DR. KELLEN P. SCHWEITZER, DC
1732 Topaz Drive
Loveland, CO 80537
(970) 667-4062

CHIROPRACTIC CASE HISTORY/PATIENT INFORMATION

Welcome! Please allow our staff to photocopy your driver's license and all available insurance cards.

PLEASE PRINT

Date _____

Full Name_____ **Home Phone**_____ **Cell Phone**_____

Preferred Name/Nickname_____ **Fax Number**_____

Address _____ **City** _____ **State** _____ **ZIP** _____

Age _____ **Birth Date** _____ **Gender:** M F **Marital Status:** S M W D Sep **# of Children**_____

Email _____ **SS#**_____ **Driver's License #**_____

Your Employer _____ **Your Occupation** _____ **Years on Job** _____

Employer Address _____ City _____ State ____ ZIP _____

Work Phone _____ Do ***you*** have health insurance at work? Yes No

Insurance Company _____ Plan/Group #_____ Cert #_____

Spouse_____Occupation_____Employer_____

How did you hear about our office? _____

Referring Doctor _____ Friend _____

Name & Phone Number of Emergency Contact _____

Family Medical Doctor_____ Pediatrician_____ Dentist_____

Reason for your visit today? (Please list areas of pain) _____

Is your condition due to an accident? Yes No Date of your Accident: _____

Please complete the following information only if your complaint was a result of an accident.

Accident Information

Did this injury occur as a result of a Car Accident? Yes _____No _____

Did this injury occur as a result of a Fall or other Personal Injury? Yes _____No _____

Please circle any and all insurance coverage that may be applicable in this case:

π Health Insurance π Medicare π Worker's Compensation π Auto Accident π Other

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company (if any): _____

Financial Policy: Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans. Regardless of your coverage, we will suggest the chiropractic care that we think you need. We ask that you read and understand our policy as it applies to your particular situation.

Time of Service: If fees are paid in full within the same date of service, you will qualify for our Time of Service reduction in fees. Forms of payment accepted are check, MasterCard, Visa or Discover.

Insurance: Your health and accident insurance policies are an agreement between you and your insurance company. When possible, our office will call to verify benefits as a courtesy to you; however, the benefits quoted to us by your insurance company are not a guarantee of payment. Any co-pays or known deductible amounts will be collected at the time of service. Our office will complete any necessary insurance forms and file them with your insurance company at no additional charge. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles or co-pays.

Medicare: We accept assignment from Medicare. The payment is generally sent to our office for services that Medicare will cover. Spinal manipulation is a covered service under Medicare. However, maintenance care is not considered by Medicare to be medically reasonable and necessary, and is not reimbursable by Medicare. All other services available are NON-COVERED and include but are not limited to, maintenance care adjustments, x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. You are fully responsible for charges of non-covered services and are eligible for our Time of Service reduction in fees listed above. Our office completes and files the forms for Medicare at no charge. If there are any further questions, please let us know.

Authorization and Release: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office.

I authorize the doctor and the staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney in order to process any consequences thereof.

I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage.

I authorize assignment of my insurance rights and benefits directly to the provider for services rendered.

I understand the above and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to immediately inform this office of any changes in my medical or account status.

I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

I understand that unpaid fees for services beyond thirty (30) days are subject to a 1.5% monthly finance charge (18% annually).

I agree that a photostatic copy of this agreement shall serve as the original.

I have read and understand the payment policy of Front Range Family Health & Chiropractic. I agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Front Range Family Health & Chiropractic and my insurance company. I request that Front Range Family Health & Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctor at Front Range Family Health & Chiropractic that fees will be due and payable immediately.
I agree that a photostatic copy of this agreement shall serve as the original.

Patient's Signature _____ Date _____

Spouse's or Guardian's Signature _____ Date _____

TODDLER HEALTH SURVEY (THREE TO FIVE YEARS)

Patient Name: _____ Age: _____ Date: _____

Reason for seeking chiropractic evaluation: _____

_____

Please indicate if your child has or ever had any of the following:

Back or Neck Pain	Y N	Pain in legs or arms	Y N
Torticollis (severe head tilt)	Y N	Headaches	Y N
Ear Infections	Y N	Tubes in Ears	Y N
Has frequent colds, cough, or runny nose	Y N	Had colic as an infant	Y N
Asthma	Y N	Allergies*	Y N
Eating Difficulties	Y N	Constipation	Y N
Diarrhea, upset stomach	Y N	Bed Wetting	Y N
Skin Problems (eczema, rashes, etc)	Y N	Childhood Diseases	Y N

