APPLICATION FOR CARE AT AMPLIFY CHIROPRACTIC

Today's Date: _____ HR#: _____

PATIENT DEMOGRAPHICS

Name: _____ Birthdate: _____-_____-_____ Age: _____ ○ Male ○ Female

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

E-mail Address: _____ Marital Status: ○ Single ○ Married Do you have insurance? ○ Yes ○ No

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Spouse's Name _____ Spouse's Employer _____

Number of children and ages: _____

Name & Number of Emergency Contact: _____ _____Relationship: _____

HISTORY OF COMPLAINT

Please identify the condition(s) that brought you to this office: Primary: _____

Secondary: _____ Third: _____ Fourth: _____

When did the problem(s) begin? _____ When is the problem at its worst? ○ AM ○ PM ○ mid-day ○ late PM

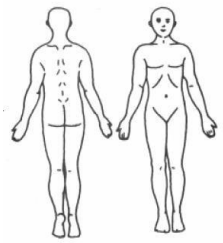
How long does it last? ○ It is constant **OR** ○ I experience it on and off during the day **OR** ○ It comes and goes throughout the week

How did the injury happen? _____

Condition(s) ever been treated by anyone in the past? ○ No ○ Yes **If yes,** when? _____ by whom? _____

PLEASE MARK the areas on the body diagram with the following **letters** to describe your symptoms:

R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness **S = S**harp/**S**tabbing **T = T**ingling



What relieves your symptoms? _____

What makes your symptoms feel worse? _____

Outcome Assessment Tool

Please **CIRCLE** the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

Example (if you have multiple complaints): Headaches Neck Pain Low-Back Pain

No pain _____ worst possible pain

0 1 2 3 (4) 5 6 (7) 8 (9) 10

1. How would you rate your pain RIGHT NOW?

No pain _____ worst possible pain

0 1 2 3 4 5 6 7 8 9 10

2. What is your typical or AVERAGE PAIN?

No pain _____ worst possible pain

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level at its BEST?

No pain _____ worst possible pain

0 1 2 3 4 5 6 7 8 9 10

4. What is your pain level at its WORST?

No pain _____ worst possible pain

0 1 2 3 4 5 6 7 8 9 10

PATIENT'S NAME: _____ HR#: _____ DATE: _____

PAST HISTORY

Have you suffered with any of this or a similar problem in the past? ○ No ○ Yes **If yes,** how many times? _____ When was the last episode? _____ How did the injury happen? _____
Other forms of treatment tried: ○ No ○ Yes **If yes,** please state what type of treatment:
_____, and who provided it? _____ How long ago? _____
What were the results. ○ Favorable ○ Unfavorable Please explain:
_____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____
_____

If you have ever been diagnosed with any of the following conditions, please indicate with:

P for in the ***Past*** **C** for ***Currently*** have **N** for ***Never*** have had

___ Broken Bone ___ Dislocations ___ Tumors ___ Rheumatoid Arthritis ___ Fracture ___ Disability ___ Cancer
___ Heart Attack ___ Osteo Arthritis ___ Diabetes ___ Cerebral Vascular ___ Other serious conditions: _____

PLEASE IDENTIFY ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	**TYPE OF CARE**	**PROVIDED BY WHOM**
INJURIES			
SURGERIES			
CHILDHOOD DISEASES			
ADULT DISEASES			

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? ○ No ○ Yes **If yes,** whom?
○ grandmother ○ grandfather ○ mother ○ father ○ sister(s) ○ brother(s) ○ son(s) ○ daughter(s)
Have they ever been treated for their condition? ○ No ○ Yes ○ I don't know

2. Any other hereditary conditions the doctor should be aware of? ○ No ○ Yes:_____

SOCIAL HISTORY

1. Smoking: ○ cigars ○ pipe ○ cigarettes How often? ○ Daily ○ Weekends ○ Occasionally ○ Never
2. Alcoholic Beverage: consumption occurs ○ Daily ○ Weekends ○ Occasionally ○ Never
3. Recreational Drug use: ○ Daily ○ Weekends ○ Occasionally ○ Never

Continued on next page/reverse side

PATIENT'S NAME: _____ HR#: _____ Date: _____

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

ACTIVITIES:	EFFECT:			
Carry Children/Groceries	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Sit to Stand	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Climb Stairs	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Pet Care	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Extended Computer Use	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Lift Children/Groceries	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Read/Concentrate	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Getting Dressed	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Shaving	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Sexual Activities	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Sleep	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Static Sitting	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Static Standing	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Yard work	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Walking	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Washing/Bathing	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Sweeping/Vacuuming	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Dishes	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Laundry	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Garbage	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Driving	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform
Other: _____	○ No Effect	○ Painful (can do)	○ Painful (limits)	○ Unable to Perform

