Waterbury Chiropractic Wellness

Dr. Robin Waterbury, DC
1332 Linden Street, Suite 1
Longmont, CO 80501
Phone 303.485.7117

Patient Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Cell Carrier: _____

Social Security Number: _____ Driver's License Number: _____

Birth Date: _____ Age: _____ Gender: M F Other ____ Height: _____ Weight:_____

☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed Number of Children:_____

Employer: _____ Work Phone: _____

Type of Work: _____

Name of Emergency Contact: _____ Phone: _____Relationship: _____

Referred to this office by: _____ How did you hear about us? _____

Major Surgery(s) / Operations & Dates: _____

Major Accidents or Falls: _____

Please list your reason(s) for this visit or your condition(s) in order of Importance:	Date you first noticed:	Using a scale in which "0" is none (no pain or pain symptoms) & "10" is severe pain or symptoms, circle the number that best reflects your pain: None.....to.....Severe	Please check the box below that best represents how much of the time your feel your pain or symptoms for the listed reason(s):
1. _____	_____	0 1 2 3 4 5 6 7 8 9 10	☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%
2. _____	_____	0 1 2 3 4 5 6 7 8 9 10	☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%
3. _____	_____	0 1 2 3 4 5 6 7 8 9 10	☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%
4. _____	_____	0 1 2 3 4 5 6 7 8 9 10	☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

For each of the reason(s) or conditions(s) listed above, please mark how it happened:

1.	☐ Developed over time	☐ Illness	☐ Injury	☐ Auto Accident	☐ _____	☐ I don't know
2.	☐ Developed over time	☐ Illness	☐ Injury	☐ Auto Accident	☐ _____	☐ I don't know
3.	☐ Developed over time	☐ Illness	☐ Injury	☐ Auto Accident	☐ _____	☐ I don't know
4.	☐ Developed over time	☐ Illness	☐ Injury	☐ Auto Accident	☐ _____	☐ I don't know

Please check the box that best describes whether your pain or symptom(s) limit normal activities:

Activity	Normal	Somewhat Limited	Severely Limited
Lifting	☐	☐	☐
Bending	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐
Sitting	☐	☐	☐
Climbing Stairs	☐	☐	☐
Running	☐	☐	☐
Resting in Bed	☐	☐	☐

Activity	Normal	Somewhat Limited	Severely Limited
Intercourse	☐	☐	☐
Computer work/typing	☐	☐	☐
Normal Work	☐	☐	☐
Household Activities	☐	☐	☐
Recreational Activities	☐	☐	☐
Others listed below:			
_____	☐	☐	☐
_____	☐	☐	☐

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HEALTH HISTORY QUESTIONNAIRE

PATIENT NAME _____ DATE _____

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall diagnosis, treatment plan and possibility of being accepted for care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ❒ Alcoholism
- ❒ Anemia
- ❒ Appendicitis
- ❒ Arthritis
- ❒ Asthma
- ❒ Cancer
- ❒ Chicken Pox
- ❒ COPD
- ❒ Diabetes
- ❒ Diphtheria
- ❒ Eczema
- ❒ Epilepsy
- ❒ Goiter
- ❒ Heart Disease
- ❒ Hepatitis
- ❒ Influenza
- ❒ Lumbago
- ❒ Malaria
- ❒ Measles
- ❒ Mental Disorder
- ❒ Mumps
- ❒ Pleurisy
- ❒ Pneumonia
- ❒ Polio
- ❒ Rheumatic Fever
- ❒ Scarlet Fever
- ❒ Shingles
- ❒ Sleep Apnea
- ❒ Small Pox
- ❒ Tuberculosis
- ❒ Typhoid Fever
- ❒ Whooping Cough

CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE
- ❒ Arm Pain
- ❒ Difficult Chewing / Clicking Jaw
- ❒ Joint Pain / Stiffness
- ❒ Low Back Pain
- ❒ Neck Pain
- ❒ Pain Between Shoulders
- ❒ Walking Problems

NERVOUS SYSTEM CODE
- ❒ Cold / Tingling Extremities
- ❒ Confusion / Depression
- ❒ Convulsions
- ❒ Dizziness
- ❒ Fainting
- ❒ Forgetfulness
- ❒ Numbness
- ❒ Paralysis

