CONFIDENTIAL PATIENT CASE HISTORY

WELCOME TO OUR OFFICE!
Please complete this questionnaire as thoroughly as possible. This confidential history will be part of your permanent records and will help us get a better understanding of your overall health. THANK YOU!

fluid Chiropractic

PERSONAL INFORMATION

Name:_____ Date:_____

Date of Birth:_____/_____/_____ Age:_____ Sex: ❑ Male ❑ Female Marital Status: S / M / D / W

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

Social Security #:_____-_____-_____ Home Phone:(_____) _____-_____

Cell Phone:(_____)_____-_____ E-mail:_____

Occupation:_____ Employer:_____

Employer Address:_____ Work Phone:(_____)_____-_____

Spouse's Name:_____ Date of Birth:_____ Age:_____

Employer Address:_____ Work Phone:(_____)_____-_____

Social Security #:_____-_____-_____ How Many Children (Ages)?:_____

Emergency Contact:_____ Phone:(_____) _____-_____

Who Referred You To Us?:_____

How Else Did You Hear About Us?:_____

CURRENT MAIN HEALTH CONCERN (List Additional Symptoms on the following pages)

What is your MAIN symptom?:_____

How long have you had this condition?:_____

Have you had this or similar conditions in the past?:_____

What do you think caused this condition?:_____

What position(s), if any, make it feel worse?:_____

What position(s), if any, make it feel better?:_____

Over time, is this condition: ❑ Improving ❑ Unchanged ❑ Getting Worse?

Is this condition interfering with your: ❑ Work ❑ Sleep ❑ Daily Routine Other:_____

Have you sought advice or treatment from other doctors or therapists for ***this*** condition? ❑ Yes ❑ No

If yes, list all doctors or therapists consulted for this condition (include approximate date of visit and diagnosis).

Name	Date of visit	Diagnosis

Describe any treatment you have had for ***this*** condition (include medication dosage and frequency)?:_____

_____

_____

Family Medical Doctor:_____ Address:_____ Date of Last Physical:_____

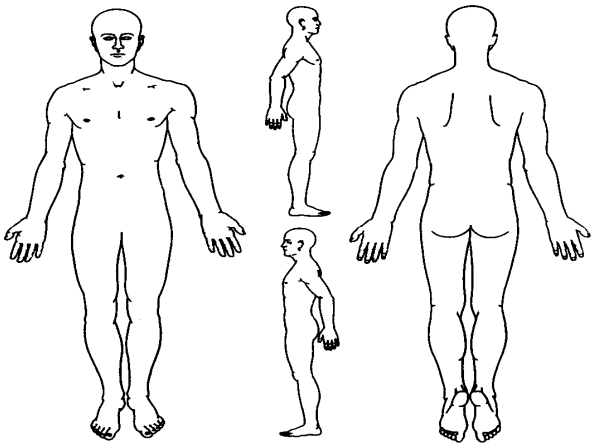
May we communicate our findings on your current health condition to the above provider(s)? ❑ Yes ❑ No

CONFIDENTIAL PATIENT CASE HISTORY

Patient Name:_____ Date:_____

CURRENT MAIN COMPLAINT (continued)

Please list the specific complaints you are experiencing at this time and mark the location on the diagram. Rate its severity on a scale of 1-10 with 1 being the least discomfort you have experienced and 10 being the most discomfort you have ever experienced.



Description of Symptoms (circle all that apply):

sharp stabbing shooting dull achey numb tingling
burning prickly hot cold tight pulling spasm
knotted cramping weak tired

PAIN SCALE: 0 1 2 3 4 5 6 7 8 9 10

PREVIOUS CONDITIONS

Days Lost From Work:_____ Date of Last Physical Exa

Have you sought care for another health condition in the past year? ❑ Yes ❑ No Past 2 years? ❑ Yes ❑ No

If yes, what condition *other than* your main complaint?:_____

- Was treatment administered? ❑ Yes ❑ No Describe: _____
  _____

CURRENT MEDICATIONS? ❑ Yes ❑ No List Dosage, Frequency and Reason:_____
_____

INJECTIONS: Spinal Tap_____ Corticosteriod: _____ (Circle) Flu / Chemo / Stem Cell

