Welcome to Alliance Health Partners and Optima Rehabilitation!

You are scheduled with	❑ Chad Abercrombie, DC ❑ James Thatcher, DC ❑ Scott Oliphant, DC ❑ Olivia Stanzer, PT	on _____ at _____.

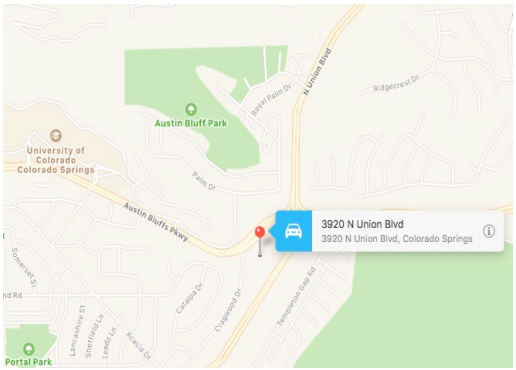
Enclosed is your initial patient paperwork. Please fill it out as completely as you can and sign by the X's. If you cannot finish your paperwork, please arrive ***at least 15 – 30 minutes*** prior to your scheduled appointment time to complete it before seeing the doctor or physical therapist. If you have any question prior to your appointment regarding your new patient paperwork, please feel free to call us. If possible, you should call your insurance carrier, prior to your scheduled appointment, to verify if you have chiropractic or physical therapy benefits. This will prevent you from acquiring any unnecessary charges.
It is very important to obtain and supply us with as much insurance information as you can. We cannot process your claims without it. ***Please bring with you to the appointment***:

Your Driver's License or Identification Card
Insurance Card of the Health Insurance your claims will be sent to
Insurance Card of the Auto Insurance your claims will be sent to (f applicable)
We MUST have a copy of these cards in your file.

In addition, please have the following information with you at your initial appointment, or indicate it on your new patient paperwork:

Health Insurance Carrier's Name, Address, Phone Number, and Policy Number
Auto Insurance Carrier's Name, Address, Phone Number, and Claim Number (if applicable)
Adjuster's Name and Phone Number (if applicable)
Name and Social Security Number of Insured
Attorney's Name, Address, and Phone Number (if applicable)

As we only have a limited number of appointments available, ***attending your initial evaluation at the scheduled day and time above is extremely important***. With your initial evaluation, the doctors and/or physical therapist will establish an appropriate plan of care, including the initial frequency and duration of your treatment. If we determine that you are a candidate for our care, it may take at least 4 – 12 visits to properly stabilize your condition. The most important factor in your treatment is consistency, thus missed or cancelled appointments are rarely tolerated.
We are located in the Premier Health Plaza, at the corner of Austin Bluffs Pkwy and Union Blvd, at 3920 N Union Blvd, Suite 160.



Thank you for your attention to this important matter. We look forward to meeting you and participating in your health care.
If you should have any questions, please contact us at: *Alliance Health Partners (719) 632-4754 info@ahpchiro.com*
Optima Rehabilitation (719) 471-4221 pt@optimarehab.com

The Doctors and Staff,
Alliance Health Partners and Optima Rehabilitation

New Patient Checklist

Dear Patient:

Listed below are the items, corresponding to your patient type, which you will need to complete prior to starting care in our office. Thank you for your cooperation in completing all items are to ensure that your care goes as smooth as possible. If you have any questions please call us at 471-4221 or 632-4754.

Please bring the following items to your first appointment:

Personal Pay Patients

- ❑ Your paperwork, with all areas filled out and signed
  **If you cannot complete the paperwork prior to your visit please arrive 15-30 minutes early.*
- ❑ Your Driver's License or Identification Card
- ❑ Doctor's Referral/Prescription, if applicable

Health Insurance Patients

- ❑ Your paperwork, with all areas filled out and signed
  **If you cannot complete the paperwork prior to your visit please arrive 15-30 minutes early.*
- ❑ Your Driver's License or Identification Card
- ❑ Your Health Insurance Card
- ❑ Doctor's Referral/Prescription, if applicable
- ❑ Please call our office to verify your benefits for our services, so we can explain what your out of pocket co-pays, co-insurance, deductibles, or other costs will be prior to your first visit.

