CAIN CHIROPRACTIC & REHAB, P.C.
PATIENT REGISTRATION INFORMATION

PRINTED NAME____DATE____________________________________
(Last) (First) (M.I.)
ADDRESS____
CITY____ STATE_________________________ ZIP_____________________
CELL NUMBER ____________________________________ HOME NUMBER____
WORK NUMBER____________________________________ EMAIL____
DATE OF BIRTH ___________________________________ AGE____
MARITAL STATUS _________________________________ SPOUSE'S NAME_______________________________________
CHILDREN'S NAMES____
PLACE OF EMPLOYMENT ____
OCCUPATION____WORK NUMBER ________________________________
HOW DID YOU HEAR OF CAIN CHIROPRACTIC & REHAB? ____

EMERGENCY INFORMATION

NAME____ RELATIONSHIP ____
HOME NUMBER ________________________ CELL ____________________ WORK NUMBER __________________________

BILLING INFORMATION
(Responsible party information, if different from above)
PRINTED NAME ____
ADDRESS ____
CITY ____ STATE ___________________ ZIP__________________________
HOME #: ________________________________ CELL #: ________________________ WORK #: _______________________

HEALTH INSURANCE INFORMATION
(**Please provide your insurance card**)

PRIMARY POLICY HOLDER (NAME OF INSURED) ____
INSURED'S DATE OF BIRTH __________________ INSURANCE COMPANY_______________________________________
ID NUMBER____________________________________GROUP NUMBER____
SECONDARY POLICY HOLDER (name of insured) ____
INSURED'S DATE OF BIRTH_______________________ INSURANCE COMPANY_______________________________________
ID NUMBER___________________________________ GROUP NUMBER____

AUTO INSURANCE INFORMATION

PRIMARY POLICY HOLDER (Name of insured)____
INSURANCE COMPANY_________________________ AGENT______________________ AGENT'S #_____________________
POLICY NUMBER _______________________________________ MEDICAL COVERAGE ("Med Pay") _______YES _______ NO
Amount of Med Pay Coverage ____

Have you ever sought Chiropractic healthcare before? (Dr.'s name, city, state, length of care, conditions treated, x-rays taken etc.)

____

____

Females: Are you pregnant? ______________________________ Due Date______________________________

HISTORY OF CHIEF COMPLAINT

Please describe your major complaint.

____

____

____

Result of an Auto Accident: __________ On the Job Accident: _____________ Date of Accident: _______________

Have you ever had this before? (Describe when, where, how, why, what caused it, if you sought treatment from whom, the diagnosis and how it was treated.)

____

____

____

When did this current complaint start?

____

____

Has it become better, worse or changed in any way since it started?

____

____

Describes what makes it better.

____

____

Describe what makes it worse.

____

____

How would you describe the complaint? (mild, moderate, severe, extreme, painful, numb, stiff, achy, burning, sharp, dull, shooting, discomfort, tight, spasms, etc.)

____

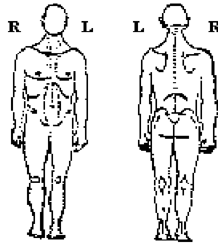
____

Does it radiate to other areas? (Please describe where, i.e. down arm or leg, into head etc.)

____

____

Please indicate on the diagrams below where your area of chief complaint is:



It is worse:

_________ In the morning
_________ In the mid-day
_________ In the evening

Following:

________ Routine activity
________ Moderate activity

Does it interfere with:

Work_________ Days Missed ________ Sleep __________
Personal Activities (describe) _________________________
Activities of daily living (describe) ____________________
____
____
Other (describe) __________________________________
____

How frequent is it? (i.e. daily, twice daily, three times weekly, occasional, intermittent, frequent, constant, etc.)

____

____

Please rate the intensity <u>at its WORST</u> on the scale below:

0____10
(absent) (extreme/ER)

Please rate the intensity <u>RIGHT NOW</u> on the scale below:

0____10
(absent) (extreme/ER)

How long does it last? (i.e. # of seconds, # of minutes, # of hours, all day, # of continuous days, etc.)

