LITTLETON CHIROPRACTIC

New Patient Application

Date: _____

Name:_____ Age: _____ Gender: _____
Home Address: _____ City: _____
_____ State: _____ Zip Code: _____
E-mail Address: _____
Date of Birth: _____
Home Phone: _____ Cell Phone: _____
Employer: _____ Work Phone: _____

How were you referred to this office? _____

PURPOSE OF THIS VISIT
Reason for this visit:
_____
_____
Is it a work or auto-accident related? Yes:___ No___ If yes, describe:
_____
_____
What activities aggravate your symptoms? _____
_____
Have you experienced this condition before? Yes: ___ No: ___

HEALTH & LIFESTYLE
Do you exercise? Yes: _____ No: _____ If yes, how often? _____ Activities?: _____
_____
Do you smoke? Yes: _____ No: _____ If yes, how much? _____
Do you drink alcohol? Yes: _____ No: _____ If yes, how much per week? _____
Do you take any supplements (i.e. vitamins, minerals, herbs)? _____

CERVICAL SPINE (NECK)
Do you experience….?

___ Neck pain	___ Recurrent Colds/Flu	___ Dizziness
___ Headaches	___ Hearing Disturbances	___ Allergies/ Hay Fever
___ Sinus	___ Coldness in Hands	___ Numbness/Tingling
___ Pain in Shoulders/ Arms/Hands	___ Coldness in Hands	in arms/ hands
	___ Fatigue/ Low Energy	___ Visual Disturbances
___Thyroid Conditions	___ TMJ/ Pain/ Clicking	___ Weakness in Grip

THORACIC SPINE (UPPER BACK)
Do you experience...?

___ Heart Palpitations	___ Recurrent Lunt Infections/ Bronchitis
___ Heart Murmurs	___ Asthma/ Wheezing
___ Tachycardia	___ Shortness of Breath
___ Heart Attacks/ Angina	___ Pain on Deep Inspiration/Expiration

THORACIC SPINE (MID BACK)
Do you experience…?
____ Mid Back Pain
____ Reflux
____ Tired/ Irritable after eating when you haven't eaten for a while
____ Indigestion/ Heartburn
____ Ulcers/ Gastritis
____ Hypoglycemia
____ Pain in your Ribs/Chest
____ Nausea

LUMBAR SPINE (LOWER BACK)
Do you experience…?
____ Low Back Pain
____ Constipation/Diarrhea
____ Weakness/Injuries in hips/knees/ankles
____ Numbness/Tingling in feet/legs
____ Sexual Dysfunction
____ Frequent/Difficulty Urinating
____ Muscle Cramps in our legs/feet
____ Pain in your hips/legs/feet
____ Menstrual Irregularities/ Cramping
____ Recurrent Bladder Infections
____ Coldness in Legs/Feet

List any health conditions not mentioned: _____
_____
List any medications/surgeries: _____
_____
List any trauma (falls, car accidents, etc): _____
_____

IN CASE OF EMERGENCY CALL
Name: _____ Relationship: _____
Work Phone: _____Cell Phone: _____ Home Phone:_____

INSURANCE INFORMATION
Primary Insurance: _____
Secondary Insurance: _____

AUTHORIZATION OF RELEASE
I hereby authorize Littleton Chiropractic to furnish any information concerning my treatment to insurance carries, which is required to process insurance claims. I hereby accept responsibility for all fees regardless of insurance coverage.

Signature: _____ Date: _____

YOUR HIPPA RIGHTS
You have the right to request that we do not disclose your PHI to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your PHI please let us know in writing.
_____
_____
_____
_____

PATIENT FINANCIAL POLICY
We offer the following information to help you understand our financial policies and aid you in planning for your payment. Carefully review the following information and please ask if you have any questions about our fees, policies, or your responsibilities.

PAYMENT PROCEDURE
Our office requires PAYMENT AT THE TMIE OF SERVICE unless the patient is covered by health insurance which pays our office and this office is received VALID INSURANCE INFORMATION OR REFERRAL (when applicable). CO-PAYMENTS ARE DUE AT THE TIME OR SERVICE. We accept payment by cash, check, credit card, or CareCredit.

FEES
Our fees are usual and customary for this area in the chiropractic specialty. We invite you to discuss any questions you may have.

