COBERLY CHIROPRACTIC

3025 N. Taft Avenue, Suite A
Loveland, Colorado 80538
Phone: 970.203.0621
Fax: 970.461.2462

Patient Information

In order to provide you the best possible chiropractic care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data

Name _____ Date _____ Whom can we thank for referring you? _____

Address _____ City _____

State _____ Zip _____ Home Phone _____ Work Phone _____

Cell Phone _____ Other Phone _____ Age _____ Birth Date _____

Marital Status _____ Spouse's Name _____ Number of Children _____

Occupation _____ Employer _____

Work Status: ☐ Fulltime ☐ Part-time ☐ Homemaker ☐ Unemployed ☐ Student

Indicate if we are seeing you for an injury from: ☐ Auto ☐ Sports ☐ Work ☐ Other ☐ No Injury

Emergency Contact _____ Home Phone _____ Cell Phone _____

Insurance Information

Please Bill: ☐ Auto Insurance ☐ Worker's Compensation ☐ Health Insurance ☐ I will be paying for the services myself.

If you want us to bill your insurance, please provide us a copy of your insurance card, and provide the following:

Social Security Number _____ Insurance Company: _____

Current Complaints

What condition has brought you in today? _____

Date of Injury _____ Date Symptoms Appeared _____

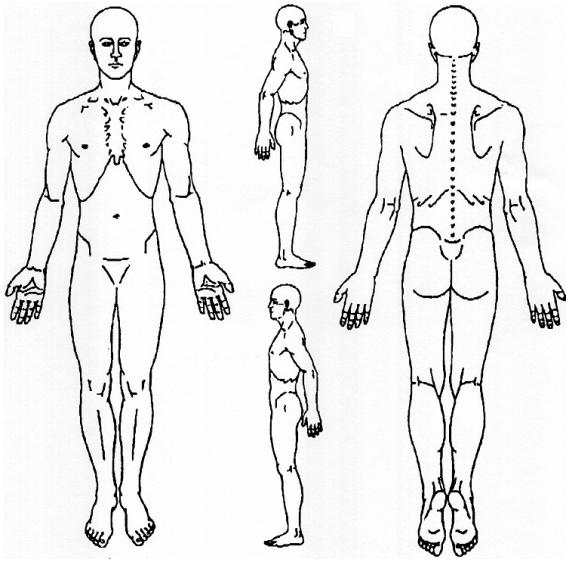
Have you ever had same condition? ☐ No ☐ Yes If yes, when? _____

Please mark on the diagram to the right to explain and locate the areas of complaint.

A=Ache O=Other

B=Burning T=Tingling

N=Numbness P=Pain



How often do you experience your symptoms?

☐ Constantly (76-100% of the time) ☐ Occasionally (26-50% of the time)

☐ Frequently (51-75% of the time) ☐ Intermittently (1-25% of the time)

How would you describe the type of pain?

☐ Sharp ☐ Shooting ☐ Shooting with motion

☐ Dull ☐ Stiff ☐ Stabbing with motion

☐ Diffuse ☐ Numb ☐ Electric like with motion

☐ Achy ☐ Tingly ☐ Other: _____

☐ Burning ☐ Sharp with motion

How are your symptoms changing with time? ☐ Getting Worse ☐ Staying the Same ☐ Getting Better

Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

How much has the problem interfered with your work? ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

How much has the problem interfered with your social activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Who else have you seen for your problem?

☐ Chiropractor _____ ☐ Neurologist _____ ☐ Primary Care Physician _____

☐ ER physician _____ ☐ Orthopedist _____ ☐ Other: _____

☐ Massage Therapist _____ ☐ Physical Therapist _____ ☐ No one

How long have you had this problem? _____

How do you think your problem began? _____

Do you consider this problem to be severe? ☐ Yes ☐ Yes, at times ☐ No

What activities aggravate your problem? _____

What concerns you the most about your problem; what does it prevent you from doing? _____

_____

How would you rate your overall health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

What type of exercise do you do? ☐ Strenuous ☐ Moderate ☐ Light ☐ None

Family History

Please note any family history of any of the below conditions and include the relationship of relative to you.