Workers Compensation Patients

- ❑ Your paperwork, with all areas filled out and signed
  **If you cannot complete the paperwork prior to your visit please arrive 15-30 minutes early.*
- ❑ Your Driver's License or Identification Card
- ❑ Your Workers Compensation Insurance information, including:
  - ❑ Insurance Company Name
  - ❑ Adjuster's Name
  - ❑ Address
  - ❑ Phone Number
  - ❑ Fax Number
  - ❑ Claim Number
- ❑ Doctor's Referral/Prescription, if applicable

Auto Accident and Personal Injury Patients

- ❑ Your paperwork, with all areas filled out and signed
  **If you cannot complete the paperwork prior to your visit please arrive 15-30 minutes early.*
- ❑ Your Driver's License or Identification Card
- ❑ Your Auto Insurance Card
- ❑ Your Auto Insurance information, including:
  - ❑ Insurance Company Name
  - ❑ Adjuster's Name
  - ❑ Address
  - ❑ Phone Number
  - ❑ Fax Number
  - ❑ Claim Number
- ❑ Liability Limits of at-fault policy
- ❑ Doctor's Referral/Prescription, if applicable
- ❑ A copy of the accident report, if available.
- ❑ The At-Fault party's insurance information, including:
  - ❑ Insurance Company Name
  - ❑ Adjuster's Name
  - ❑ Address
  - ❑ Phone Number
  - ❑ Fax Number
  - ❑ Claim Number
  - ❑ Liability Limits of at-fault policy

PATIENT INFORMATION

Name: _____ Date: _____

Address: _____
Street Address/P.O. Box *City* *State* *Zip*

Home Phone #: _____ Work Phone #: _____ E-mail Address: _____

❒ Male ❒ Female Date of Birth: ____/____/____ Age: _____ Height: _____ Weight: _____ SSN: _____

Marital Status: ❒ *Single* ❒ *Married* ❒ *Divorced* ❒ *Widowed* ❒ *Separated* ❒ *Children: # of* _____

Education: *# of years completed:* _____ ❒ *Full-time student* ❒ *Part-time student* ❒ *Non-student*

Employed: ❒ *Full-time* ❒ *Part-time* ❒ *Retired*
Work Status: ❒ *Working without restrictions* ❒ *Working with restrictions, please list:* _____ ❒ *Not working/off work since* _____

Employer: _____ Occupation/Job Title: _____

Job Description: _____ Years Employed: _____

Work Requirements: ❒ *Bend* ❒ *Stoop* ❒ *Stand* ❒ *Walk* ❒ *Climb* ❒ *Sit* ❒ *Crawl* ❒ *Reach* ❒ *Push* ❒ *Pull* ❒ *Kneel*
❒ *Computer Work* ❒ *Phone Work* ❒ *Fine hand skills* Lifting requirement: Max _____ lbs Repetitive _____ lbs

Address: _____
Street Address/P.O. Box *City* *State* *Zip*

Date of injury, surgery, or onset of symptoms: _____

What type of injury are we seeing you for?
❒ *Auto* ❒ *Sports Injury* ❒ *No specific trauma*
❒ *Work* ❒ *Slip & Fall* ❒ *Other*

Emergency Contact, not living with you:
Name: _____ Relationship _____
Address _____
Phone #: Cell #:

	Please provide the following information:	***For Office Use Only***	
✓	Copy of your Driver's License or Identification Card		
✓	Copy of the Accident Report		
✓	Copy of the Exchange of Information Form		
✓	Copy of your Auto Insurance Card		
✓	Signed Doctor's Lien		

✓ **PATIENT'S AUTO INSURANCE INFORMATION**

Insurance Company: _____ Claim #: _____

Adjuster's Name: _____ Adjuster's Phone #: _____ Med-Pay Balance $ _____

✓ **AT FAULT PARTY'S INSURANCE INFORMATION**

Insurance Company: _____ Claim #: _____

Adjuster's Name: _____ Adjuster's Phone #: _____ Liability Limits $ _____

✓ **PATIENT'S HEALTH INSURANCE INFORMATION**

Insurance Company: _____ Group/Policy #: _____

✓ **ATTORNEY INFORMATION**

Name of Attorney: _____ Date attorney was retained: _____

Phone #: _____ Fax #: _____

24 HOUR HISTORY

Patient Name: _____ **Date:** _____

Time: _____

How much sleep did you get last night? *(Please circle one)* 1 2 3 4 5 6 7 8 9 10 *(hours)*

