Thank you for carefully answering each question!

Patient: Black ink
Doctor: Blue ink

Motor Vehicle Accident Health History Form (page 1)

Date of the accident: _____ Approximate time of the accident: _____

Your Vehicle

What is the make & model of your car/truck? _____ What is the year? _____

Were you the: Driver Front right passenger Front middle passenger Rear passenger, driver's side
Rear passenger, right side Rear middle passenger Other: _____

At the time of the accident what kind of surface were you driving on?

Dry Pavement Wet Pavement Gravel Dirt Other:_____

Were you restrained by a seatbelt? No Yes If yes, what kind? Shoulder & lap belts Shoulder only Lap only

Did your seat have a headrest? No Yes Where was the top of the headrest positioned in relation to the top of your head? Above my head Below my head Level with my head

Do you recall how far your headrest was from the back of your head? No. 0-1 inches 1-3 inches 3 or more inches

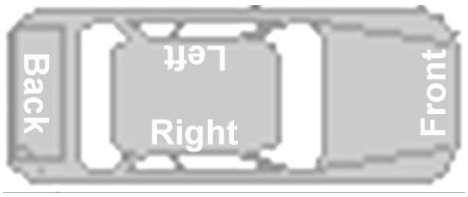
The Other Vehicle(s)

How many vehicles struck your car/truck? _____ If more than 1, please ask for another sheet of paper and answer the questions in this table for each vehicle.

What is the make & model of their vehicle? _____ What is the year?_____

The Accident

Approximately how fast were you going at the time of impact? ____MPH
Approximately how fast was the other car going at the time of impact? _____MPH
About how far did your car move after being struck? _____Ft.
If your car was standing still at the point of impact, where was your foot or feet?
Pressed on the brake Resting on the break Off the break Pressing on the clutch
Where was your head facing when the collision occurred?
Looking right at rearview mirror Looking right through a window Looking left through a window
Looking right through back window Looking up Looking down



Doctor's Notes: _____
_____
_____

Thank you for carefully answering each question!

Patient: Black ink
Doctor: Blue ink

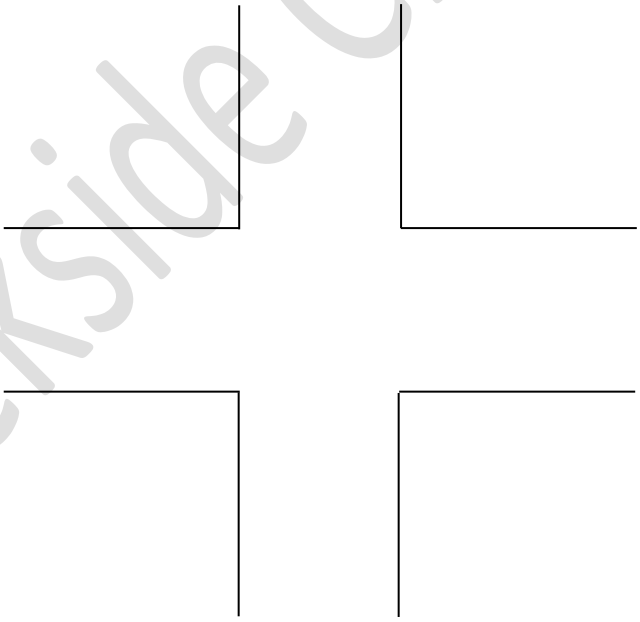
Motor Vehicle Accident Health History Form (Page 2)

The Accident (Continued)

Which direction did the striking vehicle come from?	Head on (from front) From behind From the right From the left Diagonal or obliquely from: _____
After the accident did you strike anything else? No Yes	If yes, describe: _____ _____
Was there any damage done to **your** vehicle? No Yes	If yes, how extensive: _____ _____
Was there any damage done to the **other** vehicle? No Yes	If yes, how extensive: _____ _____
Did your airbags deploy? No Yes	If yes, which airbags: _____
Did the police arrive? No Yes	If yes, was a report made? _____

The Accident, in your words:

Below please describe in your words how the accident occurred, use the diagram of an intersection if helpful:



Doctor's Notes: _____
_____
_____

Thank you for carefully answering each question!

