



**2130 Mountain View Avenue | Suite 205 | Longmont, CO 80501 | 303.835.7882**  
**www.longmontjointandspine.com**

New Patient Intake Form

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex/Gender: \_\_\_\_\_

Best form of Contact: (Circle one) Home Cell Work Don't leave messages

Home Phone (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_ Email \_\_\_\_\_

Race/Ethnicity: ☐ American Indian or Alaskan Native ☐ Latino  
☐ Asian ☐ Native Hawaiian or Other Pacific Islander  
☐ African American ☐ White

Marital Status: Single Married Other Preferred Language \_\_\_\_\_

Primary Care Provider \_\_\_\_\_

Employment Status: ☐ Employed ☐ Unemployed ☐ FT/PT Student ☐ Disability ☐ Other \_\_\_\_\_

Employer Data \_\_\_\_\_

Employer \_\_\_\_\_

Your Occupation \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Contact Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Contact Home Phone (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

Have you seen a chiropractor before? \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_



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Name: \_\_\_\_\_

**Medical History**

**Surgeries:** (Circle all that apply to you)

- |                   |                       |                       |                         |
|-------------------|-----------------------|-----------------------|-------------------------|
| 1. Brain          | 6. Lumbar spine       | 11. Cardiovascular    | 16. Uro-genital         |
| 2. Cervical spine | 7. Hip                | 12. Hysterectomy      | 17. Hernia              |
| 3. Shoulder       | 8. Knee               | 13. Prostate          | 18. Breast Augmentation |
| 4. Wrist/Hand     | 9. Ankle/Foot         | 14. Gall Bladder      | 19. Appendectomy        |
| 5. Thoracic spine | 10. Joint replacement | 15. Gastro-intestinal | 20. Other               |

If you circled one of the above, write the number below and **specify procedure/date performed:**

\_\_\_\_\_

Other known conditions or injuries: \_\_\_\_\_

\_\_\_\_\_

**Social History:** (Circle what applies to you)

Caffeine use:	frequent	occasional	never
Alcohol:	frequent	occasional	never
Smoking:	1+ pack/day	<1 pack/day	never
Exercise:	3+ days/week	1-3 days/week	never
Water:	64+ oz/day	<64 oz/day	never
Sleep:	8+ hours/night	<8 hours/night	insomnia

Hobbies: \_\_\_\_\_

**Family History:** (Circle all that apply)

Arthritis:	Parent	Sibling
Cancer:	Parent	Sibling
Diabetes:	Parent	Sibling
Heart Disease	Parent	Sibling
Hypertension	Parent	Sibling
Stroke	Parent	Sibling
Thyroid	Parent	Sibling
ALS/MS	Parent	Sibling

Other \_\_\_\_\_

Please list all current medications/vitamins/supplements being taken \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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Name: \_\_\_\_\_

**Review of Systems** (Check the box if you have had trouble with any of the following)

**CONSTITUTIONAL**

- ☐ Fever
- ☐ Fatigue
- ☐ Chills
- ☐ Night sweats
- ☐ Rapid weight loss/gain

**PSYCH**

- ☐ PTSD
- ☐ Irritability
- ☐ Depression
- ☐ Tension/Anxiety
- ☐ Bipolar disorder
- ☐ Trouble sleeping
- ☐ Memory problems
- ☐ Psychiatry treatment

**NEURO**

- ☐ Head/Brain injury
- ☐ Aneurysm
- ☐ New type of headache
- ☐ Seizures
- ☐ Paralysis
- ☐ Numbness
- ☐ Weakness
- ☐ Feeling pins/needles
- ☐ Loss of muscle size
- ☐ Muscle spasm
- ☐ Tremors
- ☐ Involuntary movement
- ☐ Loss of coordination

**EYES**

- ☐ Blurred/Double vision
- ☐ Glasses/Contacts
- ☐ Flashing lights
- ☐ Eye pain
- ☐ Glaucoma/Cataracts

**EARS, NOSE, THROAT**

- ☐ Change in hearing
- ☐ Ear pain/discharge
- ☐ Dizziness/Vertigo
- ☐ Ringing/Tinnitus
- ☐ Nose bleeds
- ☐ Frequent colds
- ☐ Trouble swallowing
- ☐ Sore throat
- ☐ Hoarseness