GASTO-INTESTINAL CODE
- ❒ Abdominal Cramps
- ❒ Black / Bloody Stools
- ❒ Colitis
- ❒ Constipation
- ❒ Diarrhea
- ❒ Excessive Thirst
- ❒ Frequent Nausea
- ❒ Gall Bladder Problems
- ❒ Gas / Bloating After Meals
- ❒ Heartburn
- ❒ Hemorrhoids
- ❒ Liver Trouble
- ❒ Poor / Excessive Appetite
- ❒ Vomiting
- ❒ Weight Trouble

GENERAL CODE
- ❒ Allergies
- ❒ Fever
- ❒ Loss of Sleep

GENITO-URINARY CODE
- ❒ Bladder Trouble
- ❒ Discolored Urine
- ❒ Painful/Excessive Urination

C-V-R CODE
- ❒ A-Fib
- ❒ Ankle Swelling
- ❒ Blood Pressure Problems
- ❒ Chest Pain
- ❒ Heart Problems
- ❒ Irregular Heartbeat
- ❒ Lung Problems / Congestion
- ❒ Short Breath
- ❒ Varicose Veins

EENT CODE
- ❒ Dental Problems
- ❒ Ear Aches
- ❒ Hearing Difficulty
- ❒ Sore Throat
- ❒ Stuffy Nose
- ❒ Vision Problems

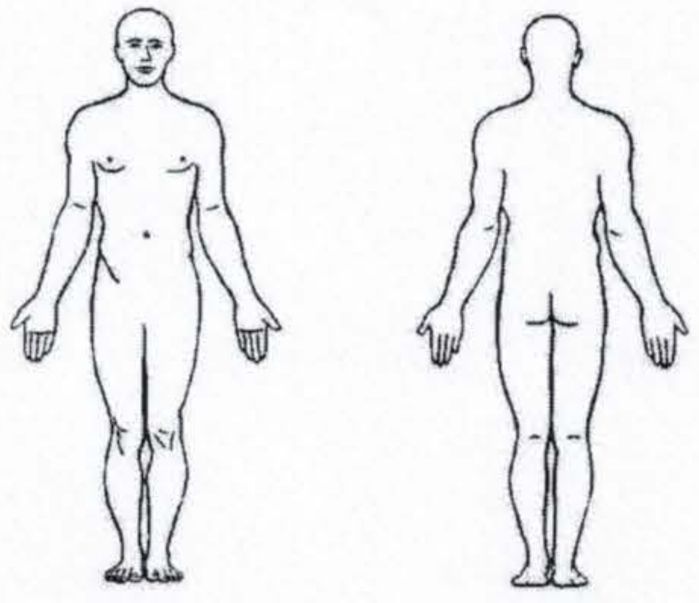
MALE / FEMALE CODE
- ❒ Breast Pain / Lumps
- ❒ Menstrual Cramping
- ❒ Menstrual Irregularity
- ❒ Vaginal Pain / Infections
- ❒ Prostate / Sexual Dysfunction
- ❒ Genital Herpes

FEMALES ONLY:

When was your last period? _____

Are you pregnant?

- ❒ Yes
- ❒ No
- ❒ Maybe



Please outline on the diagram the area of your discomfort.

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PLEASE READ AND SIGN BELOW:

Check the type of care desired so that we may be guided by your wishes whenever possible.

☐ Relief Care ☐ Corrective Care ☐ Comprehensive Care

☐ Check here if you want the doctor to select the type of care appropriate for your condition.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as she deems appropriate through the use of manipulation throughout my spine. It is understood and agreed the amount paid, for x-rays, is for examination only and the x-ray negative(s) will remain the property of this office, being on file where they may be seen at any time, during office hours, while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed condition, nor for any medical diagnosis.

Patient's Signature: _____ Date: _____

* * * * *

Minor Patient's Name: _____

Guardian Authorizing Care

Guardian's Name _____ Date: _____

Print Guardian's Name _____ Relationship _____

Waterbury Chiropractic
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FAMILY HEALTH HISTORY

PATIENT NAME: _____ DATE: _____

Please review the diseases and conditions listed below and indicate those that are current health problems of a family member by the designation **C** under the appropriate column. The designation **P** should be used to indicate a past problem. Leave blank those spaces that do not apply. If you require more space, use the reverse side of this form.

