COLORADO SPORTS CHIROPRACTIC

File number: _____
Date: ____/____/____

Please fill out the form as thoroughly and accurate as possible. This will allow for more effective and timely treatment.

Title: (check) ☐ Mr. ☐ Mrs. ☐Ms. ☐ Miss ☐ Dr. ☐ Other _____

First Name _____ **Middle Initial** ____ **Last Name** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Preferred Contact Method: (Check) ☐ Home ☐ Cell ☐ Work ☐ Email ☐ Text (SMS)

Home Phone (____) _____-_____ **Work Phone** (____) _____-_____

Cell Phone (____) _____-_____ **Email** _____

Date of Birth ____/____/____ **Sex:** ☐ Male ☐ Female

Social Security Number: _____-_____-_____ **Marital Status:** ☐ Single ☐ Married ☐ Other

Insurance Information

Current insurance provider: _____

Policy number/ ID: _____ **Group Number:** _____

Are you the primary policy holder? (Yes/No) **Who is?** _____

Relationship to policy holder _____

Secondary Insurance if applicable: _____

Policy number: _____ **Group Number:** _____

How did you hear about our office? _____

Office Use Only: Deductible: _____ Copay/CoInsurance: _____
Deductible: _____ Copay/CoInsurance: _____
Provider Services: _____ Date _____

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File number: _____
Date: _____/_____/_____

Emergency Contact _____

Contact Name _____ **Relationship to Patient** _____

Contact Home Phone (____) _____-_____ **Cell Phone** (____) _____-_____

Primary Care Provider _____

Doctor's Name _____ **Hospital/Office:** _____

Phone (____) _____-_____

Employer Data _____

Employer _____

Your Occupation _____

Medical History _____

Medical Conditions: (List any disorders you are currently being treated for or have been treated for in the past, give approximate date): _____

_____

_____

_____

Surgeries: (List any surgeries you have had and date) _____

_____

_____

_____

_____

Allergies: (List any allergies you have) _____

_____

_____

Social History: (List in Cups/Packs/Minutes or Hrs/Day and how many days/week)

Caffeine use: _____
Drink Alcohol: _____
Exercise: _____
Drink Water: _____
Cigarettes: _____
Sleep: _____
Other: _____

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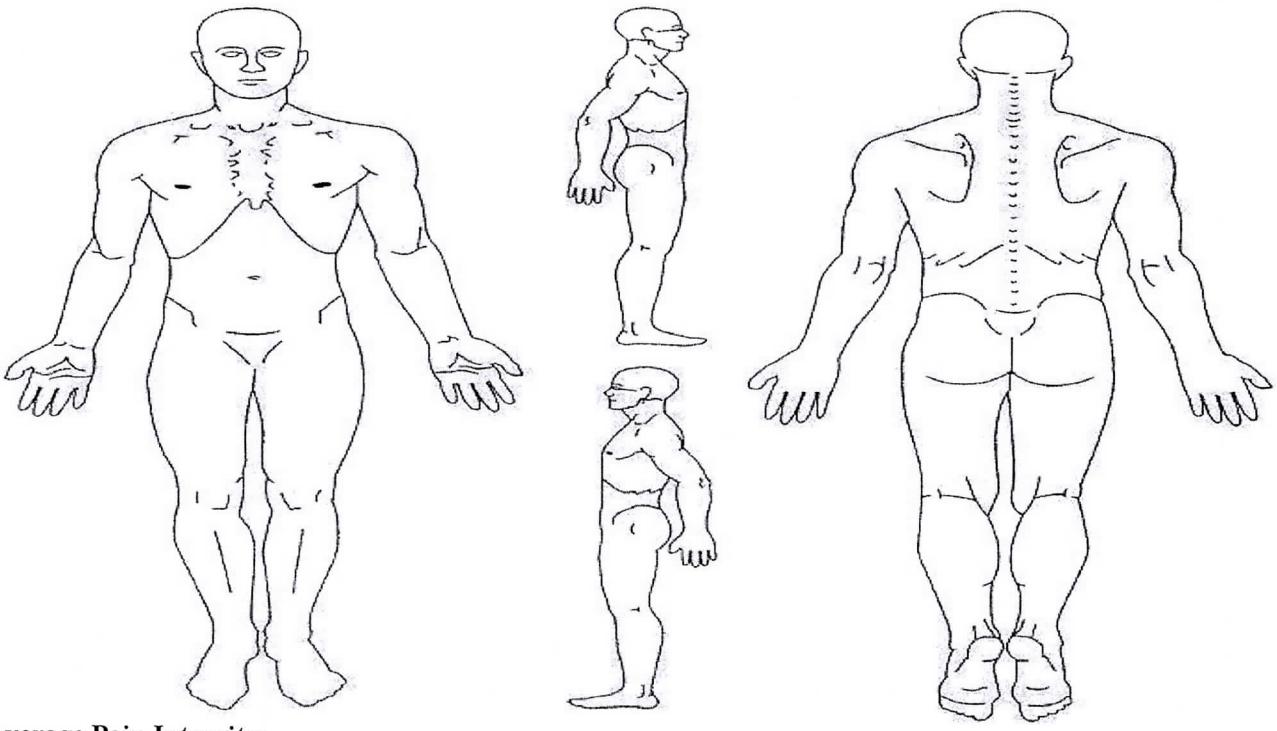
What is you chief complaint? _____
_____
_____

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:
N=Numbness **B=Burning** **S=Sharp** **T=Tingling** **A=Dull Ache**



Average Pain Intensity:
Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain
Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Does anything improve your pain? Yes No **If Yes, please list:** _____
_____

When did your symptoms begin? _____

Are your symptoms a result of: ☐ Motor Vehicle Accident ☐Work related Accident ☐ Other_____

How did your symptoms begin? _____
_____

How often do you experience your symptoms?
(76-100% of the day) ☐ (51-75% of the day) (26-50% of the day) ☐ (0-25% of the day)

What describes the nature of your symptoms?
☐ Sharp_____ Ache_____ ☐ Numb_____Shooting_____
☐ Burning_____☐ Tingling_____☐ Throbbing_____Other _____

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If you experience tingling/radiations/ or numbness where do you feel it and when?_____
_____

How are your symptoms changing? ☐ Getting better ☐ Not changing ☐ Getting worse

Do you have any secondary complaints?

