POWERS CHIROPRACTIC

5430-A Powers Center Point, Colorado Springs, CO, 80920

719-594-4223

Name _____ Gender _____ Date _____

Address _____ City_____

State _____ Zip _____ Date of Birth_____ Cell Phone _____

Home Phone _____ Work Phone_____

Occupation_____ Employer _____

Marital Status (M) (S) (W) (D) Soc Sec Number _____

I AUTHORIZE POWERS CHIROPRACTIC TO SEND ME E-MAILS REGARDING MY CONDITION, CLINIC UPDATES, AND HEALTH NEWSLETTERS, ETC…

E-mail _____ Signature _____

Referred by _____

Have you previously had chiropractic care? _____ If so when & where? _____

1. Primary reason for seeking chiropractic care

Chief Complaint _____

Secondary Complaint _____

2. What aggravates your condition _____

_____

3. Any lost work days _____ If so, # of days lost ____ Currently off work? _____

4. Previous interventions related to your <u>PRESENT</u> condition

Medical Treatments _____

Medications _____

Surgeries _____

Physical Therapy _____

Home Remedies _____

Other _____

5. Do these conditions disrupt (check those that apply)

___ Career ___ Family Life ___ Sleep ___ Social Life ___ Exercise

6. How long have you been living this way # of weeks___ # of months___ # of years__

7. What results would you want for yourself (please circle)

Pain Relief Correct cause of symptoms Optimal Health

8. Past/Present Illnesses _____

_____

9. Previous injuries, falls, traumas, &/or accidents _____

_____

10. Previous Surgeries (Type & Date)

_____ _____

_____ _____

_____ _____

11. Current Medications

Name	Reason for taking	How long have you taken it?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

12. Allergies _____

13. WOMEN ONLY Pregnancies

Date of Delivery	Type of Delivery (abbrev.)
_____	_____
_____	_____
_____	_____
_____	_____

Examples of types of delivery

(N)-Normal Natural Birth

(C)-C Section

(B)-Breech (SB)-spinal block

(M)-Miscarriage (F)-Forceps/suction

14. Social and Occupational History

Job Description _____

Work Schedule _____

Recreational Activities _____

Lifestyle (hobbies, exercise, diet) _____

15. Immediate Family Health History

Relation	Condition	Cause of Death (If applicable)	Age of Death (If applicable)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

POWERS CHIROPRACTIC TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both parties to be working towards the same objective.

Chiropractic has only one goal. 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.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____, have read and fully understand the above statements
Print name

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

_____ _____
Signature ***Date***

WOMEN ONLY **Pregnancy Release**

Are you pregnant? ____ Yes ____ No If yes, Due Date _____
Sign here _____ **Today's Date** _____

OR ….. This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her 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 period: _____

_____ _____
Signature ***Date***

CONSENT TO TREAT A MINOR CHILD

I, _____, being the parent or legal guardian of _____

Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

_____ _____
Signature ***Date***

POWERS CHIROPRACTIC

**** This page is for MEDICARE as Primary Insurance Carrier or VA (Veteran's Administration) Pre-Authorization ONLY ****

Authorization to Release Information

I hereby authorize Powers Chiropractic Group to release any information concerning my physical condition which may be deemed appropriate and necessary to any insurance company and/or adjuster, attorney, or social worker in order to have processed any claim for reimbursement to charges incurred by me as a result of professional services rendered by my treating doctor at Powers Chiropractic.

Assignment of Benefits/Authorization to Pay Doctor Directly

CIRCLE ONE::: MEDICARE or TRIWEST (VA)

I hereby assign benefits directly to my treating doctor at Powers Chiropractic for all professional services rendered. I hereby authorize payment to be made by the above-named insurance company to my treating doctor for any sum I owe, or may owe in the future, to my treating doctor in connection with any professional services rendered to me.

Please Initial

_____ I understand that if my insurance company does not pay, that I will be held financially liable for any amount the insurance does not cover.

_____ It's my responsibility to know my insurance coverage. Powers Chiropractic will verify my Insurance only as a courtesy.

_____ _____

Signature of Patient ***Date***

Powers Chiropractic

Electronic Communication Agreement

We use email and text messaging to communicate with patients regarding care, treatment, scheduling, and billing. By signing below, you consent to these communications.

Benefits

- Convenient and efficient
- Creates a written record
- Allows non-urgent questions to be addressed without a call or visit

Please be aware

- Messages may be delayed, misdirected, or lost
- Unauthorized access or impersonation is possible
- Not suitable for emergencies or urgent matters

Our Policies

1. No Emergencies: Do not use email or text for urgent or emergency issues. Call 911 if needed.
2. Privacy & Records: All messages become part of your medical record and are protected under our privacy policies.
3. Your Responsibility: Keep your contact info secure and notify us of changes.
4. Voluntary: Use of email/text is optional. We may disable it if misused or if your account is compromised.
5. Limited Use: We will only contact you for matters related to your care. Your information will not be shared outside our office.

Acknowledgement and Consent

I understand the above and agree to communicate electronically with Powers Chiropractic as it relates to my care.

PRINTED Name: _____

Signature: _____

Date: _____

Cell (for texts): _____

Email: _____

HIPAA PATIENT CONSENT FORM

Authorization for Use and Disclosure of Protected Health Information

Patient Full Name _____ Date of Birth _____

1. Purpose of This Form

This form authorizes Powers Chiropractic ("the Practice") to use and disclose your protected health information (PHI) as described below, in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and applicable regulations.

2. Information That May Be Used or Disclosed

Your PHI may include, but is not limited to:

- Medical history, diagnoses, and treatment records
- Billing and insurance information
- Laboratory results, imaging, and test reports

3. Permitted Uses and Disclosures

The Practice may use or disclose your PHI for the following purposes:

- Treatment: Coordinating your care with other healthcare providers
- Payment: Processing insurance claims and billing
- Healthcare Operations: Quality improvement, audits, and staff training
- As Required by Law: Reporting to public health authorities or law enforcement when mandated

4. Your Rights

You have the right to: (a) request restrictions on how your PHI is used; (b) revoke this consent in writing at any time, except where disclosure has already occurred; (c) receive a copy of our Notice of Privacy Practices; and (d) file a complaint with the U.S. Department of Health & Human Services if you believe your privacy rights have been violated.

5. Acknowledgment

By signing below, I acknowledge that I have received, read, or been offered a copy of this practice's Notice of Privacy Practices, and I consent to the use and disclosure of my protected health information as described above.

Patient Signature (or Authorized Representative) _____ Date _____

Printed Name of Patient or Representative _____ Relationship to Patient (if not self) _____

For Office Use Only — Staff Initials: _____ Date Received: _____