Patient Information

Today's Date _____

Patient Name

_____
Last, First, Middle Initial

Sex [ ] M [ ] F
Social Security No. _____

Birthdate_____ Age_____

Address_____

City_____State_____Zip_____
[ ] Married [ ] Widowed [ ] Single
[ ] Divorced [ ] Separated [ ] Other

Contact Information

Phone_____ [ ]Mobile [ ]Home [ ]Work

Phone_____ [ ]Mobile [ ]Home [ ]Work

Email_____

Race_____
(You may decline the above)

Occupation _____

Business Name _____

Spouse's Name _____

Spouse's Birthdate _____

Pharmacy _____

Whom may we thank for referring you?

_____

In Case of Emergency

Name_____

Relationship_____

Phone_____

Patient Account Information

Who is financially responsible for this account?

_____

Will you be paying through insurance?[ ]Y [ ]N
If so, what type of insurance do you have?

_____

Subscriber's Name _____

Auto, Work or Personal Injury Accident

Is this condition due to an Auto, Work or Personal Injury accident? [ ] Y [ ] N

Date of Accident_____

Type of Accident [ ] Auto [ ] Work [ ]Personal
Other_____

WE DO NOT ACCEPT WORKMANS COMP, AUTO ACCIDENT OR PERSONAL INJURY CLAIMS

**If this is the result of an accident, please let our staff know immediately. Thank you.*

Name: _____

DOB: _____

Patient Condition

Reason for visit? _____

When did your symptoms appear? _____

Does anything improve your pain? If YES, please list: _____

How often do you experience these symptoms? [ ] Constantly (76-100% of the day) [ ] Frequently (51-75% of the day) [ ] Occasionally (26-50% of the day) [ ] Intermittently (0-25% of the day)

Symptoms (Check all that apply): [ ] Burning [ ] Sharp [ ] Shooting [ ] Radiating [ ] Numbness [ ] Tingling [ ] Tightness [ ] Ache

Please rate the severity of your pain: (No Pain) 1 2 3 4 5 6 7 8 9 10 (Worst Pain)

Does it interfere with your: [ ] Work [ ] Sleep [ ] Daily Routine

What services or treatment have you already received for your condition? [ ] Medications [ ] Surgery [ ] Physical Therapy [ ] Chiropractic services [ ] Massage [ ] Other _____

Have you seen another doctor for this condition? [ ] Y [ ] N….If yes, whom and where?

_____

Have you ever seen a chiropractor before? [ ] Y [ ] N…If yes, Facility name: _____

Please list any relevant x-rays or exams that we may ask for in order to further treat you including where they were taken and who they were taken by: _____

_____

Medications & Supplements	Dose & Purpose	Allergies

Tobacco Use	Alcohol Use	Activity Level
[ ] None [ ] Former [ ] Few [ ] 1 pack per day [ ] 2 or more packs	[ ] None [ ] Former Alcoholic [ ] Light/Moderate [ ] Heavy	[ ] None [ ] Light [ ] Moderate [ ] Vigorous

Name:_____

DOB:_____

Please circle or check below to indicate if you HAVE any of the following conditions:

Alcoholism	Menopause
Arthritis	Menstrual Problems
Asthma	Migraine Headaches
Bleeding Disorder	Miscarriage
Breast Lump	Nausea/vomiting
Broken Bones	Neurological Disorder
Cancer	Type:
Cataracts	**NONE**
Chemical Dependency	Osteoporosis
Chest Pain	Pacemaker
Constipation	Pancreatitis
Depression/Anxiety	Parkinson's Disease
Diabetes	Psychological Disorder
Digestive Problems	Type:
Dizziness	Pinched Nerve
Emphysema	Pregnant Due:
Epilepsy	Prostate Problems
Fainting	Prosthesis
Fatigue	Psoriasis
Fever/Chills	Rheumatoid Arthritis
Fibromyalgia	Scoliosis
Fractures	Significant weight change
Frequent Urination	Sinus Problems
Gall Bladder problems	Sprain/Strain
GERD	STDs Type:
Glaucoma	Stroke/Heart Attack
Gout	Suicide Attempt
Headaches	Thyroid Problems
Hearing Problems	TMJ Problems
Heart Disease	Tuberculosis
Hernia	Tumor
Herniated Disc	Ulcer/s
High Blood Pressure	Vaginal Infections
High Cholesterol	Varicose Veins
Liver Problems	**Other- Please List**
Type:	

Family History: (grandparents, parents or siblings)

[ ] Scoliosis [ ] Cancer
[ ] Rheumatoid Arthritis
[ ] Multiple Sclerosis
[ ] Diabetes [ ] Parkinson's disease
[ ] Heart Disease [ ] Stroke
Other: _____

Hospitalizations:

_____
_____
_____
_____
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Injuries, Broken bones, Dislocations and Surgeries with dates:

_____
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If a family member had any of the following, please include these details in the "Family History" section

Updated 03/21/2022

Name: _____

DOB: _____

Consent To Treatment

Whenever a patient is treated by a medical doctor, hospital, chiropractor, or other type of doctor there is always a possibility, no matter how remote, that the patient will not respond well or even undergo a negative response. When this happens, it is almost always due to some overlooked or undetected factor in the patient's history or physical condition. While we can never reduce the risk of adverse reaction to zero, appropriate patient history and examination procedures can and do minimize the risk. Some areas of special concern are listed below. **Please initial that you have read and understand that it is your responsibility to make the doctor aware of any concerns that apply to you.**

PAST SURGERY: Initial _____

Any past surgery, especially any spinal surgery, should be reported to the doctor. Since the scar tissue after surgery is not as flexible as normal tissue, special care must be taken to avoid the possibility of aggravating the condition.

CARDIOVASCULAR: Initial _____

Any problems with the heart and blood vessels such as hardening of the arteries, high blood pressure, phlebitis, or any vascular trouble should be reported to the doctor. Special precautions will also be explained so that risk of further injury is avoided.

FRACTURES AND DEGENERATIVE JOINTS: Initial _____

Fractures, degenerative joint disease and osteoporosis (which could lead to fractures) can all be detected on x-rays and will be explained and shown to you if/when x-rays are viewed. Proper precautions will also be explained so that risk of further injury is avoided.

OTHER RISKS: Initial _____

It is impossible to include all potential risks. If there are any other concerns, please discuss them with the doctor, so we can proceed with care.

YOUR CONSENT TO TREATMENT

I wish to receive examinations and treatments at the Aspen Chiropractic Clinic; I have read and understand the above risks and precautions. I understand that individuals respond differently to chiropractic treatment and that no guarantee can be given for the result of any treatment. I therefore authorize examination and treatments to be performed by the staff at the Aspen Chiropractic Clinic.

_____ _____

PATIENT SIGNATURE DATE

_____

PARENT SIGNATURE (if minor)

Name: _____

DOB: _____

Notice of Privacy Practice Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

PATIENT NAME or LEGAL GUARDIAN (PRINT) DATE

_____

SIGNATURE

Communication Preferences

I, _____ hereby consent and state my preference to have my chiropractor, Dr. Arthur John Chatellier, Dr Bonnie Harder, and other staff at Aspen Chiropractic communicate with me by email or standard SMS/text messaging, in addition to or to replace leaving phone messages, regarding various aspects of my health care, which may include, but shall not be limited to, test results, appointments, and billing. I understand that email and standard SMS/text messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS/text messaging regarding my medical care might be intercepted and read by a third party.

I give my permission to leave both appointment reminders and my private health information at the following (**please check the ones you agree to**):

[ ] CALL [ ] TEXT [ ] EMAIL

OFFICE USE ONLY

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date _____ Attempt _____

Staff Name _____

Updated 01/01/2021

Name: _____

DOB: _____

Financial Policy Acknowledgement

Our clinic has established a single fee schedule that applies to all patients for each service provided. You may be entitled to a network, contractual discount, or time-of-service discount under the circumstances dictated in the Financial Policy.

I have read, received a copy, and understand the Aspen Chiropractic Clinic's Financial Policy. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Aspen Chiropractic Clinic and my insurance company. I understand that if Aspen Chiropractic Clinic is an "in-network" provider for my insurance company, I will be responsible for the charge(s) allowed applied, and discounts will be applied after my insurance has processed the information and sent this information to Aspen Chiropractic Clinic.

I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctors at Aspen Chiropractic Clinic that fees will be due and payable immediately. The only exception is if I signed a monthly or weekly payment plan that I discussed with the doctors and billing specialist at Aspen Chiropractic Clinic.

The Patient/Responsible Party authorize(s) the release or receipt of and disclosure of all medical information related to the Patient's treatment and care, to or from any entity, which is, or may be liable, for Physicians charges, or to or from any Professional Review Organization associated therewith. The Patient/Responsible Party authorize(s) the release or receipt and disclosure of all or any part of the Patient's medical records to or from any other health care provider who may be of assistance, in the opinion of the P.C., in providing medical care and treatment for the patient, and/or assisting in any reimbursement or benefits to which patient may be entitled. A photostatic copy of these authorizations and agreement shall be as valid as the original.

By signing this document, I authorize this office to bill my insurance company directly for their services, release or receive any information necessary to expedite insurance claims, as well as authorizing direct payment to this physician of any insurance benefits otherwise payable to me.

I understand that failure to pay my bill in a timely manner or set up and adhere to a monthly payment plan will result in my account being turned over to a collections agency with an additional collection charge (up to 33% of the balance) added to the total bill. The collections company will be provided with any and all information on file necessary to support the collections process.

_____ _____

PATIENT SIGNATURE DATE

_____

PARENT SIGNATURE (if minor)

Updated 01/01/2020