WELCOME

one ABOUT YOU

Today's Date: ____/____/____ File #: ____

Patient Name: ____
LAST FIRST MI

What You Prefer To Be Called: ____ ❑ Male ❑ Female

Birthdate: ____/____/____ Age: ____ SS#: ____

Mailing Address: ____

CITY STATE ZIP

Home Phone #: (____) ____

Work Phone #: (____) ____ Ext: ____

Cell Phone #: (____) ____

E-mail Address: ____

Referred By: ____

Employer: ____ How Long? ____

Employer's Address: ____

CITY STATE ZIP

Occupation: ____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: ____

Do you have children? ❑ Yes ❑ No How many? ____

two INSURANCE INFO

Primary Insurance

Co. Name: ____

Address: ____

CITY STATE ZIP

Phone #: (____) ____

Insured's ID#: ____

Group # (Plan, Local, or Policy #): ____

Insured's Name: ____

Relation: ____ Date of Birth: ____/____/____

Insured's Employer: ____

Secondary Insurance

Co. Name: ____

Address: ____

CITY STATE ZIP

Phone #: (____) ____

Insured's ID#: ____

Group # (Plan, Local, or Policy #): ____

Insured's Name: ____

Relation: ____ Date of Birth: ____/____/____

Insured's Employer: ____

three ACCOUNT INFO

Person ultimately responsible for account

Name: ____

Relation: ____

Billing Address: ____

CITY STATE ZIP

SS #: ____

Drivers License #: ____

Work Phone #: (____) ____

____ Initials I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

four IN EVENT OF EMERGENCY

Whom should we contact? ____

Relation: ____

Home Phone #: (____) ____

Work Phone #: (____) ____

Cell Phone #: (____) ____

Who is your Medical Doctor? ____

Medical Doctor's Phone #: (____) ____

PLEASE CONTINUE ON BACK

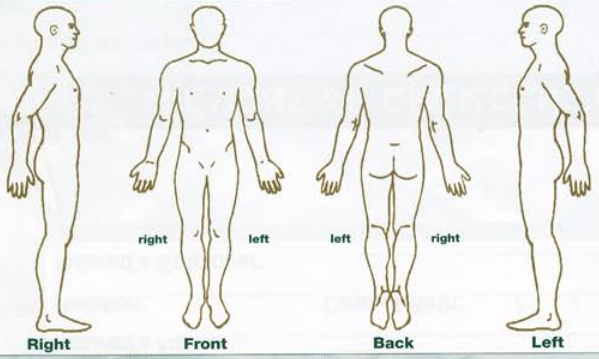
five 5 REASON FOR VISIT

Reason for today's visit: ❑ Emergency ❑ New injury ❑ Old injury ❑ Chronic pain ❑ Wellness
Are you in pain: ❑ Yes ❑ No Rate your pain with the following scale: discomfort 1 2 3 4 5 6 7 8 9 10 intense
Did your injury occur during: ❑ Work ❑ Sports/play ❑ Auto Accident ❑ Routine/Household activity
When did your condition/accident occur? ___/___/___ Where did your injury occur?_____
Please explain what happened:_____
Is your condition getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes.
Is your condition interfering with your: ❑ Work ❑ Sleep or ❑ Daily routine? If so, how: _____

Has this or something similar happened in the past?
❑ Yes ❑ No Explain:_____

Using the adjacent body charts, please circle all affected areas.
Have you been treated by a Medical Physician for this condition? ❑Yes ❑No If so, where?_____

Have you ever been treated by a Chiropractor? ❑Yes ❑No
Clinic or Dr's name:_____
Clinic phone#:_____



six 6 HEALTH HISTORY

Are you taking any of the following medications? ❑ Nerve pills ❑ Pain killers(including aspirin) ❑ Muscle relaxers
❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Other(s)_____

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack / Stroke	Y N Heart Surg./Pacemaker	Y N Heart Murmur	Y N Congenital Heart Defect	Y N Mitral Valve Prolapse
Y N Artificial Valves	Y N Alcohol / Drug Abuse	Y N Venereal Disease	Y N Hepatitis	Y N HIV+ / AIDS / ARC
Y N Shingles	Y N Cancer	Y N Frequent Neck Pain	Y N Glaucoma	Y N Anemia / Diabetes
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever	Y N Severe / Frequent Headaches	Y N Kidney Problems
Y N Ulcers / Colitis	Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Emphysema / Asthma	Y N Tuberculosis
Y N Difficulty Breathing	Y N Chemotherapy	Y N Lower Back Problems	Y N Artificial Bones/Joints/Implants	Y N Arthritis

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above:_____
List any past serious accidents with dates: _____
Please list anything that you may be allergic to: _____
Family Health History:_____
Do you take Supplements or Vitamins? ❑ Yes ❑ No Do you exercise? ❑ No ❑ Yes ____ hours per week
Do you smoke? ❑ No ❑ Yes How much?_____ How long?_____
Are you wearing: ❑ Shoe lifts ❑ Inner soles ❑ Arch supports Are you dieting: ❑No ❑Yes Since: ___/___/___
For woman: Are you taking Birth Control? ❑ Yes ❑ No
Are you Nursing? ❑ Yes ❑ No Are you Pregnant? ❑ No ❑ Yes If so, how many weeks?_____

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ___/___/___
❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE (OFFICE USE)
Initials ___/___/___ Date
Comments
Initials ___/___/___ Date
Comments
Initials ___/___/___ Date
Comments

Colony Chiropractic Financial Policy/Assignment of Benefits

If you do not have insurance: All payments are expected at the time of service.

If you have insurance: Our office will accept your insurance on assignment. However, it must be fully understood that your insurance policy is a contract between you and your insurance company. Our office will not enter into a dispute with your insurance company over policy limitations or issues. This is your responsibility and obligation. **All charges incurred are your responsibility.** If you have a question or problem with the reimbursement level, contact your employer or insurance company. Our office will file your claims for you and assist you in every way possible to ensure benefit recovery.

If you have Medicare: I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act, is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for doctor services. I understand that I am responsible for my health insurance deductibles and coinsurance.

Please read the following office policy regarding assignments:

1. At the beginning of your treatment in our office we will verify your policy benefits. However, phone or fax verification of coverage is never a guarantee of payment.

2. You are considered a cash patient until we qualify and accept your insurance coverage.

3. Your insurance will be filed as a courtesy to you. We file insurance claims on a weekly basis.

4. You will be responsible for your deductible and co-payment. Payment is due when services are rendered. If your insurance company does not pay something that was anticipated, you will be responsible for the amount as soon as we/you are aware of the denial.

5. If your insurance company has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance company has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance.

6. Our fees are considered usual, customary and reasonable by most insurance companies, and therefore are covered up to the maximum allowance determined by each insurance company. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

7. We do not accept assignment for secondary insurance companies, but we will be happy to provide you with a receipt for you to supply to your secondary carrier.

I have read and understand this financial policy. I hereby assign payment directly to Dr. Kelly Smith or Colony Chiropractic accepting this assignment of benefits applicable and otherwise payable to me but not to exceed the doctor's regular charges. I realize that I am responsible for all charges incurred by me at Colony Chiropractic. I understand that if payment is not received within ninety (90) days after the date of service, I will owe the amount due.

_____

Signature **Date**

_____

Colony Chiropractic Staff Signature **Date**

Revised 09/2011

Informed Consent

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment we use as Doctors of Chiropractic is spinal manipulative therapy. We will use that procedure to treat you. We may use our hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, exam and treatment, you are consenting to the following procedures.
Please cross off any you do NOT wish to consent to.

spinal manipulative therapy palpation vital signs massage/manual therapy radiographic studies
range of motion testing traction cold therapy orthopedic testing postural analysis
electric muscle stimulation basic neurological testing

The material risks inherent in chiropractic adjustments.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These rare complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. We will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform us.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. The incidences of stroke are exceedingly rare and are estimated to occur in less than one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read { } or have had read to me { } the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Kelly Smith or Dr. Danielle Horning and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risk involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended.

Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

_____
Patient's Name

_____
Signature

_____
Signature of Parent or Guardian (if a minor)

_____
Dr. Kelly D. Smith, D.C.
Dr. Danielle F. Eastman, D.C.
Dr. Jennifer Soto, DC

Colony Chiropractic Missed Appointment Policy

We want to thank you for choosing us as your chiropractic health provider. In order to provide you and our other patients with the best optimal care, we request that you follow our guidelines regarding broken and/or cancelled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. When you cancel your appointment at the last minute, everyone loses – you, the doctor and other patients that would like to have utilized your appointment time.

Please realize how important it is to keep your reserved time. Thank you for your consideration of our policies and for the opportunity to be your chiropractic office of choice.

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic doctor has the right to refuse to give care.
9. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
10. This notice is effective on the date stated below.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Name of Patient Date

For further information regarding this notice, please contact Dr. Smith at 972-625-4800

COLONY CHIROPRACTIC

Client Information and Consultation Form For Manual and Massage Therapy

Name: _____ Date: _____
Last First MI

Address: _____
Street City State Zip

Home #: _____ Work: _____ Cell: _____

Email: _____ Date of Birth: _____

Emergency Contact: _____
Name Phone Number

1) How did you hear about our office? Fax, Newspaper, Coupon, Internet or Referred by_____

2) Have you had a massage or chiropractic care before? YES ____ NO ____ Did it help? YES ____ NO ____

3) Do you presently have any of the symptoms below?

( ) Neck Pain ( ) Shoulder Pain ( ) Hip Pain ( ) Fibromyalgia ( ) Headaches
( ) Lower Back Pain ( ) Radiating Leg Pain ( ) Mid Back Pain ( ) Numbness ( ) Tingling

4) Please check if you have any of the following medical conditions:

( ) Skin Problems ( ) High/Low Blood Pressure ( ) Blood Clots ( ) Seizures ( ) Diabetes
( ) Contagious Illness ( ) Varicose Veins ( ) Blood Diseases ( ) Heart Problems ( ) Cancer

5) List any other medical conditions, major illness, broken bones, surgeries, or accidents that you have had within the last three (3) years. _____

6) Have you been involved in a motor vehicle accident within the past year? YES ____ NO ____

7) Are you interested in joining The Massage Club? YES ____ NO ____

8) What type of massage do you prefer? LIGHT MEDIUM DEEP

9) List current medications: _____

10) List any allergies:_____

11) Are you pregnant? YES ____ NO ____

Should a cancellation or date change be necessary for any reason, we request a minimum of 24-hours notice for all massage appointments. $25.00 will be charged on any late cancellations or no-show appointments.

I have read and fully understand this form in its entirety. If at any time there are changes in the information given or in my condition, I will notify my therapist, and update this form before receiving additional treatment. The manual and massage treatment given here is for the reduction of muscle tension and spasms, to increase circulation, and to provide relief of symptoms. The massage therapist does not diagnose or prescribe for medical illness, disease, or any other physical or mental disorder. The massage therapist does not do spinal manipulations. Massage therapy is not a substitute for medical examination or diagnosis, and it is recommended that a physician be seen for any ailment that you may have. It is your responsibility to explain and discuss all physical conditions with the massage therapist so that they may do their job.

Client Signature: _____ Date: _____