

TERMS OF ACCEPTANCE

When a person seeks chiropractic and rehabilitation health care and is accepted for such care, it is essential for both parties to be working towards the same objective. As a Chiropractic & Rehab facility we have one main goal, to detect and correct/reduce the vertebral subluxation complex. It is important that each person understand both the objective and the method that will be used to attain this goal. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method 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 which 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.

We do not offer to diagnose or treat a disease or condition other than vertebral subluxation. Regardless of what a disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **Our Only Practice Objective** is to eliminate a major interference to the expression of the body's innate wisdom and ability to heal. Our only method is specific adjusting to correct vertebral subluxations combined with rehabilitation procedures and to correct joint dysfunctions associated with extremities.

NOTE: It is understood and agreed the amount paid to *Shimer Chiropractic, PC* for x-rays are for examination of spinal alignment only and the x-rays will remain the property of this office, being on file where they may be seen at any time while a patient of this office. Also patient understands that *Shimer Chiropractic, PC* **does not** have on-site x-rays and provide invasive testing/treatment. In the doctor's professional opinion, should any of our patients need x-rays, additional diagnostic testing, or other forms of health care services, they will be referred to an appropriate provider or facility, when indicated.

INFORMED CONSENT TO EXAMINATION AND TREATMENT

I do hereby authorize the doctor(s) of *Shimer Chiropractic, PC* and any therapist(s) and chiropractic technician(s) working at the clinic to administer such care that is necessary for my particular case (or my child/dependent/ward's particular case). This care may include consultation, examination, spinal adjustments, extremity adjustments and other chiropractic procedures, including various modes of physical therapy, spinal flexion/distraction, and spinal alignment assessment on x-rays or any other procedure that is advisable, and necessary for my health care. I intend this consent form to cover the entire course of treatment for my present condition(s) and any future condition for which I seek treatment.

I understand and have been informed that during the process of a thorough examination that my current symptoms/condition may be exacerbated due to the nature of the examination. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise clinical judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interests. The doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal structural conditions treated at this clinic. There are no guaranties or assurances concerning the intended results of the treatments.

I have had an opportunity to discuss with the doctor of chiropractic and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments/manipulation and other procedures related to my health care (or my child's/dependent's/Ward's health care). I understand that I am responsible for all fees incurred for the services provided, and agree to ensure full payment of all charges. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether results are obtained or not.

I understand and have been informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to fractures, disk injuries, dislocations, sprains, paralysis, increased symptoms and pain, or no improvement of symptoms and pain. A rare but serious risk associated with neck manipulation is stroke. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise clinical judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. The doctor will not be held responsible for any health conditions or diagnoses which are pre-existing, given by another health care practitioner, or are not related to the spinal and/or extremity structural and or biomechanical conditions treated at this clinic. There are no guaranties or assurances concerning the intended results of the treatments.

I also clearly understand that if I do not follow the Doctor's specific recommendations at this clinic, I will not receive the full benefit from the programs offered, and if I terminate my care prematurely, all fees incurred will be due and payable at that time. I understand that *Shimer Chiropractic, PC* **does not** accept or bill insurance, Medicare, and/or any third party carrier for payment and I shall be personally liable for any and all of the services used by the doctor.

I, _____, have read or have had read to me, the above consent to care. I have also had the opportunity to
(*PRINT patient name or Parent/Guardian*)

ask questions about the care, and my questions have been fully answered. By signing below, I consent to this treatment. I intend this consent form to cover the entire course of treatment for my (or my child/dependent/ward's) present condition and for any future conditions for which I seek treatment.

Signature _____ Date _____
(*If under age 18, parent/guardian signature*)

Revised: 1/21/2017, NewPatientHistoryForm

PATIENT INFORMATION

Patient Name: _____ (Age) _____ Gender: M F

Home Address: _____ Home Phone: () _____

City, State, Zip: _____ Work Phone: () _____

Email Address: _____ Cell Phone: () _____

Do we Have your permission to send appointment reminders, health newsletters, and occasional promotions to your E-mail Address: Yes No

We will not sell or give your e-mail to any other agency.

Birth Date: ____ / ____ / ____ Marital Status: S M D W

Employer Name: _____ Work Address: _____

Emergency Contact: _____ Relation: _____

Home Phone () _____ Cell/Work Phone: () _____

How were you referred to this office? _____

Are you Medicare eligible? () Yes () No Medicare is 65 or more years old or disabled and the government put you on Medicare.

