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 _____

Date of Birth _____/_____/_____ Sex/Gender: □ Male □ Female □ Other_____

Address _____

City _____ State _____ Zip Code _____

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 □ Asian □ African American □ Latino

□ Native Hawaiian or Other Pacific Islander □ White **Preferred Language _____**

Marital Status: □ Single □ Married □ Other **Primary Care Provider _____**

Employment Status: □ Employed □ Unemployed □ FT Student □ PT Student □ 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? _____

LONGMONT
JOINT & SPINE

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

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: (Check all that apply 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: (Check 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_____

_____

_____

LONGMONT JOINT & SPINE

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

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 vision
- ☐ 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
- ☐ Bleeding gums

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

Other:_____

_____

_____

_____

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

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

BREAST
- ☐ Lumps
- ☐ Pain
- ☐ Nipple discharge
- ☐ BSE

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

LONGMONT JOINT & SPINE

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

Name: _____

Chief Complaint

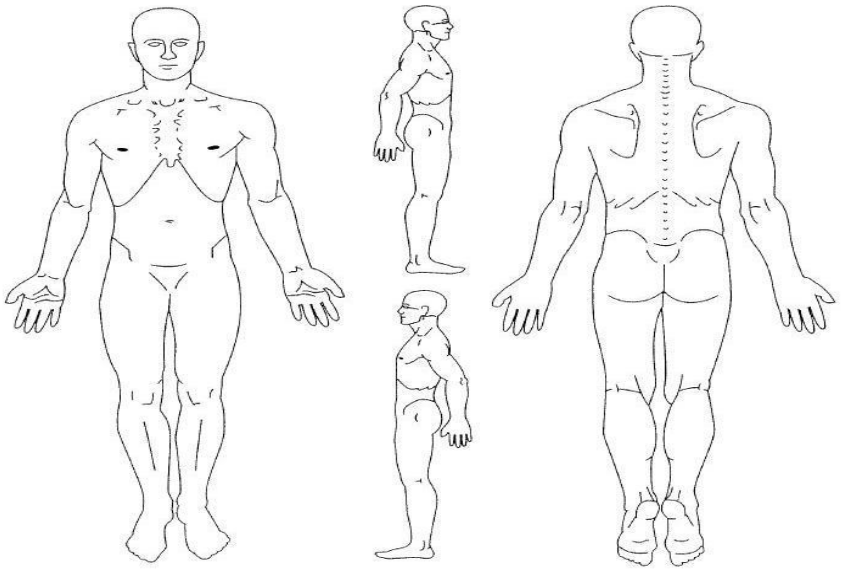
Please indicate on the body diagram the location and severity (0-10) of your symptoms.

How do your symptoms feel?

- ☐ Achy
- ☐ Burning
- ☐ Sharp
- ☐ Tingling
- ☐ Numbness
- ☐ Other: _____

0 1 2 3 4 5 6 7 8 9 10

No pain — Worst possible pain



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.

_____

LONGMONT
JOINT & SPINE

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

Payment Policy

1. INSURANCE. We participate in most major medical insurance plans. We encourage you to call your insurance company with any specific questions related to your policy's chiropractic benefits including pre-authorization requirements. If you are not insured by a plan we participate with, payment in full is expected at each visit. As a courtesy to our patients, we will contact your insurance provider to verify your chiropractic coverage. We cannot, however, guarantee the accuracy of the information we receive from your insurance provider.
2. COINSURANCE AND DEDUCTIBLES. If you have a plan with a coinsurance percentage or deductible which has not been met, we will estimate the coinsurance/deductible amounts based on your insurance card/provider portal. Please note that any payment made on the date of service is considered a DEPOSIT toward your ESTIMATED patient balance. Because this is an estimate, there is the possibility that you may be responsible for an additional balance. An unpaid balance over 120 days past due may be referred to a collection agency. Our fees are representative of the usual and customary charges for our area.
3. OUT OF POCKET PAYMENT: If you do not have or decline to use your major medical insurance, we offer a pay at time-of-service discount of $69 for the initial visit and $60 per each subsequent chiropractic visit. All exams, treatments, and therapeutic modalities are included each visit. All other services (massage, acupuncture, etc.) have their own fee schedule.
4. CLAIM SUBMISSION. We will submit your claims and assist you in any way we reasonably can to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefits are a contract between you and your insurance company; we are not party to that contract.
5. COVERAGE CHANGES. If your insurance coverage changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you.
6. CANCELLATION POLICY: Your practitioner's time is reserved for your appointment – if you are unable to keep your appointment, we kindly ask that you provide us with 4-hour advance notice of cancellation. If you fail to cancel a scheduled appointment 4 hours in advance, or "no-show" an appointment, we reserve the right to assess a $40.00 cancellation fee.

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.
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 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

LONGMONT
JOINT & SPINE

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

Informed Consent to Treatment

I hereby request and consent to the performance of chiropractic (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated complementary and alternative medical treatments: physical examination, tests, diagnostic x-rays, physiotherapy, physical medicine, physical therapy procedures, etc. on me by the doctor of chiropractic named above and/or other assistants and/or licensed practitioners.

I understand, as with any health care procedures, that there are certain complications, which may arise during treatments. Complications related to spinal manipulation include but are not limited to: fractures, disc injuries, injuries to neck vasculature leading to or contributing to complications including stroke, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations.

I do not expect the practitioner to be able to anticipate all risks and complications, and I wish to rely upon the practitioner to exercise judgment during the administration of the procedure(s) which they feel at the time, based upon the facts then known, that are in my best interest.

I have had an opportunity to discuss with the doctor(s) or therapist named above and/or with office personnel the nature, purpose and risks of chiropractic treatments and other recommended procedures. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed.

I have read (or have had read to me) the above explanation of the chiropractic treatments.

By signing below, I state that I have been informed and weighed the risks involved in chiropractic and/or complementary and alternative medical treatment at Longmont Joint & Spine. I have decided that it is in my best interest to receive said treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment.

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

LONGMONT
JOINT & SPINE

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

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.

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.

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).

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: _____

LONGMONT
JOINT & SPINE

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

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