DUGGAN CHIROPRACTIC

APPLICATION FOR TREATMENT

Date:_____

Name:_____ Nickname:_____ Date of Birth:_____

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

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email:_____

Check if you are: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Name of Husband or Wife: _____ Ages of Children:_____

Where are you or your husband/wife employed?_____

Your days off:_____ Referred to our office by:_____

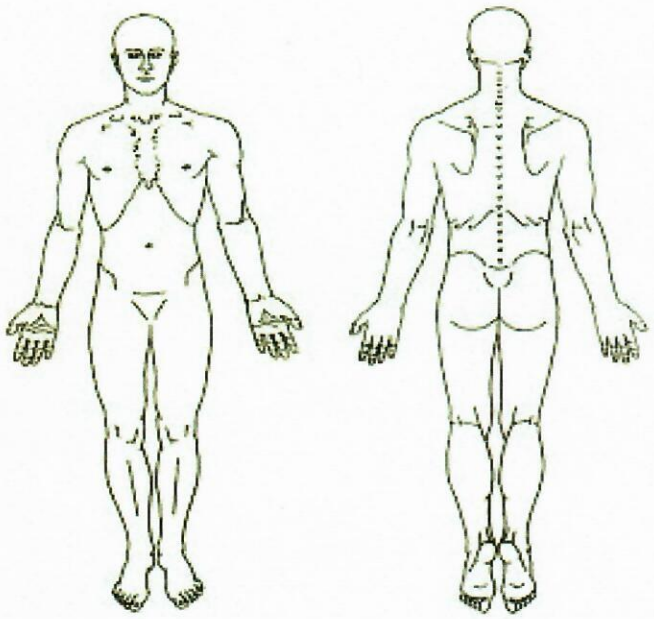
Who is responsible for your bill: ☐ Self ☐ Spouse ☐ Employer ☐ Insurance ☐ Other_____

How payment will be made: ☐ Cash ☐ Check ☐ Credit Card ☐ Workers' Comp.
☐ Auto Insurance Policy ☐ Health Insurance

Name of Company and Address:_____

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing

A= Ache **B**=Burning **N**= Numbness
O= Other **P**= Pins & Needles **S**= Stabbing



Major Complaint
(Please describe only your major complaint)

How did this condition develop? (What caused it? How did it start?)_____

When was the very first time you were aware of this problem? ☐ Immediately ☐ Within Hours ☐ Within Days
☐ Other, explain: _____

Have you ever had this problem or a similar problem before? If yes, please explain:_____

Have you received any treatment for this condition? If yes when, where and what were your results?_____

Has this problem been getting better, worse or staying the same? _____

Is there anything you do that makes your condition worse? (Example: sitting, standing, bending, etc) _____

Is there anything that makes it better? (Example: medication, heat, ice, rest, etc) _____

How has your condition affected the activities of your daily life? (What has it stopped you from doing?) _____

When was your last physical exam? _____

When is the last time you had x-rays taken? Where? (Dates) _____

Is there any chance you could be pregnant? ☐ Yes ☐ No

Have you ever been in an automobile accident? If yes, briefly explain injuries and gives dates: _____

Have you ever had surgery? If yes, briefly explain and gives dates: _____

Have you broken/fractured bones? If yes, briefly explain and gives dates: _____

Have you ever had any sprains/strains? If yes, briefly explain and gives dates: _____

Have you ever been hospitalized? If yes, briefly explain and gives dates: _____

Have you ever experienced any head injuries or been knocked unconscious? If yes, briefly explain and gives dates:

What medications or dietary supplements do you take? _____

Do you have any family history of illness? (Example: Arthritis, back problems, cancer, diabetes, heart disease, high blood pressure, other…) _____

Categorize the following habits in terms of none, light, moderate or heavy:

Habit	None	Light	Moderate	Heavy
Alcohol				
Coffee				
Tobacco				
Drugs				
Exercise				
Sleep				
Appetite				
Soft Drinks				
Water				
Salty Foods				
Sugary Foods				
Artificial Sweeteners				

Quadruple Visual Analogue Scale

PLEASE READ CAREFULLY

Instructions: Please circle the number that best describes the question being asked based on your complaint.

Note: If you have more than one complaint, please answer each question with the pain score that coordinates with each individual complaint

Example:

Headache Neck Low Back

No Pain _____ Worst possible pain

0 1 (2) 3 4 (5) 6 7 (8) 9 10

1– What is your pain RIGHT NOW?

No Pain _____ Worst possible pain

0 1 2 3 4 5 6 7 8 9 10

2– What is you TYPICAL or AVERAGE pain?