List Prescription & Non-Prescription drugs you take: _____

_____

_____

PATIENT'S NAME: _____ HR#: _____ Date: _____

REVIEW OF SYSTEMS

Please mark: **P** for in the **Past** **C** for **Currently** have

___ Headache	___ Pregnant (Now)	___ Dizziness	___ Prostate Problems	___ Ulcers
___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance	___ Impotence/Sexual Dysfun.	___ Heartburn
___ Jaw Pain, TMJ	___ Convulsions/Epilepsy	___ Fainting	___ Digestive Problems	___ Heart Problem
___ Shoulder Pain	___ Tremors	___ Double Vision	___ Colon Trouble	___ High Blood Pressure
___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Diarrhea/Constipation	___ Low Blood Pressure
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menopausal Problems	___ Asthma
___ Low Back Pain	___ Foot or Knee Problems	___ Hearing Loss	___ Menstrual Problem	___ Difficulty Breathing
___ Hip Pain	___ Sinus/Drainage Problem	___ Depression	___ PMS	___ Lung Problems
___ Back Curvature	___ Swollen/Painful Joints	___ Irritable	___ Bed Wetting	___ Kidney Trouble
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Learning Disability	___ Gall Bladder Trouble
___ Numb/Tingling arms, hands, fingers		___ ADD/ADHD	___ Eating Disorder	___ Liver Trouble
___ Numb/Tingling legs, feet, toes		___ Allergies	___ Trouble Sleeping	___ Hepatitis (A,B,C)

Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations, such as quality assessments and physician's certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is disclosed to carry out treatment, payment, or healthcare operation.

_____ _____ - _____ - _____

Patient or Authorized Person's Signature **Date Completed**

I hereby authorize payment to be made directly to Amplify Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application, or copies thereof, for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Amplify Chiropractic for any and all services I receive at this office.

_____ _____ - _____ - _____

Patient or Authorized Person's Signature **Date Completed**

PATIENT'S NAME: _____ HR#: _____ _____

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke-which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at Amplify Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____
Patient Name (print)

_____ ____/____/____
Patient or Authorized Person's Signature Date

REGARDING: X-rays/Imaging Studies

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your xrays in our files. At your request, we will provide you with a copy of your x-rays. The medical records request is a one-time $15 charge. Digital x-rays on a CD will be available within 72 hours of any regular practice hour day. Please note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctor of Amplify Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found we will bring it to your attention so that you can seek proper medical advice.

By signing below you are agreeing to the above terms and conditions.

_____
Patient Name (print)

_____ ____/____/____
Patient or Authorized Person's Signature Date

Female Patients Only: To the best of my knowledge, **I BELIEVE I AM NOT PREGNANT AT THE TIME THE X-RAYS ARE TAKEN AT AMPLIFY CHIROPRACTIC.**

_____ ____/____/____
Patient or Authorized Person's Signature Date

AMPLIFY CHIROPRACTIC

Automobile/PI Accident or Work Comp Questionnaire

Patient's Name **Date of Birth** **HR#:**

Dear Patient:
This information is considered confidential. Your answers will help us determine if chiropractic care can help your condition. We will not accept your case if we do not believe your condition will respond satisfactorily to care. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form.
Thank you.

Please answer all questions completely.

Please explain in detail how your accident happened: _____

_____

_____

What were the time and date of present injury? _____

Where did you feel pain immediately after the accident? _____

List the extent of your injuries as you know them: _____

_____

_____

Did you require post-accident hospitalization? ☐ Yes ☐ No

Check symptoms you have noticed since the accident:

___ Headache
___ Light Bothers Eyes
___ Head Seems too Heavy
___ Pins and Needles in Arms
___ Sleeping Problems
___ Pins and Needles in Legs
___ Numbness in Fingers
___ Numbness in Toes
___ Shortness of Breath
___ Dizziness
___ Buzzing in Ears
___ Memory Loss
___ Ears Ring
___ Back Pain
___ Constipation
___ Loss of Smell
___ Loss of Taste
___ Stomach Upset
___ Depression
___ Diarrhea
___ Feet Cold
___ Hands Cold
___ Face Flushed
___ Tension
___ Fever
___ Chest Pain
___ Fatigue
___ Neck Pain
___ Neck Stiff
___ Fainting
___ Loss of Balance
___ Nervousness
___ Irritability
___ Cold Sweats

Symptoms other than above: _____

_____

Where were you taken after the accident? _____

Hospitalized? ☐ Yes ☐ No If yes, admitted? _____ How long? _____

Name of Hospital: _____

Name of Doctor(s): _____

What treatment was given? _____

Patient's Name **Date of Birth** **HR#:**

Was any other doctor consulted after your accident? ☐ Yes ☐ No

If so, what was the doctor's name? _____ D.C., M.D., D.O., D.D.S.