Patient: Black ink
Doctor: Blue ink

Motor Vehicle Accident Health History Form (Page 3)

Injuries:

Were you aware of the collision as it occurred? No Yes

If yes, then did you brace your arms and legs? No Yes

Did you lose consciousness at any point during or after the collision? No Yes

Were you ejected from the vehicle? No Yes

If yes, describe: _____
_____

Did any part of your body strike the interior of your vehicle? No Yes If yes, explain: _____
_____

Did any injuries occur outside of your vehicle? No Yes If yes, explain: _____
_____

Did you have any pain as a result of the collision? No Yes If yes, explain: _____
_____

Did you suffer any bruises, cuts, or broken bones from the collision? No Yes If yes, explain: _____
_____

Did you suffer any of the following symptoms (circle all that apply): Dizziness Light headedness Severe headache Vertigo Blurry vision Confusion Memory loss Extreme drowsiness Difficulty with focus or concentration Sensitivity to light Visual disturbances Nausea Vomiting Muscle weakness Numbness or tingling Ringing in the ears Difficulty sleeping Difficulty with speech Feelings of depression or sadness Crying for no reason Feelings of nervousness or anxiety Other: _____

Are any of the above circled symptoms still present? No Yes If yes, list which ones: _____
_____
_____

Doctor's Notes: _____
_____
_____

Thank you for carefully answering each question!

Patient: Black ink
Doctor: Blue ink

Motor Vehicle Accident Health History Form (Page 4)

Medical History

Did you go to the hospital after the accident? No Yes If yes, please answer the five questions below:

1. Did you travel by: Ambulance? Your car? (You drove? Yes No) Another car?
2. How long after the accident did you arrive at the hospital? _____
3. How did you leave the hospital? Someone drove me I drove myself
4. Were x-rays or other imaging procedures performed? No Yes If yes, explain:_____
5. Did you receive treatment or any prescriptions/medications at the hospital? No Yes If yes, explain: _____
   _____

Other than the hospital, have you visited any other healthcare providers since the accident? No Yes If yes, explain (include names and phone numbers): _____
_____

Have you ever been involved in a motor vehicle accident before? No Yes If yes, please answer the five questions below:

1. When and where did the accident(s) occur? a. _____
   If more than 3, please ask for another sheet of paper. b. _____
   c. _____
2. Who did you see for care? a. _____
   If more than 3, please ask for another sheet of paper. b. _____
   c. _____
3. What type of care did you receive? a. _____
   If more than 3, please ask for another sheet of paper. b. _____
   c. _____
4. Did all of your symptoms resolve from the above mentioned accidents? No Yes If not, what symptoms persisted? _____

   Did any remaining symptoms affect your daily activities in any way? No Yes If yes, explain: _____
   _____

Doctor's Notes: _____
_____
_____

Thank you for carefully answering each question!

Patient: Black ink
Doctor: Blue ink

Motor Vehicle Accident Health History Form (Page 5)

Impact on Your Life:

Please mark the activities below that have been adversely affected, or are difficult to perform, since your motor vehicle accident.