No Pain _____ Worst possible pain

0 1 2 3 4 5 6 7 8 9 10

3– What is your pain AT ITS BEST (How close to "0" does your pain get at its best)?

No Pain _____ Worst possible pain

0 1 2 3 4 5 6 7 8 9 10

4– What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No Pain _____ Worst possible pain

0 1 2 3 4 5 6 7 8 9 10

Have You Ever Suffered From: (Circle all that Apply)

Alcoholism	Digestion Problems	Loss of Balance	Swelling of Ankles
Allergies	Dizziness	Loss of Smell	Swollen Joints
Anemia	Ears Ring	Loss of Taste	Thyroid Condition
Arteriosclerosis	Excessive Menstruation	Neck Pain/Stiffness	Tuberculosis
Arthritis	Eye Pain/Difficulties	Nervousness	Ulcers
Asthma	Fatigue	Nosebleeds	Varicose Veins
Back pain	Frequent Urination	Pacemaker	Venereal Disease
Breast Lump	Headache	Polio	Other:
Bronchitis	Hemorrhoids	Poor Posture	
Bruise Easily	High Blood Pressure	Prostate Trouble	
Cancer	Hot Flashes	Sciatica	
Chest Pain/Conditions	Irregular Heart Beat	Shortness of Breath	
Cold Extremities	Irregular Cycle	Sinus Infection	
Constipation	Kidney Infection	Sleep Problems/Insomnia	
Cramps	Kidney Stones	Spinal Curvatures	
Depression	Loss of Memory	Stroke	

Have consulted any Chiropractors in the past? Name:_____
Dates consulted:_____ For what problem?_____

Fees are payable at the time of x-rays, examinations, and treatments are received, unless other arrangements are made in advance. X-rays remain property of this clinic.

Patient's Signature:_____ Social Security No.:_____ Date:_____
Emergency Contact: _____ Phone Number:_____

ASSIGNMENT, LIEN AND AUTHORIZATION INSURANCE BENEFITS AND ATTORNEY

To whom it may concern:

I hereby authorize and direct you, my insurance company, and/or my attorney , to pay directly to Duggan Chiropractic such sums as may be due and owing this Office for services rendered me, both by reason of accident or illness, and by reason of any other bills that are due this Office, and to withhold such sums from any disability benefits , medical payments benefits, No-Fault benefits, health and accident benefits, Workmen's Compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said Office. I hereby further give a lien to said Office against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment of verdict which may be paid to me as a result of the injuries or illness for which I have been treated by said Office. This is to act as an assignment of my rights and benefits to the extent of this Office's services provided.

In the event my insurance company obligated to make payments to me upon the charges made by this Office for their services refuses to make such payments, upon demand by me or this Office, I hereby assign and transfer to this Office any and all causes of action that I might have or that might exist in my favor against such company and authorize this Office to prosecute said cause of action either in my name or in the Office's name and further I authorize this Office to compromise, settle or otherwise resolve said claim of action as they see fit.

I understand that I remain personally responsible for the total amount due the Office for their services. I further understand and agree that this Assignment, Lien and Authorization does not constitute any consideration for the Office to await payments and they may demand payments from me immediately upon rendering services at their option.

I authorize other Office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization. I agree that the above mentioned Office be given power of Attorney to endorse/sign my name on any and all checks for payment of my doctor bill.

I further understand and agree, that if this Office must take any action to collect an outstanding balance on my account, I will be responsible for payment of and will reimburse this Office for all costs of such collection efforts, including but not limited to all court cases and all attorney fees.

Patient: _____ Date:_____

Witness:_____ Date:_____

DUGGAN CHIROPRACTIC

Accident Details

Please complete as thoroughly and as detailed as possible.

Name: _____ **Date of Accident:** _____ **Time of Accident:** _____

Where did the accident occur? (street name, intersection, town, etc.)

_____

Describe the accident in your own words with as much detail as possible: _____

_____

_____

_____

Road conditions at the time of accident: ☐Wet ☐Dry ☐Snow ☐Ice Other: _____

Was the accident on the job?
☐Yes ☐No
If yes, were you traveling **TO** *or* **FROM** *work? (Circle)*

What was your position in vehicle?
☐Driver ☐Passenger
If passenger, where were you sitting?
☐Front ☐Right rear ☐Left rear

Were you in a company vehicle? ☐Yes ☐No

Did the police come to the accident scene? ☐Yes ☐No **Is there a police report?** ☐Yes ☐No

Did your vehicle strike another vehicle? ☐Yes ☐No **Was your vehicle struck by another vehicle?** ☐Yes ☐No