What was the diagnosis? _____

What treatment was given? _____

How often did you see the doctor? _____

How long did you see the doctor? _____

Have you ever had any complaints in the involved area before? ☐ Yes ☐ No

If so, what were the complaints? _____

Before the injury were you capable of working on an equal basis with others your age? ☐ Yes ☐ No

Are your work activities restricted as a result of this accident? ☐ Yes ☐ No

Since this injury are your symptoms … ☐ Improving? ☐ Getting worse? ☐ Same?

Driver of other vehicle (if any):

Name _____ Insurance Company _____ Claim No. _____

Driver of vehicle in which you were injured (if applicable):

Name _____ Insurance Company _____ Claim No. _____

Name of your insurance adjustor _____

Have you retained an attorney? ☐ Yes ☐ No

If so, his/her name and
Address/Phone_____

You were heading North/ East/ South/ West on _____ (street or highway)

Other vehicle was heading North/ East/ South/ West on _____ (street or highway)

Were police notified? ☐ Yes ☐ No

Were you knocked unconscious? ☐ Yes ☐ No If yes, for how long? _____

You were struck from Behind/ Front/ Left Side/ Right Side _____

You were Driver/ Passenger/ Front seat/ Back Seat/ Using seat belts _____

Patient Signature _____ Date _____

Doctor Signature _____ Date _____

HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

1. Authorization

I authorize _____ (healthcare provider) to use and disclose the protected health information described below to _____ (individual seeking the information).

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. ☐ _____ to _____.

OR

b. ☐ all past, present, and future periods.

3. Extent of Authorization

a. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. □ I authorize the release of my complete health record with the exception of the following information:

□ Mental health records

□ Communicable diseases (including HIV and AIDS)

□ Alcohol/drug abuse treatment

□ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative

Printed name of patient or personal representative and his or her relationship to patient

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Date

ASSIGNMENT, LIEN, RELEASE & POWER OF ATTORNEY

THIS AGREEMENT, entered into this date_____ and between_____ called "PATIENT" and Amplify Chiropractic LLC .

WHEREAS Patient desires to receive medical/rehabilitation services from Amplify Chiropractic, LLC and desires to assign certain rights and benefits to Amplify Chiropractic, LLC as consideration for Amplify Chiropractic, LLC awaiting payment of such benefits.

Accordingly, it is hereby agreed:

A. Patient hereby authorize Amplify Chiropractic, LLC to furnish a full report and records regarding case history, examination, diagnosis, treatment and prognosis, x-rays, laboratory reports and the results of all tests of any type or character of Patient as such persons as Amplify Chiropractic, LLC deems appropriate.

B. Patient assigns to Amplify Chiropractic, LLC any and all benefits payable by Patient's insurance or health care plan(s) as a result of charges incurred by Patient for services rendered by Amplify Chiropractic, LLC. Patient also assigns to Amplify Chiropractic, LLC any and all contractual rights Patient has against insurance company, health care benefit plan, or any other party possibly liable to Patient for payment of health care costs incurred by Patient as a result of services rendered by Amplify Chiropractic, LLC.

C. Patient fully understands that Patient is directly and fully responsible to Amplify Chiropractic, LLC for all bills submitted for services rendered and that this agreement is made solely for additional protection and consideration for awaiting payment.

D. Patient fully understands that the lien and assignment given to Amplify Chiropractic, LLC herein is irrevocable.

E. By executing this agreement, Patient hereby instructs and directs any attorney representing Patient to honor the above lien and assignment and make payment under the lien and assignment directly to Amplify Chiropractic, LLC. Patient directs that attorney be bound by this lien and treat it, irrevocably, as an assignment due to Amplify Chiropractic, LLC. Amplify Chiropractic, LLC is relying upon this lien, assignment and directive to any attorney, and as a result of such reliance, Amplify Chiropractic, LLC is providing care and treatment for which this lien, assignment and directive provides security for payment. Moreover, Patient agrees that Amplify Chiropractic, LLC is to be viewed as a third party beneficiary of this direction to Patient's attorney and it is Patient's intent to impose upon Patient's attorney an obligation to comply with the terms of this directive.

F. Patient hereby directs all insurers and other persons possibly responsible for Patient's healthcare costs to make all payments for healthcare services rendered by Amplify Chiropractic, LLC directly to Amplify Chiropractic, LLC.

