

Date: \_\_\_\_\_ Referred By: \_\_\_\_\_  
 Name: \_\_\_\_\_ Email: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone \_\_\_\_\_  
 Birth date: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: \_\_\_\_\_ # of Children \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Employment \_\_\_\_\_ Work Phone#: \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_ Cell Phone # \_\_\_\_\_

**PLEASE FILL IN THE APPROPRIATE SPACES (All information you give is confidential)**

MAJOR COMPLAINT \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_

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

Have you lost work days?  Yes  No How Many? \_\_\_\_\_

Have you had this similar before?  Yes  No When? \_\_\_\_\_

Was The Injury related to:  Work accident  Auto Accident

When did you last see a chiropractor \_\_\_\_\_ Dr.: \_\_\_\_\_

Why did you see this chiropractor? \_\_\_\_\_ Were you helped? \_\_\_\_\_

What spinal maintenance programs were you given to follow, to maximize the future stability of your spine? \_\_\_\_\_

Did you follow it?  Yes  No If not why? \_\_\_\_\_

Why are you changing chiropractors? \_\_\_\_\_

**PAST (O) OR PRESENT (X) CONDITIONS:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Fractured Bones               | <input type="checkbox"/> Mistake Sidedness (Rt. from Lt.)       | <input type="checkbox"/> Lung Problems                     |
| <input type="checkbox"/> Auto Accidents                | <input type="checkbox"/> Stutter                                | <input type="checkbox"/> Wheezing                          |
| a. <input type="checkbox"/> 0-1 years ago              | <input type="checkbox"/> Dyslexia                               | <input type="checkbox"/> Heart problems                    |
| b. <input type="checkbox"/> 1-5 years ago              | <input type="checkbox"/> Mood Changes                           | <input type="checkbox"/> Stroke                            |
| c. <input type="checkbox"/> More than 5 years ago      | <input type="checkbox"/> Lose Temper Easily                     | <input type="checkbox"/> High or Low blood pressure        |
| <input type="checkbox"/> Other Accidents/Falls         | <input type="checkbox"/> Headache                               | <input type="checkbox"/> Varicose veins                    |
| <input type="checkbox"/> Knocked Unconscious           | <input type="checkbox"/> Neck Pain or Stiff R. L.               | <input type="checkbox"/> Liver trouble                     |
| <input type="checkbox"/> Back Curvature                | <input type="checkbox"/> Numbness, Tingling, or Pain in arms,   | <input type="checkbox"/> Gall Bladder trouble              |
| <input type="checkbox"/> Mental or Emotional Disorders | hands or fingers  | <input type="checkbox"/> Digestive problems                |
| <input type="checkbox"/> Arthritis                     | <input type="checkbox"/> Jaw Pain or Click (T.M.J.) R. L.       | <input type="checkbox"/> Excessive gas                     |
| <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> Head seems too heavy                   | <input type="checkbox"/> Belching/bloating after meals     |
| <input type="checkbox"/> Swollen or Painful Joints     | <input type="checkbox"/> Head & Shoulders feel tired            | <input type="checkbox"/> Heartburn                         |
| <input type="checkbox"/> Convulsions/ Epilepsy         | <input type="checkbox"/> Difficulty in excessive (standing,     | <input type="checkbox"/> Ulcers                            |
| <input type="checkbox"/> Skin Problems                 | walking, sitting riding, bending,                               | <input type="checkbox"/> Diarrhea/ constipation            |
| <input type="checkbox"/> Itching                       | lifting, twisting, household duties)                            | <input type="checkbox"/> Colon trouble                     |
| <input type="checkbox"/> Bruise Easily                 | <input type="checkbox"/> Shoulder pain R. L.                    | <input type="checkbox"/> Hemorrhoids                       |
| <input type="checkbox"/> Cancer                        | <input type="checkbox"/> Dizziness                              | <input type="checkbox"/> Prostate problems                 |
| <input type="checkbox"/> Frequent Colds/Flu            | <input type="checkbox"/> Ringing in ears R. L.                  | <input type="checkbox"/> Impotence                         |
| <input type="checkbox"/> Nervousness                   | <input type="checkbox"/> Hearing loss R. L.                     | <input type="checkbox"/> Kidney trouble                    |
| <input type="checkbox"/> Tension                       | <input type="checkbox"/> Fainting                               | <input type="checkbox"/> Kidney stones                     |
| <input type="checkbox"/> Depressed                     | <input type="checkbox"/> Loss of balance                        | <input type="checkbox"/> Frequent urination                |
| <input type="checkbox"/> Irritable                     | <input type="checkbox"/> Blurred or double vision R. L.         | <input type="checkbox"/> Discharge                         |
| <input type="checkbox"/> Anemia                        | <input type="checkbox"/> Upper back pain or stiffness R. L.     | <input type="checkbox"/> Menstrual problems/PMS            |
| <input type="checkbox"/> Excess Sweating               | <input type="checkbox"/> Mid back pain or stiffness R. L.       | <input type="checkbox"/> Menopausal problems               |
| <input type="checkbox"/> Tremors                       | <input type="checkbox"/> Lower back pain or stiffness R. L.     | <input type="checkbox"/> Breast lumps, soreness, discharge |
| <input type="checkbox"/> Light Bothers Eyes            | <input type="checkbox"/> Numbness, tingling or pain in buttocks | <input type="checkbox"/> Pregnant (currently)              |
| <input type="checkbox"/> Allergy                       | thighs, legs, feet toes R. L.                                   | <input type="checkbox"/> Bed wetting                       |
| <input type="checkbox"/> Sinus Problems                | <input type="checkbox"/> Pain with cough, sneeze or strain at   | <input type="checkbox"/> Ear infections                    |
| <input type="checkbox"/> Light Headed Upon Rising      | stools  | <input type="checkbox"/> Hepatitis                         |
| <input type="checkbox"/> Under Stress                  | <input type="checkbox"/> Hip pain R. L.                         | <input type="checkbox"/> Venereal disease                  |
| <input type="checkbox"/> Crave Sweets or Salt          | <input type="checkbox"/> Foot trouble R. L.                     | <input type="checkbox"/> AIDS/HIV                          |
| <input type="checkbox"/> Eating Disorders              | <input type="checkbox"/> Chest pain                             | Other _____  |
| <input type="checkbox"/> Trouble Sleeping              | <input type="checkbox"/> Asthma                                 | _____  |
| <input type="checkbox"/> Trouble Concentrating         | <input type="checkbox"/> Difficulty breathing                   | _____  |
| <input type="checkbox"/> Learning Disability           |   | _____  |
| <input type="checkbox"/> Loss of Memory                |   | _____  |