Was the impact from the:
☐Front ☐Rear ☐Driver's side ☐Passenger's side

Were you braced for impact?
☐Yes ☐No

Which way was your head pointing at time of impact?
☐Straight ahead ☐To the left ☐To the right

Which way was your body facing at time of impact?
☐Straight ahead ☐To the left ☐To the right

Were you wearing your seatbelt? ☐Yes ☐No **Did you receive any injury or bruising from seatbelt?** ☐Yes ☐No

Were your hands on the steering wheel? ☐Yes ☐No

Was your foot on the brake? ☐Yes ☐No

Did the airbag deploy? ☐Yes ☐No
If yes, did it strike you? ☐Yes ☐No **Did your head hit the head rest?** ☐Yes ☐No

Did you strike anything in the vehicle at the time of impact? ☐Yes ☐No

If yes, please specify:

☐Steering wheel ☐Windshield ☐Arm rest ☐Center console
☐Dashboard ☐Side door ☐Side window

Please specify which body part:

☐Head ☐ Hand ☐ Knee
☐Chin ☐Shoulder ☐Foot
☐Arm ☐ Chest Other:_____

How did you feel immediately following the accident?

☐In a daze ☐Panicked ☐Shaken-up ☐In pain
☐Unconscious ☐Confused ☐In shock ☐Other:_____

(More on back)

Did you go to the hospital? ☐Yes ☐No
If yes, when? ☐Immediately ☐Hours later ☐Next Day
How did you get to hospital? ☐Ambulance ☐Private transportation ☐Other: _____
Did the ambulance attendants place you in: ☐Neck collar ☐Splints ☐Brace

Name of Hospital: _____ **Location of hospital:** _____

Attended by Dr. _____ **Was imaging performed at hospital?** ☐X-ray ☐CT ☐MRI

What was your diagnosis? _____ **Treatment Rendered:** _____

Were you admitted to the hospital? ☐Yes ☐No **How long did you stay?** _____
What recommendations were made? ☐See own doctor ☐See orthopedic doctor ☐Physical Therapy Other: _____
Have you seen any other doctor as a result of the accident? ☐Yes ☐No

If yes, doctor name: _____ *Specialty:* _____

Treatment type: _____ *Treatment frequency:* _____ *How long did you treat?* _____

When was the onset of your pain?
☐Immediately after accident ☐Next day
☐Hours after ☐Few days after

Is your pain: ☐Constant ☐On and Off

Describe your pain:
☐Sharp ☐Dull ☐Numb/Tingling ☐Electrical Shooting
☐Aching ☐Stabbing ☐Throbbing ☐Other:_____

Do you have any numbness or tingling in your:
☐Arms ☐Fingers ☐Feet
☐Hands ☐Legs ☐Toes

Do your knees ache/hurt? ☐Yes ☐No **Do you have cramps in your:** ☐Legs ☐Arms

Does your injury affect your range of motion? ☐Yes ☐No
If yes, please explain: _____

Does your pain radiate? ☐Yes ☐No
If yes, please explain: _____

Does the following worsen your pain?
☐Prolonged standing ☐Coughing ☐Change in heel height
☐Prolonged sitting ☐Sneezing ☐Stretching or twisting
☐Rising from a chair ☐Straining your bowels ☐Bending Forward

What is your most comfortable position?
☐Sitting ☐Lying on left side ☐Lying on your stomach ☐Other:_____
☐Lying on right side ☐Standing ☐Lying on your back _____

Do any of the following relieve your pain?
☐Heating pad ☐Shower ☐Massage
☐Hot bath ☐Ice Pack ☐A brace

Do you feel better: ☐Moving around **OR** ☐Resting
Do you have a firm mattress? ☐Yes ☐No **Have you had any change in your bowel habits?** ☐Yes ☐No

Have you lost time from work due to this accident? ☐Yes ☐No
If yes, give dates of time lost: From _____ To _____