☐ Cancer _____

☐ Diabetes _____

☐ Headaches _____

☐ High Blood Pressure _____

☐ Arthritis _____

☐ Epilepsy _____

☐ Heart Disease _____

☐ Stroke _____

☐ Spine or Back Disorder _____

☐ Multiple Sclerosis _____

☐ Psychological Problems _____

Have you ever suffered from any of the following:

	Past	Current
Headaches	☐	☐
Neck Pain	☐	☐
Upper Back Pain	☐	☐
Mid Back Pain	☐	☐
Low Back Pain	☐	☐
Shoulder Pain	☐	☐
Elbow/Upper Arm Pain	☐	☐
Wrist Pain	☐	☐
Hand Pain	☐	☐
Hip Pain	☐	☐
Upper Leg Pain	☐	☐
Knee Pain	☐	☐
Ankle/Foot Pain	☐	☐
Jaw Pain	☐	☐
Joint Pain/Stiffness	☐	☐
Arthritis	☐	☐
Rheumatoid Arthritis	☐	☐
Cancer	☐	☐
Tumor	☐	☐
Asthma	☐	☐
Chronic Sinusitis	☐	☐
Other:	☐	☐
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Chest Pains	☐	☐
Stroke	☐	☐
Angina	☐	☐
Kidney Stones	☐	☐
Kidney Disorders	☐	☐
Bladder Infection	☐	☐
Painful Urination	☐	☐
Loss of Bladder Control	☐	☐
Prostate Problems	☐	☐
Abnormal Weight Gain/Loss	☐	☐
Loss of Appetite	☐	☐
Abdominal Pain	☐	☐
Ulcer	☐	☐
Hepatitis	☐	☐
Liver/Gall Bladder Disorder	☐	☐
General Fatigue	☐	☐
Muscular Incoordination	☐	☐
Visual Disturbances	☐	☐
Dizziness	☐	☐
Diabetes	☐	☐
Excessive Thirst	☐	☐
Frequent Urination	☐	☐
Smoking/Tobacco Use	☐	☐
Drug/Alcohol Dependence	☐	☐
Allergies	☐	☐
Depression	☐	☐
Systemic Lupus	☐	☐
Epilepsy	☐	☐
Dermatitis/Eczema/Rash	☐	☐
HIV/AIDS	☐	☐
Acid Reflux	☐	☐
Acne	☐	☐

Anemia	☐	☐
Arteriosclerosis	☐	☐
Bronchitis	☐	☐
Bruise Easily	☐	☐
Chronic Cough	☐	☐
Cold or Numb Extremities	☐	☐
Constipation	☐	☐
Cramps	☐	☐
Diarrhea	☐	☐
Difficulty Swallowing	☐	☐
Digestion Problems	☐	☐
Eye Pain/Difficulties	☐	☐
Heartburn	☐	☐
Hemorrhoids	☐	☐
Hot Flashes	☐	☐
Infertility	☐	☐
Irregular Heart Beat	☐	☐
Kidney Infection	☐	☐
Loss of memory	☐	☐
Loss of balance	☐	☐
Loss of smell	☐	☐
Loss of taste	☐	☐
Lumps In Breast	☐	☐
Lying Down Relieves Pain	☐	☐
Migraines	☐	☐
Nervousness	☐	☐
Night Pain	☐	☐
Nosebleeds	☐	☐
Numbness in the Groin	☐	☐
Pain Everyday	☐	☐
Pain Fails to Improve with Rest	☐	☐
Pain Greater than Four Weeks	☐	☐
Pain without Activity	☐	☐
Polio	☐	☐
Poor Circulation	☐	☐
Poor Posture	☐	☐
Ringing in the Ears	☐	☐
Sciatica	☐	☐
Shortness of breath	☐	☐
Sinus Infection	☐	☐
Sleep problems/insomnia	☐	☐
Sore Throat	☐	☐
Spinal Curvatures	☐	☐
Swelling of ankles	☐	☐
Swollen Joints	☐	☐
Thyroid Condition	☐	☐
Tuberculosis	☐	☐
Ulcers	☐	☐
Varicose Veins	☐	☐
Other:		

For Females Only

Birth Control Pills	☐	☐
Hormonal Replacement	☐	☐
Pregnancy	☐	☐

Medical History

Please list any medications or vitamins you are currently taking. _____

_____

_____

_____

List all surgical procedures you have had: _____

_____

What activities do you do at work?

☐ Sit:	☐ Most of the day	☐ Half the day	☐ A little of the day
☐ Stand:	☐ Most of the day	☐ Half the day	☐ A little of the day
☐ Computer work:	☐ Most of the day	☐ Half the day	☐ A little of the day
☐ On the phone:	☐ Most of the day	☐ Half of the day	☐ A little of the day

What activities do you do outside of work (i.e., sports)? _____

Have you ever been hospitalized? ☐ No ☐ Yes If so, why: _____

Have you had significant past trauma? ☐ No ☐ Yes If so, what? _____

How do you want us to handle your problem?

☐ Temporary Relief (Help the symptom but do not fix the cause)

☐ Maximum Correction (Correct the cause of the problem for maximum stability in the future)

Habits

Smoking:	☐ No	☐ Yes
Alcohol:	☐ No	☐ Yes
Exercise:	☐ No	☐ Yes
Caffeine:	☐ No	☐ Yes

Authorization

Financial Awareness and Consent: I understand that I am financially responsible, WHETHER OR NOT MY INSURANCE COMPANY PAYS, for all charges incurred by me. I hereby assign my major medical insurance benefits, including Medicare, private insurance and other health plans to Coberly Chiropractic. I understand that all plans are different and I may have one or more of the following that I am responsible for: referral from PCP/deductible/co-pays/percentage owed for each date of service. I understand that any accounts that are 90 days overdue are subject to collection proceedings, regardless of case type.

Release of Records: I authorize Coberly Chiropractic to release all health records necessary for my treatment and/or evaluation. I authorize Coberly Chiropractic to release any protected health information required to secure payment.

Can we brag? Coberly Chiropractic is proud to welcome you as a new patient. Part of doing so includes us posting your first name and the first initial of your last name on our in-office Welcome board. My signature below grants Coberly Chiropractic my permission to post my name in the office for the duration of the month.

_____ _____

Signature of Patient (or parent if a minor) Date

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Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science and art, which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. **Health** is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a **vertebral subluxation**. This occurs when one or more of the 24 vertebras in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an **adjustment**. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

All health care procedures carry some risk. Risks associated with chiropractic care may include, but are not limited to, muscle or ligament injuries, nerve injuries, vascular injuries and fractures. Alternatives to chiropractic care may include medications, surgery and other alternative treatments.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks, and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____

Print Name Signature Date

Consent to Evaluate and Adjust a Minor Child

I, _____, being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and herby grant permission for my child to receive chiropractic care.

Pregnancy Release

This is to certify that to the best of my knowledge, I am not pregnant and the above doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of Last Menstrual Cycle: _____

_____

Print Name Signature Date

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Assignment of Benefits

I hereby instruct and direct _____ insurance company to pay by check made out and mailed to Coberly Chiropractic, Inc., 3025 N. Taft Avenue, Suite A, Loveland, CO 80538.

or

if my current policy prohibits direct payment to Dr. Coberly, I hereby also instruct and direct you to make out the check to me and direct payment to 3025 N. Taft Avenue, Suite A, Loveland, CO 80538 for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize Doctor Coberly to initiate a complaint to the insurance commissioner for any reason on my behalf.

_____

Print Name of Policy Holder Signature of Policy Holder Date

_____

Print Name of Witness Signature of Witness Date

Thank You For Your Trust and Confidence

HIPPA HAPPENINGS

This notice describes how your health information may be used and how you can gain access to this information. Please review carefully.

