

PATIENT INFORMATION

Date _____
Last Name _____
First Name _____ Middle Initial _____
Address _____
City _____ State _____ Zip _____
Email _____
 Male Female Age _____ Date of Birth _____
Occupation _____
Employer _____
Home Phone _____ Work Phone _____
Cell Phone _____

IN CASE OF EMERGENCY, CONTACT:

Name _____
Relationship _____
Home Phone _____
Alternate Phone _____

ACCIDENT INFORMATION

Is condition due to an accident? Yes No Date _____
Type of accident Auto Work Home Other
Claim or Attorney Information
Name and Firm Name _____
Address _____
Phone Number _____
Case / Claim Number _____

PATIENT CONDITION

When did your symptoms appear? _____
Is this condition getting progressively worse? Yes No Unknown
Mark an X on the picture where you continue to have pain, numbness, or tingling:
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain): 1 2 3 4 5 6 7 8 9 10
Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other
How often do you have this pain? _____
Are you currently experiencing: Fever Chills Night Sweats Nausea Dizziness
 Arm/Hand Numbness/Tingling Leg/Foot Numbness/Tingling
 Severe Headaches Unintentional Weight Loss Pain wakes you up

INSURANCE INFORMATION

Who is responsible for this account? _____
Relationship to patient _____
Insurance Company _____
ID # _____ Group # _____
Subscriber's Name _____
Subscriber's DOB _____
Subscriber's Relationship to Patient _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with the Insurance company named above and assign directly to Dr. Geersen all insurance benefits, if any, otherwise payable to me for services rendered.

I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I UNDERSTAND AND AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY INSURANCE.

I UNDERSTAND AND AGREE THAT ALL COPAYS, DEDUCTIBLES AND TIME OF SERVICE FEES ARE DUE AND PAYABLE THE DAY OF MY VISIT.

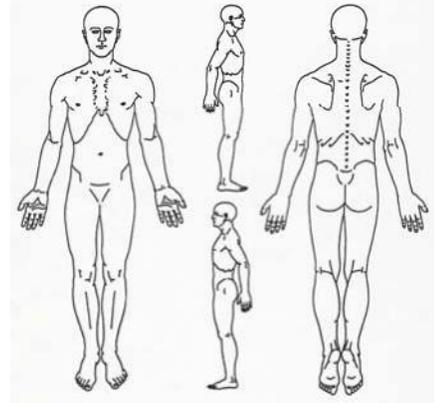
I UNDERSTAND AND AGREE THAT ANY REMAINDER AMOUNTS (SUCH AS CO-INSURANCE OR ANY PREVIOUSLY UNCOLLECTED AMOUNTS) ARE DUE AND PAYABLE UPON RECEIPT OF ANY STATEMENT RECEIVED.

Signature of Patient, Parent, Guardian or Personal Representative

Printed Name of Patient, Parent, Guardian or Personal Representative

Date

Relationship to Patient



HEALTH HISTORY

What treatment have you received for your condition? Medications Surgery Physical Therapy Chiropractic None Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-ray _____ Blood Test _____ Urine Test _____

Spinal Exam _____ Chest X-ray _____ Dental X-ray _____ MRI/CT/Bone Scan _____

Are you taking any of the following medications/vitamins/herbs/supplements ? Yes No

Please list all: _____

Do you have, or have you ever had, any major health problems such as cancer, heart disease, stroke, diabetes, etc? Please explain.

Exercise None Moderate Daily Heavy _____

Work Sitting Standing Light Labor Heavy Labor _____

Habits Smoking ___ packs/day Alcohol ___ drinks/week Caffeine ___ cups/day High stress _____

Injuries/Surgeries you have had:

Falls _____

Head Injuries _____

Broken Bones _____

Dislocations _____

Surgeries _____

Additional Information:



Paul Geersen, DC, CCEP
66 W. Springer Drive, Suite 308
Highlands Ranch, CO 80129
Phone: 303-471-4800
www.drgeersendc.com

INFORMED CONSENT

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 and extremity 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 a part of the analysis, examination, and treatment, you are consenting to the following procedures unless otherwise crossed out by you, with your initials next to each procedure you are NOT consenting to:

Spinal/extremity manipulative therapy	Palpation	Vital signs
Range of motion testing	Orthopedic testing	Basic neurological testing
Muscle strength testing	Postural analysis	Electric muscle stimulation
Exercise	Hot/cold therapy	Ergonomic recommendations
Radiographic studies	Soft tissue techniques	Nutritional recommendations
Other (please explain)		

Patient should cross out and initial each procedure above that they are NOT consenting to

The material risks inherent in chiropractic adjustment.

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 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.

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.

**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 Paul Geersen, DC 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.

Dated: _____

Dated: _____

Patient's Name

Paul Geersen, DC, CCEP

Doctor's Name

Signature

Signature

Signature of Parent or Guardian
(if a minor)



PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice’s Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (“PHI”) necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that may be used by the Practice: a) a postcard mailed to me at the address provided by me; b) telephoning my home and leaving a message on my voicemail or with the individual answering the phone; c) electronic communication via email or text message.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (Printed)

Signature of Individual

Signature of Legal Representative
(e.g. attorney-in-fact, guardian, parent if minor)

Relationship

Date signed

Witness

This form was developed by the ACA (American Chiropractic Association) and is distributed with their permission.