Totally disabled from _____ To _____ **Partially disabled from** _____ To _____

Additional Details: _____
_____

Revised Oswestry Chronic Low Back Pain Disability Questionnaire

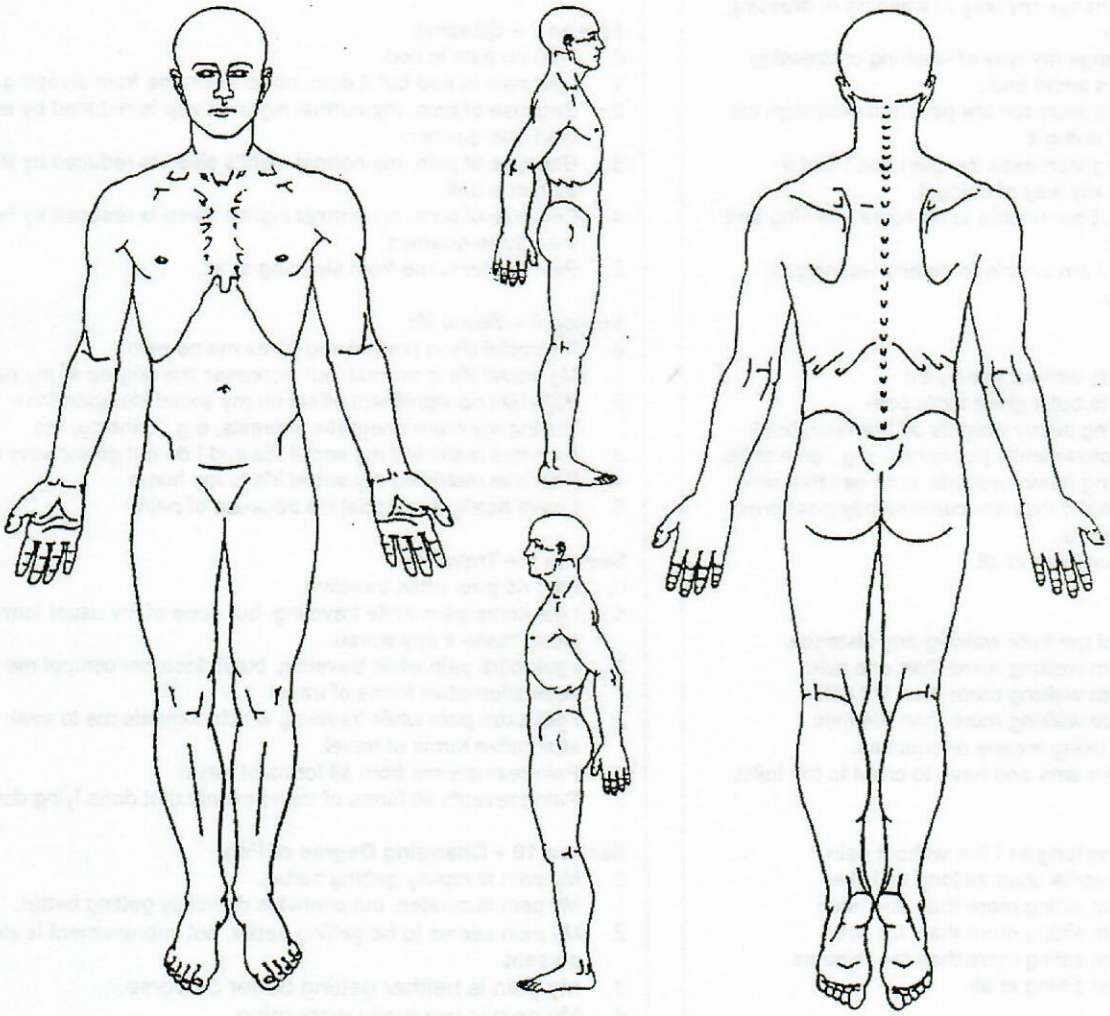
Age:_____ Date of Birth:_____ Occupation:_____

How long have you had low back pain? ___ years ___months ___weeks

Is this your first episode of low back pain? ___yes ___ no

Use the letters below to indicate the type and location of your sensations right now.
(Please remember to complete both sides of this form.)

A = Ache	B = Burning	N = Numbness
P = Pins and needles	S = Stabbing	O = Other



Over please

Revised Oswestry Chronic Low Back Pain Disability Questionnaire

Please Read: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

Section 1 – Pain intensity
0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)
0. I would not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increase the pain, but I manage not to change my way of doing it.
3. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
4. Because of the pain , I am unable to do some washing and dressing without help.
5. Because of the pain, I am unable to do any washing or dressing without help.

Section 3 – Lifting
0. I can lift heavy weights without extra pain
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor, but I manage if they are conveniently positioned, e.g., on a table.
3. Pain prevents me lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
4. I can lift very light weights.
5. I cannot lift or carry anything at all.

Section 4 – Walking
0. Pain does not prevent me from walking any distance.
1. Pain prevents me from walking more than one mile.
2. Pain prevents me from walking more than 1/2 mile.
3. Pain prevents me from walking more than 1/4 mile.
4. I can only walk while using a cane or crutches.
5. I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting
0. I can sit in any chair as long as I like without pain.
1. I can only sit in my favorite chair as long as I like.
2. Pain prevents me from sitting more than one hour.
3. Pain prevents me from sitting more than 1/2 hour.
4. Pain prevents me from sitting more than ten minutes.
5. Pain prevents me from sitting at all

Section 6 – Standing
0. I can stand as long as I want without pain.
1. I have some pain while standing, but it does not increase with time.
2. I cannot stand for longer than one hour without increasing pain.
3. I cannot stand for longer than 1/2 hour without increasing pain.
4. I cannot stand for longer than ten minutes without increasing pain.
5. I avoid standing, because it increases the pain.

