Back In Action Chiropractic LLC
Jason Gillies, D.C.
824 E. Fillmore St. – Colorado Springs, CO 80907 (719) 634-2579

ABOUT YOU:

Patient's Name:_______________________________________What you prefer to be called: ________________

Date of Birth:___/___/___ Age:_________

Home Phone:_____________________ Work Phone:_____________________ Cell Phone:___________________

Home Address:____

Street City State Zip

How Did You Hear of Us: ____

Name of General/Family Physician:____

Employer: ______________________________ Occupation: ____________________________________

How Did You Intend To Pay For Our Services: Insurance, Self Pay, PI/Workers Comp, Auto Accident

Responsible Party: Person responsible for payment of charges / parent or legal guardian of minor.

Leave Blank if Responsible Party is yourself.

Name:____ Date of Birth:___/___/___

Address:____

Phone: ___________________________

In Case of Emergency Who Should We Contact:

____

Name Address

Phone#_________________________ Relation: _________________________________

Assignment of Benefits / Authorization for Evaluation and Treatment:

I hereby authorize payment to be made directly to Back In Action Chiropractic L.L.C. for Chiropractic/Medical services rendered by insurance coverage. I shall be personally responsible for any unpaid balance. A time of service discount is available to most patients. In cases of potential insurance coverage, I understand that if my insurance company does not pay outstanding charges within 60 days of the billing, I will be financially responsible for those charges. Balances over 60 days may be subject to interest of 1.5% per month, collection charges and collection court/attorney fees. I authorize Back In Action Chiropractic L.L.C. to release any information concerning my examination or treatment for payment purposes. I further authorize Jason Gillies D.C. of Back In Action Chiropractic L.L.C. to perform any medically necessary evaluation or treatment. I understand that every effort will be made to explain my diagnosis, treatment and risk factors, however, if there are any questions or concerns, I will bring this to the immediate attention of Dr. Gillies.

______________________ ____

Date Signature of Patient (or parent if minor)

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Health Questionnaire

Patient Information:

Name:____
Last First Middle Initial

Sex: □ Male □ Female Age:______ Date of Birth:____________

Have you Gained of Lost More Than 10 LBS in the Last 6 Months: Gained Lost Neither

Are you Pregnant: YES or No Date of Last Cycle: __________ Started Menopause: YES or NO

Overall, How Would You Rate Your Health: Excellent Average Poor Other:_______________

Past Health History

HOSPITALIZATION, OPERATIONS / WORK, AUTO, OR PERSONAL ACCIDENTS OR INJURIES

Please be Specific, Include Dates, Areas Involved, and Treatments Received

1. ____
2. ____
3. ____
4. ____
5. ____

SERIOUS ILLNESSES

List Current and Past Illnesses Not Mentioned Above, Including Cancer, Diabetes etc, and Include Dates

1. ____
2. ____
3. ____
4. ____
5. ____

ALLERGIES:	MEDICATIONS / SUPPLEMENTS
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Work and Social History

Smoke: Yes or No If yes how much: ________________________________
Alcohol: Yes or No If yes how much: ________________________________
Recreational Drug Use: Yes or No If yes Type and how much: ________________________
Married Yes or No Children: Yes or No Ages: ____________________________
Activities affected by your symptoms: (sleep, relationships, recreational activities, work activites, and etc)
____
____

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-Systems Review-

List the health problems you now have, or have had, with each area. If no problem exists, write N/A in the space provided.

1. Head:____
2. Ear/Eye/Nose/Throat:____
3. Lungs/Respiratory:____
4. Heart/Circulation/Stroke:____
5. Stomach/Intestine/Colon:____
6. Kidney/Bladder/Urinary:____
7. Liver/Gallbladder/Pancreas/Spleen:_____________________________________
8. Skin/Hair/Nails:____
9. Hematological/Bleeding/Anemia:_______________________________________
10. Nervous System:____
11. Hormonal:____
12. Lymph Glands:____

13: Allergies:____

14: Other:____

Family Health History

Please list any diseases or conditions your immediate family has or has had in the past.
Example: (Heart Disease, Mother)

____
____
____
____

Patient Signature:____Date:____________

Doctors Signature:____Date:____________

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s) and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for the doctor of chiropractic named below. I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horners' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, and are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read ( ) or have had read to me ( ) the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

Name(s) and Address(es) of Office or Clinic	Print Name(s) of Doctor(s) Treating this Patient
Back In Action Chiropractic LLC	________**Jason Gillies DC**________________
824 E. Fillmore St	____
Colorado Springs, CO 80907	____

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

____
Printed name of Patient

______________________________________ __________________
Signature of Patient Date

______________________________________ __________________
Signature of Patients' Representative Date
(if minor or physically incapacitated)

______________________________________ __________________
Witness to Patients' Signature Date

______________________________________ __________________
Translated By Date

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Receipt of Notice of Privacy Practices
Written Acknowledgement Form.

PRIVACY POLICY

Your privacy is important to us. At Back In Action Chiropractic, we want you to better understand how we collect, use, communicate, disclose, share and protect information about you. By interacting with Back In Action Chiropractic, you consent to use of information that is collected or submitted as described in this privacy policy. The following outlines our privacy policy:

- Before or at the time of collecting personal information, we will identify the purposes for which information is being collected.
- We will collect and use personal information solely with the objective of fulfilling those purposes specified by us, unless we obtain the consent of the individual concerned or as required by law.
- We will only retain personal information as long as necessary for the fulfillment of those purposes.
- We will collect personal information by lawful and fair means and, where appropriate, with the knowledge or consent of the individual concerned.
- Personal data should be relevant to the purposes for which it is to be used, and, to the extent necessary for those purposes, should be accurate, complete, and up-to-date.
- We will protect personal information by reasonable security safeguards against loss or theft, as well as unauthorized access, disclosure, copying, use or modification.
- We will make readily available to customers information about our policies and practices relating to the management of personal information.

We are committed to conducting our business in accordance with these principles in order to ensure that the confidentiality of personal information is protected and maintained.

The Practice:

1) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to you PHI.
2) May be required by Colorado law to maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.
3) Is required to abide be the terms of the Privacy Notice.
4) Reserves the right to change the terms of the Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
5) Will distribute any revised Privacy Notice to you prior to implementation.
6) Will not retaliate against you for filing a complaint.

This Notice is in effect as of 01/01/2011.

I, _______________________, have received a copy of *BACK IN ACTION CHIROPRACTIC, LLC's* Notice of Privacy Practices.

_______________________________ ___________________
Signature of Patient of Guardian Date

____
Patient's acknowledgement of this Notice could not be obtained because:

______ Patient refused to sign
______ Communication barrier prohibited obtaining acknowledgement
_______Emergency Circumstances
______ Other: