GLENWOOD CHIROPRACTIC CENTER

"The doctor of the future will give no medicine but will interest his patients in the care of the human frame, in diet, and in cause and prevention of disease" –Thomas Edison

Patient Information

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)
Name _____ Date _____ SS/HIC/Patient ID#_____
First Middle Initial Last
Address _____ City _____ State _____ Zip_____
Sex: Female Male Birthdate _____ E-mail _____
Home Phone (_____)_____ Cell Phone (_____)_____ Work Phone (_____)_____
Do you prefer to receive calls at: Home Work Cell No Preference
Married Widowed Single Minor Separated Divorced Partnered for _____years
Patient Employer/School _____ Occupation _____
Employer/School Address_____ City_____ State_____ Zip_____
Spouse or parent's name _____ Employer _____ Work Phone (____)_____
Whom may we thank for referring you to us? _____
Person to contact in case of emergency _____ Phone (_____)_____

Responsible Party

Name of person responsible for this account _____
Relationship to patient _____ Phone (_____)_____
Address _____ City _____ State _____ Zip _____
Name of employer _____ Work phone (_____)_____

Insurance Information

Name of insured _____ Relationship to patient _____
Birthdate _____ Social Security # _____ Date employed _____
Name of employer _____ Work Phone (_____)_____
Address _____ City _____ State _____ Zip _____
Insurance Co. _____ Phone (____)_____ Group # _____ Employer # _____
Insurance Co. Address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____
DO YOU HAVE ADDITIONAL INSURANCE? No Yes IF YES, PLEASE COMPLETE THE FOLLOWING:
Name of insured _____ Relationship to patient _____
Birthdate _____ Social Security # _____ Date employed _____
Name of employer _____ Work Phone (_____)_____
Address _____ City _____ State _____ Zip _____
Insurance Co. _____ Group # _____ Employer # _____
Insurance Co. Address _____ City _____ State _____ Zip _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

CONFIDENTIAL

Symptoms

Reason for visit_____ When did you first notice the symptoms? _____
Is this condition getting progressively worse? _____
Where specifically is the problem(s) located? _____
Which activities are difficult to perform? Sitting Standing Walking Bending Lying down Other
Type of pain: Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Cramps Stiffness Swelling Other
Rate the severity of your pain (1, mild pain or discomfort to 10, severe pain): 1 2 3 4 5 6 7 8 9 10
Is the pain constant or does it come and go? _____
What treatment have you already received for your condition: _____

Health History *Circle only those conditions which are applicable:*

AIDS/HIV	Cataracts	Hepatitis	Osteoporosis	Suicide Attempt
Alcoholism	Chemical Dependency	Hernia	Pacemaker	Thyroid Problems
Allergy Shots	Chicken Pox	Herniated Disc	Parkinson's Disease	Tonsillitis
Anemia	Depression	Herpes	Pinched Nerve	Tuberculosis
Anorexia	Diabetes	High Cholesterol	Pneumonia	Tumors, Growths
Appendicitis	Emphysema	Kidney Disease	Polio	Typhoid Fever
Arthritis	Epilepsy	Liver Disease	Prostate Problems	Ulcers
Asthma	Fractures	Measles	Prosthesis	Vaginal infections
Bleeding Disorders	Glaucoma	Migraine Headaches	Psychiatric Care	Venereal Disease
Breast Lump	Goiter	Miscarriage	Rheumatoid Arthritis	Whooping Cough
Bronchitis	Gonorrhea	Mononucleosis	Rheumatic FeverOther _____	
Bulimia	Gout	Multiple Sclerosis	Scarlet Fever	_____
Cancer	Heart Disease	Mumps	Stroke	_____

Date of last exams _____
(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No
List any types of surgeries which you have had and the dates which they occurred: _____
_____
Please list all medications you are currently taking: _____
Allergies: _____

Daily Habits

What type of exercise do you perform on a daily basis? None Moderate Heavy
What do your daily work habits include? (ex. sitting, standing, light labor, heavy labor, computer work)
_____
What vitamins do you currently take? _____
What kind of other nutritional supplements do you take (if any)? _____
Do you smoke? No Yes How much per day? _____
How much liquor do you consume on a weekly basis? _____
How much coffee or caffeinated beverages do you consume on a daily basis? _____

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____(Name of Insurance Company (ies)) and assign directly to Dr. Steve Peltzman all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent or Personal Representative Relationship to Patient

GLENWOOD CHIROPRACTIC CENTER, P.C.
STEVEN M. PELTZMAN, D.C.

PATIENT FINANCIAL POLICY

We are privileged you have chosen us as your chiropractic care provider. We are committed to providing you and your family with quality patient care. The following is a statement of our Financial Policy, which you need to understand prior to treatment. If you have any questions, please feel free to discuss them with us at any time.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. We accept cash, checks, and most major credit/debit cards. There will be a $25.00 fee on all returned checks. We also reserve the right to charge $30.00 for missed appointments without 24 hours advance notice.