Section 7 – Sleeping
0. I get no pain in bed.
1. I get pain in bed but it does not prevent me from sleeping well.
2. Because of pain, my normal night's sleep is reduced by less than one-quarter.
3. Because of pain, my normal night's sleep is reduced by less than one-half.
4. Because of pain, my normal night's sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

Section 8 – Social life
0. My social life is normal and gives me no pain.
1. My social life is normal, but increases the degree of my pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of pain.

Section 9 – Traveling
0. I get no pain while traveling.
1. I get some pain while traveling, but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
3. I get extra pain while traveling which compels me to seek alternative forms of travel.
4. Pain restricts me from all forms of travel.
5. Pain prevents all forms of travel except that done lying down.

Section 10 – Changing Degree of Pain
0. My pain is rapidly getting better.
1. My pain fluctuates, but overall is definitely getting better.
2. My pain seems to be getting better, but improvement is slow at present.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

Comments:_____

_____

Patient signature: _____ Date:_____

PAIN CHART

ABOUT YOU

Name:_____

What is your current weight:_____lbs., and height:_____ft._____in.

Please describe your condition:_____

_____

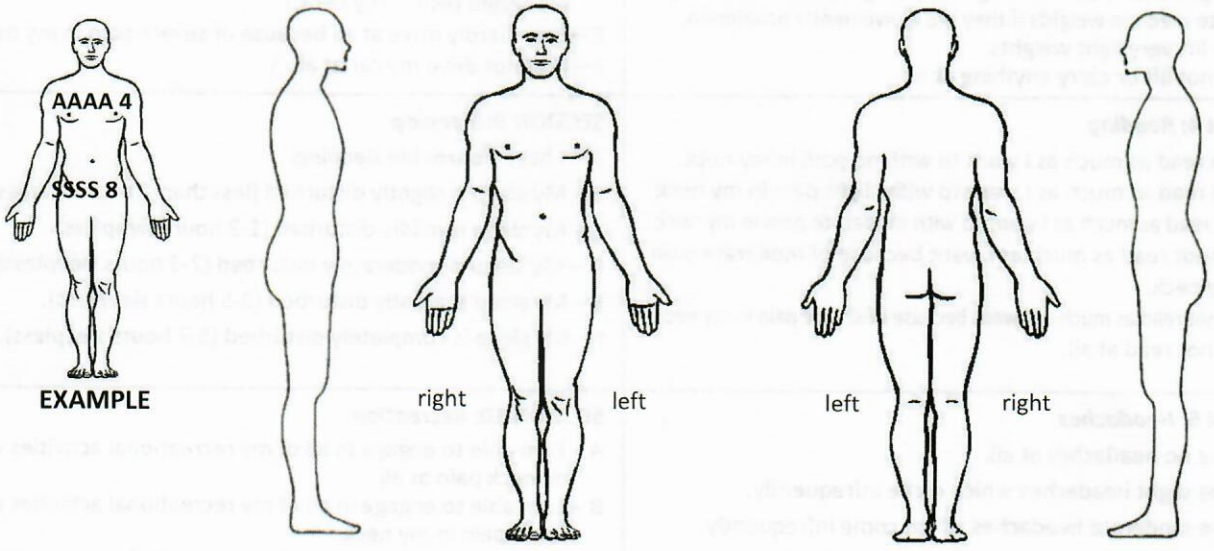
Signature:_____ Date:_____

SHOW US WHERE IT HURTS

Please mark area(s) of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain)

Description –	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol –	NNNN	PPPP	BBBB	AAAA	SSSS

Circle any area of pain not represented by a symbol.



Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorized the chiropractor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the chiropractic group insurance benefits otherwise payable to me. I understand that my chiropractic insurance carrier may pay less than the bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

Signature of Patient (or parent of minor) Date

Neck Pain Disability Oswestry Revised Questionnaire

PLEASE READ: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

SECTION 1: *Pain Intensity*

A – I have no pain at the moment.
B – The pain is very mild at the moment.
C – The pain is moderate at the moment.
D – The pain is fairly severe at the moment.
E – The pain is very severe at the moment.
F – The pain is the worst imaginable at the moment.