By signing below, I agree that the above information is accurate and true:

Patient Signature: _____ **Date:** _____

AUTHORIZATIONS & FINANCIAL POLICIES:

- A. At the patient's discretion, payment options are available after Doctor of Chiropractic has determined that chiropractic care is appropriate and has established a treatment plan.
- B. I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I (we) understand that health insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payments of any and all services, covered or not covered. I understand I am responsible for all services rendered and must pay at the time of service. I understand that if I terminate my care and treatment, any fees for professional services rendered to me or under the contract cancellation policy will be immediately due and payable.
- C. All patients acknowledge that they are financially responsible to remit payment in full for all services provided to them. All patients further understand and agree that we will not submit any billing data or related claim(s) for, or on, their behalf to any private insurance program, Medicare or any secondary Medicare Insurance Program carrier with whom they have insurance coverage.
- D. We are required by law to provide you with the HIPAA NOTICE of PRIVACY PRACTICES that explains our privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment, and for health care operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information and we also describe them in this notice. By signing below I agree that I have been provided the opportunity to read and have a copy of the clinic HIPPA Notice of Privacy.
- E. As a courtesy to you, our office will provide you a superbill if requested so you can turn it into your insurance company for possible reimbursement of services rendered at *Shimer Chiropractic, PC*. But as with all insurance plans, the superbill does not guarantee coverage of all or any services and fees. We will work with you to determine the amount of coverage and help estimate your responsibility.
- F. All patients whose treatment visitation schedule that is considered "Wellness" or is once per month or less frequent may no longer be eligible for insurance assignment as this level of care is rarely covered by insurance. Our office offers numerous wellness plans to allow you to continue needed care.
- G. We are required by the CO Board of Chiropractic Examiners that we notify you of our current fee schedule, possible fees incurred for accepting care, and your actual fee for exam, diagnostic evaluation, and treatment when you seek care through one of our promotions or advertisements. By signing below I agree that I have been provided the opportunity to discuss with the doctor or staff, read and have a copy of the clinic fee schedule and have been notified of my liability for services provided to me.

My Preferred Payment Option(s) (please indicate): Cash Visa MasterCard Discover American Express Debit FSA/HSA

By signing below I have read and agree with all of the above terms and policies.

Patient Signature: _____ **Date:** _____

If patient is under 18 years of age: Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name (please print): _____

PATIENT CURRENT HISTORY

Name: _____ Age: _____ Date of Birth: ____/____/____ Gender: M F

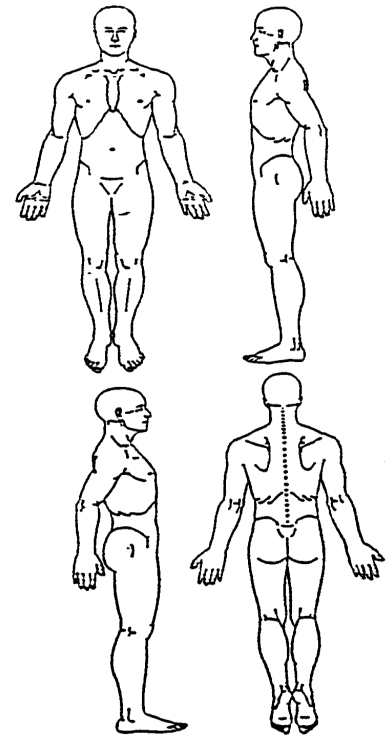
Height: ____ft. ____in. Weight: _____ Occupation: _____ For how Long? _____

1. Have you had Chiropractic care before? Yes NO If yes, how recently? _____
2. Reason for today's Visit: Pain Discomfort Stiffness Maintenance care Recent Injury Previous Injury
3. When did your complaint (s) first begin? _____ Today, is the condition: Same Better Worse
4. How did it begin: Gradual Sudden Intermittently or Comes & Goes Unknown Describe: _____
5. What makes it Better: _____ What makes it Worse: _____
6. Have you experienced this/these complaint (s) before? Yes No
If yes, when? _____

| Where is/are your area(s) of complaint TODAY? (check all that apply) | Rate pain/ Discomfort between 0-10 (1 = minimal - 10 = severe/need to be hospitalized) | Check off all the types of pain and frequency | | | | | | | | | | | | |
|--|---|---|-------|------|------|----------|----------|---------|-------|-----------|----------|-------------------|----------|--------------|
| | | Radiate/Travel | Sharp | Dull | Ache | Tingling | Numbness | Burning | Spasm | Throbbing | Shooting | Swollen/Inflamed/ | Constant | Intermittent |
| Headache/ Migraine | | | | | | | | | | | | | | |
| Neck | | | | | | | | | | | | | | |
| Shoulder (s) | | | | | | | | | | | | | | |
| Arm (s) | | | | | | | | | | | | | | |
| Elbow (s) | | | | | | | | | | | | | | |
| Wrist (s) | | | | | | | | | | | | | | |
| Upper Back | | | | | | | | | | | | | | |
| Middle Back | | | | | | | | | | | | | | |
| Lower Back | | | | | | | | | | | | | | |
| Hip (s) | | | | | | | | | | | | | | |
| Sciatica | | | | | | | | | | | | | | |
| Knee (s) | | | | | | | | | | | | | | |
| Ankle (s) | | | | | | | | | | | | | | |
| Other: | | | | | | | | | | | | | | |

Circle the area(s) causing you pain on the drawing below and label each by the type of pain.