INSURANCE PATIENTS

Your insurance policy is a contract between you and your insurance company. We have no control over their decisions and the amount they decide to pay. However, as a courtesy to our patients, we will file your primary insurance claims for you.

Before treatment, we will verify your insurance coverage and benefits. Please be aware that your insurance company does not guarantee payment over the phone. We will not know the exact amount they will pay until they respond to the claim. **REGARDLESS OF WHAT YOUR INSURANCE COMPANY PAYS, YOU REMAIN FULLY RESPONSIBLE FOR PAYMENT OF YOUR ACCOUNT.** Once a payment is received on your claim, we will send you a bill for any remaining balance on your account. Please understand that all co-payments are due the day your treatment is rendered. In order to reduce increased staff time, postage, follow-ups with your insurance companies, and keep your balance to a minimum, we prefer to keep your credit card on file, to be kept in a secure location. We require your authorization to charge your credit card once we receive your Explanation of Benefits from your insurance company. Charges will include your deductible, co-insurance, or non-covered services. You can opt out of this at any time if you choose by notifying us.

I have read and understand the above Financial Policy. By signing below, I acknowledge responsibility and agree to the terms above.

PATIENT NAME:_____ DATE:_____

PATIENT SIGNATURE: _____ DATE:_____

PLEASE NOTE INTEREST OF 1.75% IS ADDED TO ALL BALANCES NOT PAID IN FULL IN NET 30. THIS AMOUNTS TO 21% ON A YEARLY BASIS. GLENWOOD CHIROPRACTIC CENTER P.C. RESERVES THE RIGHT TO ADD ADDITIONAL FEES ASSOCIATED WITH THE COLLECTIONS PROCESS SUCH AS BUT NOT LIMITED TO COLLECTION FEES ($15.00), COURT COSTS OR PROCESSING FEES

GLENWOOD CHIROPRACTIC CENTER, P.C.
STEVEN M. PELTZMAN, D.C.

PRIVACY POLICY (HIPPA)

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AS WELL AS HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Glenwood Chiropractic Center, P.C., and under Federal Law we may use or disclose personal and health related information about you in the following ways:

- **If we are providing health care services to you based on the orders of another health care provider.**
- **Your health care records, a well as your billing records, may be disclosed to another party, such as but not limited to an insurance carrier, or your employer, if they are responsible for payment of your services.**
- **If we provide health care services to you in an emergency.**
- **If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.**
- **If we are ordered by the courts or another appropriate agency.**
- **Your name, address, phone number and email address may be used by Glenwood Chiropractic Center, P.C for the purpose of contacting you regarding reminding, scheduling, reschedule, thank you cards/emails, birthday cards/emails or information about alternatives to your present care, or other health related information that may be of interest to you.**

If you are not available to receive an appointment reminder call, a message may be left on your answering machine, voicemail or with any individual who answers the phone. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with authorization, it will not affect the care provided to you or the reimbursement avenues associated with your care.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

I can request a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right to review the 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 Chiropractor. The Notice of Privacy Practices for Chiropractor is also posted in the waiting room at Glenwood Chiropractic Center P.C. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

"Open-door" adjusting environment.

It is the desire of this office to provide chiropractic care in an "open-door" adjusting environment. An "open-door" approach involves the doctor moving from patient care area to patient care area and sometimes leaving the doors open between patient care areas. As a result, patients are occasionally within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under Federal law with respect to what is known as "incidental disclosures" of health information. It is our view that the kind of matters related in an "open-door environment are incidental matters, in the event you or someone else would not agree with us, we are providing this disclosure and requesting your authorization.

YOUR SIGNATURE INDICATES YOUR UNDERSTANDING AND AUTHORIZATION OF THESE ACTIVITIES.

NAME (PRINTED)	SIGNATURE	DATE

If you are a minor, or if you are being represented by another party:

Relationship to Minor (Printed)	Personal Representative Signature	DATE

You may revoke this authorization at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

GLENWOOD CHIROPRACTIC CENTER, P.C.
STEVEN M. PELTZMAN, D.C.

P.O. Box 8
Glenwood Springs, CO 81602
Telephone: (970) 945-8466
Fax: (970) 945-8413

NAME:
DATE:

Pain Disability Questionaire

Instructions: These questions ask your views about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

Shade bubbles like this → ●

PLEASE darken the circle next to THE ONE CHOICE which most closely describes your *CURRENT* condition.