**If child does have allergies, please list below:*

_____

_____

_____

Trauma

Fall from bicycle, scooter, skate board, etc	Y N	Fall down the stairs	Y N
Fall from significant height	Y N	Motor Vehicle Accident	Y N
Injuries (bone fracture, burn, cut, etc)	Y N	Planned C-Section	Y N
Trips and falls easily	Y N		

**Please list all medications (prescription, non-prescription & vitamins/herbs) that the child is taking or takes on an occasional basis:* _____

_____

Emotional Status

Please check if your child has or ever had any of the following:

Sleeping Difficulties	Y N	Cries a lot	Y N
Has frequent temper tantrums	Y N	Shy	Y N
Separation Anxiety	Y N	Afraid of new environment	Y N

Family History

Does anyone in the child's family have:

Asthma	Y N	Respiratory Allergies	Y N
Food Allergies	Y N	Takes Vitamin Supplements	Y N

Nutrition:

Please check if your child has received any of the following:

Breast milk: _____ How Long? _____

Formula (please indicate the brand): _____

Cow's Milk (please indicate the brand): _____

Soy Milk (please indicate the brand): _____

Fruit Juices (please indicate the brand): _____

Vegetable Juices (please indicate the brand): _____

At what age was solid food introduced? _____ What was introduced first? _____

The child is a good eater	Y N	Likes a variety of foods	Y N
Has food allergies*	Y N	Takes Vitamin Supplements	Y N

**If child does have food allergies, please list below:*

_____

_____

_____

Immunization Status:

Choosing not to immunize ____ All up to date and current ____

List the immunizations your child has received and any reaction you have observed:

Date	Immunization	Reaction
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous Health Care:

Name of Pediatrician: _____

Name of Chiropractor: _____ Date of Last Exam: _____

Is your child under medical care for a specific condition? If so, please list the condition and the care received:

_____

_____

Do you have any concerns about your child's health not listed above?

_____

_____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

- The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed to what the insurance companies require for payment.

The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Identification of Persons with Authorization of Access to Patient Health Information

Those individuals or parties that could have access to Patient Health Information at Front Range Family Health & Chiropractic include but may not be limited to:

The Staff of Front Range Family Health & Chiropractic. This includes:

_x_ Dr. Kellen P. Schweitzer, DC

_x_ All Chiropractic Assistants

Necessary health care providers or family members who may need to be consulted if related to the patient's condition. This includes:

_____ _____

_x_ Your Primary Care Physician

Name: _____

Medical Group/Office: _____

City: _____ State: _____ ZIP _____

_____ _____

Patient or Authorized Representative Signature Date

Informed Consent for Chiropractic Care

In coming to Dr. Schweitzer, you give the doctor permission and authority to care for you, the patient, in accordance with the chiropractic tests, diagnosis, and analysis. Dr. Schweitzer is licensed in chiropractic and is available to work with other types of providers in your health care regime. Dr. Schweitzer will use his hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process.

The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities, or pathologies may render a patient susceptible to injury. Dr. Schweitzer will not give any treatment or health care if he is aware that such care may be contra-indicated. It is the responsibility of the patient to make it known should they be aware of any conditions they may have. There are certain complications that can occur as a result of a spinal manipulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathethetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

Dr. Schweitzer is aware of these complications, and in order to minimize their occurrence he will take precautions. These precautions include, but are not limited to taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell Dr. Schweitzer when he takes your clinical history. I understand that if I am accepted as a patient by Dr. Schweitzer at Front Range Family Health & Chiropractic, I am authorizing him to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

DATE _____ _____

Printed Name

_____

Patient or Authorized Representative Signature

Photo/Announcement Release:

I, Patient Name (please print) _____, give Front Range Family Health & Chiropractic permission to use my name and picture in its patient newsletter and on any office bulletin or other notice boards for purposes of announcing births, birthdays, weddings, graduations or acknowledging my referrals.

Initial _____

Missed Appointment Policy

We want to thank you for choosing us as your chiropractic health provider. In order to provide you and our other patients with the best optimal spinal care, we request that you follow our guidelines regarding broken and/or cancelled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hour notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. When you cancel your appointment at the last minute, everyone loses – you, the doctor and other patients that would like to have utilized the appointment time.

Our office does reserve the right to charge for missed appointments without 24 hour notice. Thank you for your consideration of our policies and for the opportunity to be your chiropractic office of choice.

Initial _____