**CARDIAC/RESPIRATORY**

- ☐ Chest pain
- ☐ Swollen hands/feet
- ☐ Blue fingers/toes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Skipping heart beats
- ☐ Heart murmur
- ☐ History of heart meds
- ☐ Swollen feet/ankles
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Cough
- ☐ Coughing up phlegm
- ☐ Coughing up blood
- ☐ Bronchitis/emphysema
- ☐ Rheumatic heart disease

**GASTROINTESTINAL**

- ☐ Abdominal pain
- ☐ Change of appetite
- ☐ Nausea/Vomiting
- ☐ Heartburn
- ☐ Ulcers
- ☐ Constipation
- ☐ Diarrhea
- ☐ Change in bowel habits
- ☐ Excessive gas
- ☐ Yellow skin
- ☐ Rectal bleeding/hemorrhoid

**GENITOURINARY**

- ☐ Painful/Difficult urination
- ☐ Frequent/Urgent urination
- ☐ Incontinence/Retention
- ☐ Dribbling/decreased stream
- ☐ Blood in urine
- ☐ UTI/Stones/Prostatitis

**SKIN**

- ☐ Easy bruising
- ☐ New rash
- ☐ Itching
- ☐ Change in hair or nails

**MUSCULOSKELETAL**

- ☐ Morning pain/stiffness lasting >1 hour
- ☐ Pain gets worse at rest
- ☐ Alternating buttock pain
- ☐ Corticosteroid injections
- ☐ Arthritis
- ☐ Joint stiffness
- ☐ Joint swelling
- ☐ Joint replacement surgery
- ☐ Fractures
- ☐ Gout
- ☐ Osteoporosis
- ☐ Neck pain
- ☐ Midback pain
- ☐ Low back pain
- ☐ Jaw Pain/TMJ Diagnosis

**ALLERGIES/IMMUNE**

- ☐ Hives
- ☐ Immune disorder
- ☐ Swelling of the lips/tongue
- ☐ Hay fever
- ☐ Asthma
- ☐ Eczema/Sensitive skin
- ☐ Sensitive to drugs, food, pollen
- ☐ HIV/AIDS

**BREAST**

- ☐ Lumps
- ☐ Pain
- ☐ Nipple discharge

**ENDOCRINE**

- ☐ Abnormal growth
- ☐ Increased thirst/appetite
- ☐ Thyroid trouble
- ☐ Heat/Cold intolerance
- ☐ Excessive sweating
- ☐ Diabetes
- ☐ Hair loss
- ☐ Menopausal
- ☐ PMS

**HEMATOLOGIC**

- ☐ Anemia
- ☐ Past transfusions
- ☐ Blood clots
- ☐ Cancer
- ☐ Other: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_



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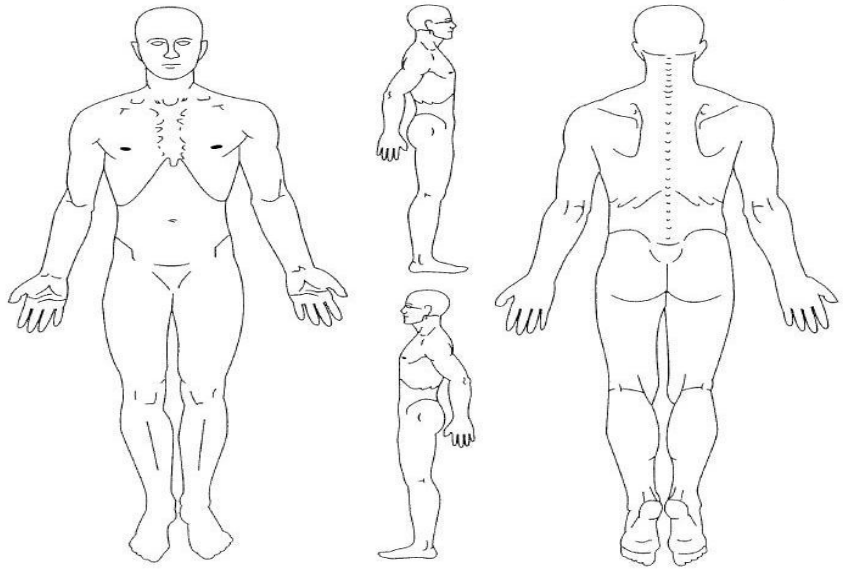
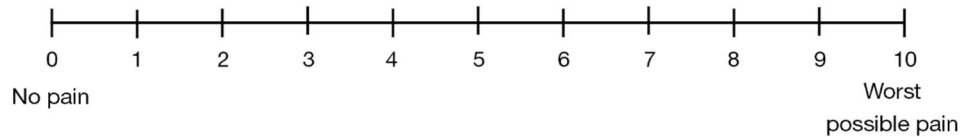
Name: \_\_\_\_\_

Chief Complaint

Please indicate on the body diagram the location and severity (0-10) of your symptoms.