Domestic Activities:

Cleaning	Folding Laundry	Moving items	Standing	Cooking
Getting into/out of bed	Lifting objects	Vacuuming	Sitting down	Eating

Other: _____

Personal Care Activities:

Combing hair	Nail care	Toilet care	Shaving	Brushing teeth
Showering	Bathing	Gargling	Applying makeup	Dressing
Shampooing hair	Other: _____			

Relationship Activities:

Hugging	Laughing	Sexual activity	Kissing	Holding hands
Personal relationships	Other: _____			

Child Care Activities:

Carrying your child	Bathing your child	Packing lunch	Pushing a stroller	Breast feeding
Changing diapers	Picking up your child	Toweling after bath	Washing/shampooing	Bottle feeding
Playing with your child	Entertaining your child	Rocking your child	Hugging your child	

Other: _____

Sports & Athletic Activities:

Aerobics	Canoeing	Ice Skating	Rock Climbing	Tennis
Archery	Cross country skiing	Jet Skiing	Roller skating	Walking
Baseball	Downhill skiing	Jogging	Rugby	Waterskiing
Badminton	Football	Martial arts	Soccer	Weight train
Basketball	Golf	Mountain biking	Softball	Wind surfing
Biking	Gymnastics	Pilates	Snowboarding	Wrestling
Bowling	Horseback riding	Rafting	Surfing	Volleyball
Camping	Hunting	Rollerblading	Swimming	Yoga
Other: _____	_____	_____	_____	_____

Doctor's Notes: _____

_____

_____

Thank you for carefully answering each question!

Patient: Black ink
Doctor: Blue ink

Motor Vehicle Accident Health History Form (Page 6)

General Household Activities:

Mowing the lawn	Yard work	Car maintenance	Shoveling snow
Fertilizing	Clearing brush	Washing car	Taking out the trash
Tree trimming	Raking	Using tools	Walking the dog
Watering the lawn	Cleaning the gutters	Painting	Caring for pets
Weeding	Spraying	Hammering	Other: _____

Activities that Impact your Career:

Attendance at work	Grasping actions	Prolonged walking	Stairs
Performance at work	Group tasks	Perform required tasks	Telephone operation
Bending activities	Heavy work	Pushing actions	Tool operation
Bookkeeping	Keyboarding	Pulling actions	Transportation to work
Communication	Lifting objects	Reaching actions	Writing
Concentration	Machine operation	Reading	Working on the computer
Data entry	Memory	Repetitive motion	Other: _____
Driving	Operation a mouse	Safety is affected	_____
Fine visual work	Prolonged sitting	Shoulder checking	_____
Forceful exertion tasks	Prolonged standing	Speech	_____

General Movement Activities:

Movements requiring neck strength or motion	Movements requiring upper back strength or motion
Movements requiring mid back strength or motion	Movements requiring lower back strength or motion
Movements requiring hand strength or motion	Movements requiring wrist strength or motion
Movements requiring elbow strength or motion	Movements requiring shoulder strength or motion
Movements requiring hip strength or motion	Movements requiring knee strength or motion
Movements requiring ankle strength or motion	Movements requiring foot strength or motion

Thank you for taking the time to fill out this MVA history questionnaire. This information is important for the doctor to obtain a clinical picture so as to make an appropriate diagnosis and treatment plan. Please sign below authorizing that the information in this form has been read and filled out completely and accurately to the best of your understanding. Also, understand that the information in this form is considered confidential and for use by your doctor at McKinley Chiropractic, PC. Any disclosure is outlined in our privacy policies.

Patient's Signature (*or guardian's signature*)_____Date_____
Signature of translator or person assisting with this form (*if any*)_____Date_____
Printed name of said person _____Date_____

Doctor's Notes: _____
_____
_____

Creekside Chiropractic

Dr. Jennaleigh McKinley, DC
19555 E. Parker Square Drive Suite 105
Parker, CO 80134
www.chiropractorinparker.com
Office: 720.851.9878 Fax: 303.805.9554

Motor Vehicle Accident Claim Information

Insurance Company: _____

Adjuster's Name: _____

Adjuster's Phone Number: _____

Claim Number: _____

Date of Accident: _____

Insurance Fax Number: _____

Do you have MedPay: **Y** **N***

If yes, how much MedPay: $ _____

How much have you used for this accident: $ _____

*If No, Please provide a copy of your signed MedPay Denial Form from your Auto Insurance Agent.

