CONFIDENTIAL HEALTH INFORMATION QUESTIONNAIRE

This information is needed so we can better serve you. Please fill in ALL portions of the form.
If you need assistance, please ask our receptionist, and we will be happy to help you.

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Age: _____ Date of Birth: _____ / _____ / _____ E-mail: _____

SS#: _____ Marital Status: M S D W Driver's License: _____

Your Occupation: _____ Employed By: _____

Address: _____

Is your visit due to an accident? Yes / No

Your Spouse's Name: _____

Spouse's Employer: _____ Spouse's Work #: _____

Name of person to contact in case of emergency: _____

Their cell and work phone number: (Cell) _____ (Work) _____

Who referred you to our office so we can thank them? _____

Referring Physician? _____

THERE WILL BE NO CHARGED SERVICES WITHOUT YOUR INFORMED CONSENT

I attest that the above information is true and correct to the best of my knowledge. I further understand that any charges incurred by me in this office are my sole responsibility, despite any insurance plan, legal involvement, or settlement.

Patient Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

Patient Name: _____ Date: _____

PAIN LOCATION, INTENSITY & FREQUENCY QUESTIONAIRE

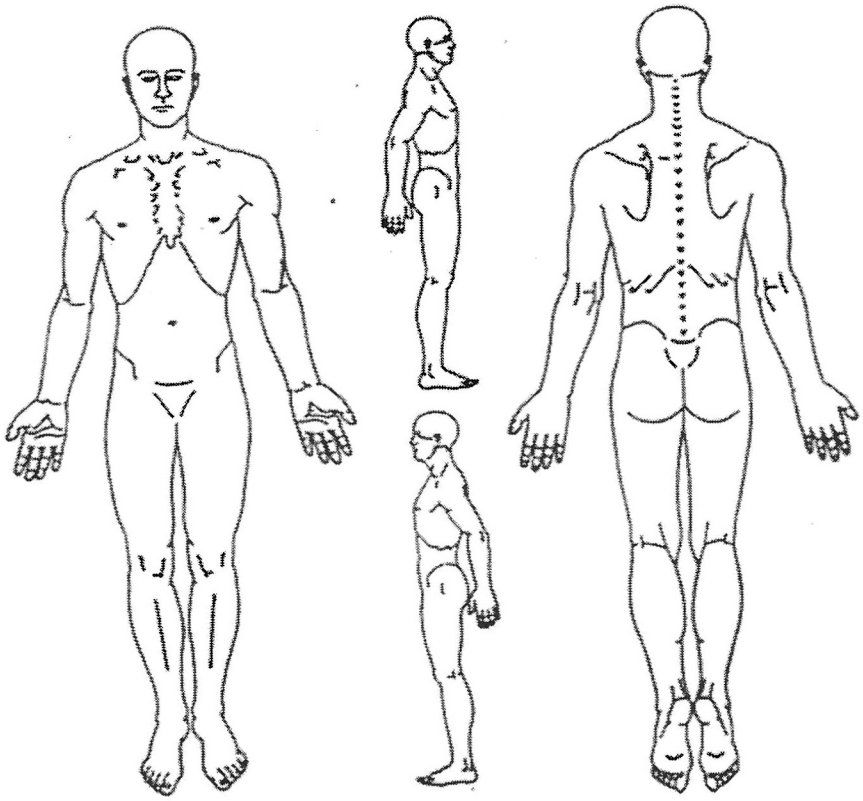
Primary Complaint: _____

Secondary Complaint: _____

Comments: _____

USE THESE LETTERS TO INDICATE TYPE AND LOCATION OF DISCOMFORT

A = ACHE	B = BURNING	C = STABBING
N = NUMBING	P = PINS & NEEDLES	O = OTHER



Please rate the INTENSITY and FREQUENCY of your pain using 0-10 pain scale
(0 = No pain, 10 = Most Severe Imaginable)

Present pain level ____ / Average pain level ____ / Present ____ % of the time

Worse pain ____ / Present ____ % of the time / Lowest pain level ____ / Present ____ % of the time

What increases your pain? _____

What gives you the greatest relief / control of pain? _____

What are you unable to do because of your pain? _____

Present Complaints (please circle all applicable):

Chest Pain	Fear	Mental Dullness	Pins and Needles - Arms (Right / Left)
Confusion	Feet/Hands Cold	Midback Pain	Pins and Needles - Hands (Right / Left)
Constipation	Head Seems Heavy	Midback Stiffness	Pins and Needles - Legs (Right / Left)
Depression	Headache	Neck Restriction	Unbalanced
Dizzy	Irritability	Neck Pain	Upper Back Pain
Ears - Ringing / Buzzing	Loss of Memory	Neck Stiffness	Upper Back Stiffness
Eyes - Strain / Pain	Loss of Taste	Nervousness	
Eyes - Blurred Vision	Loss of Smell	Rib Pain	
Eyes - Double Vision	Lower Back Pain	Shortness of Breath	
Fainting	Lower Back Stiffness	Tension	

Difficulty in: ❑ Standing ❑ Sitting ❑ Bending ❑ Walking

Pain radiation in: ❑ Right Arm ❑ Left Arm ❑ Right Leg ❑ Left Leg

Cannot lift: ❑ Light ❑ Moderate ❑ Heavy ❑ Repetitive

Pain radiating in: ❑ Neck ❑ Base of Skull ❑ Ribs ❑ Shoulders ❑ Arms

OTHER: _____

Since these complaints began, what have you tried that has not worked? _____

_____

Has the problem interrupted your sleep? Yes / No How? _____

List any doctors or therapists you have seen for these complaints:

1. _____ Specialty _____
2. _____ Specialty _____
3. _____ Specialty _____

Relevant medical history (please circle any current or previous conditions):

Arthritis	Digestion Problems	High Blood Pressure	Polio
Asthma	Dizziness	HIV	Rheumatic Fever
Anemia	Epilepsy	Measles	Sinus Trouble
Back Pain or Spasm	Fibromyalgia	Multiple Sclerosis	Sciatica
Cancer	Hand or Wrist Pain	Muscular Dystrophy	TB
Concussion	Headaches	Neck Pain or Spasms	Venereal Disease
Convulsion	Heart Problems	Neuritis	
Diabetes	Hepatitis	Numbness	

List any operations you've had, along with approximate dates

1. _____ Date: _____ Dr: _____
2. _____ Date: _____ Dr: _____
3. _____ Date: _____ Dr: _____
4. _____ Date: _____ Dr: _____

Any medication allergies? Yes / No

List: _____

Are you taking any medications? Yes / No

List: _____

Are you pregnant? Yes / No Due Date: _____

Smoke: Yes / No Amount per day: _____

Drink: Yes / No ❑ Light ❑ Medium ❑ Heavy

Exercise: ❑ Never ❑ Sometimes ❑ Frequently ❑ Regularly

Does anyone in your family have a similar condition? Yes / No

Relationship: _____ Explain: _____

Care they are receiving: _____

Is it helping? Yes / No

May we contact them regarding their condition? Yes / No

OFFICE FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care. Our payment plans make care an affordable part of your family budget.

IF YOU DO NOT USE INSURANCE: All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $100 at any time or care may be terminated.

IF YOU USE INSURANCE: All deductibles and co-payments are expected at the time of service or by an authorized payment plan. You are financially responsible for services that are not covered or denied by your insurance provider. Your co-insurance balance may not exceed $100 or care may be terminated.

You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage. Though we verify your eligibility and coverage with your insurance company, our verification is not a guarantee of coverage. You will be billed according to the explanation of benefits received for your claims.

Our fees are considered usual, customary, and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility of payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

When your schedule of visits is once per month or longer, you will not be eligible for insurance assignment. Charges for services rendered will be due as they are rendered or by an authorized payment plan.

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

Patient Name: _____

Signature: _____ Date: _____

ROCKY MOUNTAIN CHIROPRACTIC
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose our health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use or disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualification of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will affect any use or disclosures permitted by your authorization while it is in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except by those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment of your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative, or another responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials, health information required for lawful intelligence, or counterintelligence, or other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemails messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1.00 for each printed page, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer a summary or an explanation of your health information fees, contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint with the US Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the US Department of Health and Human Services.

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I, (print) _____ have received a copy of this office's Notice of Privacy Practices.

_____ _____
Signature Date

Contact Officer:
Dr. Vincent P Loparco DC
1880 Dublin Blvd. Ste. E
Colorado Springs, CO 80918
Phone: (719) 535-9900
Fax: (719) 535-9901

FRONT RANGE DIAGNOSTIC RADIOLOGY

226 PONDEROSA LN WOODLAND PARK, CO 80863 (719) 471-3070 FAX (719) 477-1990

PATIENT INFORMATION FORM

Date: _____ Name: _____ Date of Birth_____

Age: _____ Sex: _____ Marital Status (circle one): S M Sep Div Wid Social Security No: _____

Address: _____ City: _____

State _____ Zip Code: _____ Home #:_____ Cell#:_____

Work Phone: _____ Employer: _____

Spouse (parent, if patient is a child):_____ Work#:_____

Who is Responsible for this bill? _____

Nearest Relative not living with you: _____ Phone: _____

INSURANCE INFORMATION: PLEASE COMPLETE IN ITS ENTIRETY

PRIMARY INSURANCE

Insurance Company:_____

Address: _____

City, State, Zip: _____

Telephone:_____

Insured's Name_____

Insured's Date of Birth: _____

SS# of Insured Person: _____

ID or Claim#: _____

If Health Ins., Group No: _____

SECONDARY INSURANCE:

Insurance Company:_____

Address:_____

City, State, and Zip: _____

Telephone: _____

Insured's Name:_____

Insured's Date of Birth: _____

SS# Of Insured Person: _____

ID Or Claim#:_____

If Health Ins., Group No: _____

Type of Case: Group Health____ Auto ___ If Auto, Med Pay Benefits? Yes___ No___ Work Comp___ Self Pay____ Other:____

Attorney Information: Name:_____

Address:_____Telephone #:_____

CLINICAL INFORMATION

Chief Complaint: _____

Trauma: _____ Injury Date: _____

Surgery: _____ Malignancy: _____

Referring Clinic/Doctor: _____

I understand that there will be a separate fee for radiology services, I authorize the release of any medical information necessary to process this claim. I also authorize all claims to be sent directly to my insurance company and I authorize payment to be made directly to Front Range Diagnostic Radiology. I also agree to pay for any copay or deductible, and in the event that I should receive payment for these services, I agree to promptly remit payment to Front Range Diagnostic Radiology. I also accept personal responsibility for any balance due.

_____ _____

PATIENT SIGNATURE DATE