- A = Ache & Dull S = Stabbing & Sharp
- B = Burning N = Numbness
- P = Pins & Needles T = Tingling



7. Are you pregnant? Yes NO N/A If yes, how many weeks? _____
8. Are you currently experiencing any of the following: Double vision Rapid eye movement Blurriness Dizziness
 Numbness on one side of the face or body Fainting or lightheadedness Difficulty walking Difficulty speaking
 Headache or neck pain like you have never had before Difficulty swallowing Nausea or vomiting
(If yes to any, please describe) _____

(Patient/Legal Guardian Signature)

(Date)

PATIENT CURRENT HISTORY CONT.

1. **What Activities of Daily Living are affected by your symptoms/complaint(s):** (Check ALL that apply) Almost all activities My Daily Routine
 Standing Standing for long periods Sitting Sitting for long periods Going from Sitting or Lying to Standing Changing Positions
 Lying Down Walking Running Lifting Bending Over Getting out of Bed in morning Daily Personal Care Work Duties Driving
 Sleeping Hobbies Recreation/Sports Activities Concentrating Computer Work Daily Household Chores Getting Dressed
 Going Up/Down Stairs Reading Social Activities; Please explain or list others: _____

2. Are you currently under medical or chiropractic care for this complaint(s)? Yes No

If yes, Who have you seen for this complaint? _____

What did they do? _____ How did you respond? _____

3. Are you currently under medical care for any other health condition? Yes No If yes, Please Explain: _____

4. **Have you had any changes in bodily functions since the condition began?** Yes No If yes, please check all that apply:

- | | | | | | |
|---------------------------------------|---------------------------------------|------------------------------------|--|--------------------------------------|--|
| <input type="checkbox"/> Balance | <input type="checkbox"/> Bowel Habits | <input type="checkbox"/> Breathing | <input type="checkbox"/> Vision | <input type="checkbox"/> Weakness | <input type="checkbox"/> Grip Strength |
| <input type="checkbox"/> Coordination | <input type="checkbox"/> Urination | <input type="checkbox"/> Coughing | <input type="checkbox"/> Hearing | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Gait | <input type="checkbox"/> Menstrual | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Sexual Function | <input type="checkbox"/> Temperature | <input type="checkbox"/> Weight Gain |

5. **Do you have any other complaints or concerns with your health?** _____

CHIROPRACTIC KNOWLEDGE ASSESSMENT

1. Did you know the absence of **pain** alone is not an indication of health?
 Yes NO

2. Did you know: pain has a cause and many times that cause **begins in the spine?** Yes NO

3. Did you know: over-the-counter pain medications/[prescriptions may only **mask the pain?** Yes No

4. Did you know: **your daily activities** can cause joint dysfunctions and pain in the spine and extremities? Yes No

5. Did you know: these joint dysfunctions can cause decreased joint motion and function in the body? Yes No

6. Did you know: decreased joint motion can also affect your ability to enjoy a **healthy and active lifestyle?** Yes No

7. Did you know: the health benefits of routine chiropractic care may include and of the following: 1) Improve nerve communication to body 2) improve joint motion 3) improve joint coordination 4) improve physical function 5) improved physical performance 6) improve posture 7) increase daily activity 8) provide pain and stress relief. Yes NO

HEALTHY LIFESTYLE - SOCIAL HISTORY

1. In general, would you say your health is: Excellent Very Good Good Fair Poor

2. Compared to one year ago, how would you rate your health in general now?

- | | |
|--|---|
| <input type="checkbox"/> Much better now than one year ago | <input type="checkbox"/> Somewhat worse than one year ago |
| <input type="checkbox"/> Somewhat better now than one year ago | <input type="checkbox"/> Much worse than one year ago |
| <input type="checkbox"/> About the same | |

3. Where do you consider your health? Highest Priority High Priority Average Priority Low Priority Haven't thought about it.