SECTION 2: *Personal Care*

A – I can look after myself normally without causing extra pain.
B – I can look after myself normally, but it causes extra pain.
C – It is painful to look after myself and I am slow and careful.
D – I need some help, but manage most of my personal care.
E – I need help every day in most aspects of self-care.
F – I do not get dressed; I wash with difficulty and stay in bed.

SECTION 3: *Lifting*

A – I can lift heavy weights without extra pain.
B – I can lift heavy weights, but it causes extra pain.
C – Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
D – Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E – I can lift very light weights.
F – I cannot lift or carry anything at all.

SECTION 4: *Reading*

A – I can read as much as I want to with no pain in my neck.
B – I can read as much as I want to with slight pain in my neck.
C – I can read as much as I want to with moderate pain in my neck.
D – I cannot read as much as I want because of moderate pain in my neck.
E – I cannot read as much as I want because of severe pain in my neck.
F – I cannot read at all.

SECTION 5: *Headaches*

A – I have no headaches at all.
B – I have slight headaches which come infrequently.
C – I have moderate headaches which come infrequently.
D – I have moderate headaches which come frequently.
E – I have severe headaches which come frequently.
F – I have headaches almost all the time.

SECTION 6: *Concentration*

A – I can concentrate fully when I want to with no difficulty.
B – I can concentrate fully when I want to with slight difficulty.
C – I have a fair degree of difficulty in concentrating when I want to.
D – I have a lot of difficulty in concentrating when I want to.
E – I have a great deal of difficulty in concentrating when I want to.
F – I cannot concentrate at all.

SECTION 7: *Work*

A – I can do as much work as I want to.
B – I can only do my usual work, but no more.
C – I can do most of my usual work, but no more.
D – I cannot do my usual work.
E – I can hardly do any work at all.
F – I cannot do any work at all.

SECTION 8: *Driving*

A – I can drive my car without any neck pain.
B – I can drive my car as long as I want with slight pain in my neck.
C – I can drive my car as long as I want with moderate pain in my neck.
D – I cannot drive my car as long as I want because of moderate pain in my neck.
E – I can hardly drive at all because of severe pain in my neck.
F – I cannot drive my car at all.

SECTION 9: *Sleeping*

A – I have no trouble sleeping.
B – My sleep is slightly disturbed (less than 1 hour sleepless).
C – My sleep is mildly disturbed (1-2 hours sleepless).
D – My sleep is moderately disturbed (2-3 hours sleepless).
E – My sleep is greatly disturbed (3-5 hours sleepless).
F – My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10: *Recreation*

A – I am able to engage in all of my recreational activities with no neck pain at all.
B – I am able to engage in all of my recreational activities with some pain in my neck.
C – I am able to engage in most, but not all of my recreational activities because of pain in my neck.
D – I am able to engage in a few of my recreational activities because of pain in my neck.
E – I can hardly do any recreational activities because of pain in my neck.
F – I cannot do any recreational activities at all.

Comments:_____

_____

Name:_____ Date:_____ Score:_____

DUGGAN CHIROPRACTIC

Med Pay Insurance 101

Insurance is essential to our society. Insurance is a fully-funded social device used to spread risk when losses occur to help people who are in need. Insurance is intangible – you buy good service and peace of mind when you pay insurance premiums.

If you elected for this additional coverage, your insurance company is committed to helping you by promptly providing you with Med Pay benefits. Many policyholders choose to pay additional premiums just to have this added level of coverage. Use the added benefits of Med Pay to obtain the necessary chiropractic care to restore your health after a collision.

Why purchase/use Med Pay?

1. **Premiums:** You already paid for the Med Pay insurance protection (unless you opted out of this coverage) with your *monthly or yearly premiums*. You should take advantage of the insurance you bought.

2. **Optional:** You could have rejected Med Pay, as Colorado does not require drivers to buy this *optional* insurance. However, you purchased Med Pay insurance to protect you, so why not utilize the additional insurance?

3. **Won't Increase Your Rates:** Making a Med Pay claim and receiving your benefits will not increase your insurance rates if you were not at fault in the collision. The Colorado Division of Insurance Reg. Section 5-2-12, 5(B.)(2.)(a) states that an insurance company *cannot increase insurance rates* when you or your chiropractor files a Med Pay claim and obtains your Med Pay insurance benefits. Benefits may only be used to pay your health care providers.

4. **Available even if you are at fault for the collision:** Regardless of who was at fault, you have Med Pay insurance benefits available to you (if you opted for this additional coverage). If you were at fault, your insurance company has the ability to raise your rates.