CONDITION	FATHER AGE ___	MOTHER AGE ___	SPOUSE AGE ___	☐BROTHER ☐SISTER AGE ___	☐BROTHER ☐SISTER AGE ___	☐BROTHER ☐SISTER AGE ___	CHILD AGE ___	CHILD AGE ___	CHILD AGE ___
ARTHRITIS									
ALLERGIES									
ASTHMA									
BACK TROUBLE									
BURSITIS									
CANCER									
CONSTIPATION									
COPD									
DIABETES									
DISC PROBLEM									
EMOTIONAL PROBLEMS									
EMPHYSEMA									
EPILEPSY									
HEADACHES									
HEART TROUBLE									
HIGH BLOOD PRESSURE									
INSOMNIA									
KIDNEY TROUBLE									
LIVER TROUBLE									
MIGRAINE									
NERVOUSNESS									
NEURITIS									
PINCHED NERVE									
SCOLIOSIS									
SINUS TROUBLE									
STOMACH TROUBLE									
OTHER									

If any of the above family members are deceased, please list their age at death and cause

_____ _____

_____ _____

Waterbury Chiropractic Wellness

MEDICATION / ALLERGY HISTORY

As of February 11, 2015 Waterbury Chiropractic Wellness started using an electronic health system and due to changes with Medicare and Obamacare we are required to have on file in your records the following information:

PATIENT NAME: _____ **DATE OF BIRTH:** _____

MEDICATIONS

Are you taking pain medications?

☐ No ☐ Yes, over the counter pain medications ☐ Yes, prescribed pain medications

List your medications:

Medication Name	Dose	Frequency

Need more room please list on back

ALLERGIES

Allergy to Latex? ☐ No ☐ Yes, explain _____

Allergies to Medications: ☐ No ☐ Yes, explain _____

Food Allergies: ☐ No ☐ Yes, explain _____

Environmental Allergies: ☐ No ☐ Yes, explain _____

Other Allergies: explain _____

Need more room please list on back

PAST SURGICAL HISTORY -- Have you had prior spine surgery? ☐ No ☐ Yes, Explain below

List Your Previous Surgeries

Surgery	Month/Day/Year	Surgeon	Any Complications?

DIAGNOSTIC STUDIES

Indicate if you have undergone any of the following therapies or diagnostic studies for your condition:

☐ Acupuncture
☐ Anti-Depressant
☐ Bed Rest
☐ Behavior Therapy
☐ Bone Density Study
☐ Bracing/Immobilization
☐ Chiropractor
☐ CT of Brain
☐ CT of Cervical Spine
☐ CT of Lumbar Spine
☐ CT of Pelvis
☐ CT of Thoracic Spine
☐ EMG Biofeedback
☐ Exercise Therapy
☐ Medications
☐ MRI of Brain
☐ MRI of Cervical Spine
☐ MRI of Lumbar Spine
☐ MRI of Thoracic Spine
☐ Physical Therapy
☐ Tens
☐ Traction
☐ X-Ray of Cervical Spine
☐ X-Ray of Hip
☐ X-Ray of Lumbar Spine
☐ X-Ray of Thoracic Spine

Waterbury Chiropractic
Wellness

PAYMENT POLICY

We are committed to providing you with the best possible care. In order to achieve these goals, we need your assistance and understanding of our payment policy. If you have medical insurance, we will assist you in receiving your maximum allowable benefits. Payments for services are due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept Cash, Checks, Visa and MasterCard.

We will be happy to file all primary insurance for you as a courtesy. However you must realize:

1. Not all services are covered by insurance contracts, i.e. radiology reports, some blood work, massage, etc. If your insurance determines your visit and/or massage are not medically necessary, you will be responsible for services rendered.
2. All charges are your responsibility for the date/dates the services are rendered.
3. All co-pays are due at the time of service.
4. There is a $41 charge for returned checks. (fee subject to change)
5. Patient balances over 60 days old will be assessed a 1.5% per month charge on outstanding balances.
6. **There will be a $30 missed appointment fee charged to your account** without 24 hour notice of cancellation.