4. Do you consciously exercise, eat nutritious meals, minimize stress and do things to maintain good health or improve your health? Yes No

5. Do you exercise? Yes No How often? 1X 2X 3X 4X 5X per week Other: _____

What activities? Walking Jogging Weight Training Cycling Yoga Pilates Swimming Other: _____

6. Do you smoke? Yes No How much? 1-5 cig/day 6-10 cig/day 1 pack/day > 1 pack/day: _____

7. Do you drink alcohol? Yes No How much / week on average? _____

8. Do you drink coffee/caffeinated drinks? Yes No How many cups / day? _____

9. Do you currently have a drug or substance abuse problem? Yes No If yes, discuss with doctor.

10. Are you currently smoking marijuana? Yes No How much? 1-5 x/day 6-10 x/day > 11 x/day: _____

HEALTHY LIFESTYLE - SOCIAL HISTORY CONT.

1. Please describe you Work.

Type: Professional Physical Labor Driver Clerical Factory Homemaker Other: _____

Physical Demands: Heavy Moderate Mild Sedentary

Stress Level: High Medium Low

2. Do you currently take any **prescription or over-the-counter drugs or supplements**, i.e. vitamins, minerals, herbs? Please list below:

| Name | Reason for taking | Name | Reason for taking |
|------|-------------------|------|-------------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

REVIEW OF SYSTEMS

1. Do you have skin, hair or nail problems? Yes No _____

2. Do you have mouth and/or throat problems? Yes No _____

3. Do you have nose and/or sinus problems? Yes No _____

4. Do you have ear problems? Yes No _____

5. Do you have eye problems? Yes No _____

6. Do you have chest or lung (breathing) problems? Yes No _____

7. Do you have heart and/or blood vessel problems? Yes No _____

8. Do you have blood or lymph node problems? Yes No _____

9. Do you have digestive problems? Yes No _____

10. Do you have genital problems (e.g. prostate, testicular, vaginal, uterus)? Yes No _____

11. Do you have urinary (including kidney or bladder) problems? Yes No _____

12. **Females only (males skip to question 13):** Do you have menstrual problems? Yes No _____

Have you ever taken birth control pills? Yes No Currently taking? Yes No How long : _____ yrs.

Are you now or is there a possibility you be pregnant? Yes No

Do you have any breast problems? Yes No _____

13. Do you have any nervous system diseases and/or mental health problems? Yes No _____

14. Do you have any gland and/or hormone problems? Yes No _____

15. Do you have any allergy or immunity problems? Yes No _____

16. Do you have any muscle, tendon or ligament problems? Yes No _____

17. Do you have any bone or joint diseases (examples: bone = osteoporosis, joint = arthritis)? Yes No _____

PAST MEDICAL HISTORY

Musculoskeletal Conditions: (please check all conditions below that apply)

Other Conditions:

- | | | | | |
|--|--|---|--|--|
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Hip Pain/Discomfort | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Neck Pain/Discomfort | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Fused/Fixated Joints | <input type="checkbox"/> Tumors | <input type="checkbox"/> AIDS/HIV |
| <input type="checkbox"/> Shoulder Pain/Discomfort | <input type="checkbox"/> Elbow Pain/Discomfort | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Upper Back Pain/Discomfort | <input type="checkbox"/> Wrist Pain/Discomfort | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Seizure Disorders | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Middle Back Pain/Discomfort | <input type="checkbox"/> Knee Pain/Discomfort | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Low back Pain/Discomfort | <input type="checkbox"/> Ankle Pain/Discomfort | <input type="checkbox"/> Osteopenia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Hernia |
- Allergies: _____
- Inflammation/Swelling; Where: _____
- Other: _____

1. Have you suffered any physical injuries, such as falls or blows, automobile accidents, whiplash, concussion or head trauma, lacerations, sprains, strains, dislocations, broken or cracked bones? Yes No If yes, list ALL, please describe: _____

2. List all surgeries or operations you have had (don't forget appendix, tonsils, ear tubes, vasectomy, hysterectomy):

- | | |
|----------------------|----------------------|
| 1. _____ date: _____ | 5. _____ date: _____ |
| 2. _____ date: _____ | 6. _____ date: _____ |
| 3. _____ date: _____ | 7. _____ date: _____ |
| 4. _____ date: _____ | 8. _____ date: _____ |

3. Have you ever been Hospitalized for anything? Yes No If yes, list ALL and please describe: _____

FAMILY MEDICAL HISTORY

Please note any family history of the below conditions and note the relationship of relative.

