



Welcome to Alliance Health Partners and Optima Rehabilitation!

You are scheduled with Chad Abercrombie, DC on _____ at _____.

James Thatcher, DC

Scott Oliphant, DC

Olivia Stanzer, PT

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:**

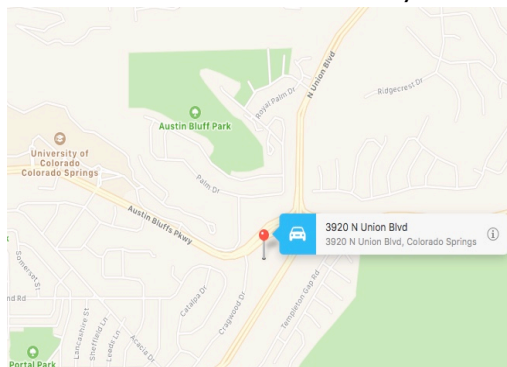
- Your Driver's License or Identification Card
- Insurance Card of the Health Insurance your claims will be sent to
- Insurance Card of the Auto Insurance your claims will be sent to (if applicable)
- We MUST have a copy of these cards in your file.**

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

Exercise Habits: Aerobic: Frequency ____/week Type: _____ Other: Frequency ____/week Type: _____

Dominant Hand: Left Right Corrective glasses/contacts: Yes No Implants/Devices: Yes No

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: _____

Emergency Contact, not living with you:

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

Name: _____ Relationship _____
 Address _____
 Phone #: _____ Cell #: _____

Please provide the following information:		For Office Use Only	
<input checked="" type="checkbox"/>	Copy of your Driver's License or Identification Card		
<input checked="" type="checkbox"/>	Copy of your Health Insurance Card		

PATIENT'S HEALTH INSURANCE INFORMATION

Insurance Company: _____ Group/Policy #: _____

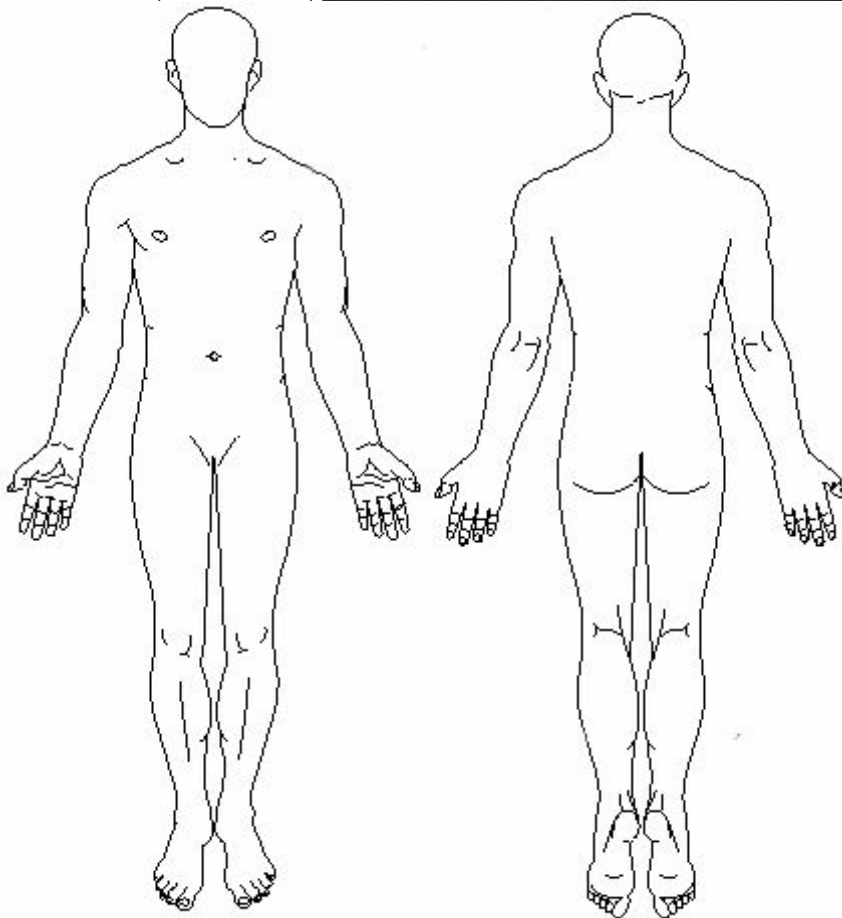
PATIENT PAIN PROFILE

Patient Name: _____

Date: _____

On the following illustration, use the letter keys below to mark the areas on your body where you feel the described sensation:

- KEY
- A = ACHE N = NUMBNESS P = PINS & NEEDLES B = BURNING S = STABBING
 O = OTHER (Please describe): _____



What percent of the time is your pain present? *If your pain is there all the time, in varying degrees, that would indicate 100%.* _____%

Rate the intensity level of your pain. *Refer to the color chart we have provided to rate your pain intensity. 10/10 is considered "Emergency Room" pain.*

Average day: _____/10 Good day: _____/10 Bad day: _____/10 Today: _____/10

Rate the level of functional deficit you experience due to your pain. _____/10

A rating of 10/10 would indicate severe disability where you are bedridden or should be in the emergency room.

Complete the following chart to assess your present symptoms, which resulted from your injuries:

	<u>Symptom Description</u> <i>Describe each symptom, including area, as clearly as possible.</i>	<u>Frequency</u> <i>Enter the amount of time, on a percentage basis, that the symptom is present during your waking hours</i>	<u>Intensity Range</u> <i>Using a scale of 0-10, where 10 is the <u>worst</u> pain imaginable, rate the pain intensity level for each symptom.</i>
1		%	/10
2		%	/10
3		%	/10
4		%	/10
5		%	/10

FUNCTIONAL RATING INDEX – FOR USE WITH NECK AND/OR BACK PROBLEMS ONLY

Patient Name: _____ **Date:** _____

In order to properly assess your condition, we must understand how much **your neck and/or back problems** have affected your ability to manage everyday activities.

For each item below, **please mark the number that most closely describes your condition right now.**

SECTION 1 - Pain Intensity

- ⓪ No pain
- ① Mild pain
- ② Moderate pain
- ③ Severe pain
- ④ Worst possible pain

SECTION 2 - Sleeping

- ⓪ Perfect sleep
- ① Mildly disturbed sleep
- ② Moderately disturbed sleep
- ③ Greatly disturbed sleep
- ④ Totally disturbed sleep

SECTION 3 - Personal Care (washing, dressing, etc.)

- ⓪ No pain; no restrictions
- ① Mild pain; no restrictions
- ② Moderate pain; need to go slowly
- ③ Moderate pain; need some assistance
- ④ Severe pain; need 100% assistance

SECTION 4 - Travel (driving, etc.)

- ⓪ No pain on long trips
- ① Mild pain on long trips
- ② Moderate pain on long trips
- ③ Moderate pain on short trips
- ④ Severe pain on short trips

SECTION 5 - Work

- ⓪ Can do usual work plus unlimited extra work
- ① Can do usual work; no extra work
- ② Can do 50% of usual work
- ③ Can do 25% of usual work
- ④ Cannot work

SECTION 6 - Recreation

- ⓪ Can do activities
- ① Can do most activities
- ② Can do some activities
- ③ Can do a few activities
- ④ Cannot do any activities

SECTION 7 - Frequency of Pain

- ⓪ No pain
- ① Occasional pain; 25% of the day
- ② Intermittent pain; 50% of the day
- ③ Frequent pain; 75% of the day
- ④ Constant pain; 100% of the day

SECTION 8 - Lifting

- ⓪ No pain with heavy weight
- ① Increased pain with heavy weight
- ② Increased pain with moderate weight
- ③ Increased pain with light weight
- ④ Increased pain with any weight

SECTION 9 - Walking

- ⓪ No pain; any distance
- ① Increased pain after 1 mile
- ② Increased pain after ½ mile
- ③ Increased pain after ¼ mile
- ④ Increased pain with all walking

SECTION 10 - Standing

- ⓪ No pain after several hours
- ① Increased pain after several hours
- ② Increased pain after 1 hour
- ③ Increased pain after ½ hour
- ④ Increased pain with any standing