1. Does your pain interfere with your normal work inside and outside the home?
   Work normally — Unable to work at all
   0 1 2 3 4 5 6 7 8 9 10

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?
   Take care of self completely — Need help with all personal care

3. Does your pain interfere with your traveling?
   Travel anywhere I like — Only travel to see doctors

4. Does your pain affect your ability to sit or stand?
   No problems — Can not sit/stand at all

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
   No problems — Can not do at all

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?
   No problems — Can not do at all

7. Does your pain affect your ability to walk or run?
   No problems — Can not walk/run at all

8. Has your income declined since your pain began?
   No decline — Lost all income

9. Do you have to take pain medication every day to control your pain?
   No medication needed — On pain medication throughout day

10. Does your pain force your to see doctors much more often than before your pain began?
    Never see doctors — See doctors weekly

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?
    No problems — Never see them

12. Does your pain interfere with recreational activities and hobbies that are important to you?
    No interference — Total interference

13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the homeand housework) because of your pain?
    Never need help — Need help all the time

14. Do you now feel more depressed, tense, or anxious than before your pain began?
    No depression/tension — Severe depression/tension

15. Are there emotional problems caused by your pain that interfere with your family, social and or work activities?
    No problems — Severe problems
    0 1 2 3 4 5 6 7 8 9 10

GLENWOOD CHIROPRACTIC CENTER, P.C.
STEVEN M. PELTZMAN, D.C.

PATIENT INFORMED CONSENT

PLEASE READ THIS ENTIRE DOCUMENT PRIOR TO SIGNING IT. IT IS IMPORTANT THAT YOU UNDERSTAND THE INFORMATION CONTAINED IN THIS DOCUMENT. PLEASE ASK QUESTIONS BEFORE YOU SIGN IF THERE IS ANYTHING THAT IS UNCLEAR.

THE NATURE OF THE CHIROPRACTIC ADJUSTMENT:

The primary treatment used by Doctors of Chiropractic is spinal manipulative therapy. I will use this procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may also feel a sense of movement.

ANALYSIS/EXAMINATION/TREATMENT:

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

- -Vital signs
- -Range of motion testing
- -Orthopedic testing
- -Basic neurological testing
- -Muscle strength testing
- -Postural analysis testing
- -Palpation
- -Therapeutic exercises
- -Nutritional Therapy
- -Spinal manipulative therapy
- -Hot/cold therapy
- -Ultrasound therapy
- -Electrical muscle stimulation therapy
- -Cool laser therapy
- -Acupuncture therapy
- -Neuromuscular re-education therapy
- -Vaso-pneumatic compression therapy

THE MATERIAL RISKS INHERENT IN CHIROPRACTIC ADJUSTMENTS:

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries of the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The Doctor will make every reasonable effort during the examination to screen for contraindications to care, however if you have a condition that would otherwise not come to the Doctor's attention, it is your responsibility to inform the Doctor. Additionally, nutritional remedial and supplements used in our practice are generally considered safe, however, they may involve some risks including, without limit, changes in blood sugar or gastrointestinal upset. They may also interact with certain drugs and may be inappropriate during pregnancy.

THE PROBABILITY OF THOSE RISKS OCCURRING:

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during the examination. Stroke and/or arterial dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research on the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all, it is extremely rare and remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of arterial stroke.

THE AVAILABILITY AND NATURE OF OTHER TREATMENT OPTIONS:

Other treatment options for your condition may include:

- -Self-administered, over-the-counter analgesics, and rest.

-Medical care and prescription drugs such as anti-inflammatory, muscle relaxants, and pain-killers.
-Hospitalization.
-Surgery.

If you choose to use one of the above noted "other treatment options" you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

THE RISKS AND DANGERS ATTENDANT TO REMAINING UNTREATED:
Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time, this process may complicate your chiropractic treatments making it more difficult and less effective the longer it is postponed.

CONCERNS, QUESTIONS AND ANSWERS:
The doctor-patient relationship is one of mutual trust, confidence, and respect. It is important that we know at all times that you are satisfied with our services, that there is open communication, and that we know of any concerns about your care. If you wait to relate concerns, we may not be able to take meaningful steps to address them. Accordingly, you agree to relay any concerns right away.

CONSENT TO TREATMENT OF A MINOR

I hereby request and authorize Steven M. Peltzman, D.C. to perform diagnostic tests and render chiropractic adjustments and related treatment to my minor son/daughter:_____. This authorization also extends to all other office staff members at the doctor's discretion. As of this date, I have the legal right to select and authorize health care services for the minor child named above. Under the terms and conditions of a 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.

DO NOT SIGN UNTIL YOU HAVE READ AND FULLY UNDERSTAND THE ABOVE. PLEASE CHECK BELOW AND SIGN.

_____I have read (or have had read to me) the above explanation of the chiropractic adjustment and related treatments. I have discussed it with Steven M. Peltzman, D.C. and have had my questions answered to my satisfaction. I fully understand this consent form, and understand that I should not sign this form if any of my questions have not been explained to my satisfaction or if I do not understand any of the terms or words. By signing below, I state that I have weighed the risks involved with undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give *my consent to the treatment.*

Date:_____ Date:_____

_____ ___Steven M. Peltzman, D.C._____
Patient's Name Doctor's Name

_____ Steven M. Peltzman DC.
Patient's Signature Doctor's Signature

_____
Signature of Parent or Guardian (if patient is a minor)