**WHAT IS YOUR HEALTH PHILOSOPHY? (What should you do to be healthy?)** \_\_\_\_\_

**HOW DO YOU WANT US TO HANDLE YOUR PROBLEM?**

- \_\_\_\_\_ Temporary Relief (Help the symptom but not necessarily fix the cause of the problem)
- \_\_\_\_\_ Maximum Correction (Correct the cause of the problem for maximum stability in the future)

**WHY DID YOU COME INTO OUR CLINIC AND WHAT ARE YOUR EXPECTATIONS OF US?** \_\_\_\_\_

1. What are your favorite activities or hobbies to do now? \_\_\_\_\_
2. Are your current problems affecting these activities or hobbies? \_\_\_\_\_
3. What activities are you looking forward to doing in retirement? \_\_\_\_\_
4. Who would you like to be doing these with? \_\_\_\_\_

On a scale of 1-10 (10 being the most, and 1 being the least).

- \_\_\_\_\_ How committed are you at being at your maximum health potential?
- \_\_\_\_\_ How important is it for your family to be at their maximum health potential?
- \_\_\_\_\_ How committed are you to preventing arthritis and maximizing your spinal stability?

What surgeries have you had? \_\_\_\_\_

List drugs you now take (prescription & non-prescription) \_\_\_\_\_

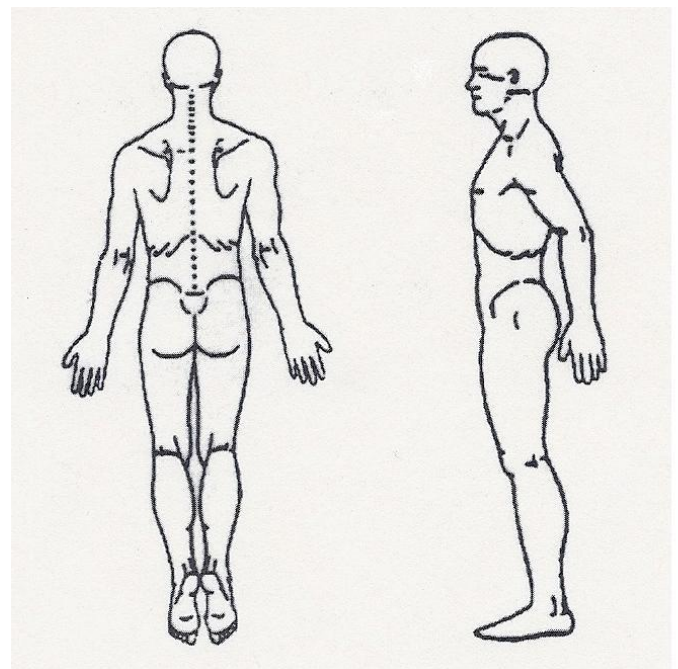
Name other doctors you have seen for this condition, what was done, and for how long?

