (f applicable)
We MUST have a copy of these cards in your file.

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) 471-42z21 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: _____

Address: _____
Street Address/P.O. Box *City* *State* *Zip*

Home Phone #: _____ Work Phone #: _____ E-mail Address: _____

❒ Male ❒ Female Date of Birth: ____/____/____ Age: _____ Height: _____ Weight: _____ SSN: _____

Marital Status: ❒ *Single* ❒ *Married* ❒ *Divorced* ❒ *Widowed* ❒ *Separated* ❒ *Children: # of* _____

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* _____

Employer: _____ Occupation/Job Title: _____

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

Address: _____
Street Address/P.O. Box *City* *State* *Zip*

Date of injury, surgery, or onset of symptoms: _____

What type of injury are we seeing you for?

❒ *Auto* ❒ *Sports Injury* ❒ *No specific trauma*
❒ *Work* ❒ *Slip & Fall* ❒ *Other*

Emergency Contact, not living with you:

Name: _____ Relationship _____
Address _____
Phone #: Cell #:

	Please provide the following information:	***For Office Use Only***	
✓	Copy of your Driver's License or Identification Card		
✓	Copy of the Accident Report		
✓	Copy of the Exchange of Information Form		
✓	Copy of your Auto Insurance Card		
✓	Signed Doctor's Lien (Pages 12 ***and*** 13)		

