COLORADO
Injury Treatment Center, PC

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____Social Security #: _____ Sex: ( ) M ( ) F

Home Phone: _____Alternate Phone #: _____

E-mail Address: _____

Employer: _____Work Phone: _____

Occupation: _____

Emergency contact: _____ Phone: _____

Physician: _____Phone: _____

How did you hear about us? *( ) Phonebook ( ) Google ( ) Attorney ( ) Doctor ( ) Friend*
( ) Other: _____

Insurance Information

Insurance Type: ( ) Work Comp ( ) Auto ( ) Private ( ) Medicare ( ) Injury Finance ( ) Western Healthcare

Insurance Name: _____

Insurance Address: _____

Insurance Phone Number: _____

Claim/ ID#: _____Date of Injury: _____

Group #: _____Adjuster: _____

Name of Insured: _____Employer of insured: _____

I understand and acknowledge that my insurance coverage is a contract between me and my insurance carrier and that I am personally responsible for all medical expenses incurred during evaluation and treatment. I understand that as a courtesy my insurance will be billed; however, it is my responsibility to follow up on delinquent claims. If I am a member of a PPO or an HMO I am required to make my co-pay and co- insurance payments in a timely fashion, and I am responsible for keeping my primary care physician referral current. I authorize CITC to release all medical information to my insurance carrier for processing my claims. I assign all benefits from said claims to this practice. I further agree that a photocopy of this agreement shall be as valid as the original

Signature _____Date_____
(**Patient/ Responsible Party**)

Colorado Injury Treatment Center, PC
14001 E. Iliff Ave., #111
Aurora, Co 80014
Ph: 303-745-0803 Fax: 720-306-3758

Therapist initial_____

Informed Consent for Examination and Treatment

I hereby consent to the performance of examination and treatment on me (*patient name*) _____, by the licensed doctors of chiropractic, licensed/ doctor of physical therapy, and/ or licensed/ certified massage therapist who may be employed by or engaged in practice in this clinic, Colorado Injury Treatment Center, PC.

I understand that the chiropractic, physical therapy, and massage therapy are not an exact science and that my treatment may involve judgment based upon facts and information known to the therapist. The therapists use this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the therapist to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic, physical therapy, and massage therapy health care. Which includes rarely but not limited to, fractures, disc injuries, stroke, and sprain/strains and I am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedure prescribed for my condition and for any further conditions for which I seek treatment.

_____ _____

Patient's Name (Print) Patient's Signature

_____ _____

Date Relationship to patient or authority

_____

Witness

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Therapist initial_____

Patient Questionnaire

Date of Injury: _____ **Type of injury**: ( ) WC ( ) Auto ( ) other

Area(s) injuried: _____

Please describe **in detail** the accident/injury: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____.
_____

************Below is for therapist to fill out************

Complaint #1:
What is your major complaint (body part): _____?
When did your symptoms begin: ( ) immediately ( ) hrs/days/weeks after
What percent of the time do you experience/ feel this symptom? _____%.
What activities make this symptom worse? _____
What makes this symptom better? _____
Pain scale (circle): Mild Moderate Severe
Has this condition: ( ) Improved ( ) unchanged ( ) Getting Worse
Is this condition interfering with your: ( ) Work ( ) Sleep ( ) Daily Routine ( ) Exercise

Complaint #2:
What is your major complaint (body part): _____?
When did your symptoms begin: ( ) immediately ( ) hrs/days/weeks after
What percent of the time do you experience/ feel this symptom? _____%.
What activities make this symptom worse? _____
What makes this symptom better? _____
Pain scale (circle): Mild Moderate Severe
Has this condition: ( ) Improved ( ) unchanged ( ) Getting Worse
Is this condition interfering with your: ( ) Work ( ) Sleep ( ) Daily Routine ( ) Exercise

Complaint #3:
What is your major complaint (body part): _____?
When did your symptoms begin: ( ) immediately ( ) hrs/days/weeks after
What percent of the time do you experience/ feel this symptom? _____%.
What activities make this symptom worse? _____
What makes this symptom better? _____
Pain scale (circle): Mild Moderate Severe
Has this condition: ( ) Improved ( ) unchanged ( ) Getting Worse
Is this condition interfering with your: ( ) Work ( ) Sleep ( ) Daily Routine ( ) Exercise

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Are you currently Working? ( ) Yes ( ) No **Work Status**: ( ) Full Duty ( ) Modified

If working, are you able to work without pain? ( ) Yes ( ) NO
Have you lost days of work from this injury? ( ) Yes ( ) No

Job Title_____

What are your job requirements: _____?
_____

Elaborate on your limitations: _____
_____

Therapist initial_____

Patient History

Do you have or have you ever had any of the following:

	YES	NO
Severe Headaches	_____	_____
Vision/hearing difficulties	_____	_____
Numbing/tingling	_____	_____
Dizziness/fainting	_____	_____
Weakness	_____	_____
Weight loss/ Energy loss	_____	_____
Allergies	_____	_____
Infectious disease (Not common cold etc)	_____	_____
High/low blood pressure	_____	_____
Diabetes	_____	_____
Arthritis	_____	_____
Degenerative joint disease	_____	_____
Are you pregnant?	_____	_____
Do you smoke?	_____	_____

LIST ANY PRIOR INJURY: _____
_____

Any and All Serious illness: _____

List current Medications: _____

List surgical operations and years: _____

Prior Sports related injuries: _____

Prior motor vehicle crashes: _____

Prior work related injuries: _____

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New Patient Consent to use and Disclose of Health Information

For Treatment, Payment, or Healthcare Operations

I understand that as part of my health care, Colorado Injury Treatment Center originates and maintains paper and/or electronic record describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand I have the right to request a copy and/or I have been offered to take a copy to read over the Notice of Privacy Practice that provides a more complete description of information used and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to request restrictions as to how my health information may be used or disclosed

Restrictions_____

0- Accepted Notice of Privacy Practice 0- Declined Notice of Privacy Practice

Initial _____

I understand that Colorado Injury Treatment Center is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign or revoking this consent Colorado Injury Treatment Center may refuse to treat me as permitted by section 164.506 of the code of Federal Regulations.

I further understand that Colorado Injury Treatment Center reserves the right to change their Notice of Privacy Practice, in accordance with section 164.520 of the code of Federal Regulations. Should Colorado Injury Treatment Center change their notice, they will send a copy of the revised notice to the address I have provided (U.S. Mail).

I understand that as part of Colorado Injury Treatment Center's treatment, payment, or health care operations it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand the terms of this consent_____

Patient's Signature **Date**

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Patient Record of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication or that the communication of PHI is made by alternative means. i**.e. sending correspondence to the individual's office rather than the individuals home. (Please keep in mind that we do courtesy reminder calls for all appointments, so please make sure that we maintain an updated contact number or notify us in the others section if you wish not to be contacted).**

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (**Check all that apply**)

Home/ Cell Phone Number _____

__ Ok to leave detailed message
__ Leave message with call back number ONLY

Work Phone Number _____

__ Ok to leave detailed message
__ Leave message with call back number ONLY

Written Communications

__ Ok to mail to home address
__ Ok to mail to my work address
__ Ok to fax to this number _____

Other: _____
_____

RELEASE OF INFORMATION

Reports will automatically be sent to your insurance company and verbal updates provided to your adjuster/case manage. If you would like the same information sent to your attorney or other treating physician, then please provide us with the complete information (Name, Address, Phone #).

____Attorney_____
_____

____Physicians_____
_____

Supplemental Data

Please list any family members or caregivers you would like to authorize us to communicate with regarding your healthcare, appointments, emergencies, etc.

Name & # _____

Name & #: _____

AUTHORIZATION TO PAY BENEFITS TO COLORADO INJURY TREATMENT CENTERS: I hereby authorize payment directly to Colorado Injury Treatment Center Chiropractic, Physical Therapy, and/or Massage Therapy. If any otherwise payable to me, for their service as described, realizing I am responsible to pay for non-covered services.

_____ _____

Signature (Patient/Parent of Minor) **Date**

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Colorado Injury Treatment Center to release information acquired in the course of my treatment necessary to process insurance claims.

_____ _____

Signature Date

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Colorado Injury Treatment Center- CITC
Cancellation Policy

Therapies prescribed are imperative to your recovery for your injuries. It is of utmost importance that you attend your therapy sessions. This form ensures that you understand that you will be charged $25 for each cancellation or no-show, a cancellation on the same day, as your scheduled appointment is considered a no show.

Please note: If you are 10 minutes late or more you are considered late and will **NOT** be treated for that visit, this will be considered a no show and $25 charge will apply.

All no show and cancellation fees are your responsibility, the patient, not your insurance. The no Show fee will be due at the beginning of your next visit. If you acquire more than 3 no-shows or cancellations you will be discharged. If you are a worker's compensation patient, your employer and adjuster will be notified of your cancel or no-show. If you are Injury Finance patient, Injury Finance, your doctor, and your attorney will be notified. The no- show/ cancellation fee applies to **EACH** provider, (i.e., If you have PT and MT on same day and you no show, it's $25.00 for each provider.)

Patient Signature_____ Date _____

Witness_____ Date _____

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