NOTE
Our financial relationship is with YOU, not your insurance company. When asked and as a courtesy to you, we will try to give you general guidelines about what your insurance policy might cover. Since insurance is an agreement entered into by you and your insurance carrier, you are ultimately responsible for knowing the specifics of what your policy covers.

COST OF COLLECTIONS
Upon default, you are responsible for attorney's fees and/or cost of collections.

I understand the Patient Financial Policy of Littleton Chiropractic.

Signature: _____ Date: _____

Notice of Privacy Practices
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

RIGHT TO NOTICE
As a patient, you have the right to adequate notice of the uses and disclosures of your protected health information (PHI). Under the Health Insurance Portability and Accessibility Act (HIPPAA), Littleton Chiropractic can use your PHI for treatment, payment and health care options.

YOUR AUTHORIZATION
Most uses and disclosures that do not fall under treatment, payment healthcare operations will require written authorization. Upon signing, you may revoke your authorization (in writing) through our practice at any time.

EMERGENCY SITUATIONS
In the event of your incapacity or emergency situation, we will disclose health information to a family member, or another person responsible for your care, using our professional judgement. We will only disclose health information that is directly relevant to the person's involvement in your healthcare.

MARKETING
We will not use your health information for marketing communications without your written authorizations.

REQUIRED BY LAW
We may also use or disclose your health information when we are required to do so by law.

LEGAL REQUIREMENTS
Littleton Chiropractic is required by law to maintain the privacy of your protected health information. We are required to abide by the terms of this notice as it is currently stated, and reserve the right to change this notice. The policies in any new notice will not be in effect until they are posted to www.littleton-chiropractic-co.com, or are available within our office.

SHARING INFORMATION
If and when we believe it is necessary to share your protected health information in any situation that is not included in the above paragraphs we will first seek written permission.

Littleton Chiropractic Privacy Policy Acknowledgement:
I have received and read the Notice of Privacy Practices.

Patient Name (Print): _____ Signature: _____
Date: _____

PLEASE FEEL FREE TO DISCUSS OUR FEES. FEES ARE PAYABLE WHEN SERVICES ARE RENDERED UNLESS SPECIAL ARRANGEMENTS ARE MADE IN ADVANCE.

INFORMED CONSENT AND PERMISSION FORM

When you give permission to have chiropractic spinal adjustments and physical medicine modalities performed, you or your guardian should understand the most common risks and hazards of the procedures. The following are all rather infrequent but any may occur.

1. Post-treatment discomfort, soreness or stiffness, which may persist 12-24 hours after treatment.
2. Transient lightheadedness or dizziness following chiropractic adjustments of the neck. Please alert Dr. Bourne should this reaction occur.
3. Aggravation of acute intervertebral disc bulge or herniation. Please be advised that Dr. Bourne will make every reasonable effort to determine the possibility of an underlying disc problem and modify your treatment recommendations accordingly.
4. Spontaneous vertebral body or rib fracture in an osteoporosis patient. Please be advised that Dr. Bourne will make every reasonable effort to diagnose this preexisting condition and modify your treatment recommendations accordingly.
5. Acute muscle spasm alongside the spine in the area being treated or in an adjacent area. These muscle spasm reactions are commonly present, even before treatment, in the acute patient and every effort will be made to reduce them prior to spinal adjustments.

I understand that no guarantee has been made that the procedures used will cure my condition.

Patient / Guardian Signature _____ Date _____

Printed Name _____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal, physical, mental and social well-being, not merely the absence of infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, _____, have read fully and understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

_____ _____ _____

Print Sign Date

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and Dr. Bourne has my permission to perform an X-Ray evaluation. I have been advised that X-Rays can be hazardous to an unborn child. Date of last menstrual period: _____.

X-Ray Consent Form

The doctor has explained that the purpose of the X-Rays about to be taken is to analyze the spine for vertebral subluxations and to determine the appropriateness for chiropractic adjustments. If the doctor discovers a non-chiropractic "unusual finding" when reviewing this X-Ray, I will be informed. I then must determine if I should seek the services of an additional health care provider for advice, diagnosis or treatment for the unusual finding. I understand that seeking advice from another type of health care provider should not interfere with the subluxation correction care provided by this office.

I fully understand the above and consent to chiropractic spinal X-Rays.

Signature: _____ Date:_____