M = Mother, F = Father, S = Sibling, ♀GP = Maternal Grandparent, ♂GP = Paternal Grandparent

- | | |
|--|--|
| <input type="checkbox"/> Cancer: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> ♀GP <input type="checkbox"/> ♂GP | <input type="checkbox"/> Stroke: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> ♀GP <input type="checkbox"/> ♂GP |
| <input type="checkbox"/> Diabetes: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> ♀GP <input type="checkbox"/> ♂GP | <input type="checkbox"/> Headaches: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> ♀GP <input type="checkbox"/> ♂GP |
| <input type="checkbox"/> High Blood Pressure: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> ♀GP <input type="checkbox"/> ♂GP | <input type="checkbox"/> Spine or Back Disorders: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> ♀GP <input type="checkbox"/> ♂GP |
| <input type="checkbox"/> Heart Disease: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> ♀GP <input type="checkbox"/> ♂GP | <input type="checkbox"/> Multiple Sclerosis: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> ♀GP <input type="checkbox"/> ♂GP |
| <input type="checkbox"/> Arthritis: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> ♀GP <input type="checkbox"/> ♂GP | <input type="checkbox"/> Psychological Disorders: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> ♀GP <input type="checkbox"/> ♂GP |

Are there any other diseases or conditions that are common among your family members, i.e. inherited diseases or conditions? Yes No
Describe: _____

HEALTH CONDITIONS

Abnormal postural habits or distortions of our bodies are the result of trauma, stress, unbalanced muscles and the affect of gravity on our bodies. When any part of our body becomes misaligned and unbalanced from its normal position, this will cause stress to the nervous system and structures of our body. These imbalances cause poor or abnormal biomechanics within the joints of our bodies. This alteration of biomechanics not only stresses the nervous system but weakens the physical structures of our body leaving us more prone to injury and degeneration. It has been extensively documented that abnormal joint biomechanics, causing stress to your nerves, will weaken and distort the overall structure of your spine. This results in a weakened and distorted POSTURE. Postural distortions have many serious and adverse affects on your overall health. The most common and detrimental postural distortion is called Forward Head Posture, a "hunched forward" posture starting in the neck and progressively moving down your spine weakening the entire body.

Our bodies are one complete integrated system; any injury to our foot will affect our knee, hip and spine. A neck injury such as whiplash can affect our entire body. Please review the health conditions below and identify which condition or symptom you are currently experiencing (current is defined within the last 3 to 6 months) or you have experienced in the past (longer than 6 months ago).

Check the box next to "C" for current condition, "P" for past condition, or you may check both boxes.

CERVICAL SPINE (NECK) including the upper extremity:

Postural distortions (causing Forward Head Syndrome), in your neck will weaken the nerves into your arms, hands and head affecting these parts of your body. Do you experience...?

- | | | |
|---|---|---|
| <input type="checkbox"/> C <input type="checkbox"/> P Neck pain | <input type="checkbox"/> C <input type="checkbox"/> P Eye redness or discharge | <input type="checkbox"/> C <input type="checkbox"/> P Loss of smell |
| <input type="checkbox"/> C <input type="checkbox"/> P Neck stiffness | <input type="checkbox"/> C <input type="checkbox"/> P Dry eyes | <input type="checkbox"/> C <input type="checkbox"/> P Allergies/hay Fever |
| <input type="checkbox"/> C <input type="checkbox"/> P Neck lump or mass | <input type="checkbox"/> C <input type="checkbox"/> P Dizziness | <input type="checkbox"/> C <input type="checkbox"/> P Nasal discharge |
| <input type="checkbox"/> C <input type="checkbox"/> P Headaches: stress | <input type="checkbox"/> C <input type="checkbox"/> P Loss of balance | <input type="checkbox"/> C <input type="checkbox"/> P Recurrent colds/flu |
| <input type="checkbox"/> C <input type="checkbox"/> P Headaches: migraine | <input type="checkbox"/> C <input type="checkbox"/> P Spinning sensation or vertigo | <input type="checkbox"/> C <input type="checkbox"/> P Low energy/fatigue |
| <input type="checkbox"/> C <input type="checkbox"/> P Pain into your shoulders/arms/hands | <input type="checkbox"/> C <input type="checkbox"/> P Ear pain | <input type="checkbox"/> C <input type="checkbox"/> P TMJ/pain/clicking |
| <input type="checkbox"/> C <input type="checkbox"/> P Numbness/tingling in arms/hands | <input type="checkbox"/> C <input type="checkbox"/> P Ringing in ears | <input type="checkbox"/> C <input type="checkbox"/> P Bad breath |
| <input type="checkbox"/> C <input type="checkbox"/> P Weakness in grip | <input type="checkbox"/> C <input type="checkbox"/> P Hearing loss or disturbance | <input type="checkbox"/> C <input type="checkbox"/> P Loss of taste |
| <input type="checkbox"/> C <input type="checkbox"/> P Coldness in hands | <input type="checkbox"/> C <input type="checkbox"/> P Ear discharge | <input type="checkbox"/> C <input type="checkbox"/> P Loss of touch sensation |
| <input type="checkbox"/> C <input type="checkbox"/> P Eye pain | <input type="checkbox"/> C <input type="checkbox"/> P Thyroid conditions | <input type="checkbox"/> C <input type="checkbox"/> P Stroke or TIA |
| <input type="checkbox"/> C <input type="checkbox"/> P Visual disturbances | <input type="checkbox"/> C <input type="checkbox"/> P Sinusitis | |

THORACIC SPINE (UPPER BACK):

Postural distortions in the upper back will weaken the nerves to the heart and lungs and affect these parts of your body. Do you experience...