Personal Injury Insurance Information

Date of Accident: _____

Choose one: At-fault Not-at-fault

Circle applicable: Operator of vehicle Passenger of vehicle Pedestrian/Bicyclist Motorcyclist

Did this accident involve Uber or Lyft? (Circle if Applicable)

Automobile Insurance (patient)

Primary Secondary Tertiary

Automobile Insurance Carrier: _____

Policy Number: _____

Claim Number: _____

Med Pay Amount: $_____

Amount of Med Pay Exhausted to Date: $_____

Adjustor Name: _____

Adjustor Direct Line: _____ ext: _____

Driver's Automobile Insurance (if patient was passenger)

Primary Secondary Tertiary

Name of Driver: _____ Driver's DOB_____

Automobile Insurance Carrier: _____

Policy Number: _____

Claim Number: _____

Med Pay Amount: $_____

Adjustor Name: _____

Adjustor Direct Line: _____ ext: _____

Major Medical Insurance

Primary Secondary Tertiary

Major Medical Insurance carrier: _____

Member ID: _____

Policy Number: _____

3rd Party Insurance (At-fault party if not patient)

Primary Secondary Tertiary

3rd Party Automobile Insurance Carrier: _____

Policy Number: _____

Claim Number: _____

3rd Party Name: _____

3rd Party DOB: _____

Adjustor Name: _____

Adjustor Direct Line: _____ ext: _____

AUTHORIZATION FOR RELEASE OF RECORDS

Patient Name: _____
Date of Birth: _____
Social Security: _____
Date: _____

You, and any other person associated with you, are hereby authorized to release any and all records, including, x-rays, imaging studies and treatment records, that you have in your possession.

I hereby authorize and request you to release any and all health records concerning the undersigned to:

Duggan Chiropractic
2439 Broadway
Boulder, CO 80304
(303) 443-1553

Thank you for your cooperation and timely response to this request for records.

Patient Signature: _____ Date: _____

Name of Facility: _____

Name of Doctor: _____

Contact Name: _____

Contact Phone: _____

Facility Address: _____

_____

Authorization to Use or Disclose My Health Information

Patient Name: _____ Date of Birth: _____

Please complete all sections or this could delay release

I. My Authorization

You may use or disclose the following health care information **(check all that apply)**:

☐ All my health information maintained by the above-named practice

☐ My health information relating to the following treatment or condition: _____

☐ My health information for the date(s): _____

Other: _____

☐ My complete billing information

Other: _____

You may disclose this health information to:

Name (or title) and organization: _____

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

Reason(s) for this authorization (check all that apply):

☐ At my request **Reason:** _____

***Fee required $25.88 (20 or fewer pgs. 0.97 per pg. 21-100/$0.83 per pg. 100+ $0.66/page, REPORTS EXTRA)**

☐ Other (specify)

***If you need records for an upcoming appointment, please note the date:** _____

My Rights

I understand that I have the right to inspect or copy the protected health information to be used or disclosed under this authorization.

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment).

However, I do have to sign authorization form to receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above practice based upon this authorization. I may not be able to revoke authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

* fill out a revocation form. This form is available from this office, **-OR-**
* write a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Questions:

I may contact Duggan Chiropractic with questions about the privacy of my health information at 2439 Broadway Boulder, CO 80304, by telephone at (303)443-1553, or by email at dcoffice03@aol.com

_____ _____ _____

Patient or legally authorized individual signature | Date | Time

_____ _____

Printed name if signed on behalf of the patient | Relationship (parent, legal guardian, personal representative)

Acknowledgement of HIPAA Notice of Privacy Practices

To help us ensure clarity of communication, **please initial the following:**

_____I acknowledge that I was presented with a copy of the Notice of Privacy Practices on today's visit which 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 Duggan Chiropractic.

- Our Notice of Privacy Practices is subject to change. The most current Notice of Privacy Practices is available at the front desk.
- We encourage you to read it in full. You may ask the front desk for a copy, if you'd like to retain it for your records. Should you have any further questions, you may ask the receptionist.

_____Duggan Chiropractic may send me birthday cards, thank you notes, and holiday greetings.

_____Duggan Chiropractic may use my email to contact me about appointments through our online scheduling system, Schedulicity.

Name of Patient: _____

Signature: _____ **Date:**_____

Guardian Signature, if applicable:_____ **Date:**_____

Witness:_____ **Date:**_____

ASSIGNMENT, LIEN, RELEASE & POWER OF ATTORNEY

This agreement, entered into this date _____ and between _____ called "Patient" and Duggan Chiropractic.

Whereas Patient desires to receive chiropractic services from Duggan Chiropractic and desires to assign certain rights and benefits to Duggan Chiropractic awaiting payment of such benefits.