✓ **PATIENT'S AUTO INSURANCE INFORMATION**

Insurance Company: _____ Claim #: _____ Name of Insured _____

Adjuster's Name: _____ Adjuster's Phone #: _____ Med-Pay Balance $ _____

✓ **AT FAULT PARTY'S INSURANCE INFORMATION**

Insurance Company: _____ Claim #: _____ Name of Insured _____

Adjuster's Name: _____ Adjuster's Phone #: _____ Liability Limits $ _____

✓ **PATIENT'S HEALTH INSURANCE INFORMATION**

Insurance Company: _____ Group/Policy #: _____

✓ **ATTORNEY INFORMATION**

Name of Attorney: _____ Date attorney was retained: _____

Phone #: _____ Fax #: _____

PATIENT PAIN PROFILE

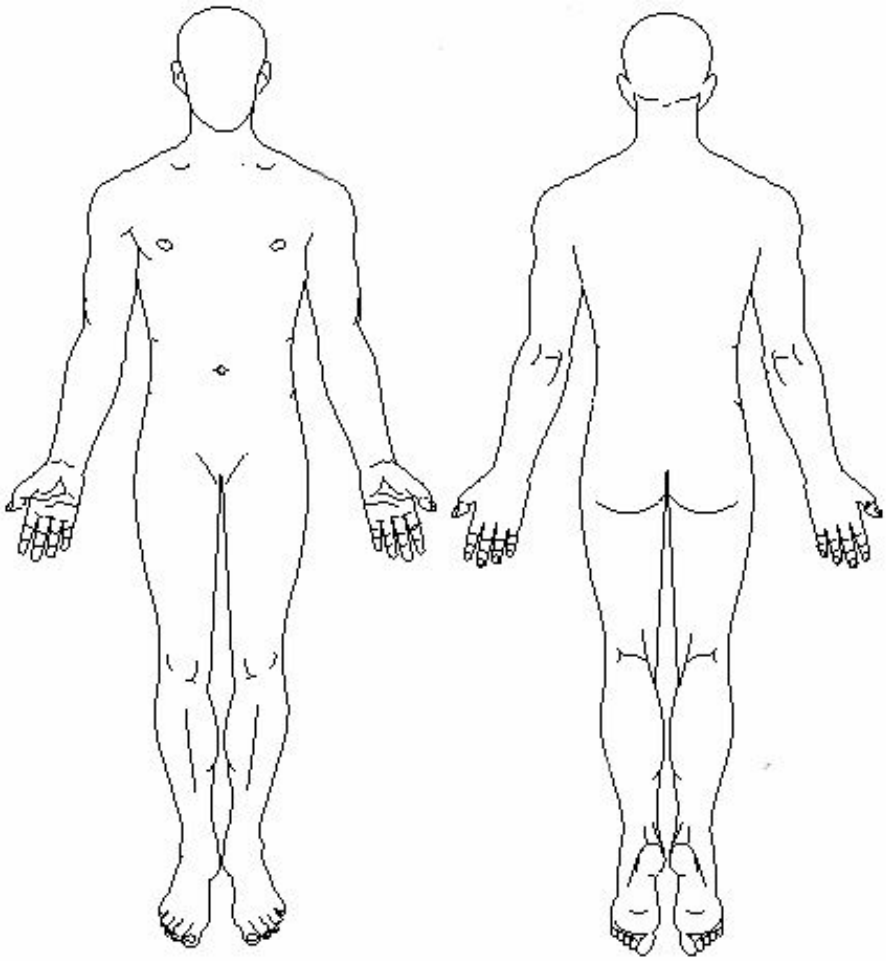
Patient Name: _____ **Date:** _____

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

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

	Symptom Description *Describe each symptom, including area, as clearly as possible.*	Frequency *Enter the amount of time, on a percentage basis, that the symptom is present during your waking hours*	Intensity Range *Using a scale of 0-10, where 10 is the worst pain imaginable, rate the pain intensity level for each symptom.*
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 ½ mile
③ Increased pain after ¼ 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 ½ hour
④ Increased pain with any standing

Score

Patient Name: _____ **Date**: _____

Please mark "x" all symptoms that apply:

SYMPTOM LIST	*Symptoms **RELATED** to auto accident/trauma*	*Symptoms **PRIOR** to auto accident/trauma*
Headache		
Dizziness		
Tinnitus (ear ringing)		
Visual changes		
Memory problems		
Poor concentration		
Irritability		
Balance problems		
Loss of coordination		
Excessive perspiration		
Cold feet/hands		
Trouble sleeping/insomnia		
Tension		
Pain behind eyes		
Palpitation		
Nervousness/anxiety		
Fatigue		
Sinus trouble		
Pain/difficulty swallowing		
Jaw pain		
Neck pain/soreness/stiffness		
Radiating arm or leg pain		
Shoulder pain/soreness/stiffness		
Arm pain/numbness/tingling		
Wrist/hand/finger pain/numbness		
Tingling/weakness in arms/legs		
Upper/mid back pain		
Chest wall pain (rib)		
Low back pain/soreness/stiffness		
Hip pain		
Leg pain/numbness/tingling		
Knee pain		
Ankle/foot pain		
Shortness of breath		
Fainting		
Stomach digestive problems		
Head seems heavy		
Menstrual cycle changes		
Neuritis		
Trouble with bowel or bladder		
Loss of taste or smell		
Nausea/vomiting		
Depression		
Face flushed		
Swelling, where?:		
Increased pain with coughing/sneezing		
Throbbing pain or pain that seems to bore through whole body		

Patient Name: _____ **Date**: _____

CARDIOVASCULAR

Do you currently or in the past have:	*Current*	*Past*	*Never*
Fast or slow heart rate	☐	☐	☐
Extremity swelling	☐	☐	☐
Chest pain	☐	☐	☐
High or low blood pressure	☐	☐	☐
Artery plaque-hardening	☐	☐	☐

RESPIRATORY

Do you currently or in the past have:	*Current*	*Past*	*Never*
Chronic cough	☐	☐	☐
Coughing up blood	☐	☐	☐
Coughing up, other	☐	☐	☐
Pneumonia	☐	☐	☐
Wheezing	☐	☐	☐
Pain with step or walking	☐	☐	☐
Breathing problems	☐	☐	☐
Circulation problems	☐	☐	☐
Arm or hand achiness	☐	☐	☐