- | | | |
|--|--|--|
| <input type="checkbox"/> C <input type="checkbox"/> P Chest pain | <input type="checkbox"/> C <input type="checkbox"/> P Fatigue | <input type="checkbox"/> C <input type="checkbox"/> P Shortness of breath |
| <input type="checkbox"/> C <input type="checkbox"/> P Heart palpitations | <input type="checkbox"/> C <input type="checkbox"/> P Swelling in the legs | <input type="checkbox"/> C <input type="checkbox"/> P Pain on deep inhalation/Exhalation |
| <input type="checkbox"/> C <input type="checkbox"/> P Heart murmurs | <input type="checkbox"/> C <input type="checkbox"/> P Changes in skin color | <input type="checkbox"/> C <input type="checkbox"/> P Frequent/chronic cough |
| <input type="checkbox"/> C <input type="checkbox"/> P Tachycardia | <input type="checkbox"/> C <input type="checkbox"/> P Heart valve problems | <input type="checkbox"/> C <input type="checkbox"/> P Phlegm/expectorant |
| <input type="checkbox"/> C <input type="checkbox"/> P Heart attacks/angina | <input type="checkbox"/> C <input type="checkbox"/> P Recurrent lung infections/bronchitis | <input type="checkbox"/> C <input type="checkbox"/> P Coughing up blood (Hemoptysis) |
| <input type="checkbox"/> C <input type="checkbox"/> P Fainting | <input type="checkbox"/> C <input type="checkbox"/> P Asthma/wheezing | <input type="checkbox"/> C <input type="checkbox"/> P Blue skin (Cyanosis) |

THORACIC SPINE (MID BACK):

Postural distortions in the mid back will weaken the nerves into your ribs/chest, urinary and upper digestive tract, and affect these parts of your body. Do you experience...

- | | | |
|---|--|--|
| <input type="checkbox"/> C <input type="checkbox"/> P Mid back pain | <input type="checkbox"/> C <input type="checkbox"/> P Reflux | <input type="checkbox"/> C <input type="checkbox"/> P Bloating/abdominal distention |
| <input type="checkbox"/> C <input type="checkbox"/> P Pain into your ribs/chest | <input type="checkbox"/> C <input type="checkbox"/> P Nausea | <input type="checkbox"/> C <input type="checkbox"/> P Hypoglycemia |
| <input type="checkbox"/> C <input type="checkbox"/> P Abdominal pain | <input type="checkbox"/> C <input type="checkbox"/> P Ulcers/gastritis | <input type="checkbox"/> C <input type="checkbox"/> P Tired/irritable after eating or when you haven't eaten for a while |
| <input type="checkbox"/> C <input type="checkbox"/> P Indigestion/heartburn | <input type="checkbox"/> C <input type="checkbox"/> P Cramping | |

LUMBAR SPINE (LOW BACK):

Postural distortions in the low back will weaken the nerves into your legs/feet, lower digestive tract, urinary and pelvic organs and affect these parts of your body. Do you experience...

- | | | |
|---|--|---|
| <input type="checkbox"/> C <input type="checkbox"/> P Low back pain | <input type="checkbox"/> C <input type="checkbox"/> P Constipation | <input type="checkbox"/> C <input type="checkbox"/> P Kidney stones |
| <input type="checkbox"/> C <input type="checkbox"/> P Pain into your hips/legs/feet | <input type="checkbox"/> C <input type="checkbox"/> P Diarrhea | <input type="checkbox"/> C <input type="checkbox"/> P Menstrual irregularities/cramping (females) |
| <input type="checkbox"/> C <input type="checkbox"/> P Numbness/tingling in your legs/feet | <input type="checkbox"/> C <input type="checkbox"/> P Pain during urination | <input type="checkbox"/> C <input type="checkbox"/> P Sexual dysfunction |
| <input type="checkbox"/> C <input type="checkbox"/> P Coldness in your legs/feet | <input type="checkbox"/> C <input type="checkbox"/> P Recurrent bladder infections | <input type="checkbox"/> C <input type="checkbox"/> P Genital itching |
| <input type="checkbox"/> C <input type="checkbox"/> P Muscle cramps in your legs/feet | <input type="checkbox"/> C <input type="checkbox"/> P Change in frequency of urination | <input type="checkbox"/> C <input type="checkbox"/> P Rectal bleeding |
| <input type="checkbox"/> C <input type="checkbox"/> P Weakness/injuries in your hips/knees/ankles | <input type="checkbox"/> C <input type="checkbox"/> P Change in urine flow | |
| | <input type="checkbox"/> C <input type="checkbox"/> P Change in urine color | |