____
____

Additional symptoms noticed since the onset of this problem? (i.e. headaches, blurred vision, loss of strength, trouble with bowel or bladder habits, etc.)

____
____

Have you sought treatment elsewhere for this condition? (name(s), diagnosis, how it was treated, images taken)

____
____
____
____
____

PAST HEALTH HISTORY

Prior conditions requiring surgeries/operations/hospitalizations (include year):
____
____

Prior fractures/broken bones (bone(s) and year):
____
____

Serious illnesses (condition and year):
____
____

Motor vehicle injuries (injury and year):
____
____
____

Significant falls/accidents (injury and year):
____
____

Present health problems (condition and year diagnosed):
____
____

Vitamins/Supplements (indicate for what use/condition):
____
____

Medications (indicate for what use/condition):
____
____

FAMILY HEALTH HISTORY

Please indicate who in your family has or had the following conditions:

Arthritis: ____

Blood Pressure (high or low):____

Cancer (location): ____

Diabetes (type or age of onset): ____

Epilepsy (type): ____

Fatalities (other than listed already): _____________________________________

Genetic Problems (specify): ____

Heart or Vascular Conditions (specify): ____________________________________

Headaches (specify type i.e. migraines, cluster, etc.): ________________________

Lung Conditions (specify): ____

Other (specify):____

Patient Instructions: Please check any conditions whether it is past or present that you consider **SIGNIFICANT**.

1.	General	☐ Fever ☐ Weight loss ☐ Weight gain	☐ Chills ☐ Fatigue ☐ Sweats	☐ Sleep Disturbances ☐ Change in daily routines ☐ Nausea
2.	Head	☐ Headache ☐ Trauma	☐ Dizziness ☐ Loss of consciousness	☐ Other
3.	Eyes	☐ Contacts ☐ Glasses ☐ Cataracts	☐ Blurry vision ☐ Flashes in front of eyes ☐ Spots in front of eyes	☐ Double vision ☐ Sensitive to lights ☐ Other
4.	Ears	☐ Ringing in ears ☐ Frequent infections	☐ Hearing loss ☐ Drainage	☐ Pain ☐ Other
5.	Nose	☐ Post-nasal drip ☐ Sinus	☐ Nosebleeds	☐ Other
6.	Mouth	☐ Gum bleeds ☐ Dentures ☐ Changes in taste	☐ Cold sores ☐ Difficulty swallowing ☐ Sore throat	☐ Jaw pain ☐ Swelling ☐ Other
7.	Neck	☐ Masses ☐ Swelling	☐ Stiffness	☐ Other
8.	Lungs	☐ Asthma ☐ Cough ☐ Tuberculosis	☐ Pneumonia ☐ Coughing up sputum ☐ Coughing up blood	☐ Wheezing ☐ Difficulty breathing
9.	Vascular	☐ Chest pain ☐ Palpitations ☐ High blood pressure	☐ Swelling ☐ Leg cramps ☐ Low blood pressure	☐ Calf pain ☐ Ankle swelling ☐ Varicose veins
10.	Gastro-Intestinal	☐ Gas ☐ Diarrhea ☐ Digestion	☐ Vomiting ☐ Constipation ☐ Abdominal pain	☐ Heartburn ☐ Blood in stool ☐ Hemorrhoid
11.	Urinary	☐ Difficulty with urination ☐ Pain with urination ☐ Blood in urine	☐ Increased urination ☐ Decreased urination ☐ Incontinence	☐ Foul odor of urine ☐ Urinary tract infections
12.	Skin	☐ Rash ☐ Bruising ☐ Hair loss	☐ Warts ☐ Brittle nails ☐ Changes in moles	☐ Itching ☐ Other
13.	Neurology	☐ Seizures ☐ Strokes	☐ Tingling sensation ☐ Numbness	☐ Weakness ☐ Difficulty walking
14.	Musculo-Skeletal	☐ Joint pain ☐ Stiffness ☐ Muscle ache	☐ Arthritis ☐ Deformities ☐ Bone pain	☐ Fractures ☐ Dislocations
15.	Psychiatric	☐ Depression	☐ Mood swings	☐ Anxiety
16.	Diagnosed Medical Condition	☐ Hypertension ☐ Diabetes ☐ Thyroid Condition	☐ Heart Condition ☐ Rheumatoid Arthritis ☐ Epilepsy	☐ Alcoholism ☐ Cancer / Tumor ☐ Other
17.	Current Medication	☐ Prescribed	☐ Allergies	☐ Self-medicated (i.e. aspirin, Motrin)
18.	Past Medical History	☐ Surgery - any area ☐ Hospitalization	☐ History of medications ☐ Prescribed	☐ Substance Abuse
19.	Social History	☐ Consume Alcohol ☐ Smoker Past or Present	☐ Exercise regularly ☐ Consume Coffee	☐ Consume Teas ☐ Consume Soft Drinks
20.	Female Only OB-GYN	☐ Hysterectomy ☐ Pregnancy past/present ☐ Age period began:	☐ PMS ☐ Last PAP date: ☐ Breast Exam date:	☐ Lumps in breast ☐ Mastectomy ☐ Discharge from nipple