How much sleep did you get the night before last night? *(Please circle one)* 1 2 3 4 5 6 7 8 9 10 *(hours)*

Symptoms compared to your last visit with referring physician? *(Please circle one)* Worse Same Better

If worse or better, how much? *(Please circle one)* 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Today your symptoms are?? *(Please circle one)* Lower Average Higher than normal

Today your pain/symptoms are? *(Please circle one)* 0 1 2 3 4 5 6 7 8 9 10
(10 being most severe and 0 being none)

When did you last consume, do or have the following items:

Smoke: _____ *Packs per day:* _____ *Cigarettes per day:* _____ *How long have you smoked?* _____

Drugs/Medications *(including aspirin):* _____

Alcohol: _____ *How much:* _____ *How often:* _____ *How long have you drank?* _____

Donated blood: _____

Any recent illness: _____

What sort of exercise did you perform yesterday?_____

What sort of exercise did you perform today?_____

_____
Patient's Signature

FINANCIAL POLICY

Welcome to our office! We are pleased that you have chosen Alliance Health Partners/Optima Rehabilitation/Colorado Springs Massage to provide your care and services. We would like to take a moment to inform you of our policies, regarding payment with the office. We accept cash, personal checks and credit card (VISA, MasterCard, American Express or Discover) for payment on your account.

PATIENTS WHO NEGLECT TO SUPPLY THIS OFFICE WITH THE NECESSARY INFORMATION/FORMS WITHIN A REASONABLE AMOUNT OF TIME **WILL BE RESPONSIBLE FOR PAYMENT IN FULL**.

AUTO/PERSONAL INJURY INSURANCE (PIP, Med-Pay, 3rd Party, Lien): You will be required to complete specific forms pertaining to your situation. If this information is not provided within a reasonable amount of time, you will be responsible for payment in full. If we are required to send your account to collections, the balance due on that date will be doubled and interest at the rate of 1.5% per month will also be added to the balance due, plus collection fees and reasonable attorney fees. If you have scheduled an appointment and do not cancel 24 hours prior to your appointment, you will be charged a $50.00 no show fee. ***Auto insurance/personal injury claims will not be billed under a general health or contracted insurance plan***.

WORKER'S COMPENSATION: You will be required to complete specific forms pertaining to your situation. If this information is not provided within a reasonable amount of time, you will be responsible for payment in full.

CONTRACTED HEALTH INSURANCE (HMO, PPO, EPO, POS): If you have insurance we are contracted with, we will submit your insurance claims for you, if you supply us with the necessary information. This includes a copy of your card, and address to submit claims to and a telephone number to allow us to verify coverage. You are still responsible for payment of your co-payment at the time of service, and any amounts not covered by your insurance, including co-insurance and deductibles. If your coverage is denied for any reason including but not limited to denials for not medically necessary, you are responsible for payment of the entire balance due, based on our normal fee schedule. ***You are responsible for obtaining your referral or authorization to be seen in our office. If you do not have a current referral or authorization, we ask that you reschedule or sign a waiver for no referral or authorization thus holding you financially responsible.***

PRIVATE INSURANCE: As a courtesy, we are happy to file your insurance for you. You will be required to provide all the necessary billing information. ***If you owe on your deductible or a co-insurance, we will need to collect at the time of service.*** All insurance payments that are paid directly to you should be endorsed and paid to Alliance Health Partners/Optima Rehabilitation. It is your responsibility to contact your insurance in the event of non-payment.

MEDICARE: We are participating with the Medicare program. *We will submit your claim/services to Medicare. Medicare will process payment to us.* You will be responsible for your deductible and any co-insurance, if you do not have secondary/supplemental insurance. If the payment from your secondary/supplemental is directed to you, we will expect you to forward payment to us.