GI/GU SYSTEM/SKIN

Do you currently or in the past have:	*Current*	*Past*	*Never*
Constipation	☐	☐	☐
Diarrhea	☐	☐	☐
Frequent gas or belching	☐	☐	☐
Colitis	☐	☐	☐
Polyps	☐	☐	☐
Gallbladder problems	☐	☐	☐
Ulcers	☐	☐	☐
Pain with eating	☐	☐	☐
Bloating	☐	☐	☐
Hemorrhoids	☐	☐	☐
Kidney stones	☐	☐	☐
Menstrual pain or cramps	☐	☐	☐
Urine flow or stop problems	☐	☐	☐
Pain with urination	☐	☐	☐
Bowel movement pain	☐	☐	☐
Lumps in breast	☐	☐	☐
Hot flashes	☐	☐	☐
Skin lesions or bleeding	☐	☐	☐
Changing moles	☐	☐	☐

TRAUMA OR PAIN HISTORY

	Never	*Yes, Year*	*Body Area(s)*	*Resolved*	*Persisted*
Auto collisions	☐	☐ _____	_____	☐	☐
		☐ _____	_____	☐	☐
Work injuries	☐	☐ _____	_____	☐	☐
		☐ _____	_____	☐	☐
Other injuries	☐	☐ _____	_____	☐	☐
		☐ _____	_____	☐	☐
Other pain syndromes	☐	☐ _____	_____	☐	☐

If yes, please describe: _____

HABITS

Currently or in the past:	*Amount/Day*	*Current*	*Past*	*Never*
Smoking	_____	☐	☐	☐
Alcohol	_____	☐	☐	☐
Street drugs	_____	☐	☐	☐
Marijuana card	_____	☐	☐	☐
Coffee or tea consumption		☐	☐	☐

EXERCISE HABITS

☐ Aerobic Frequency _____/week Type _____

☐ Other Frequency _____/week Type

GENERAL

Dominant hand ☐ Left ☐ Right

Education completed ☐ High school ☐ College ☐ Other

Wear corrective glasses ☐ Yes ☐ No

Implants or devices ☐ Yes ☐ No

CONSTITUTIONAL

Do you currently or in the past have:	*Current*	*Past*	*Never*
Night sweats	☐	☐	☐
Fevers	☐	☐	☐
Unexplained weight loss	☐	☐	☐
Blood in urine	☐	☐	☐
Blood in stools	☐	☐	☐
Blood in sputum	☐	☐	☐
Bore through pain	☐	☐	☐
Pain that awakens you	☐	☐	☐
Drop attacks	☐	☐	☐
Lip or face numbness	☐	☐	☐
Speech problems	☐	☐	☐
Body chills or convulsions	☐	☐	☐
Serious infections	☐	☐	☐
Diffuse itchiness	☐	☐	☐
Balance or gait issues	☐	☐	☐
Feeling off balance or faint	☐	☐	☐
Nose bleeds	☐	☐	☐
Frequent bruising	☐	☐	☐
Double or altered vision	☐	☐	☐
One-sided weakness	☐	☐	☐

FAMILY HISTORY

Please list the age at diagnosis of each individual's condition, when applicable:

	Self	*Mother*	*Father*	*Sibling*
Breast/brain cancer				
Liver or pancreatic				
Cancer of GI system				
Blood cancer				
Bone cancer				
Other cancer				
Inflammatory				
Other arthritis				
Alcoholism				
Diabetes				
Hyper/hypo thyroid				
Heart disease				
High blood pressure				
Chronic pain				
Kidney disease				
Liver disease				
Spinal operations				
Psychiatric issues				
Headaches				
Migraine				
Vascular disease				
Peripheral vascular				
Clots or occlusions				
Stroke				
Blood disorder				
Bleeding disorder				
Palsy or seizures				
Nerve disorders				

ALLERGIES

Please list all known allergies:

Food: _____

Airborne: _____

Medications: _____

_____

MEDICATIONS/HOSPITALIZATIONS

Please list all currently used drugs (Rx/non-Rx), vitamins & herbs, other meds:

_____

_____

Please list any & all ***hospitalizations/operations****:* _____

_____

Patient Name: _____ **Date**: _____

ACCIDENT QUESTIONNAIRE

Date of Accident: _____

Location of Accident: _____

Questions about the accident circumstances

Year and Make of vehicle you were riding in: _____

Number of other vehicles involved _____

Year and Make of other vehicle(s):

Vehicle #2 _____

Vehicle #3 _____

Monetary damage to your vehicle: $_____

Monetary damage to other vehicles: $ _____

Speed of vehicles at impact:

Your vehicle: _____ mph

Vehicle #2 _____ mph

Vehicle #3 _____ mph

Were you the driver or passenger?

❒ Driver ❒ Passenger

If passenger, where were you seated?

❒ Passenger's seat
❒ Rear seat, driver's side
❒ Rear seat, passenger's side

Were you wearing a seat belt at the time? ❒ Yes ❒ No

Was your vehicle moving or stopped? ❒ Moving ❒ Stopped

Did your vehicle strike another vehicle? ❒ Yes ❒ No

Did another vehicle strike yours? ❒ Yes ❒ No

Where was your vehicle hit?

❒ In the front
❒ In the rear
❒ On the driver's side
❒ On the passenger's side

Describe the impact: _____

_____

_____

If your vehicle had airbags, did they deploy? ❒ Yes ❒ No

What were the road conditions?

❒ Dry
❒ Wet
❒ Icy
❒ Snow-packed
❒ Other, *describe* _____

How far did your car move after impact?

Car lengths _____

Feet _____

Questions about your circumstances at impact

Did you see the impact? ❒ Yes ❒ No

If yes, did you brace yourself before the impact? ❒ Yes ❒ No

Were you looking in a mirror? ❒ Yes ❒ No

If yes, please describe:_____

What was your body position at time of impact?

❒ Neutral
❒ Forward
❒ Rotated: Left/Right

Did you strike another object?

❒ Steering wheel
❒ Dash
❒ Window
❒ Other_____

Did you experience any of the following at the time of impact?

❒ Cuts ❒ Abrasions, *where?* _____
❒ Bruises ❒ Dislocations
❒ Bumps ❒ Immediate dizziness
❒ Nausea ❒ Altered consciousness
❒ Immediate head pain
❒ Vision problems
❒ Immediate pain, *where?* _____
❒ Loss of consciousness, *how long?* _____

Questions about your circumstances after the accident

Were you able to get out of the vehicle and walk on your own?

❒ Yes ❒ No

Was your car drivable from scene of accident? ❒ Yes ❒ No

Where did you go after the accident?

❒ Home
❒ Work
❒ Hospital

Were you taken by ambulance? ❒ Yes ❒ No

Where? _____

Who was at fault for this accident? _____

Did the police write any tickets? ❒ Yes ❒ No

To whom? _____

If you went to a hospital, did you stay overnight? ❒ Yes ❒ No

If you went to a hospital, were any x-rays taken? ❒ Yes ❒ No

If x-rays were taken, what areas of your body were x-rayed?

_____

How did you feel that night?

❒ Restless ❒ Stiff ❒ Fine
❒ In pain ❒ Sore

How did you feel the next day?