_____
_____
_____

Average Pain Intensity:
Last 24 hours: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain
Past week: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain
Does anything improve your pain? Yes No **If Yes, please list:**_____
_____

When did your symptoms begin? _____

How are your symptoms changing? ☐ Getting better ☐ Not changing ☐ Getting worse

What are your goals with treatment/care?_____
_____
_____

Family History: (check all that apply)
Arthritis: ☐ Parent ☐ Sibling
Cancer: ☐ Parent ☐ Sibling
Diabetes: ☐ Parent ☐ Sibling
Heart Disease ☐ Parent ☐ Sibling
Hypertension ☐ Parent ☐ Sibling
Stroke ☐ Parent ☐ Sibling
Thyroid ☐ Parent ☐ Sibling

Please list all current medications being taken _____
_____
_____
_____

Are You Pregnant or is there a possibility of pregnancy? (Check) ☐ **Yes** ☐ **No**

If at any time during the course of care I, _____(print name), become pregnant, or pregnancy status changes will notify my attending chiropractor.

I attest that I have given a true and accurate medical history to the best of my knowledge.

Patient Signature_____**Date**_____

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PAYMENT POLICY

Colorado Sports Chiropractic, Performance Therapy, and Massage aims to provide the highest quality care and values spending more time with each patient to achieve optimal results in a shorter period. We have found that the limitations placed by insurance companies impede patient progress and restrict providers continuum of care. By being an out of network provider, we are ensuring the highest quality of individualized care for our patients!

Our goal is to give patients as many financial options as possible to remove the stress of payment so that you can focus on your rehab and recovery. Outlined below you will find options available to make treatment more affordable to avoid interruption of service due to payment.

1. METHOD OF PAYMENT: Payment is due at the time of service. The amount due for services will depend on whether you have **insurance**, are **self-pay**, or are going through a **Third-Party Administrator**. See below for further information regarding each of these. The accompanying adult to a minor patient is responsible for payment. For your convenience we accept credit card, cash, and personal checks.

2. INSURANCE: We are out-of-network (OON) with all insurance providers and only Dr. Schroeder is a participating Medicare provider. Our services are rendered to you, not your insurance company. In most cases we will call to verify your insurance benefits. However, the benefits quoted to us by your insurance company are not a guarantee of payment. Should you choose to bill your insurance using your OON benefits, we will provide you with a Superbill for each visit which you can submit to your insurance and receive any reimbursement directly. **You will be responsible for paying the insurance rates at the time of your visit**. If the Superbill gets denied for any reason, please contact our office, provide the Eligibility of Benefits from your insurance stating the reason for denial and we will contact your insurance company on your behalf to resolve the issue and provide an updated Superbill to be re-submitted. If your insurance company requires a referral it is your responsibility to provide us with a referral dated the day of your first visit from your primary care physician prior to your first visit.

3. SELF-PAY: If you either do not have insurance coverage or chose to not use your insurance benefits, you can use our self-pay and/or package options. Single session and package rates are in our Service Guide. All rates are expected at the time of your visit with the exception being the ten package sessions. These can be split into two payments, the first being due at the time of the first visit, the second being due four weeks later or at the sixth visit, whichever occurs first. If the second payment is not completed, you will be responsible for the full price of any previous and future services rendered. Specific payment plans can be set up on a case-by-case basis if the patient is able to provide proof of their financial need.

4. THIRD PARTY ADMINISTRATOR (Personal Injury/Auto Injury/Worker's Comp): Please advise our office on your first visit whenever you have one of the above claims. We will work with any insurance companies/attorneys involved, but please remember that you are ultimately responsible for your bill if payment cannot be obtained from another party. If you, your attorney, or the insurance company does not cooperate in protecting the doctor's interest, we will not await payment and may declare the entire balance due and payable immediately.

5. COLLECTIONS: If a collection agency's services are required, the patient agrees to pay for all legal fees, court costs, reasonable attorney fees, and collection agency fees in connection to the patient's debt. If the debt is not paid within 45 days, we will begin to incur interest at the rate of 1.5% monthly or 18% annually until the debt is paid. The patient also understands that to collect the patient's debt, the patient's credit history may be checked using the patient's social security number or any other information the patient has given to Colorado Sports Chiropractic.

6. MISSED APPOINTMENT: The time reserved for your appointment is completely one-on-one with our therapists, allowing us to provide a higher quality of care. Therefore, out of respect for our therapists time and livelihood, we kindly ask for at least 24 hours notice if you need to cancel an appointment. If there is a cancellation with less than 24 hours notice, you will still be responsible for the full cost of your session. The charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regular scheduled appointment.

I have read and understood the payment policy and agree to abide by its guidelines.

_____ _____

Signature of patient or responsible party **Date**