PATIENT NAME: _____

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 I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my 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 part of the analysis, examination, and treatment you are consenting to the following procedures:

___ spinal manipulative therapy	___ palpation	___ vital signs
___ range of motion testing	___ orthopedic testing	___ basic neurological testing
___ muscle strength testing	___ postural analysis	___ electric muscle stimulation
___ radiographic studies	___ cold laser	___ Nutrition

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 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. I will make every reasonable effort during the examination to screen for contraindications to your care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare. **We almost exclusively use instrument adjusting, so the occurrence of these complications listed above are even less than traditional chiropractic adjustments.**

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

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

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.

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. Parker and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks 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.

_____ _____

Patient's Name Doctor's Name

_____ _____

Signature Date Signature Date

_____

Signature of Parent or Guardian (if a minor)

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The following information is needed in order to better serve you. Please complete all questions.
If you need help, please ask the receptionist. PLEASE PRINT.

Today's Date: _____ Referred by: _____

Name: _____

Cell Phone: _____ Home Phone: _____ Office Phone: _____

Email Address: _____

Address: _____

City: _____ State: _____ Zip: _____

Age: _____ Birth Date: _____ Marital Status: M S W D P No. of Children: _____

Occupation: _____ Years on Job: _____

Employer / School: _____

Emergency Contact:

Name: _____ Phone Number: _____ Relationship: _____

Describe The Major Complaints That Bring You To Our Office:

_____

_____

Is Your Condition Due To An Accident? ❑ Yes ❑ No Date of Accident: _____

If so, Type of Accident? ❑ Auto ❑ Work/Job ❑ At Home ❑ Other: _____

How would you like Appointment Reminders? ❑ Text ❑ Email ❑ Phone Call ❑ No Thanks

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself, therefore I am personally responsible for payment of any and all services covered or non-covered. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian's Signature (For Minors): _____ Date: _____

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the doctor.

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Health History

What brings you in today? _____

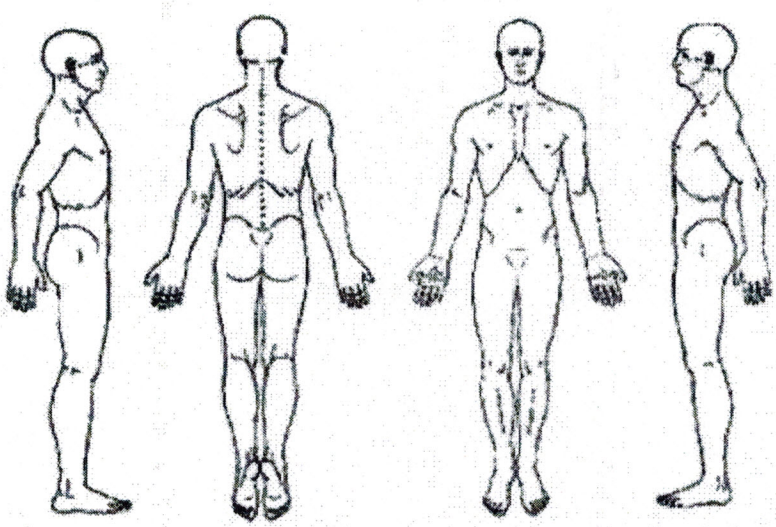
_____

Describe your symptoms you are experiencing, if any? _____

_____

How intense are your symptoms? **(Circle)** ***(None)*** 0 1 2 3 4 5 6 7 8 9 10 ***(Extreme)***

Please circle areas below where you have pain or other symptoms:



What does it feel like? (Check ✓)

- ❑ Numbness
- ❑ Tingling
- ❑ Stiffness
- ❑ Dull
- ❑ Aching
- ❑ Cramping
- ❑ Nagging
- ❑ Sharp
- ❑ Shooting
- ❑ Burning
- ❑ Throbbing
- ❑ Stabbing
- ❑ Swelling
- ❑ Other: _____

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How is this symptom / condition interfering with your life? (Check ✓)

	No Effect	*Mild Effect*	*Moderate Effect*	*Severe Effect*
Work	❑	❑	❑	❑
Exercise	❑	❑	❑	❑
Recreation	❑	❑	❑	❑
Relationships	❑	❑	❑	❑
Sleep	❑	❑	❑	❑
Self-Care	❑	❑	❑	❑
Energy	❑	❑	❑	❑
Attitude	❑	❑	❑	❑
Patience	❑	❑	❑	❑
Productivity	❑	❑	❑	❑
Creativity	❑	❑	❑	❑

How committed are you to correcting this issue? ***(Circle)*** 0 1 2 3 4 5 6 7 8 9 10

Please (Check ✓) the boxes in which you have / had the following conditions:

Head / Neck
- ❑ Headaches/Migraines
- ❑ Neck Pain
- ❑ Dizziness/Vertigo
- ❑ Eyes/Ears/Sinuses
- ❑ Tinnitus
- ❑ Poor Immune Function
- ❑ Chronic Colds and Flu
- ❑ TMJ
- ❑ Facial Pain/Numbness
- ❑ Hormone Problem
- ❑ Thyroid Issue
- ❑ Pituitary/Adrenal Issue