HIPPA Notice of Privacy Practices

Effective Date: January 2017

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

We are required by law to provide you with this notice that explains our privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment, and for health care operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information and we also describe them in this notice.

Our Privacy Pledge

We have always and will always respect your privacy. Other than the uses and disclosures we described above, we will not sell or provide any of your health information to any outside marketing organization.

Permitted Uses And Disclosures Without Your Consent Or Authorization

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- 1) We are permitted to use or disclose your health information if we are providing health care services to you based on the orders of another health care provider.
- 2) We are permitted to use or disclose your health information if we provide health care services to you as an inmate.
- 3) We are permitted to use or disclose your health information if we provide health care services to you in an emergency.
- 4) We are permitted to use or disclose your health information if we are required by law to treat you and we are unable to obtain your consent after attempting to do so.
- 5) We are permitted to use or disclose your health information if there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

Other than the circumstances described in the preceding examples, any other use or disclosure of your health information will only be made with your written authorization.

Our Duties

We are required by law to maintain the privacy and security of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement, we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms the change will apply for all of your health information in our files.

We are required by law to notify you if we are unable to agree to a requested restriction.

The Methods in Which We May Uses and Disclosures Medical Information About You

The following categories describe different ways we may use and disclose your medical information. The examples provided serve only as guidance and do not include every possible use or disclosure.

- 1) For treatment. Your Doctor or a staff member may have to disclose your health information including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.
- 2) For payment. We will use and disclose medical information about you so that payment for the treatment you receive may be collected from you or another party.
- 3) For practice operation. Your Doctor and members of the staff may need to use your health information, examination and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run our practice.
- 4) For contacting you and appointment reminders. Your chiropractor(s) and members of the practice staff may need to use your name, address, phone number, text, e-mail, and your clinical records to contact you with notifications, text, messages, birthday and holiday relates messages, billing inquires, to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to your. 164.520 (b)(1)(iii) (A). If you are not at home to receive an appointment reminder, a message will be left on your answering machine.
- 5) For health care operations. We may use and disclose medical information about you for our office operations. These and disclosures are necessary to run the clinic in an efficient manner and provide that all patients receive quality care. For example, your medical records may be used in the evaluation of services, and the appropriateness and quality of chiropractic treatment we provide. Chiropractic services will be provided in an open room where other patients are also receiving care. Other persons in the office may overhear some of your protected medical information during the course of care. Should you need to speak with the doctor at any time in private, a place for these conversations will be provided upon request. To the extent permitted by law, we may use cameras or other recording devices in our clinic. The clinic will have notice posted at the clinic informing you of the use of such devices.
- 6) As required by law. We will disclose medical information about you when required to do so by federal or state laws or regulations.
- 7) Health oversight activities. We may discuss medical information to a health oversight agency for activities authorized by law. Health oversight agencies include public and private agencies authorized by law to oversee the health care system. These oversight activities include, for example, audits, investigations, inspections, and licensure. The activities are necessary for government to monitor the health care system, government programs, eligibility or compliance, and to enforce health-related civil rights and criminal laws.
- 8) Lawsuits and disputes. If you are involved in certain lawsuits or administrative disputes, we may disclose medical information about you in response to a court or administrative order.
- 9) Law enforcement. We may release medical information if asked to do so by a law enforcement official in response to a court or subpoena.
- 10) Electronic disclosure. We may use and disclose your medical information electronically. For example, your medical information is maintained on an electronic health record. If another provider requests a copy of your record for treatment purposes, we may forward such record electronically.

Disclosures Requiring Authorization

- 1) **Marketing:** Marketing generally includes a communication made to describe a health-related product or service that may encourage you to purchase or use the product or service. We will obtain your written authorization to use and disclose your medical information for marketing purposes unless the communication is made face-to-face, involves a promotional gift of nominal value, or otherwise permitted by law. *All other uses and disclosures of your information for marketing purposes require your written authorization. You have the right to revoke such authorization in writing.*

HIPPA Notice of Privacy Practices Cont.