Score

Patient Name: _____

Date: _____

REVIEW OF SYSTEMS					
CARDIOVASCULAR					
Do you currently or in the past have:	Current	Past	Never		
Fast or slow heart rate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Extremity swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Artery plaque-hardening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
RESPIRATORY					
Do you currently or in the past have:	Current	Past	Never		
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Coughing up, other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Pain with step or walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Breathing problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Circulation problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Arm or hand achiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
GI/GU SYSTEM/SKIN					
Do you currently or in the past have:	Current	Past	Never		
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Frequent gas or belching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Gallbladder problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Pain with eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Menstrual pain or cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Urine flow or stop problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Pain with urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Bowel movement pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Lumps in breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Skin lesions or bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Changing moles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
MEDICATIONS					
Please list all currently used drugs (Rx/non-Rx), vitamins & herbs, other meds:					

HOSPITALIZATIONS/OPERATIONS					
Please list any & all hospitalizations/operations:					

HABITS					
Currently or in the past:	Amount/Day	Current	Past	Never	
Smoking	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Alcohol	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Street drugs	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Marijuana	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Coffee or tea	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CONSTITUTIONAL					
Do you currently or in the past have:			Current	Past	Never
Night sweats			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained weight loss			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood in stools			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood in sputum			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bore through pain			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain that awakens you			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drop attacks			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lip or face numbness			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech problems			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Body chills or convulsions			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Serious infections			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diffuse itchiness			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Balance or gait issues			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling off balance or faint			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nose bleeds			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent bruising			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double or altered vision			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
One-sided weakness			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FAMILY HISTORY					
Please list the age at diagnosis of each individual's condition, when applicable:					
	Self	Mother	Father	Sibling	
Breast/brain cancer					
Liver or pancreatic					
Cancer of GI system					
Blood cancer					
Bone cancer					
Other cancer					
Inflammatory					
Other arthritis					
Alcoholism					
Diabetes					
Hyper/hypo thyroid					
Heart disease					
High blood pressure					
Chronic pain					
Kidney disease					
Liver disease					
Spinal operations					
Psychiatric issues					
Headaches					
Migraine					
Vascular disease					
Peripheral vascular					
Clots or occlusions					
Stroke					
Blood disorder					
Bleeding disorder					
Palsy or seizures					
Nerve disorders					
TRAUMA OR PAIN HISTORY					
	Never	Yes, Year	Body Area(s)	Resolved	Persisted
Auto collisions	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Work injuries	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Other injuries	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Other pain syndromes	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please describe: _____					

Patient Name: _____ **Date:** _____

PATIENT TREATMENT HISTORY

Please list any type of test or treatment you have received:

Name of Hospital: _____

X-rays: _____

CT Scan: _____

MRI: _____

Other diagnostic test: _____

Name of Urgent Care: _____

X-rays: _____

CT Scan: _____

MRI: _____

Other diagnostic test: _____

Name of Doctor: _____

Treatment received: _____

Referrals prescribed: _____

Medication prescribed: _____

Name of Doctor: _____

Treatment received: _____

Referrals prescribed: _____

Medication prescribed: _____

Name of Physical Therapy Clinic: _____

Treatment received: _____

Name of Massage Therapy Clinic: _____

Treatment received: _____

Name of Rehabilitation Clinic: _____

Treatment received: _____

Exercise recommended: _____

Bracing/Splints: _____

Spinal manipulation/adjustments: _____

Heat packs: _____

Cold/ice packs: _____

Ultrasound: _____

Electrical muscle stimulation: _____

Other: _____

Treatment received: _____

Referrals prescribed: _____

Medication prescribed: _____

Other: _____

Treatment received: _____

Referrals prescribed: _____

Medication prescribed: _____

Other: _____

Treatment received: _____

Referrals prescribed: _____

Medication prescribed: _____

Other: _____

Treatment received: _____

Referrals prescribed: _____

Medication prescribed: _____

CONSENT FORM FOR CHIROPRACTIC TREATMENT

Manipulation/mobilization helps restore proper motion to the vertebral (facet) joints. During chiropractic treatment, the doctor will use his/her hands or a mechanical device in order to reestablish proper function to the spine and to reduce pain, edema and muscle spasm. You may feel a “click” or “pop”, such as the noise when a knuckle is “cracked”, and you may feel movement of the joint.

Possible risks:

As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joint, or injury to intervertebral discs, nerves or spinal cord. Stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment.

Dry needling or acupuncture treatment is generally safe and side effects are rare – less than 1 in 10,000 treatments. Drowsiness occurs after treatment in a small number of patients and, in rare instances, fainting can occur. Minor bleeding or bruising occurs in about 3% of treatments. Discomfort during treatment is normal. THIS OFFICE ONLY USES SINGLE-USE, STERILE, DISPOSABLE NEEDLES.

