

## Patient Information

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Street: \_\_\_\_\_ Apt: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Marital Status: S M W D Spouse: \_\_\_\_\_

DOB: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ email: \_\_\_\_\_

Cell phone carrier (for text messaging only): \_\_\_\_\_ Emergency Contact: \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

## Insurance Information

*We will make a copy of your insurance card/s. However, please complete the following information.*

Are you the policy holder? Y N If no, who is policy holder: Spouse Parent Employer Other

Policy Holder's Name:

First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_\_ Policy Holder's SS#: \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_

Do you have secondary insurance coverage? Y N If yes, please complete the following:

Policy Holder's Name:

First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_\_ Policy Holder's SS#: \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_

Please visit our website [www.AccelerateHealthPC.com](http://www.AccelerateHealthPC.com). There you can also check OUR BLOG, where we explain the philosophy behind our practice and the different ailments that we tend to treat. We also give some helpful tips! Learn about us, your physicians, our clinic, and the research that has been compiled to help make important health decisions for you and your family.

### IF THIS IS AN AUTO ACCIDENT

INSURANCE COMPANY: \_\_\_\_\_ Phone #: \_\_\_\_\_

Claim#: \_\_\_\_\_ Billing Address: \_\_\_\_\_

Name of the Insured: \_\_\_\_\_ Contact/Claim Agent: \_\_\_\_\_

Accelerate Health P.C.  
38 East 5<sup>th</sup> Avenue  
Denver, CO 80203  
(303) 863-8330

## OFFICE INTRODUCTION

We wish to extend a warm and personal welcome to you. Our mission is to provide you with the best chiropractic and acupuncture care through education, knowledge, service and treatment!

### WHY?

First, you'll want to make an informed decision regarding your health. During the course of your care you'll be presented with several choices that will affect your ability to reach your individual health goals.

Secondly, this information will be useful in making decisions about your health for the rest of your life. So, to begin this process, listed below are some important bits of information you need to understand:

### FIRST VISIT

On your first visit we obtain information about you through a consultation and examination. If you are not sure about what we need, just ask. We are always here to assist you in each step along the way. Nothing will be done without your consent and full understanding of our services, treatment, and recommendations based on your condition.

### PATIENT EDUCATION

We will be giving you information and clinical data in the form of literature, structural models, and/or personal presentations. These are designed to help you understand your own case and procedures you'll experience in this office. Everything is brief and to the point. It is recommended that you read the materials and keep it together for reference during the course of your care.

### CHIROPRACTIC EDUCATION

Just as we need to know about you, you should know about us. Chiropractic currently consists of years of pre-chiropractic under-graduate education in the biological sciences followed by another 4 years of chiropractic

education, training, and clinical internship. As Chiropractors, we are required to attend a minimum of 30 post-graduate educational credits per year for license renewal.

### OFFICE FORMS

We strive to minimize office forms for you to fill out. These clinical forms must be filled out accurately and completely for your health, legal and professional reasons. The more we know about you, the more likely my services will be capable of helping you meet your health goals. If you have questions, please ask!

### HEALTH ATTITUDES

Your attitude and belief about your health is as important to me as is the specific reason you've consulted this office. Listed below are the 3 most prevalent health attitudes. *Please CHECK the one that most accurately and closely reflects your personal values.*

- ACUTE SYMPTOM CARE: I am only concerned about relief of symptoms.
- REHABILITATIVE/PREVENTATIVE CARE: I am concerned about symptom relief AND preventing the return of symptoms in the future.
- WELLNESS CARE / FAMILY CARE: I am interested in relief of symptoms, prevention, and lifestyle changes to maximize my genetic potential for health and the health of my family members.

I have read and understand the content of this page.

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Signature

Date

Accelerate Health P.C.  
38 East 5<sup>th</sup> Avenue, Suite 100  
Denver, CO 80203  
(303) 863-8330

## CONSENT FORM

To Our Patients:

Chiropractic examination and therapeutic procedures (including spinal and extra-spinal adjustments, heat and ice application, and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, headache, and temporary transient worsening of symptoms. More serious complications are extremely rare. Additional information on side-effects and complications is available upon request.

I have read and understand the above statement regarding treatment side-effects. I also understand that there is no guarantee or warranty for specific care results.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian Signature

\_\_\_\_\_  
Date

Please read the following carefully and initial each statement.

\_\_\_\_\_ I understand that this is a rehabilitative clinic licensed to provide chiropractic treatment. I will receive the majority of my care under the supervision of the attending physician licensed to provide chiropractic care. However, there may be times that it will be clinically warranted to have the therapy provided by the attending massage therapist, limited to the scope of their license to provide care. By my signature above and initialing of this statement, I give permission for my attending physician and the licensed massage therapist to discuss my care as needed in order to provide complete clinical care.

\_\_\_\_\_ I understand that I play an important role in my own health care. Just as a patient can choose to discontinue care at any time, Accelerate Health P.C. reserves the right to terminate a doctor-patient relationship if a patient is continually unable to comply with clinically warranted treatment plans.

\_\_\_\_\_ I understand that I may request and will receive, in substantial detail, any further explanation of any procedure or treatment. I also understand that I will be given an explanation of the procedures to be rendered, any alternatives available to me, relative risks for specific procedures, and any questions I have will be welcomed, appreciated, and answered to the best of the physician's ability.

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FORMAL NOTICE OF PRIVACY PRACTICE SUMMARY

This summary discloses how protected health information about you may be used. A full notice of your privacy rights is listed at our website: [www.AccelerateHealthPC.com](http://www.AccelerateHealthPC.com). This notice is effective as of April 14, 2003.

This clinic uses health information about you for treatment, to obtain payment for treatment with your authorization as required by state laws, for administrative purposes, and to evaluate the quality of care that you receive.

This chiropractic/acupuncture clinic may use your information to provide appointment reminders, information, about treatment alternatives or other health-related issues; sharing test results or physical exam findings with other health care professionals for confirmation of a diagnosis; providing treatment and diagnosis information with third party payers (insurance companies) to obtain payment; providing diagnosis and treatment information with independent billing services to obtain payment from third party payers; and reviewing information as part of our ongoing review of patient satisfaction and service.

This clinic may also use or disclose your protected health information, in compliance with guidelines outlined by law, for the following purposes:

- Providing you with information related to you health status.
- Incidental uses or disclosures (e.g. listing your name on our referral board, or sign in sheet).
- Posting to all who enter our practice, in our lobby photos or written testimonials sent by you or other family members.
- Compliance with laws regarding reports of suspected abuse, neglect, or violence.
- Providing certain specified information to law enforcement or correctional institutions.
- Providing information to coroner, medical examiner, funeral director, or organ procurement organizations.
- Public health activities when requested by a public health authority or the FDA.
- Responding to health oversight agencies.
- Responding to court or administrative tribunal orders, subpoenas, discovery requests or other lawful process.
- Research activities.
- When necessary to avert a serious, national, security, intelligence, Dept. of State, or presidential protective service activities.
- Providing information regarding your location, general condition or death to public or private disaster relief agencies; or
- Informing family members, other relatives, or a close personal friend when:
  - ❖ Information is relevant to the individual's involvement with your care;
  - ❖ Notification of your location, general health condition or death;
  - ❖ To assist in your health care (e.g. pick-up x-rays, documents or other notes for follow-up care instructions, etc.).

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

***Your signature only proves that we have provided you this privacy notice summary  
from our office***

**ACCELERATE HEALTH'S FINANCIAL/OFFICE POLICIES**

Our goal is to help our patients receive the best health care at the most affordable rates. Please carefully read the following payment options and office policies below. THANK YOU FOR YOUR COOPERATION AND UNDERSTANDING OF OUR POLICIES.

**PAYMENT OPTION A: "NO INSURANCE COVERAGE"**

- PAY PER VISIT:** Payment is made in full and paid at the time of your first visit and subsequent follow up visits. Cash, check, or credit cards are accepted. Returned checks incur a \$30.00 charge to your account.
- PRE-PAY PROGRAM:** Pre-paying for 10 visits provides you with a \$60 savings off the total cost of care. A \$30 savings is given for a pre-pay on 6 visit packages. This option is available after the new patient appointment to allow the physicians to determine the extent of necessary care.

**PAYMENT OPTION B: "INSURANCE MAY COVER CHIROPRACTIC CARE"**

- MOTOR VEHICLE ACCIDENTS:** Under the new TORT law, you must carry optional MED PAY coverage as there is no guarantee that your major medical insurance will pay for your care. We **do not** accept liens at this time. Please discuss your case with us prior to beginning care.
- MEDICAL INSURANCE COVERAGE:** *THERE IS NO GUARANTEE THAT YOUR INSURANCE WILL COVER CHIROPRACTIC TREATMENTS (even if you have the benefits).* We can directly submit bills to most insurance companies. For BC/BS we will gladly give you all documentation that can be submitted to them for reimbursement. You will however, be subject to our time of service discounted rates with the intent of being reimbursed directly by your insurance company. We will submit bills to your insurance company if we are in-network providers for them and for some out-of-network companies. Please inquire with the receptionist about your insurance company's status with us, as it changes frequently.

**ALL PATIENTS: YOUR OBLIGATIONS/RESPONSIBILITIES**

**\*\*A 24-HR. NOTICE MUST BE GIVEN FOR ANY CANCELLATIONS OR MISSED APPOINTMENTS AS YOU WILL BE CHARGED FOR THE APPOINTMENT TIME.**

**\*\*PLEASE INFORM US OF ANY CHANGES IN YOUR MEDICAL CONDITION OR MEDICATIONS.**

**\*\*IF YOU ARE IN ACUTE PAIN OR HAVE EXPERIENCED RECENT PHYSICAL TRAUMA, EVERY ATTEMPT WILL BE MADE TO PROVIDE TREATMENT ON THE DAY OF YOUR CALL.**

**\*\*WE ASK FOR YOUR REFERRAL OF FRIENDS AND LOVED ONES IF YOU ARE PLEASED WITH OUR APPROACH TO CARE. THANK YOU!**

I understand that health/accident insurance policies are an arrangement between me and my carrier. I understand that this office will prepare any necessary records to assist in expediting re-imburement for care rendered. I understand that any amount authorized is to be paid directly to Accelerate Health P.C. and will be credited to my account upon receipt. I understand and agree that all services rendered to me are my personal responsibility for prompt payment in the event that my insurance *does not cover chiropractic care*. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable. I understand that a service charge of \$5.00 minimum will be added to my account if past due of 30 days AND my account may be turned over to a collections agency if the balance is not paid off within 60 days. I understand that payment is for Accelerate Health's service, education, examination, treatment and opinions regarding my condition, and rendered in good faith.

**PATIENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_**

**GUARDIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_**



