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***:

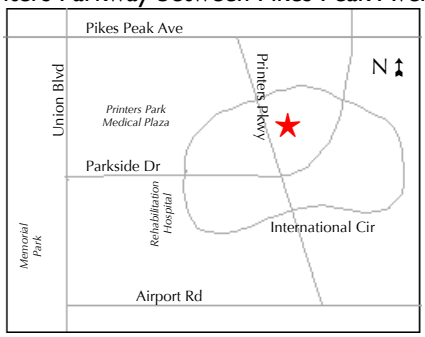
Your Driver's License or Identification Card
Insurance Card of the Health Insurance your claims will be sent to
Insurance Card of the Auto Insurance your claims will be sent to (f applicable)
We MUST have a copy of these cards in your file.

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 your Health Insurance Card		

✓

PATIENT'S HEALTH INSURANCE INFORMATION

Insurance Company: _____ Group/Policy #:_____

PATIENT PAIN PROFILE

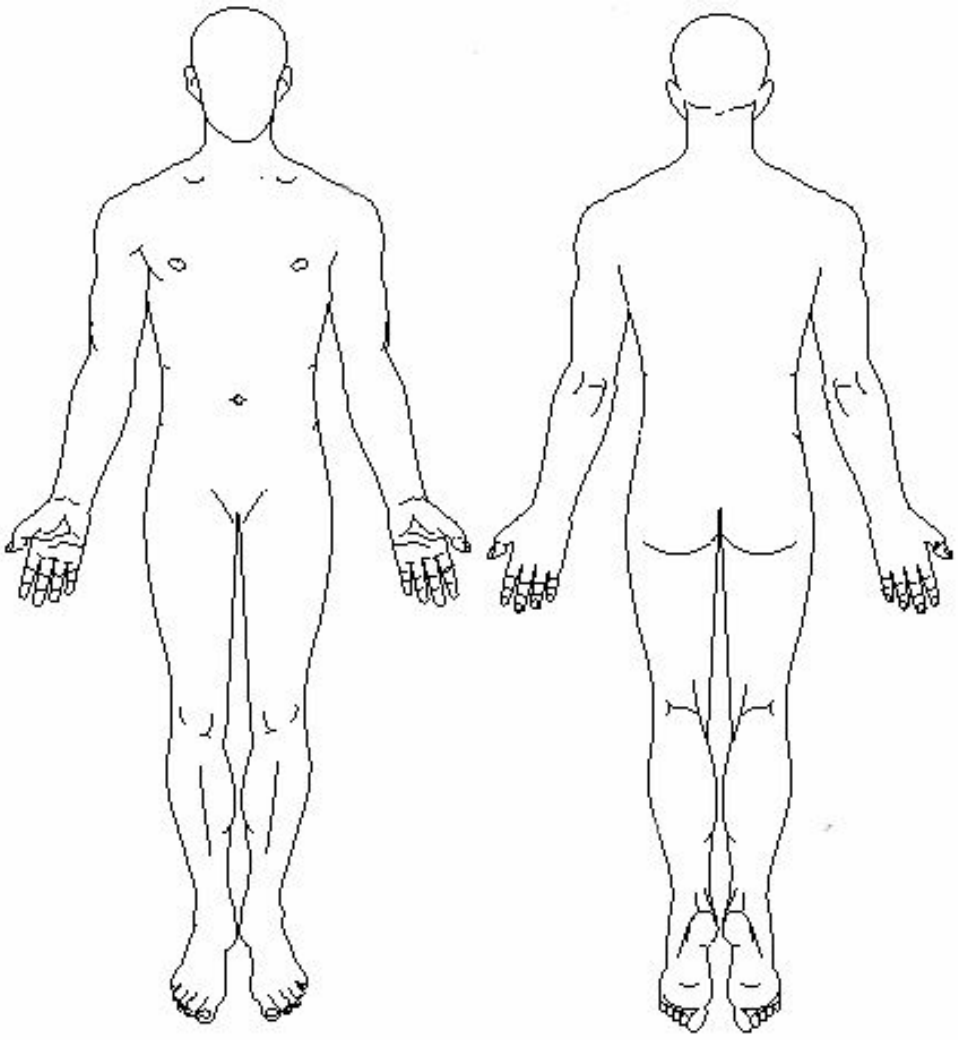
Patient Name: _____ **Date:** _____

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

Rate the level of functional deficit you experience due to your pain. A rating of 10/10 would indicate severe disability where you cannot perform or complete your work, social, or recreational activities.

	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**: _____

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**: _____

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.

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*

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: _____