



CHILD NEW PATIENT FORMS

Please print clearly

GENERAL INFORMATION (please complete in detail, all information is confidential)

Patient Last Name: _____		First Name: _____		MI: _____
Mother's Last Name: _____		First Name: _____		MI: _____
Father's Last Name: _____		First Name: _____		MI: _____
Child's Info:			Number of Siblings: _____	
Address: _____			Names & Ages: _____	
City: _____ State: _____ Zip: _____			_____	
_____			_____	
Today's Date / /	Age	Date of Birth / /	Sex: M F	Child's Social Security Number - -

Financially Responsible Party (FRP) Info:		Parent Status:	
<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone (Home): _____ Email: _____ Phone (Work): _____ Phone (Cell): _____		<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
FRP's Employer's Name: _____		FRPs Social Security Number - -	
Address: _____		FRP's Date of Birth / /	
City: _____ State: _____ Zip: _____		FRP's Driver's Lic. #:	
Phone: _____ Occupation: _____		EMPLOYED <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Not Employed	
STUDENT <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time			
Referred By: _____			
If you were not referred to us, how did you hear about Alpine Wellness Chiropractic? _____			

INSURANCE INFORMATION

Check If Self-Pay

<i>Primary Insurance Company Name</i> _____ Type: _____ Group: _____ Private: _____ Membership/Cert #: _____ Policy / Group #: _____	<i>Complete ONLY if patient is not the insured</i> Insured's Name: _____ M F <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced Patient's Relationship to Insured: _____ Insured's Date of Birth: _____ Insured's Employer: _____
<i>Secondary Insurance Company Name</i> _____ Type: _____ Group: _____ Private: _____ Membership/Cert #: _____ Policy / Group #: _____	<i>Complete ONLY if patient is not the insured</i> Insured's Name: _____ M F <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced Patient's Relationship to Insured: _____ Insured's Date of Birth: _____ Insured's Employer: _____

ALPINE WELLNESS CHIROPRACTIC...Unlocking the Healer Within

T: 303.431.8588 ♦ F: 303.421.9232



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CHILDREN'S HEALTH & INJURY HISTORY INFORMATION

Please check health complaints your child is currently experiencing or has experienced in the last six months.

- Asthma Allergies Headache Dizziness Ringing in the Ears Ear infection
 Seizures ADHD Unintended Weight Gain/Loss Sleeping Problems Fatigue
 Chronic Colds Colic Digestive Problems Bed wetting Scoliosis
 Car Accident Neck Pain Numbness in Arms/Hands "Growing pains" Arm/Wrist Pain
 Shoulder Pain Back Pain Tingling in Arms/Legs Foot/Ankle/Knee pain Other Pain

Which of the problems you have checked off is the worst? _____

Is this problem: Constant (66-100% of the time) Intermittent (33-65% of the time)
 Occasional (0-32% of the time) Cyclic (occurs w/regular pattern, not every day)

How long has it been going on? _____

When it is at its worst, how does it make your child feel? _____

What have you done about it that has NOT worked? _____

What makes it worse? _____

What effect does this problem have of your child's body functions? _____

On his/her participation in daily activities? _____

Additional parent comments about child's health status _____

When was the last time your child had a spinal examination to determine proper alignment for optimal growth and development, and by whom? _____

Mainly for Moms:

Tell us about your pregnancy:

Did you carry to full term? _____

Describe any complications and when they occurred: _____

Tell us about your delivery and birth of this child:

Did you use a midwife? Yes No Hospital? Yes No Obstetrician? Yes No

Did you have a C-Section? Yes No Were forceps used? Yes No

Vacuum Extraction? Yes No Were you induced? Yes No

Did you have an Epidural? Yes No Was it a difficult birth? Yes No

What was the baby(s) APGAR Score? ____ at 5 minutes? ____

Tell us more:

Did you breastfeed? Yes No How long? _____ What formula after? _____

Did you consume alcohol during your pregnancy? Yes No How much? _____

Did you smoke? Yes No How much? _____ How long? _____

Did you take any medication during your pregnancy? Yes No

For what? _____ What type? _____

Any exposures to ultrasound? Yes No How many? _____



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About your Child:

As a baby/toddler, (birth to 4 years), did any of the following occur?