I have completed the above survey to the best of my ability. Signature: ___________________________________

CAIN CHIROPRACTIC & REHAB, P.C.
TREATMENT AUTHORIZATION RECORD

Consent for Release of Information & Patient Notification Statement

I hereby authorize Dr. Cain and/or her employees to release to employer groups, insurance companies, government agencies or other third party payers and their agents, information concerning health care, advice, treatment, supplies or other information that may be necessary for the purpose of determining eligibility and available benefits and obtaining payment on my behalf, for the Chiropractic health care provided to me. This authorization may be revoked in writing at any time, however, revocation will not apply to the previous dates of service. I understand that the care and service I will receive are subject to review by health care professionals, third party payers and review agencies.

I understand that I will be financially responsible for all charges incurred for my treatment if I revoke or refuse to authorize the disclosure of my medical records to a third party payer, and payment denial of my insurance claims results.

Payment Guarantee/Assignment of Insurance

I understand that if **I PRESENTLY MAINTAIN MEDICAL INSURANCE COVERAGE** which will reimburse the charges for the Chiropractic health care being provided, but if my medical coverage is not sufficient to satisfy the Chiropractic charges in full, I acknowledge that if the resulting balance is not covered by this assignment, I will be fully responsible for the payment of the balance due immediately as consideration for Chiropractic health care rendered, and I agree to abide by the established rates of Dr. Cain for all services and supplies provided. I understand that I will be provided with a rate list that apply to my case at my request.

In consideration of those Chiropractic health care services rendered by Dr. Cain's office, I hereby assign to Dr. Cain's office all of my rights to medical reimbursement, including, but not limited to, the right to designate a beneficiary, add dependent eligibility and to have an individual policy continued or issued in accordance with the terms and benefits under any insurance policy, subscription certificate or other health benefit indemnification agreement otherwise payable to me for those services rendered by Dr. Cain and/or her employees.

I also understand that if I DO NOT MAINTAIN MEDICAL INSURANCE COVERAGE for which benefits are payable for Chiropractic health care, I agree to be fully responsible for the payment of all charges for all services rendered by Dr. Cain's office, and I understand that all charges are payable at the time services are requested. If payment arrangements other than immediate payment are agreed upon by both parties, I agree that the balance due will be paid in full within 90 days, and will include interest at the maximum rate allowed by law. In the event a dispute arises requiring litigation, the prevailing party shall be entitled to their reasonable attorney fees and costs.

Patient/Guardian Signature ____Date: _______________

TERMS OF ACCEPTANCE
Cain Chiropractic & Rehab, P.C.

When a patient seeks Chiropractic health care and I accept a patient for care, it is essential for the patient and the doctor to be working toward the same objective. It is important that each patient understand both the objective and the method that is to attain it.