PATIENT HISTORY FORM

Welcome to McKinley Chiropractic. Our goal is to help you to the best of our ability. This requires that we learn about your illness/injury and about how you came to visit us. The questions below will help us to not overlook any important information. Please answer them briefly. Some of them may not apply to you, answer them as N/A. If you cannot remember specific dates, the month or approximate year will be helpful. If you cannot recall a requested name or place, draw a line through the space to greatly help us give you the best possible care.

NAME_____AGE_____ □ Male □ Female BIRTHDATE _____/_____/_____
HOME ADDRESS_____ APT OR SUITE_____
CITY_____STATE_____ZIP_____PRIMARY PHONE_____
OCCUPATION_____WORK PHONE_____
HEIGHT_____WEIGHT_____SS#_____/_____/_____
How were you referred to our office? □ Insurance Company □ Walk-In □ Friend/Relative □ Internet □ Other_____
Patient Referral Name_____
Employer_____ In the event of an emergency who should we contact?_____
Relation_____ Primary Phone _____ Secondary Phone _____
WOMEN – Are you or could you be pregnant? □ Yes □ No

CHIEF COMPLAINTS/MAIN PROBLEMS (List most severe first)

1. _____
2. _____
3. _____
4. _____

Date these problems began _____ Are you still working? □ Yes □ No Last day on the job _____

Did your problems begin following:

□ A fall □ Lifting □ Twisting □ Bending Over □ Work Injury □ Motorized Vehicle Accident □ Recreational Injury □ Sport Injury
□ No apparent cause □ Other_____

Describe all the details of any accident, incident or the way these problems began: _____

_____

_____

Where is the location of your pain today? _____

Is your pain today: □ Worse □ Better □ The same compared to when it began?

What reduces the pain?

□ Lying down	□ Exercises	□ Muscle Relaxant Pills	□ Injections for pain
□ Sitting	□ Home exercises	□ Aspirin Anti-inflammatory Pills	□ Walking
□ Standing	□ Pain pills	□ Chiropractic Adjustments	□ Massage
□ Nothing	□ Other _____		

What activities make it worse?

□ Exercises (during)	□ Standing	□ Bending backward	□ Driving
□ Exercises (after)	□ Walking	□ Coughing	□ Lying down
□ Sitting	□ Bending forward	□ Sneezing	□ Changing position

What is the time interval between attacks of pain? □ Constantly □ Daily □ Weekly □ Monthly □ Yearly

Have you been in constant pain since it began or is your pain intermittent? Describe: _____

_____

Does your pain intensity vary throughout a 24 hour period? □ Yes □ No

Have you noticed any: □ Numbness □ Tingling □ Sensitivity with your pain?

Has your pain affected your sex life? □ Yes □ No

What position do you have to be in at rest? □ Stand □ Sit □ Lying down

Can you climb or descend stairs? □ Yes □ No

Do your arms/legs get weak with your pain? □ Yes □ No

Do you have full control of your bladder & bowels? □ Yes □ No

Choose the number which best answers the question:

0	2	4	6	8	10
None	**Mild**	**Discomforting**	**Distressing**	**Horrible**	**Excruciating**

_____Your pain right now _____Your pain at its worst _____Your pain at its least

Is your pain and disability so severe that you would consider surgery for some relief? □ Yes □ No

Have you been hospitalized for your pain problem? □ Yes □ No Number of times:_____ Dates: _____

Please check what treatments you have had for this condition.

	DATE STARTED	DATE STOPPED
Chiropractic……	_____	_____
Acupuncture……..	_____	_____
Physical Therapy……..	_____	_____
Home Stretching Exercises……	_____	_____
Home Strengthening Exercises……	_____	_____
Epidural Block……	_____	_____
Facet Block……..	_____	_____
Neurological Consult……..	_____	_____
Orthopedic Consult…….	_____	_____
Pain Medication……..	_____	_____
Massage Therapy……..	_____	_____

Have you had any of these diagnostic studies?