G. Patient agrees that in the event Patient receives any check, draft, or other payment subject to this agreement, Patient agrees to act as fiduciary agent for Amplify Chiropractic, LLC and will immediately deliver said check, draft, or payment to Amplify Chiropractic, LLC to be applied to Patient's debt for services rendered.

H. Patient hereby appoints Amplify Chiropractic, LLC as Patient's true and lawful attorney, irrevocably, and with full power of substitution, for Patient and in Patient's name, to ask, demand, sue for, collect, endorse, sign and receive proceeds from insurance, other health benefits, and third party claims relating to services rendered to Patient by Amplify Chiropractic, LLC. Amplify Chiropractic, LLC is not obligated or compelled to exercise such powers but may do so in Amplify Chiropractic, LLC's sole discretion. Patient agrees to fully cooperate with Amplify Chiropractic, LLC in collecting said amounts.

I. Amplify Chiropractic, LLC agrees to submit a copy of this agreement with the initial claim form(s) which Amplify Chiropractic, LLC submits to third party payor(s) as notice to the third party payor(s) of the assignment and other agreements contained herein. At the time each claim is submitted, a copy of the claim will be stored for safekeeping in Patient's file and may be picked up by the Patient, upon reasonable request and during normal business hours, or upon written request by Patient, be mailed to the designated address.

J. I hereby authorize my attorney to disclose any distribution sheet or final accounting sheet to me and waive any attorney/client privilege as it relates to any settlement or distribution of funds.

K. Patient hereby authorizes Amplify Chiropractic, LLC to receive a complete copy of Patient's insurance policy, including any endorsements, conditions, limitations or exclusions.

L. A copy of this document shall be as binding as the document bearing the original signatures.

M. Patient understands and acknowledges the following disclosures and advisements: that there are other potential methods for payment of a health-care provider's billed charges including the creation of a health-care provider lien; the use of benefits available from any payer of benefits as defined in Section 38-27-101(9) to which the injured person is a beneficiary, including that the injured party can obtain information about the payer of benefits' network from the payer of benefits or the health-care provider; any other payment method or arrangement agreed to in writing by both the health-care provider or its assignee and the injured person; or a combination of the payment methods specified above in paragraph M.

N. Patient understands and acknowledges the following disclosures and advisements: that the health-care provider or its assignee is not a health insurer or payer of benefits.

O. Patient understands and acknowledges the following disclosures and advisements: that, except in the event of fraud or misrepresentation by the Patient, if the Patient does not receive a judgment, settlement or payment on the Patient's claim against third parties or under an uninsured or underinsured motorist policy, the Patient is not liable to the holder of the health-care provider lien or Amplify Chiropractic, LLC for any portion of the health-care provider lien. If the Patient receives a net judgment, settlement, or payment that is less than the full amount of the health-care provider lien, the Patient is not liable to the holder of the health-care provider lien for any amount beyond the net judgment, settlement, or payment and the holder of the health-care provider lien may not file a complaint or counterclaim against the Patient directly to be reimbursed for any amount beyond the net judgment, settlement or payment. The health-care provider or its assignee may not assign a lien to a collection agency or debt collector.

P. Patient understands and acknowledges the following disclosures and advisements: that a health-care provider's assignee's compensation from the injured person is based on the difference between the health-care provider's usual and customary billed charge and the amount that the assignee pays to purchase the health-care provider lien

Q. IF APPLICABLE: and the Patient's legal counsel have a common ownership interest in ……

R. IF APPLICABLE: Amplify Chiropractic, LLC and the assignee of the lien have a common ownership interest in …..

S. If the Patient has obtained health insurance even after this lien has been created, the Patient (or his/her legal counsel) may inform the holder of the health-care provider lien and all future may be billed to the health insurance carrier at the Patient's discretion.

T. Upon request by the Patient or the Patient's legal counsel, the holder of the health-care provider lien shall provide a written itemized statement of all the billed charges for the treatment comprising the total value of the health-care provider lien as the bill charges are accrued, to the extent practicable, and when the health-care provider lien is final. The final

itemized statement will include a summary of all treatment provided, the total amounts billed for each treatment and the total amount of the health-care provider lien due and owing.

_____	_____
Date	Patient's Signature
_____	_____
Date	Attorney's Signature
_____	_____
Date	Amplify Chiropractic, LLC

REFERENCES:

Valley State Bank v. Dean, 97 Colo. 151, 47 P.2d 924 (1935)
Fort Lupton State Bank v. Murata, 626 P.2d 757 (Colo. App. 1981)
Barcucas v. Bohemia Import Co., Inc., 518 P.2d 850 (Colo. App. 1974)
Thomas v. Oken, 699 P.2d 7 (Colo. App. 1984)