Are you currently wearing  Heel Lifts  Arch Supports  Foot Orthotics

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

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Please mark your areas of concern on the figures below



**Signature** \_\_\_\_\_

## WELCOME TO OUR OFFICE

We are committed to providing you the best care and are pleased to discuss our professional fees with you at anytime. Your clear understanding of our financial policy is important to our professional relationship. Please ask any questions you may have regarding our fees in complying with our financial policy and/or procedures. The best health services are based on a friendly, mutual understanding between you and your doctor.

**CASH PATIENTS:** Payment is due when services are rendered. We gladly accept Mastercard, Visa, check or cash.

**INSURANCE PATIENTS:** Professional services are rendered and charged to your insurance on your behalf. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made. Any services not covered by your insurance are ultimately your responsibility and may have to be paid by you at the time of service. If you fail to keep your scheduled appointments or if you discontinue care for any reason other than discharge by the doctor, the bill is due and payable by you in full immediately, regardless of any insurance claim submitted. In certain cases our office accepts billing for individual or group insurance policies, personal injury claims, authorized worker's compensation and Medicare.

**DISCLOSURE OF INFORMATION:** If your insurance company should send a check to you that cover services rendered in this office, you agree to deliver that check, and any associated paperwork, to this office within (1) one week of receipt. You hereby authorize assignment of your insurance rights and benefits directly to your provider for service rendered. You authorize the staff to perform any necessary services during diagnosis and treatment.

**If this was the result of a motor vehicle accident:** Your health insurance may not cover specific treatments that may be beneficial in your case. We reserve the right to collect our usual and customary fees for services rendered during your treatment in our office. We also reserve the right to bill any and all insurance carriers that may be responsible for provided coverage.

**Authorization to Process Drafts:** I agree that Aspen Ridge Chiropractic P.C. shall be appointed as my agent to endorse drafts on any checks for payment of my bill for medical services rendered.

**Limited Release of Medical Information:** I authorize Aspen Ridge Chiropractic P.C to make inquires and to release any pertinent information to any insurance company, government agency, adjuster or attorney to facilitate collection under these assignments.

**Assignment of Cause of Action:** In the event that any insurance company or third party obligated to make payment to me or to Aspen Ridge Chiropractic P.C for the charges made for the services, refuses to make such payment upon demand, I hereby assign, transfer, and convey to Aspen Ridge Chiropractic P.C any and all cause of action that might exist in my favor against any such company or person. I authorize Aspen Ridge Chiropractic P.C to prosecute said action in my name or their name to collect fees due for care rendered and legal expenses, and to resolve said claims as they see fit.

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

Patient Signature: \_\_\_\_\_  
(if patient is under 18 years of age, legal guardian must sign above)

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

Witness: \_\_\_\_\_

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

*It is the Patient's responsibility to inform our office of any changes in your medical or insurance status.*



## Notice of Privacy Practices

This summary discloses how health information about you may be used. A full notice of Privacy rights has also been provided to you.

Aspen Ridge Chiropractic P.C. uses health information about you for treatment, to obtain payment for treatment with your authorization, for administrative purposes, and to evaluate the quality of care that you receive.

Aspen Ridge Chiropractic P.C. will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Aspen Ridge Chiropractic P.C. may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

Aspen Ridge Chiropractic P.C. may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, government function in order to comply with workers compensation laws and regulations.

Aspen Ridge Chiropractic P.C. has the right to adjust your spine in an open adjusting room where other patients are also present. You acknowledge that the doctor will be talking to you about your case openly in each visit as he adjusts you and other people may hear information about your particular case. Should you request privacy regarding anything to do with your case, you will request it with the staff or doctor and will be placed in a private adjusting room or consultation room.