	Yes	No
Diagnostic X-rays……	____	____
CT (computer tomography) scan……	____	____
Myelogram (x-ray with dye injection)...	____	____
Electromyogram (EMG)…….	____	____
Nerve Conduction Velocity (NCV)…..	____	____
Discogram……	____	____
MRI (Magnetic Resonance Imaging)…	____	____
Arthogram or Sonogram…….	____	____
Blood Work……..	____	____
DEXA Bone Scan……	____	____

PAST MEDICAL HISTORY

Circle if you currently have, or previously suffered from:

Arthritis……..	Yes	No	When_____	Psoriasis……..	Yes	No	When_____
Asthma……..	Yes	No	When_____	Psychiatric or Emotional…	Yes	No	When_____
Cancer……..	Yes	No	When_____	Rheumatic Fever…….	Yes	No	When_____
Diabetes……	Yes	No	When_____	STD's……	Yes	No	When_____
Emphysema…….	Yes	No	When_____	Stroke……	Yes	No	When_____
Gastritis……	Yes	No	When_____	Thyroid Disorders……	Yes	No	When_____
Glaucoma……..	Yes	No	When_____	Transient Ischemic……	Yes	No	When_____
Heart Disease……..	Yes	No	When_____	Tuberculosis…….	Yes	No	When_____
HIV+/AIDS……	Yes	No	When_____	Ulcers……	Yes	No	When_____
Liver Conditions……	Yes	No	When_____	High/Low Blood Pressure…	Yes	No	When_____
Migraines……	Yes	No	When_____	Seizures/Epilepsy…….	Yes	No	When_____
Osteoporosis……	Yes	No	When_____	Other_____			
Polio……	Yes	No	When_____				

Are you currently taking any medications? □ Yes □ No If yes, please list including dosage and times per day.

_____ Number/Each Day_____ _____ Number/Each Day_____

_____ Number/Each Day_____ _____ Number/Each Day_____

_____ Number/Each Day_____ _____ Number/Each Day_____

Women: Are you or were you taking birth control? □ Yes □ No When?_____ For how long?_____

Who is your current primary doctor? Name:_____ Location_____

Do we have your permission to consult your PCP if needed in your case? □ Yes □ No Please Sign_____

PAST SURGICAL HISTORY

Have you ever had any surgeries including spine surgery? □ Yes □ No If yes, please give the dates and types of operation(s).

DATE	**SURGERY**
_____	_____
_____	_____
_____	_____
_____	_____

HISTORY OF ILLNESS IN YOUR FAMILY

Stroke/TIA……..	□ Yes	□ No	Relation_____	High Cholesterol…….	□ Yes	□ No	Relation_____
Rheumatoid Arthritis…….	□ Yes	□ No	Relation_____	High Blood Pressure…..	□ Yes	□ No	Relation_____
Diabetes (Type I or II)…..	□ Yes	□ No	Relation_____	Heart Attack…….	□ Yes	□ No	Relation_____
Cancer……	□ Yes	□ No	Relation_____	Other_____			

REVIEW OF SYSTEMS (if not previously mentioned)

Cardiovascular System Neurological System Gastrointestinal System Respiratory System

Genitourinary System Musculoskeletal System Psychiatric or Emotional

Please explain:_____

SOCIAL HISTORY

Marital Status: □ Single □ Married □ Widowed □ Divorced

Tobacco Use: □ Yes □ No If yes, what type (smoking, chewing)? _____ How often?_____ How many years? _____

What is your interest level in quitting tobacco use? _____ If a previous tobacco user, when did you quit? _____

Alcohol Use: □ Beer □ Wine □ Mixed drinks How many per day/per week?_____

Drug Use: □ Yes □ No Type and frequency:_____

DOCTOR'S LIEN

TO: _____

_____

_____

Fax: _____

Creekside Chiropractic

19555 E. Parker Sq. Dr. #105

Parker, CO 80134

Fax: 303-805-9554

Re: Medical Reports and Doctor's Lien

I, _____, do hereby authorize the above doctor's office to furnish you with a report of her examination, diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was involved. I also instruct you, my attorney, to disclose all settlement information to the treating doctor at the above doctor's office in regard to the accident in which I was involved.