- | | | |
|--|---|--|
| <input type="checkbox"/> Fall from a changing table | <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Colic |
| <input type="checkbox"/> Tumble down stairs | <input type="checkbox"/> Tonsilitis | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Fall out of crib | <input type="checkbox"/> Reaction to vaccination | <input type="checkbox"/> Frequent fevers |
| <input type="checkbox"/> Involved in car accident | <input type="checkbox"/> Frequent crying spells | <input type="checkbox"/> Frequent colds |
| <input type="checkbox"/> Fall off playground equipment | <input type="checkbox"/> Frequent bouts of diarrhea | <input type="checkbox"/> Did not gain weight |
| <input type="checkbox"/> Play in "Jolly Jumper" | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Other _____ |

Please explain the above: _____

As a young child, (5-12 years), did any of the following occur?

- | | | |
|--|--|--|
| <input type="checkbox"/> Fall from a tree | <input type="checkbox"/> Stomach pains | <input type="checkbox"/> Learning Difficulties |
| <input type="checkbox"/> Fall off a bicycle | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Fall off playground equipment | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Sports accident | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Leg/knee pains |
| <input type="checkbox"/> Car accident | <input type="checkbox"/> Autism | <input type="checkbox"/> Other: _____ |

Please explain the above: _____

Tell us about any vaccinations your child has had: _____

Any reactions to any of these? Yes No Which and what happened: _____

Were you told that you had a choice in vaccinating your child? Yes No

Would you like information on the "other side" of this issue? Yes No

Describe any hospital stays or surgeries: _____

How many prescriptions of antibiotics has your child taken:

During the past six months _____, Total during his/her lifetime _____

How many other prescription medications has your child taken:

During the past six months _____, Total during his/her lifetime _____

What kind? _____



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CONSENT FOR TREATMENT (MINOR)

We recognize that life can be hectic and that it may be necessary for a grandparent, babysitter, or other trusted guardian to bring your child to his/her appointments. In addition, at times, a child may prefer to be seen without their parent/guardian present. For these situations it is necessary for us to have your signed permission to take care of your child without your presence.

Patient Name: _____

Alpine Wellness Chiropractic
16205 West 64th Avenue
Suite B-1
Arvada, CO 80007

I hereby request and authorize **the staff of Alpine Wellness Chiropractic** to perform diagnostic tests and render chiropractic adjustments and other treatment to **my minor child¹** :
_____ ***without my physical presence.*** This authorization extends to all doctors and office staff members and includes radiographic examination at the doctor's discretion.

As of the date listed below, I have the legal right to select and authorize health care services for the minor child named above.

(If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/ former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Parent/Guardian Signature

Parent/Guardian Printed Name

Date

Witness Signature

Witness Printed Name

¹ minor son/daughter/ward or other.



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TERMS OF ACCEPTANCE

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

It is important that each patient understand both the objectives and the methods of chiropractic care.

This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral Subluxation. Our chiropractic method of correction is by specific adjustment of the spine and the use of stretching and exercising to maximize the improvement.

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

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of both muscle and nerve function, and interference to the transmission of nerve impulses, resulting in a lessening of the body's ability to function properly.

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

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others.

I _____ have read and fully understand the above statements.
(Print name)

I, therefore, accept chiropractic care for my child on this basis.

Parent/Guardian Signature

Date

Consent to evaluate and adjust a minor child

I _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Parent/Guardian Signature

Date

Pregnancy Release

This is to certify that to the best of my knowledge my child is not pregnant and the above doctor and her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of child's last menstrual period _____ .

Parent/Guardian Signature

Date



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FEE STRUCTURE

Please note our fees for your initial visit:

<i>Consultation</i>	Complimentary
<i>Examination</i>	\$ 65.00
<i>Radiology</i>	Variable (up to a maximum of \$100.00)
TOTAL	\$ 165.00

Please note that if you have been involved in a motor vehicle accident or have health insurance, our fee structure may differ.

Please also note that your clinical Report of Findings, the time that your doctor will spend with you to go over your results, is complimentary.