CASH ONLY PLAN/NO INSURANCE: *Payment in full is due the day services are rendered* by all patients on a cash only plan. *Prompt payment is expected.* Unless prior arrangements are made, overdue accounts will incur a 1.5% interest rate per month, plus collection fees and reasonable attorney fees.

I have read and understand the payment policies set forth and have been given the opportunity to ask questions about this policy. I understand my responsibility for payment with Alliance Health Partners/Optima Rehabilitation/Colorado Springs Massage.

_____ _____

Patient's Signature (Responsible party over 18 years old) *Date*

DOCTOR'S LIEN

Patient Name: _____

Facility: *Optima Rehabilitation*
3920 N Union Blvd Suite 160
Colorado Springs, CO 80907
Phone: (719) 632-4754 or (719) 471-4221
Fax: (719) 471-3734
E-mail: pt@optimarehab.com

Re: Authorization for Release of Records and Doctor's Lien, Assignment, and Direction to my Attorney

I hereby authorize *Optima Rehabilitation* to furnish you, my attorney, with a full report and records regarding case history, examination, diagnosis, treatment, and prognosis with regard to treatment related to my accident, which occurred on _____.

I hereby give a lien and assignment to *Optima Rehabilitation* on the proceeds or any settlement, claim, judgment, or verdict which results from said accident and hereby authorize, direct, and instruct you, my attorney, to pay directly to *Optima Rehabilitation* such sums as may be due and owing for service rendered me, and to withhold such sums from such settlement, claim, judgment, or verdict as may be necessary to protect *Optima Rehabilitation* adequately and such sums as may be necessary to fully and completely pay *Optima Rehabilitation* any outstanding balance owed at the time of distribution of funds from an settlement, claim, judgment, or verdict.

If *Optima Rehabilitation* is required to send your account to collections the balance due on that date will be doubled and interest at the rate of 1.5% per month will also be added to the balance due, plus collection fees and reasonable attorney fees. If you have scheduled an appointment and do not cancel 24 hours prior to your appointment, you will be charged a $50.00 no show fee.

I fully understand that I am directly and fully responsible to *Optima Rehabilitation* for all bills submitted by *Optima Rehabilitation* for services rendered to me, and that this agreement is made solely of *Optima Rehabilitation* additional protection and in consideration of said doctors awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict.

To My Attorney: I direct that you be bound by this lien an treat it, irrevocably, as an assignment to *Optima Rehabilitation* of any sums that may be due to me, to the extent and according to the terms set forth above. Be advised that *Optima Rehabilitation* is relying upon this lien, assignment, and directive to you, and as a result of such reliance, at my request, is providing health care and treatment for which this lien, assignment, and directive to you provides security for payment. Moreover, it is my intention that *Optima Rehabilitation* be viewed as a third party beneficiary of this direction to you, and I intend thereby to impose upon you an obligation to *Optima Rehabilitation* to comply with the terms of this direction to you.

_____ _____
Patient's Signature *Date*

NOTICE TO INSURANCE COMPANY ASSIGNMENT

PLEASE SIGN, DATE AND ADDRESS AT THE "X" ONLY

Patient Name: _____

Pay to: *Optima Rehabilitation*
3920 N Union Blvd Suite 160
Colorado Springs, CO 80907
Phone: (719) 471-4221
Fax: (719) 471-3734
E-mail: pt@optimarehab.com

You are instructed to pay directly to the doctor/therapist at the doctor's/therapist's office, for all professional services rendered to me. This instruction to you is an assignment of my rights under medical coverage to the extent of this bill. Any sum of money paid under this assignment shall be credited to my account, and I shall be personally liable for any unpaid balance to the doctor/therapist. Also I am personally liable for any unpaid accounts for hospital diagnostic, and consultant services.

In the event you should make payment directly to me, I agree that I will become personally liable for all charges submitted to you for payment, including all costs, attorney fees and collections fees.

I hereby authorize the doctor/therapist listed above to furnish you the information and evidence in the doctor's possession regarding my history and physical condition.

Signature: **X** _____

Date: _____

Address: _____

_____

Witness: _____

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act f 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out.

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company).
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date: _____

Patient Name (print): _____

Relationship to patient: _____

Signature: _____