The risks of complications due to chiropractic treatment have been described as “rare”, about as often as complications are seen from the taking of a single aspirin tablet. The risk of stroke has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures.

Your chiropractor may also use modalities to enhance your recovery and reduce symptoms. These may include ultrasound, electrical modalities, laser therapy, heat and ice, and other modalities. These are rarely associated with side effects or complications, and the risks may include soreness, skin reactions, or other mild side effects. Please report these and any other side effects or complications to your doctor right away. If you have skin sensitivities, a pacemaker, pregnancy or any other health condition that would change your ability to be exposed to electrical modalities, topical creams, or other care restrictions, please advise your doctor immediately.

I, _____, understand the hazards and potential dangers involved in treatment by means of chiropractic. I believe that this treatment is in my best interest and I understand that no guarantee of results has been made.

I understand that it usually requires a series of chiropractic treatments to significantly change a condition and receive benefit.

My signature indicates that I have read and fully understand the above information regarding the consent to this procedure. I have had the opportunity to ask questions about any matter which I did not understand, and I have received satisfactory explanation to my questions. My signature below authorizes this procedure.

Patient/Authorized Representative Signature

Relationship to Patient

Date

Practitioner Statement:

The patient (or patient’s representative) and I have discussed this procedure, the risks and alternatives to this procedure. To the best of my knowledge, the patient (or patient’s representative) understands this procedure and consents to it.

Practitioner Signature

Practitioner Printed Name

Date

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

NOTICE TO INSURANCE COMPANY ASSIGNMENT

PLEASE SIGN, DATE AND ADDRESS AT THE “X” ONLY

Patient Name: _____

Pay to: Alliance Health Partners
3920 N Union Blvd Suite 160
Colorado Springs, CO 80907
Phone: (719) 632-4754
Fax: (719) 471-3734
E-mail: info@ahpchiro.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: _____

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: _____

NOTICE TO INSURANCE COMPANY ASSIGNMENT

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

Patient Name: _____

Pay to: Colorado Springs Massage
3920 N Union Blvd Suite 160
Colorado Springs, CO 80907
Phone: (719) 632-4754
Fax: (719) 471-3734
E-mail: info@ahpchiro.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.

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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 of 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: _____

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTHCARE INFORMATION FOR A SPECIAL PURPOSE

1. Individual Patient (or personal representative) Confirming the Authorization

I give authorization to use or disclose certain protected health information (PHI) about me as described below.
This authorization permits the use and/or disclosure of specific individually identifiable health information about me.

Patient's Legal Name (print): _____ *Date of Birth: _____
Patient's Previous Name: _____ Social Security #: _____
Address: _____ Phone Number: _____
City, State, Zip _____

2. People or Organizations Authorized to Use and Disclose

Physician or facility to **provide** records: _____
Address: _____ City, State, Zip: _____

3. People or Organizations Permitted to Use and Receive

Person to **receive** records: _____
Address: _____ City, State, Zip: _____

4. Protected Health Information To Be Used And Or Disclosed

Describe in detail the protected health information you are authorizing to be used and or disclosed:

Laboratory tests and other diagnostic reports All medical records at this facility

5. Purposes of the Requested Uses and/or Disclosures

The information will be used or disclosed for the following purposes: (at my request) _____

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

6. Ending this Authorization - Select ONE of the Following:

This authorization will expire on (Month/Day/Year) _____.
 This authorization will end when the following event happens. The event must be related to the individual or the purpose of the authorization us and for disclosure. Please describe the event: _____

7. Changing your mind about this Authorization

I understand that I may revoke this authorization at any time by giving written notice to the Privacy Officer listed below. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy.
Alliance Health Partners/Optima Rehabilitation/Colorado Springs Massage, 3920 N Union Blvd Ste 160, Colorado Springs CO 80907

8. Signing this Authorization is not a Condition of Treatment

I understand that under most circumstances a healthcare provider may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization.

9. Signature

I have had the chance to read and think about the contents of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations listed in this form.

Patient Name (print): _____
Signature: _____ Date (Month/Day/Year): _____
If a personal representative for the individual patient signs this authorization, complete the following:
Representative's Name (print): _____ Relationship to the Individual Patient: _____
Signature: _____ Date (Month/Day/Year): _____