You have a right to request restriction, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health records. You may complain to the Privacy Officer and to the Department of Health and Human Services if you believe your rights have been violated. You will not be retaliated against for filing a complaint.

Aspen Ridge Chiropractic P.C. must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative location and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

If you have any questions or concerns, please contact our office at 208-552-8866.

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

Patient Signature: \_\_\_\_\_  
(if patient is under 18 years of age, legal guardian must sign above)

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

Witness: \_\_\_\_\_

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

## Informed Consent to Chiropractic Treatment

The following is Aspen Ridge Chiropractic's informed consent for treatment. We intend this consent form to cover the entire course of treatment for your present condition and for any conditions for which you seek treatment at this clinic.

**The nature of chiropractic treatment:** The doctor will use his/her hands or a mechanical device in order to adjust/manipulate your joints. You may hear a "click" or "pop", similar to when a knuckle is "cracked" and you may feel movement of the joint. Various ancillary procedures, such as a hot or cold packs, electric muscle stimulation, mechanical traction, as well as exercise instruction may also be used.

**Possible risks and probability:** There are inherent risks in my and all treatment derived by any health care provider ranging from taking a single aspirin to a complicated brain surgery. Chiropractic care is no exception. Although we take every precaution, there are indeed some slight risks to chiropractic adjustments/manipulations. The risk is very minor in any treatment of the extremities. The risks involved in treatment to the spine while rare are as still possible. A list from the least to the most serious would include muscular strain (rare), ligamentous sprain (rare), fractures (rare), and injury to the intervertebral discs, nerves, or spinal cord (very rare). There is the remote possibility of stroke (extremely rare) with adjustments in the neck. A minority of patients may notice a stiffness or soreness after the first few days of treatment (common). The ancillary physical therapy procedures could produce skin irritations, burns or other minor complications (rare).

**Other treatment options, not provided by this clinic, which could be considered, may include the following:**  
**Over-the-counter analgesics.** The risks of these medications include irritations to the stomach, liver and kidneys and other side effects in a significant number of cases. Medical care, typically anti-inflammatory drugs, tranquilizers and analgesics. Risks of these drugs include numerous undesirable effects, usually more serious than those listed above and patient dependence in a significant number of cases. Surgery in conjunction with medical care adds the risks of adverse reactions to anesthesia (which include death), as well as extended convalescent period in a significant number of cases.

**Risks of remaining untreated:** Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and include chronic pain cycles. It is quite probable the delay of treatment will complicate the condition, and make further rehabilitation more difficult.

**Concerns or questions:** Please ask your Doctor of Chiropractic, Dr. Miller and the staff at Aspen Ridge Chiropractic has gone to great lengths to make your health and safety a top priority. Dr. Miller will be glad to explain any concerns about treatment you may have. Suffice to say we will only recommend treatment for you that we would feel comfortable having performed on ourselves.

I have read the above explanation of chiropractic care. I also had the opportunity to ask questions and have them answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

I have read and understand the above and I give my consent to undergo spinal adjustments at Aspen Ridge Chiropractic P.C.

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

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

(if patient is under 18 years of age, legal guardian must sign above)

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

Witness: \_\_\_\_\_

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

## Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Aspen Ridge Chiropractic P.C. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations.

I understand that my diagnosis or treatment by Aspen Ridge Chiropractic P.C. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Aspen Ridge Chiropractic P.C. is not required to agree to the restrictions that I may request. However, if Aspen Ridge Chiropractic P.C. agrees to a restriction that I request, the restriction is binding. I have the right to revoke this consent, in writing, at any time, except to the extent that Aspen Ridge Chiropractic P.C. has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a healthcare clearing house. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Aspen Ridge Chiropractic P.C. Notice of Privacy Practices prior to signing this document. Aspen Ridge Chiropractic P.C.'s Notice of privacy Practices have been provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Aspen Ridge Chiropractic P.C. This notice of Privacy Practices also describes my rights and the duties of Aspen Ridge Chiropractic P.C. with respect to my protected health information.

Aspen Ridge Chiropractic P.C. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment

### ***Notice of Privacy Practices - Acknowledgment***

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Aspen Ridge Chiropractic P.C..

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and you can access your information. ***By my signature below I acknowledge receipt of the Notice of Privacy Practices.***

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

Patient Signature: \_\_\_\_\_  
(if patient is under 18 years of age, legal guardian must sign above)

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

Witness: \_\_\_\_\_

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

**This form will be retained in your health record**