❒ Better ❒ Same ❒ Worse

Have your complaints kept you from doing anything? ❒ Yes ❒ No

What? _____

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:

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

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

❒ Exam Consultation	❒ Rehabilitation	❒ Spinal manipulation/adjustments
❒ X-ray of neck	❒ Physical Therapy	❒ Muscle massage/myotherapy
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❒ Other diagnostic test	❒ Low back brace	❒ 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:

❒ Exam Consultation	❒ Rehabilitation	❒ Spinal manipulation/adjustments
❒ X-ray of neck	❒ Physical Therapy	❒ Muscle massage/myotherapy
❒ X-ray of lower back	❒ Exercise recommended	❒ Heat packs
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❒ Other diagnostic test	❒ Low back brace	❒ Other, *describe below:*

   Indicate if treatment:
   ❒ Made condition worse
   ❒ Did not help
   ❒ Helped

CONSENT FORM FOR CHIROPRACTIC MANIPULATION/MOBILIZATION

Manipulation/mobilization helps restore proper motion to the vertebral (facet) joints. During chiropractic treatment, the doctor will use his/her hands or a mechanical device in order to reestablish proper function to the spine and to reduce pain, edema and muscle spasm. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint.

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 joint, or injury to intervertebral discs, nerves or spinal cord. 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. Acupuncture can carry risks of bruising, bleeding, infection or more sever complications, which are very rare.

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 stroke has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures.

Your chiropractor may also use modalities to enhance your recovery and reduce symptoms. These may include ultrasound, electrical modalities, laser therapy, heat and ice, and other modalities. These are rarely associated with side effects or complications, and the risks may include soreness, skin reactions, or other mild side effects. Please report these and any other side effects or complications to your doctor right away. If you have skin sensitivities, a pacemaker, pregnancy or any other health condition that would change your ability to be exposed to electrical modalities, topical creams, or other care restrictions, please advise your doctor immediately.

I, _____, understand the hazards and potential dangers involved in treatment by means of chiropractic. I believe that this treatment is in my best interest and I understand that no guarantee of results has been made.

I understand that it usually requires a series of chiropractic treatments to significantly change a condition and receive benefit.

My signature indicates that I have read and fully understand the above information regarding the consent to this procedure. I have had the opportunity to ask questions about any matter which I did not understand, and I have received satisfactory explanation to my questions. My signature below authorizes this procedure.

_____	_____	_____
Patient/Authorized Representative Signature	*Relationship to Patient*	*Date*

Practitioner Statement:

The patient (or patient's representative) and I have discussed this procedure, the risks and alternatives to this procedure. To the best of my knowledge, the patient (or patient's representative) understands this procedure and consents to it.

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

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.

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*

*MISSED APPOINTMENT POLICY**

To ensure that our office can provide the highest quality access to our care and get our patients the best outcomes possible, your doctor or therapist's care or treatment plan must be followed as close as possible. If an appointment is missed, it does not allow that time slot to go to another patient, and does negatively alter the possible outcome of your care with our office. In light of our goal to get your care completed as quickly and efficiently as possible, enhance our ability to limit costs, and raise your response to care, we have implemented the following policies:

Chiropractic/Physical Therapy/Massage Therapy

For each chiropractic, physical therapy and/or massage therapy appointment you miss and do not call at least 24 hours prior to your scheduled appointment time, you will be charged $50 per date of service, per treatment discipline. For example, if you miss a scheduled visit for chiropractic care, physical therapy and massage therapy on the same day and do not call at least 24 hours in advance, you will be charged $150 in missed appointment fees. ***If you miss a fourth appointment date without calling at least 24 hours prior, you will be discharged from treatment in our office.***

Massage Therapy

If you miss a second massage the7rapy appointment and do not call at least 24 hours prior to your scheduled appointment time, ***all future massage therapy appointments will be canceled, and you will not be allowed to reschedule massage therapy in our office.***

These charges are the patient's responsibility to pay. Should you have any questions about this policy, please discuss them with your therapist or doctor.

****This policy does not apply to workers compensation patients***

I have read, understand and agree to this policy. I understand my responsibility for payment with Alliance Health Partners/Optima Rehabilitation.