How do your symptoms feel?

- ☐ Achy
- ☐ Burning
- ☐ Sharp
- ☐ Tingling
- ☐ Numbness
- ☐ Other: \_\_\_\_\_



Have you had these symptoms before?

Yes No

When did your symptoms begin?

\_\_\_\_\_

How did your symptoms begin?

\_\_\_\_\_

What (if anything) improves your symptoms? \_\_\_\_\_

What (if anything) worsens your symptoms? \_\_\_\_\_

How often do you take medication for your pain? ☐ Never ☐ As needed ☐ Daily ☐ Multiple times/day

How are your symptoms changing over time? ☐ Getting better ☐ Getting worse ☐ Not changing

How often do you experience your symptoms? ☐ Constantly ☐ Frequently ☐ Occasionally ☐ Intermittently

Are your symptoms affecting your sleep? ☐ Struggle falling asleep ☐ Struggle staying asleep ☐ No impact

What are your specific goals of care? \_\_\_\_\_

Are your symptoms preventing you from doing anything you want to do or have to do? If so, please explain.

\_\_\_\_\_



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### Payment Policy

1. **Insurance**

We participate in most major medical insurance plans. We encourage you to contact your insurance provider directly with any questions regarding your chiropractic benefits, including pre-authorization requirements. If you are not insured by a plan we participate with, payment in full is expected at the time of each visit. As a courtesy, we will verify your coverage; however, we cannot guarantee the accuracy of the information provided by your insurance company.

2. **Coinsurance and Deductibles**

If your plan includes a coinsurance percentage or unmet deductible, we will estimate your financial responsibility based on information from your insurance card or provider portal. Please note: any payment collected on the date of service is considered a **deposit** toward your **estimated** patient balance. Final balances may vary. Any balance left unpaid for more than 120 days may be referred to a collection agency. Our fees are consistent with the usual and customary charges for our region.

3. **Out-of-Pocket Payment**

If you are uninsured or choose not to use your insurance, we offer a prompt-pay discount:

- \$99 for the initial chiropractic visit
- \$60 for each subsequent chiropractic visit

Fees for all other services (e.g., massage, acupuncture) are separate and follow their own pricing structure.

4. **Claim Submission**

We submit claims on your behalf and will assist with reasonable efforts to help your claims get processed. Your insurance company may require additional information directly from you, and it is your responsibility to provide it. Please remember: regardless of insurance coverage, you are ultimately responsible for any balance. Your benefits are a contract between you and your insurance provider; we are not a party to that agreement.

5. **Coverage Changes**

Please inform us of any insurance changes **prior to your next visit** so we can update our records. If your insurer has not paid your claim within 90 days, the outstanding balance will be billed to you.

6. **Cancellation Policy**

Your appointment time is reserved specifically for you. We kindly request at least **4 hours' notice** if you need to cancel or reschedule. Missed appointments or those cancelled with less than 4 hours' notice may incur a **\$40 cancellation fee**.

7. **Non-Refundable Package Policy**

Packages or pre-paid services purchased **in-office** are **non-refundable**. We recommend you ask any questions and ensure the package is right for your needs before purchasing. Unused portions of service packages may be transferred to another eligible service or person at our discretion, but no cash refunds will be issued.

By signing below, I consent to be contacted by regular mail, by email or on my cell phone regarding any matter related to the above referenced account by the creditor, its successors or assigns. This consent includes any updated or additional contact information that I may provide and includes phone calls that employs auto-dialer technology and prerecorded messages. This consent shall apply to all current accounts I have with Longmont Joint and Spine LLC. including accounts that have been assigned to a third-party collection agency. By signing this agreement, customer will also be liable for all costs (including legal costs), charges, commissions, fees, and disbursements incurred by Longmont Joint and Spine in the attempt to recover any unpaid account, including charges for any dishonored checks or credit card payments. If we deem it necessary to use a collection agency or attorney to collect money owed by you, you agree to pay the collection costs, fees, and commissions that we are assessed by the collection agency or attorney.