I hereby authorize and direct you to pay directly to said doctor such sums as may be due and owing her for medical services rendered both by reason of this accident and by reason of any other bills that are due to her office and to withhold such sums from settlement, judgment, or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment, or verdict which may be paid to you or myself as the result of the injuries for which I have been treated or injuries in connection herewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him/her for services rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration of her awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee. I do not expect the doctor to take a reduction of his/her fees as he/she will be paid in full. In the event that my Med Pay is exhausted I understand that I am responsible for the remainder of the bill.

Dated: _____ Patient Signature: _____

The undersigned does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said doctor above named.

This lien does not constitute a request or agreement between the parties for the attorney or law firm to act as a collection agency for the above-named doctor/doctor's office. There is to be no reduction in said doctor's fees, 100% of medical bills are to be paid in full.

Dated: _____ Attorney Signature: _____

Please date, sign and return one copy
Keep one copy for your records

Doctor's Lien

Creekside Chiropractic

Dr. Jennaleigh McKinley, DC ~ Dr. Ryan Baack, DC
19555 E. Parker Square Drive Suite 105
Parker, CO 80134
720.851.9878

Dear Patient:

Every type of health care is associated with some risk of a potential problem. This includes chiropractic health care. We want you to be informed about the potential problems associated with chiropractic health care before consenting to treatment. This is called **Informed Consent.**

Chiropractic adjustments are the mobilization of joints with the doctor's hands or with the use of an instrument. Frequently, adjustments create a "pop" or "click" sound or sensation on the area being treated.

In this office, we may use trained staff personnel to assist the doctor with portions of your consultation, examination, x-rays, physical therapy applications, traction, massage therapy, exercise instruction, etc.

The following is a list of possible complications that can arise from an adjustment.

STROKE: Stroke is the most serious problem associated with receiving an adjustment. Stroke means that a portion of the brain does not receive enough oxygen from the blood stream. The result can be a temporary or permanent dysfunction of the brain, and very rarely, death. Cervical (neck) adjustments have been associated with strokes that arise from the vertebral artery; this is because the vertebral artery is actually found inside the neck vertebrae. The type of adjustment that is related to vertebral artery stroke is called the "maximal extension-rotation" adjustment. We do not perform this type of adjustment on patients. Other types of neck adjustments may also be potentially related to vertebral artery strokes, but no one is certain. The most recent studies (Journal of the CCA, Vol 35 No. 2, June 1993) estimate that the incident of this type of stroke is 1 per every 5,850,000 upper neck adjustments. This means that an average chiropractor would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

DISC HERNIATION: Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustments, traction, etc. This includes both back and neck. Yet occasionally chiropractic treatment (adjustments, traction, etc.) will aggravate the problem and rarely surgery may become necessary for correction. Chiropractic adjustments may also cause a disc problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify their probability.

SOFT TISSUE INJURY: Soft tissues primarily refer to the muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely, adjustments, traction, massage, etc., may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary

treatments for resolution, but there are no long term affects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

RIB FRACTURES: The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely an adjustment will crack a rib bone; this is referred to as a fracture. This occurs only on patients that have weakened bones from such things as osteoporosis on their x-rays. We adjust all patients very carefully, and especially those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

PHYSICAL THERAPY BURNS: Some of the machines we use generate heat. We also use both heat and ice and recommend them for home care on occasion. Everyone's skin has different sensitivity to these modalities, and rarely, either heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain and in extreme cases there may even be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.