Your Rights Regarding Your Medical Information

You have the following rights regarding medical information collected and maintained about you.

- 1) **Your right to revoke your authorization.** You may revoke your authorization to us at any time; however, our revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:
 - a. If we have already released your health information before we receive your request to revoke your authorization. 164.508(b)(5)(i)
 - b. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. If you wish to revoke your authorization please write to us at *Shimer Chiropractic, PC, 2330 N. Main Street, Unit A, Longmont, CO 80501.*
- 2) **Your Right to Limit Uses or Disclosures.** If there are health care providers, hospitals, employers, insurers or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.
- 3) **Your Right To Receive Confidential Communication Regarding Your Health Information.** We normally provide information about your health to you in person at the time you receive chiropractic services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home or, if you would like the information in a different form. To help us respond to your needs, please make any request in writing.
- 4) **Your Right To Inspect And Copy Your Health Information.** You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files.
- 5) **Your Right To Amend Your Health Information.** You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.
- 6) **Your Right To Receive An Accounting Of The Disclosures We Have Made Of Your Records.** Colorado law requires that we furnish you, upon your request, a copy of any information related in any way to you, which we have transmitted, to any company, or any public or private agency, or any person.
 - a. You may charge reasonable copying charges for this service which are set forth in the statutes as well as a handling charge and actual postage.
 - b. We may deny access to a record if we reasonably conclude that knowledge of the information contained in the record would be injurious to the health or welfare of the patient or could reasonably be expected to endanger the life or safety of any other person.
- 7) **Your Right To Obtain A Paper Copy Of This Notice.** If you have agreed to receive privacy notices by e-mail, you may request a paper copy of this notice at any time.
- 8) **Re-Disclosure.** Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.
- 9) **Your Right To Complain.** You may complain to us or to the Secretary for Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and we will not take any action against you if you file a complaint. You may make an oral or written complaint at any time with our practice manager or directly to the Secretary of Health and Human Services.
- 10) **Uses or Disclosures Not Covered.** Uses or disclosures of your health information not covered by this notice or the laws that apply to us may only be made with your written authorization. You may revoke such authorization in writing at any time and we will no longer disclose health information about you for the reasons stated in your written authorization. Disclosures made in reliance on the authorization prior to the revocation are not affected by the revocation.
- 11) **Your right to disclose to in-house practitioners.** We have the right to share / discuss your health information to in-house practitioners as needed for your care plan, but only if you are being seen by one of the in-house practitioners.

By signing below I agree that I have read and agree with all of the above terms and policies and that a copy will be made available, if I request one.

Patient Signature: _____ **Date:** _____

If patient is under 18 years of age: Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name (please print): _____

Dr. Wendy M. Shimer, DC 2330 Main St. Ste. A Longmont, CO. 80501 720-340-4107

Appointment and Cancellation Policies and Procedures

We are excited that you have chosen Shimer Chiropractic, PC. It is our patients that make this office possible and keep it growing. As our office is growing, we need to implement new policies and procedures for appointments and cancellations **effective January 1, 2019.**

Appointments

Walk-In's:

Walk-ins are always welcome however previously scheduled patients take precedence over walk-in patients. Therefore, we cannot ensure that you will be seen if you choose to walk in. Although we are aware of people's busy schedules, we highly recommend scheduling your appointments in advance.

Early Arrival:

Please be aware when arriving early to your appointment – if our schedule is light, we are happy to get you in early. However, if there are patients on the schedule prior to your appointment and present for their appointment, you will have to wait for your scheduled appointment time.

Late Arrival: (5 minutes or greater)

Please be aware, if you happen to arrive late to your appointment – If our schedule is light, we are happy to keep you on the schedule. However, if we have scheduled patients in office for their scheduled appointments, you will forego your scheduled appointment and will be considered a walk-in at that time. If you are the last scheduled appointment for the day and you are over 5 minutes late without a phone call, you will be refused service and charged a no call no show fee of \$35.

Cancellation Policy

For scheduled patients - we ask that if you need to cancel your appointment, you do so 24 hours in advance. We recognize that this is not always possible therefore we appreciate being notified as soon as possible. Please note that a \$35 fee will be charged to your account without a 24-hour notice.

No Call, No Shows:

We understand that people get busy and occasionally forget to make it to their scheduled appointments. However, this does take away the possibility for another patient to receive care. We will waive the first no call, no show. However, after the first no call, no show going forward there will be a \$35 fee charged to your account per scheduled visit missed. This is a separate fee from our packages and plans.

We appreciate your understanding on this matter.

Many Thanks,

Dr. Wendy M. Shimer, DC and Hassie

Patient / Legal Guardian Signature

Date