Lifetime Health & Wellness

A Member of the WellnessOne™ Alliance

●8155 W. 94th Ave., Westminster, CO 80021● Phone: 303-423-4610● Fax: 303-431-8658●

Name: _____ **Date**: _____

Date of Birth: _____ **Sex**: Male Female **Marital Status**: S M D W Other

Address: _____

City & State: _____ **Zip Code**: _____

Phone Number: _____

Emergency Contact Name: _____ **Relation**: _____

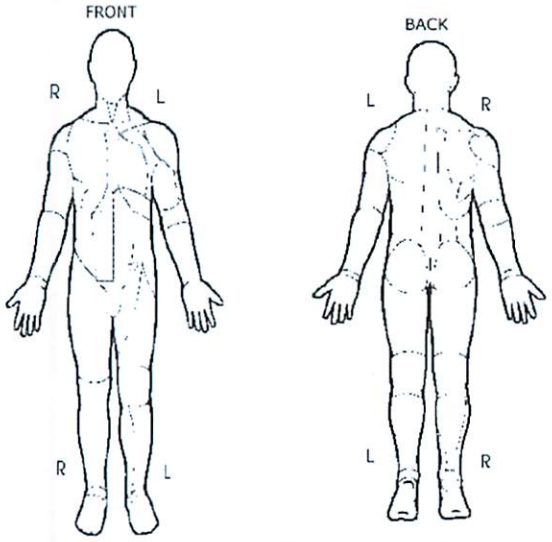
Emergency Contact Phone Number: _____

E-mail Address: _____

Employer: _____ **Occupation**: _____

Main Complaint: _____

Please mark what areas are bothering you:



Are you currently under medical care of chiropractic care for this condition? Yes No

If yes, may we have the name and phone number of your doctor? _____

_____

How did you hear about our office? _____

OFFICE POLICIES

Please read our policies and acknowledge by initialing next to each statement and sign the bottom

_____ All payments are **DUE AT TIME OF SERVICE** including co-pays, co-insurance, deductible amounts, and/or non-covered procedures. If payment is not made at time of service, a **$10 billing fee** will be applied to your balance.

_____ Insurance cards presented are current and accurate. We will contact your insurance to verify benefits, however, this is not a guarantee of coverage or payment. Ultimately, it is the patient's responsibility to know insurance coverage. We know your claim is processed once we receive payment and an explanation of benefits (EOB).

_____ Insurance companies have 45 days to approve or deny a claim. In some cases, this may take longer if extra information is requested.

_____ For any balance remaining after insurance has paid, you will be mailed a statement. Please contact your insurance company if you feel insurance has paid incorrectly.

_____ If bill is not paid within 30 days of receiving statement or billing department is not contacted, a **$15 billing fee** will be applied each billing thereafter.

_____ We understand there are times where you are unable to keep an appointment. We request 24-hour notice for cancelling an appointment. A **$20 fee** may be assessed if we are not contacted in time. You may leave a voicemail if the office is closed.

_____ In accordance with the State of Colorado statutes, no doctor shall engage in a personal relationship with any patient outside the parameters of normal conduct of doctor-patient interaction.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize CEO Westminster Inc. to release any appropriate information concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered and hereby release CEO Westminster Inc. of any consequences thereof. I authorize my insurance and/or attorney to pay by check made out and directly mailed to CEO Westminster Inc. Further, I agree to pay CEO Westminster Inc. the difference, if any, between the total amount of charges and the amount paid by the insurance carried and/or attorney. A photocopy of this document will be deemed as valid and binding on all parties involved.

I have read and have full understanding of all policies and HIPPA agreement of Lifetime Health & Wellness.

Patient Name: _____

Patient Signature: _____ Date: _____

OR

Legal Guardian Signature: _____ Date: _____

Relationship to Patient: _____ Witness Initials: _____

To the patient: Please read the document in its entirety prior to signing it. It is important that you understand the information explained below. If you have any questions please ask before you sign.

Nature of Chiropractic Treatment

Prior to beginning treatment, you will be given a physical examination that can include taking vital signs, range of motion testing, muscle strength testing, palpation, orthopedic testing, and neurological testing. Once your condition has been diagnosed, the primary method of treatment will be spinal manipulation, also known as spinal adjustment. An adjustment is a quick, precise movement of the spine over a short distance. Adjustments are usually performed by hand but may be performed by handguided mechanical instruments. In addition to spinal manipulation, treatment can also involve other forms of therapy including electrical stimulation, traction, cold packs, hydrotherapy, infrared heat, exercise, acupuncture, dry needling, massage, A.R.T., cranial therapy, rapid release, and nutritional supplements.

Risks of Chiropractic Treatment

All health care procedures carry some degree of risk. The most common side effect of spinal manipulation is short-term muscle soreness. More serious side effects can include bone fractures, muscle strain, ligament sprain, joint dislocation and injury to the discs, nerves or spinal cord. Some manipulations of the upper spine have been associated with injury to the arteries in the neck, which could cause or contribute to stroke. However, documented cases are exceedingly rare, and it has been estimated by researchers that the probability of a spinal adjustment causing a stroke is one in several million. Compared to other forms of health care, chiropractic is extremely safe, and complications are generally rare.

Treatment Options Other Than Chiropractic

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics;
- Medical care and prescription drugs such as muscle relaxers, pain killers and drugs to reduce inflammation;
- Surgery;
- Remaining untreated.
- Physical therapy

If you decide to pursue other treatment options, you should discuss the risks and benefits with your medical physician. Remaining untreated carries its own risks and may allow the formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce mobility and induce chronic pain cycles.

I have read above the explanation and risks of Chiropractic treatment and possible therapies. By signing below, I state that I have weighted the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

_____ _____

Patient/Guardian Signature Date

_____ _____

Witness Date