SORENESS: It is common for an adjustment, traction, massage therapy, exercise, etc. to result in a temporary increase in soreness in the region being treated. This is almost always a temporary symptom while your body is undergoing therapeutic change. It is not dangerous, but please notify your doctor if it occurs.

ACUPUNCTURE: Patients will receive information regarding all methods of treatment used in acupuncture, which involves the insertion of fine needles at specific points in the body, manual manipulation of the needles and/or electrical stimulation or application of localized heat. In addition, recommendation of herbal supplements as related to the scope of practice of oriental medicine according to Federal Legislation may be used. Mild discomfort may be experienced, but this pain is unusual. Bruising at the acupuncture point is a possibility. Due to differences in human constitution and response, it is not possible to guarantee any specific effect resulting from the acupuncture treatment. This practice of acupuncture uses disposable needles only and complies with all regulations set forth by the NCCAOM and NCCA.

OTHER PROBLEMS: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These problems or complications occur so rarely that it is not possible to anticipate and/or explain all of them in advance to treatment.

Chiropractic is a system of health care delivery, therefore, as with any health care delivery system we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always give you our best care, and if results are not acceptable, we will refer you to another provider who we feel will assist your situation.

If you have any questions on the above, please ask your doctor. When you have a full understanding, please sign and date below.

_____	_____
Patient's Name Printed	Today's Date
_____	_____
Patient's Signature	Parent or Guardian Signature

Creekside Chiropractic

PATIENT CONSENT

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

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

1. The Practice's Privacy Notice has been provided to me prior to 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 me 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 will be used by the Practice:
    a. A text message sent to me at the phone number provided by me
    b. Emailing a reminder to the email account I have designated.

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 specific health care options.

5. I understand that I have the right to request that Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care options. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to 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 be 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.

_____ _____

Patient's Name Printed Patient's Signature

_____ _____

Signature of Legal Representative/Parent if minor Relationship

Date Signed ___ /___ /___ Witness: _____

CREEKSIDE CHIROPRACTIC

Dr. Jennaleigh McKinley, DC ~ Dr. Ryan Baack, DC
www.chiropractorinparker.com ~ **Office: 720.851.9878** ~

Have you been to a chiropractor before? **Y** **N**

Are you currently under chiropractic care? **Y** **N** Date of last adjustment: _____

Do you suffer from?

Headaches **Y** **N** Neck Pain **Y** **N**

Back Pain **Y** **N** Other: _____

Please circle all that are of interest to you:

Weight loss Removing toxins from the home Nicotine cessation

How did you hear about us?

_____

Email address:

_____

Would you like to receive our monthly e-newsletter? Y N

Appointment Policy: In order to guarantee an appointment, a credit card must be on file. When you schedule an appointment with Creekside Chiropractic, we set aside enough time to provide you with the highest quality of care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. A 24-hour or more notice will allow other patients access to timely care. Please see our Appointment Cancellation/No Show Policy below:

- Effective July 1, 2018, any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hour notice** will be will be charged a **$25 fee** to the card on file.
- Any established patient who fails to show or cancels/reschedules an appointment without a 24 hour notice a **second or more** time will be charged a **$50 fee** to the card on file.
- Any new patient who fails to show for their initial visit will not be rescheduled.
- As a courtesy, we provide e-mail or text appointment reminders for scheduled appointments. If you do not receive your reminder message, the above Policy will still remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our office. You may contact Creekside Chiropractic 24 hours a day, 7 days a week at the number below. Should it be after regular business hours Monday through Friday, or a weekend, you may leave a message or e-mail us at Chiro80134@gmail.com. Messages left or e-mails sent within the required timeframe are acceptable.

With my signature I agree to and authorize Creekside Chiropractic to charge my credit card in accordance with the policy outlined above.

Cardholder Signature _____

Name (please print clearly) _____Date: _____