Accordingly, it is hereby agreed:

A. Patient hereby authorizes Duggan Chiropractic to furnish a full report and records regarding case history, examination, diagnosis, treatment and prognosis, x-rays, laboratory reports and the results of all tests of any type or character of Patient's to such persons as Duggan Chiropractic deems appropriate.

B. Patient assigns to Duggan Chiropractic any and all benefits payable by Patient's insurance or health care plan(s) as a result of charges incurred by Patient for services rendered by Duggan Chiropractic. Patient also assigns to Duggan Chiropractic any and all contractual rights Patient has against insurance company, health care benefit plan(s), or any other party possibly liable to Patient for payment of health care costs incurred by Patient as a result of services rendered by Duggan Chiropractic.

C. Patient fully understands that Patient is directly and fully responsible to Duggan Chiropractic for all bills submitted for services rendered and that this agreement is made solely for additional protection and consideration for awaiting payment. Patient further understands that such payment is not contingent on any settlement, claim, judgment or verdict which Patient may eventually recover. In the event of non-payment by any insurance company, health care benefit plan(s) or any other party possibly liable to Patient for payment of health care costs incurred by Patient as a result of services rendered by Duggan Chiropractic, Patient agrees to be responsible for any such outstanding balance, including interest at a rate of 9%, reasonable attorney's fees and costs.

D. Patient fully understands that lien and assignment given to Duggan Chiropractic herein is irrevocable.

E. By executing this agreement, Patient hereby instructs and directs any attorney representing Patient to honor the above lien and assignments and make payment under the lien and assignment directly to Duggan Chiropractic. Patient directs that attorney be bound by this lien and treat it, irrevocably, as an assignment due to Duggan Chiropractic. Duggan Chiropractic is relying upon this lien, assignment and directive to any attorney, and as a result of such reliance, Duggan Chiropractic is providing care and treatment for which this lien, assignment and directive provides security for payment. *Moreover,* Patient agrees that Duggan Chiropractic is to be viewed as third party beneficiary of this direction to Patient's attorney and it is Patient's intent to impose upon Patient's attorney an obligation to comply with the terms of this directive.

F. Patient hereby directs all insurers and other persons possibly responsible for Patient's healthcare costs to make all payments for healthcare services rendered by Duggan Chiropractic directly to Duggan Chiropractic.

G. Patient agrees that in the event Patient receives any check, draft or other payment subject to this agreement, Patient agrees to act as fiduciary agent for Duggan Chiropractic and will immediately deliver said check, draft or payment to Duggan Chiropractic to be applied to Patient's debt for services rendered.

H. Patient hereby appoints Duggan Chiropractic as Patient's true and lawful attorney, irrevocable and with full power of substitution, for Patient and in Patient's name, to ask, demand, sue for, collect, endorse, sign and receive proceeds from insurance, other health benefits, and third party claims relating to services rendered to Patient by Duggan Chiropractic. Duggan Chiropractic is not obligated or compelled to exercise such powers but may do so in Duggan Chiropractic's sole discretion. Patient agrees to fully cooperate with Duggan Chiropractic in collecting said amounts.

I. Duggan Chiropractic agrees to submit a copy of this agreement with the initial claim form(s) which Duggan Chiropractic submits to third party payor(s) as notice to the third party payor(s) of the assignment and other agreements contained herein. At the same time, each claims is submitted, a copy of the claim will be stored for safekeeping in Patient's file and may be picked up by the Patient, upon reasonable request and during normal business hours, or upon written request by Patient, be mailed to designated address.

J. Patient hereby authorizes Duggan Chiropractic to receive a complete copy of Patient's insurance policy, including any endorsements, conditions, limitations or exclusions.

K. A copy of these documents shall be as binding as the documents bearing the original signatures.

_____ _____

Patient Date

_____ _____

Clinic Representative Date

_____ _____

Attorney Date

PERSONAL INJURY FINANCIAL POLICY

It is the policy of Duggan Chiropractic that all payment of fees be deferred until your personal injury case is settled, provided the following conditions are satisfied:

1. That you are represented by an attorney specialized in personal injury cases

2. That a Doctor's Lien Form is signed by you and acknowledged by your attorney. This allows the Doctor's fees to be paid from the final settlement.

3. That the merits of your case are established by your attorney and communicated to Duggan Chiropractic.

4. That you are personally responsible for setting up a reasonable payment plan until the charges have been met in full should your personal injury case not be settled within nine months of discharge. If action is not taken at that time, interest will be charged to your balance with Duggan Chiropractic.

I understand and agree to this policy.

Patient's Signature: _____ Date: _____

Duggan Chiropractic | 2439 Broadway Boulder, CO 80304 |office: 303.443.1553 | fax: 303.443.8069
www.dugganchiropractic.com