_____ _____

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

DOCTOR'S LIEN

Patient Name: _____

Facility: *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

Re: Authorization for Release of Records and Doctor's Lien, Assignment, and Direction to my Attorney

I hereby authorize *Alliance Health Partners* to furnish you, my attorney, with a full report and records regarding case history, examination, diagnosis, treatment, and prognosis with regard to treatment related to my accident, which occurred on _____.

I hereby give a lien and assignment to *Alliance Health Partners* on the proceeds or any settlement, claim, judgment, or verdict which results from said accident and hereby authorize, direct, and instruct you, my attorney, to pay directly to *Alliance Health Partners* such sums as may be due and owing for service rendered me, and to withhold such sums from such settlement, claim, judgment, or verdict as may be necessary to protect *Alliance Health Partners* adequately and such sums as may be necessary to fully and completely pay *Alliance Health Partners* any outstanding balance owed at the time of distribution of funds from an settlement, claim, judgment, or verdict.

If *Alliance Health Partners* is 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.

I fully understand that I am directly and fully responsible to *Alliance Health Partners* for all bills submitted by *Alliance Health Partners* for services rendered to me, and that this agreement is made solely of *Alliance Health Partners* additional protection and in consideration of said doctors awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict.

To My Attorney: I direct that you be bound by this lien an treat it, irrevocably, as an assignment to *Alliance Health Partners* of any sums that may be due to me, to the extent and according to the terms set forth above. Be advised that *Alliance Health Partners* is relying upon this lien, assignment, and directive to you, and as a result of such reliance, at my request, is providing health care and treatment for which this lien, assignment, and directive to you provides security for payment. Moreover, it is my intention that *Alliance Health Partners* be viewed as a third party beneficiary of this direction to you, and I intend thereby to impose upon you an obligation to *Alliance Health Partners* to comply with the terms of this direction to you.

_____ _____
Patient's Signature *Date*

DOCTOR'S LIEN

Patient Name: _____

Facility: *Optima Rehabilitation*
155 Printers Parkway Suite 200
Colorado Springs, CO 80910
Phone: (719) 632-4754 or (719) 471-4221
Fax: (719) 471-3734
E-mail: pt@optimarehab.com

Re: Authorization for Release of Records and Doctor's Lien, Assignment, and Direction to my Attorney

I hereby authorize *Optima Rehabilitation* to furnish you, my attorney, with a full report and records regarding case history, examination, diagnosis, treatment, and prognosis with regard to treatment related to my accident, which occurred on _____.

I hereby give a lien and assignment to *Optima Rehabilitation* on the proceeds or any settlement, claim, judgment, or verdict which results from said accident and hereby authorize, direct, and instruct you, my attorney, to pay directly to *Optima Rehabilitation* such sums as may be due and owing for service rendered me, and to withhold such sums from such settlement, claim, judgment, or verdict as may be necessary to protect *Optima Rehabilitation* adequately and such sums as may be necessary to fully and completely pay *Optima Rehabilitation* any outstanding balance owed at the time of distribution of funds from an settlement, claim, judgment, or verdict.

If *Optima Rehabilitation* is 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.

I fully understand that I am directly and fully responsible to *Optima Rehabilitation* for all bills submitted by *Optima Rehabilitation* for services rendered to me, and that this agreement is made solely of *Optima Rehabilitation* additional protection and in consideration of said doctors awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict.

To My Attorney: I direct that you be bound by this lien an treat it, irrevocably, as an assignment to *Optima Rehabilitation* of any sums that may be due to me, to the extent and according to the terms set forth above. Be advised that *Optima Rehabilitation* is relying upon this lien, assignment, and directive to you, and as a result of such reliance, at my request, is providing health care and treatment for which this lien, assignment, and directive to you provides security for payment. Moreover, it is my intention that *Optima Rehabilitation* be viewed as a third party beneficiary of this direction to you, and I intend thereby to impose upon you an obligation to *Optima Rehabilitation* to comply with the terms of this direction to you.

_____ _____
Patient's Signature *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: _____

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 f 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: _____