FINANCIAL POLICIES

1. All first visit charges are payable when services are rendered, if your visit is promotional or you have a gift certificate, please inform the chiropractic assistant.
2. The fee paid for treatment x-rays is for analysis only. The film itself is the property of this office. Once films are used for treatment purposes, they cannot be released. Films may be release upon request, but must be returned within 30 days. Please allow 24 hours to prepare x-rays for pickup.
3. Payment is required at the time of service. You are responsible for giving your payment when you check in. The front desk staff may ask for your co-payment however, even if someone does not ask, you are responsible for knowing the amount and for payment before your visit.
4. Self-pay patients without insurance are expected to make payment in full on the day services are rendered. If you are unable to pay in full, a "good faith" pre-payment of \$25.00 is required and you will need to setup a payment plan and make regularly scheduled payments.
5. Patients are responsible for ALL charges that are not covered by insurance plans. This includes co-payments, deductibles, co-insurance, and non-covered services.
6. **Insurance companies do not pay for corrective or maintenance care.** Insurance may only be used until maximum therapeutic benefit is achieved, according to insurance company guidelines, usually within the first two weeks of care or a maximum of 12 visits. If during the course of corrective or maintenance care you develop a new condition or a previous condition becomes significantly worse, care may no longer be considered corrective or maintenance and may be covered by your health plan. Please alert the front desk staff of any significant changes in your condition status as soon as possible so that your insurance can be billed accordingly.
7. If you have a service that is **not a covered benefit** of your insurance, such as weight loss or nutrition counseling, you will be financially responsible for payment of such services. We will not change reasons for visits. All claims will be filed in accordance with the documentation in the chart.



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FINANCIAL POLICIES (continued)

- 8. When you receive a bill from us, payment is expected within 30 days. If you need to make payment arrangements, please contact front desk staff before the 30 day period. Failure to pay will result in the account being assigned to a collection agency.
- 9. There will be a \$25 fee for all returned checks..
- 10. If payments are not received in accordance with the above guidelines, the accounts will be turned over to the collection agency, Rickenbaker Group. The patient will be responsible for any collection fees, attorney fees and other costs involved in referring their delinquent account to the collection agency.
- 11. All lab services provided outside our office are billed separately. We do not handle any of the lab billing. If you have questions or concerns about a bill from the lab you must contact them directly.
- 12. Orthopedic supplies, supplements, food and other retail items provided by our office are not covered by insurance and will not be billed to the insurance company (some exceptions may apply). Payment is expected at the time of purchase.
- 13. Method of payment you plan to use to take care of today's charges, if any?

Cash Check Visa/MasterCard/Discover/AMEX

I _____ understand and agree that health and accident
(Print name)

insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand Alpine Wellness Chiropractic will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to Alpine Wellness Chiropractic will be credited to my account upon receipt. *However*, I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment.

I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this account. I authorize Alpine Wellness Chiropractic to obtain a credit report if deemed necessary.

Patient Signature

Date

Guardian Signature Authorizing Care

Print Name

Date



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Name: _____

ASSIGNMENT AND MEDICAL INFORMATION RELEASE FORM

This form will help us coordinate the exchange of information and release of 3rd party reimbursement.

Assignment of Insurance Benefits and Payment Guarantee

I, _____ (Patient) assign to Alpine Wellness Chiropractic and/or Dr. Denesa Pozner (AWC) 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 AWC. Patient also assigns to AWC 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 AWC. Patient hereby directs all insurers and other persons possibly responsible for Patient's healthcare cost to make all payments for healthcare services rendered by AWC directly to AWC.

Release of Information

Patient hereby authorizes AWC to furnish a full report and records regarding case history, examination, diagnosis, treatment and prognosis, x-rays, laboratory reports and the results of all test of any type or character of patients such persons as MHC deems appropriate.

Please provide Primary Care Physician's information:

Doctor's Name: _____

Office/ Clinic Name: _____

Address: _____

Clinic Phone Number: _____

Doctor's E-mail: _____

Specialty or scope of practice: _____

If referred by specialist please provide their information as well:

Doctor's Name: _____

Office/ Clinic Name: _____

Address: _____

Clinic Phone Number: _____

Doctor's E-mail: _____

Specialty or scope of practice: _____

(Please do not neglect to fill in your Doctor's information)

Signature of Insured / Guardian

Please Print Name

Date

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Notice Of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET 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. This Notice takes effect March 28, 2003, and will remain in effect until we replace it. 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 copies, we will charge you \$1.00 for each page, \$20.00 per hour (with a minimum of \$20.00) for staff time to locate and copy your health information, and postage if you want the copies mailed to you. 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. Contact Officer: Denesa Pozner, DC. 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.

Contact Officer: Denesa Pozner, DC

Alpine Wellness Chiropractic, 16205 W. 64th Ave., Ste. B-1, Arvada, CO 80007 Phone: 303.431.8558 Fax: 303.431.9232



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's
Notice of Privacy Practices.

{Please Print Name}

{Signature}

{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)