Chiropractic has only one goal. My practice objective is to eliminate interference to the expression of the body's innate wisdom/natural healing ability. My methods are specific adjusting to correct vertebral subluxations, soft tissue therapy, and nutritional support if needed.

Adjustment: The specific application of forces to facilitate the body's correction of vertebral subluxation. Our Chiropractic method of correction is by specific adjustments of the spine.

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 vertebra in the spinal column that causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

I do not offer to diagnose or treat any disease or condition other than vertebral subluxation/misalignments. However, if during the course of a Chiropractic spinal or x-ray examination, a non-Chiropractic or unusual finding is encountered or asked about, I will advise you as best I can. If you desire further advice, diagnosis or treatment for those findings, I will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the condition is, I will be happy to provide you with nutritional support and/or as much information as I know, however I do not offer to treat it. I will not offer advice regarding treatment prescribed by others. My practice objective is to eliminate a major interference to the expression of the body's innate wisdom/natural healing ability. My methods include specific adjusting to correct vertebral subluxations, soft tissue therapy, and nutritional support.

I understand that seeking advice from another type of health care provider should not interfere with the subluxation/misalignment corrective care being provided by this office.

Signature ____ Date: ____________

Patient Name: ____

ATTENTION PATIENTS
PLEASE READ!!

Cain Chiropractic & Rehab, P.C. Cancellation Policy

$50.00

Patients will be charged for missed
Chiropractic & Massage
Appointments

<u>24 HOUR NOTICE</u>
is required for all appointment
cancellations or rescheduling.

A missed appointment is a loss for all.
These times are reserved exclusively for you.

Appointments are in high demand.
Your early notice will give another
person who is in urgent need of treatment
the opportunity to have access to
timely health care.

Thank you!

I understand and consent to the payment if I do not give at least 24 hour notice of cancellation.

Sign: ____ Date: _____________

Cain Chiropractic & Rehab, P.C.
Dr. Karen A. Cain, BA MBA DC

NOTICE OF PRIVACY PRACTICE SUMMARY

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

Cain Chiropractic & Rehab, P.C. maintains health information about you for treatment, to obtain payment for treatment, with your authorization as required (check your state laws), for administrative purposes, and to evaluate the quality of care that you receive.

Cain Chiropractic & Rehab, 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.

Cain Chiropractic & Rehab, P.C. may use your information to provide appointment reminders, information about treatment alternatives, collection and/or other health-related issues.

Cain Chiropractic & Rehab, P.C. may disclose your information for public health activities, for research, for health and safety reasons, for governmental function, to comply with workers compensation laws and regulations. You reserve the 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 you health records.

You may contact Cain Chiropractic & Rehab, P.C. and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Cain Chiropractic & Rehab, P.C. must maintain the privacy of your personal and 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 of how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations 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 complaints please contact Cain Chiropractic & Rehab, P.C. at (303) 399-2447, Fax: (303) 691-5772; 1720 South Bellaire Street, Suite #1210, Denver, Colorado 80222.

By signing below, I acknowledge receipt of this Notice of Privacy Practices as required by Federal Law effective, April 2003. This original form will be kept as part of your permanent medical record with Cain Chiropractic & Rehab, P.C.

____ ____________________

Patient or Guardian of Patient Signature Date

____

Printed Name, if signed on behalf of patient, please list relationship.

NOTICE OF PRIVACY PRACTICES (NOPP)

Your Privacy Rights as a Patient with Cain Chiropractic & Rehab, P.C.

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, AND SIGN AND RETURN THE SUMMARY PAGE TO OUR STAFF (TO BE KEPT IN YOUR PATIENT FILE). A COPY IS AVAILABLE FOR YOUR FILES UPON REQUEST.

Cain Chiropractic & Rehab, P.C. respects your privacy as our patient. We understand that your personal and health information can be very sensitive. We 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.

The law protects the privacy of your personal and health information. Your protected health information includes; symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to services received. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Information obtained at Cain Chiropractic & Rehab, P.C., will be recorded in your health record and used to help determine the course of your care. We may also share information with other doctors and/or practitioners who are providing care to you.