Our Promise to you, our Valued Patient…

This is not meant to alarm you, quite the opposite. We want to assure you that we take the new Federal (HIPPA – Health Insurance Portability and Accountability Act) laws seriously. These laws were written to protect the confidentiality of your health information. We trust you will never delay treatment in our offices because of fear that your personal health information might be unnecessarily disclosed to others outside our office.

Why A Privacy Policy Now?

The most significant variable that has motivated the Federal government to legally enforce the privacy of health information is the rapid evolution of the use of electronic technology in the administration of health care business. The government has appropriately sought to standardize and protect the electronic exchange of your health information. This has challenged us to review not only how your information is used within our computers but also with the Internet, phones, fax machines and any device used to copy or transfer data.

We want to advise you that we have developed policies and procedures for our practice to assure that your personal or health information will be shared only as required and only for the purpose of administering your case. Our office is subject to State and Federal laws regarding the confidentiality of your health information and we will assure adherence to those laws and we want you to understand our procedures and your rights as a valued patient.

Your health information will be communicated only for the purpose of obtaining payment for services and conducting health care business. Be assured that without your written permission, your health information will not be used for any other purpose.

How Your Health Information May Be Used to Provide Treatment

Within our office, your health information will be used to provide you the best care and services possible. This may include administrative and clinical procedures designed to optimize scheduling and coordination between you and all office personnel. In addition, we may share this information with referring physicians, clinical pathology laboratories or other health care professionals providing you want treatment.

To Obtain Payment

Your health information may be included with an invoice for the purpose of collecting payment for services provided to you in our office. We may do this with insurance forms filed for you by mail or electronically. We will make all effort to work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care in our office. As a result, your health information may be included in the training programs for students, interns, associates, as well as business and clinical employees. It is also possible that your health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process of certification, licensing, or credentialing activities.

In Patient Reminders

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or members of your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best care chiropractic can provide. They may include postcards, newsletters, flyers, telephone or electronic reminders such as e-mail (unless you tell us that you prefer not to receive reminders).

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health and or national security.

For Law Enforcement

As permitted or required by state or Federal law, we may disclose your health information to a proper authorities for the purpose of law enforcement including, under certain circumstances, if you are a victim of a crime or in order to report a suspected crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be assisting you with your home hygiene, care, treatment or payment. We will be certain to obtain your permission prior to sharing your information. In the event of an emergency, were you unable to tell us what you want, we will use our very best judgment when sharing your health information with anyone participating in your care.

Medical Research

Advancing health care knowledge often involves learning from the careful study of health histories as a part of a research study will happen only under the ethical guidance, requirements and approval of an Institutional Review Board.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. *You may revoke that authorization in writing any time*.

Confidential Communications

You have the right to request that we communicate with you in a specific way. You may request that we only communicate your health information privately with or without other family members present or through sealed mail communications. We will make a reasonable effort to honor your request.

Inspect and Copy Your Health Information

You have the right to read, review and copy your health information including complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information is incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe as completely as possible your reason for the request.

Your request may be denied if the health information record in question was not created by our office, is not a part of our records, or if the records containing your health information have been requested sealed and or delivered to any authority for review.

Documentation of Health Information

You have the right to request from us a description of how and where your health information was used by our office for any reason other than for treatment or payment, or health care operations. Our documentation procedures will enable us to provide information on your health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. We will greatly appreciate you limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to request and obtain a copy of the Notice of Privacy Practices directly from our office at any time. Just let us know of your request. We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice, but we do reserve the right to change the terms of our notice. Patients would be notified of any such changes.

You have the right to express concerns or complaints to us or the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express in writing, any concerns you may have regarding the privacy of your health information.

Patient Acknowledgement

Patient Name(s):

_____

_____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions, please let us know. If not, we would really appreciate your acknowledging by signature that you have received, thoroughly reviewed, and understood this policy.

_____ Date _____/_____/_____

Patient Signature