Lungs
- ❑ Allergies
- ❑ Asthma
- ❑ Shortness of Breath
- ❑ Sleep Apnea
- ❑ Other

Heart
- ❑ Palpitations
- ❑ Murmur
- ❑ Irregular Beat/Arrhythmia
- ❑ High/Low Blood Pressure
- ❑ Heart Attack or Heart Disease
- ❑ Circulation Issues
- ❑ Other

Digestion
- ❑ Heartburn/Acid Reflux
- ❑ Ulcers
- ❑ Chronic Loose Stools
- ❑ Constipation
- ❑ Celiac Disease
- ❑ Colitis or Crohn's Disease
- ❑ Varicose Veins
- ❑ Liver Conditions
- ❑ Other

Reproductive / Urinary
- ❑ Prostate Issues
- ❑ Ovarian/Uterine Issues
- ❑ Irregular Menstrual Cycles
- ❑ Fertility Issues
- ❑ Kidney Issues
- ❑ Urinary Issues
- ❑ Other

Mental / Emotional
- ❑ Anxiety/Depression
- ❑ Insomnia
- ❑ Sleep Disorders
- ❑ ADD/ADHD
- ❑ Chronic Fatigue
- ❑ Poor Concentration
- ❑ Memory Loss
- ❑ Foggy Headed
- ❑ Moodiness
- ❑ Other

Notable / Neurological
- ❑ Multiple Sclerosis
- ❑ Trigeminal Neuralgia
- ❑ Meniere's Disease
- ❑ Parkinson's Disease
- ❑ Alzheimer's Disease
- ❑ Seizures/Epilepsy/Tremors
- ❑ Cerebral Palsy
- ❑ Dystonia/Paralysis
- ❑ Ataxia/Balance Issues
- ❑ POTS Syndrome
- ❑ Fibromyalgia
- ❑ Diabetes
- ❑ Cancer
- ❑ Autoimmune Disorder
- ❑ Spasms/Tremors
- ❑ AIDS/HIV
- ❑ Alcoholism
- ❑ Arteriosclerosis
- ❑ Arthritis
- ❑ Back Pain
- ❑ Osteoporosis
- ❑ Childhood Illness
- ❑ Shoulder/Elbow/Wrist/Hand
- ❑ Endocrine Issues
- ❑ Hip/Knee/Ankle/Foot
- ❑ Gout
- ❑ Hepatitis
- ❑ Lymphatic Issues
- ❑ Scoliosis
- ❑ Stroke

Financial Office Policy

All patients are on a cash basis until their respective insurance coverage and deductible are verified by our staff.

The Doctor will give you an estimate of the fees for service before they are performed or rendered.

If the deductible has not been met, you will be on a cash basis until such time that the deductible has been met.

After coverage and deductible are verified, this office may accept assignment on most policies provided the Insured /Patient signs an appropriate assignment of benefits and or lien (authorizing payment to be sent to the doctor).

Waiting for insurance payment is a courtesy and it may be withdrawn under certain circumstances.

We request full payment for your first office visit. As a patient, it is your responsibility to take care of the copayment, coinsurance, deductibles, and any non-covered services at the time of your office visit.. Supplements must be paid for at the time of purchase. This office may make payment arrangements on an individual basis. Any such plan or arrangement will be discussed during your report of findings. If you feel you need some assistance from a family member or parent with making a decision about your care, it is advisable that you bring them with you when the Doctor talks with you about your care.

This office does not warrant or guarantee that your insurance will pay. Nor does this office promise that an insurance company will or should pay the fees charged. Insurance policies are an arrangement between an insurance carrier and a patient or insured. Any services not covered or coverage reduction by your insurance will be the patient's responsibility. This office will resubmit a claim one time. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjuster, or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges on a timely basis.

If you receive any correspondence or checks from your insurance company, you agree to bring these into our office so that we may determine if any action needs to be taken or if the check is an assignment to this office.

If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, the bill is due and payable in full immediately, regardless of any claims submitted.

If you change insurance companies or employers, you agree to provide this office with current information immediately.

This office accepts, MasterCard, Visa, Cash, and Personal Checks.

Client understands that if they wish to stop care prior to utilizing all credits, clients account balance will be prorated based upon the full rate cash fee per visit.

I have read and understand the Financial Office Policy and agree to abide by these terms.

Patient Signature _____ **Date** _____

Parker
wellness center

Jeffry T. Parker, D.C.
7200 E. Hampden Avenue
Ste 103
Denver, CO 80224
(303) 758-0224

ACKNOWLEDGEMENT RECEIPT FOR NOTICE OF PRIVACY PRACTICE

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, hereby acknowledge that the office of Dr. Jeffry T. Parker has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints, I may contact:

Dr. Jeffry T. Parker
303-758-0224

I also understand that I am entitled to receive updates upon request if Dr. Parker amends or changes the Notice of Privacy Practices in a material way.

_____ _____
Signature Relationship to Patient, if signed by someone other than patient.

_____
Date

THIS SECTION IS TO BE COMPLETED BY THE STAFF
IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable because:

( ) Patient declined to sign this Written Acknowledgment
( ) Other (specify): _____

_____ _____
Name and title of employee Date

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