If claims are submitted to your health insurance plan, per your request, health care information may be provided to obtain payment. Information provided to health plans may include; diagnoses, procedures performed, or recommended care.

Your health records may be used to assess proficiency and improve services within this practice. Your health records may be used to review qualifications and performance of this practice and/or to train our staff.

We may contact you, by phone or mail, to remind you about appointments, give you information about treatment alternatives, and/or other health-related benefits and services or relay concerns regarding payment or account information.

We may use and/or disclose your information to conduct or arrange services, including: health quality review by your health plan; accounting, legal, risk management, and insurance services; audit functions, including fraud and abuse detection and compliance programs.

The health and billing records we create and store are the property of Cain Chiropractic & Rehab, P.C. The protected health information in it, however, generally belongs to you. You have a right to:

1. To request, in writing, to restrict certain uses and disclosures of your health information. Requests will be granted according to the federal and state of Colorado laws and the request will become part of your permanent file.

2. To request, in writing, a review of any denial of access to your health information—except in certain circumstances.

3. To request, in writing, a copy of the most current Notice of Privacy Practices (NOPP) used by this office.

4. To request, in writing, a copy of your personal and protected health information on file in this office.

5. To request, in writing, to change your health information. Any and all statements of disagreement regarding your records will become part of your permanent record.

6. Upon your request, we will give you a list of disclosures of your health information. The list will not include disclosures to third party payers. This information is available without charge to the patient, once every 12 months.

7. To request, in writing, that your health information be released to you via alternate means or at another location other than information on file.

8. To request, in writing, to cancel prior authorizations to use or disclose health information. Your revocation does not affect information that has already been released prior to the request to cancel, or information that is required to obtain payment or information protect by other legal authorizations.

Cain Chiropractic, P.C agrees to:

Keep your personal and protected health information private.

Furnish you a copy of this notice upon request.

Follow the terms of this Notice.

We have the right to make reasonable changes regarding your protected health information, without notice to you. Updated notices will be posted in our office and available upon request.

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact:

Cain Chiropractic & Rehab, P.C. 1720 South Bellaire Street, Suite #1210 Denver, CO 80222 *(303) 399-2447*

If you believe your privacy rights have been violated, please discuss your concerns with any staff member. You may also submit a written complaint to the U.S. Secretary of Health and Human Services.

We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

Unless you object, we may release health information about you to a friend or family member who is involved in your health care. We may also give information to someone who helps pay for your care. We reserve the right to tell your family or friends of your condition and that you are receiving treatment at this practice.

In addition, we may disclose health information about you to assist in disaster relief efforts.

We may use and disclose your personal and protected health information without your authorization as follows:

With health researchers, when the research has been approved and has policies to protect the privacy of your health information. We may also share information with health researchers preparing to conduct a research project.

To the Food and Drug Administration (FDA) relating to problems with food, supplements, and products.

To comply with workers' compensation laws as required by a workers' compensation claim.

For Public Health and Safety purposes as allowed or required by law, to prevent or reduce a serious or immediate threat to the health or safety of a person or the public. Information can be released to public health or legal authorities to protect public health and safety, or to prevent or control disease, injury, or disability, or to report vital statistics such as births or deaths.

To report suspected abuse or neglect to public authorities.

To Correctional Institutions if you are in jail or prison, as necessary for your health and the health and safety of others.

For Law Enforcement purposes such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.

For Health and Safety oversight activities. For example, we may share health information with the Department of Health.

For Disaster Relief Purposes. For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.

For work-related conditions that could affect employee health. For example, an employer may ask us to assess health risks on a job site.

To the Military Authorities of U.S. and Foreign Military Personnel. For example, the law may require us to provide information necessary to a military mission.

In the course of Judicial/Administrative proceedings, at your request, or as directed by a subpoena or court order. For Specialized Government Functions. For example, we may share information for national security purposes.

Uses and disclosures, not in this notice will be made only as allowed or required by law or with your written authorization.

We agree to keep accurate records 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 Cain Chiropractic & Rehab, P.C.