Patient Initials _____

The Patient and the Responsible Party hereby agree to be fully responsible for any and all amounts and charges submitted by the Physicians in the course of treatment or any of their agents, employees, or contractors. Patient and the Responsible Party acknowledge that the charges may exceed the amount your insurance carrier may define as "usual and customary, or reasonable", (does not include insurances that have their own set fee schedules) but the Patient and Responsible Party agree to pay the amount of such billed charges.

_____
Signature of Patient

_____
Name of Patient

_____
Signature of Responsible Party if not Patient

_____
Name of Responsible Party

_____
Relationship to Patient

_____
Date

This form will be retained in your health record.

Waterbury Chiropractic
Wellness

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPTIONS

I consent to the use or disclosure of my protected health information by Waterbury Chiropractic Wellness Center for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Waterbury Chiropractic.

I understand that diagnosis or treatment of me by Waterbury Chiropractic 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. Waterbury Chiropractic is not required to agree to the restrictions that I may request. However, if Waterbury Chiropractic agrees to a restriction that I request, the restriction is binding on Waterbury Chiropractic.

I have the right to revoke this consent, in writing, at any time, except to the extent that Waterbury Chiropractic 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 health care clearinghouse. 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.

The office's Notice of Privacy Practices has been provided to me. I understand I have a right to review Waterbury Chiropractic's Notice of Privacy Practices prior to signing this document.

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 Waterbury Chiropractic.

The Notices of Privacy Practices also describes my rights and the duties of Waterbury Chiropractic with respect to my protected health information.

Waterbury Chiropractic 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 (303.485.7117) and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative | Name of Patient or Personal Representative

_____ _____

Description of Personal Representative's Authority | Date

This form will be retained in your health record.

Waterbury Chiropractic Wellness

NOTICE OF PRIVACY PRACTICE SUMMARY - ACKNOWLEDGEMENT

The **Health Insurance Portability and Accountability Act (HIPAA)** require us to give you a notice of our privacy practices and to acknowledge your receipt of this notice.

What is the NOTICE OF PRIVACY ACT PRACTICES?

The NOTICE OF PRIVACY PRACTIES explains how your health information may be used and or disclosed by us. In addition, it explains your rights with regard to your protected health information, as well as our legal responsibilities.

I have been provided with a copy of **the Notice of Privacy Practices Summary:** Initial _____

May we share your medical information with others listed below to appropriately care for you?

☐ YES ☐ NO Spouse Name: _____

☐ YES ☐ NO Partner Name: _____

☐ YES ☐ NO Childs Name: _____

☐ YES ☐ NO Childs Name: _____

☐ YES ☐ NO Other Name: _____

Relationship: _____

☐ YES ☐ NO Other Name: _____

Relationship: _____

May we leave appointment information on your voice mail?
Home Voice ☐ YES ☐ NO Cell Voice ☐ YES ☐ NO Office Voice ☐ YES ☐ NO

May we leave DETAILED medical information on your voice mail?
Home Voice ☐ YES ☐ NO Cell Voice ☐ YES ☐ NO Office Voice ☐ YES ☐ NO

Patient Name: _____ Patient Signature: _____

Patient Date of Birth: _____ Home Phone: _____ Cell Phone: _____

Address: _____ City: _____ Zip: _____

Office Use Only:
Staff Signature: _____ *Date entered in patient chart:* _____

This form will be retained in your health record at: Waterbury Chiropractic Wellness

Waterbury Chiropractic
Wellness

NOTICE OF PRIVACY PRACTICE SUMMARY

Effective Date August 21, 2015

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

Waterbury Chiropractic uses health information about your treatment, to obtain payment, for treatment with your authorization as required, for administrative purposes and to evaluate the quality of care that you receive.

Waterbury Chiropractic 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.

Waterbury Chiropractic 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, governmental function in order to comply with workers compensation laws and regulations. You have the right to request restrictions, review 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, for which a fee may be charged.

You may complain to the Privacy Officer 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.

Waterbury Chiropractic 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, to notify you if it was unable to agree to the requested restrictions 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 locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted by law.

If you have any questions or complaints please contact:

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Phone 303-485-7117