If I wish to revoke consent to call my cell phone, I agree to provide you notice of that revocation by emailing you at [frontdesk@longmontjointandspine.com](mailto:frontdesk@longmontjointandspine.com) or mailing it to 2130 Mtn View Ave. Ste 205 Longmont, CO 80501.

**I have read and understood the payment policy and agree to abide by its guidelines.**

\_\_\_\_\_  
Signature of patient or responsible party

\_\_\_\_\_  
Date



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### Informed Consent to Treatment

I hereby request and consent to receive chiropractic care and related complementary and alternative medical treatments from a licensed practitioner at Longmont Joint & Spine, as well as by qualified chiropractic assistants, licensed massage therapists, and other supervised staff. These services may include, but are not limited to:

- Chiropractic adjustments (also known as spinal manipulation or chiropractic manipulative treatments)
- Physical examinations, tests, or diagnostic imaging review (e.g. xray or MRI)
- Physiotherapy, physical therapy procedures, and other supportive therapies (e.g. Class IV laser, ultrasound, stretching, soft tissue mobilization, hot/cold therapy, shockwave, IASTM, dry needling)

I understand that, as with any healthcare procedure, there are potential risks and complications associated with chiropractic and manual therapies. While uncommon, possible complications related to spinal manipulation may include—but are not limited to—fractures, disc injuries, dislocations, muscle or ligament strain, vascular injury (including those leading to or contributing to stroke), Horner’s syndrome, diaphragmatic paralysis, cervical myelopathy, and costovertebral strain or separation.

I understand that no practitioner can anticipate or explain all possible risks and complications. I trust my provider to use their clinical judgment to recommend procedures that are in my best interest, based on the information available at the time.

I acknowledge that I have the opportunity to discuss the nature, purpose, potential benefits, and risks of the proposed treatments with the doctor or therapist providing care, as well as with office staff as needed. I confirm that all my questions have been answered to my satisfaction. I understand that results from treatment are not guaranteed.

By signing below, I acknowledge that I have read (or had read to me) the above information and fully understand it. I give my voluntary consent for chiropractic and complementary healthcare treatments at Longmont Joint & Spine. This consent applies to the current condition(s) for which I am seeking care, as well as any future conditions for which I may seek treatment at this facility.

### **SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE**

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Guardian of Minor

\_\_\_\_\_  
Date



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

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

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#### OUR LEGAL DUTY

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.

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 the 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 our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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#### 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 your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and 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 qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

**Your Authorization:** In addition to our use of 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 not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except 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 for 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 person 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 filled prescriptions, 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, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

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

#### Email Communication Consent

By providing my email, I give Longmont Joint & Spine permission to send me appointment reminders and occasional updates about services, health tips, or office news. I understand email is not a fully secure form of communication, and I can opt out at any time. My information will not be shared without my consent.



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#### **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 an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. 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.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

#### **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 or 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 also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. 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 U.S. Department of Health and Human Services.

Patient Name Printed: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_





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## Assignment of Benefits

I hereby instruct and direct any insurance carrier that is providing insurance benefits on my behalf under any policy of insurance to make out a check to, and directly pay, Longmont Joint and Spine LLC for professional medical and rehabilitative services rendered to me. This includes a direct assignment of my rights and benefits under any policy of insurance and may only be revoked with the express written consent of Longmont Joint and Spine LLC.

This assignment of insurance benefits pertains to all professional services, including past services, provided by Longmont Joint and Spine LLC in relation to my health insurance and/or motor vehicle accident. This assignment of insurance benefits is provided so that Longmont Joint and Spine LLC may attempt to collect any unpaid or overdue insurance benefits from the insurance carrier. This includes the assignment of any cause of action that might accrue against such insurance carrier for its failure to pay insurance proceeds. Such assignment is given in consideration of professional medical and rehabilitative services.

I authorize any holder of insurance information about me to release such information to Longmont Joint and Spine LLC needed to determine the insurance benefits or to assist in the collection of payment for services. I authorize Longmont Joint and Spine LLC to contact the insurance company for an exact dollar amount of insurance benefits that are available under any policy of insurance that affords coverage, and to obtain any payout or check ledger reflecting insurance benefits that have been paid out on my behalf. I understand that there may be services provided that may not be paid under the benefits of my insurance plan and therefore I am responsible to pay for these services outside of my Co-Pay amounts.

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date