HOSPITALIZATIONS OR SURGERY? ❑ Yes ❑ No Please list year next to surgery
Appendectomy:_____ Rectal:_____ Tonsillectomy: _____ Gall Bladder:_____ Female Organs:_____
Hernia:_____ Dental:_____ Other / Additional Notes:_____

ACCIDENTS OR FALLS? ❑ Yes ❑ No Describe:_____
_____

FRACTURES OR DISLOCATIONS? ❑ Yes ❑ No Describe: _____

(Fill out Additional Symptoms on the following pages)

PLEASE FILL OUT THIS PAGE FOR EVERY SYMPTOMATIC AREA:

1. The symptom(s) that have prompted me to seek care today include: _____

_____

Patient name _____

2. And are the result of (darken circle): ○ An accident or injury
○ Work ○ Auto ○ Other _____
○ A worsening long-term problem
○ An interest in: ○ Wellness ○ Other _____

3. Onset (When did you first notice your current symptoms?)

_____

4. Intensity (How extreme are your current symptoms?)

0○-○-○-○-○-○-○-○-○-○10
Absent Uncomfortable Agonizing

5. Duration and Timing (When did it start and how often do you feel it?)

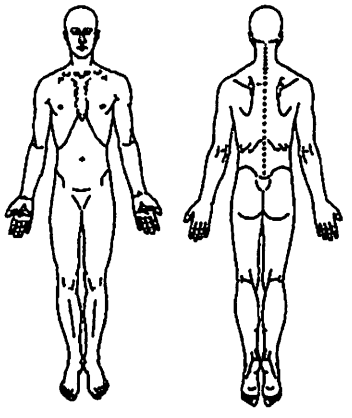
○ Constant ○ Comes and goes. How Often? _____

_____

6. Quality of symptoms (What does it feel like?)

- ○ Numbness
- ○ Tingling
- ○ Stiffness
- ○ Dull
- ○ Aching
- ○ Cramps
- ○ Nagging
- ○ Sharp
- ○ Burning
- ○ Shooting
- ○ Throbbing
- ○ Stabbing
- ○ Other _____

7. Location (Where does it hurt?)
Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)

_____

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem? _____

What tends to lessen the problem? _____

10. Prior interventions (What have you done to relieve the symptoms?)

- ○ Prescription medication ○ Surgery ○ Ice
- ○ Over-the-counter drugs ○ Acupuncture ○ Heat
- ○ Homeopathic remedies ○ Chiropractic Other _____
- ○ Physical therapy ○ Massage _____

11. What else should Dr. DenBleyker know about your current condition? _____

_____

12. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

_____

Doctor's Notes Only:

Consultation Notes

Doctor's Initials _____

Fluid Chiropractic
Dr. Jennifer DenBleyker, D.C.

PLEASE FILL OUT THIS PAGE FOR EVERY SYMPTOMATIC AREA:

1. The symptom(s) that have prompted me to seek care today include: _____

_____

Patient name _____

2. And are the result of (darken circle): ○ An accident or injury
○ Work ○ Auto ○ Other _____
○ A worsening long-term problem
○ An interest in: ○ Wellness ○ Other _____

3. Onset (When did you first notice your current symptoms?)

_____

4. Intensity (How extreme are your current symptoms?)

0○-○-○-○-○-○-○-○-○-○10
Absent Uncomfortable Agonizing

5. Duration and Timing (When did it start and how often do you feel it?)

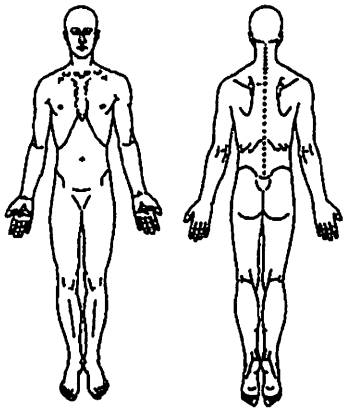
○ Constant ○ Comes and goes. How Often? _____

_____

6. Quality of symptoms (What does it feel like?)

- ○ Numbness
- ○ Tingling
- ○ Stiffness
- ○ Dull
- ○ Aching
- ○ Cramps
- ○ Nagging
- ○ Sharp
- ○ Burning
- ○ Shooting
- ○ Throbbing
- ○ Stabbing
- ○ Other _____

7. Location (Where does it hurt?)
Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)

_____

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem? _____

What tends to lessen the problem? _____

10. Prior interventions (What have you done to relieve the symptoms?)

- ○ Prescription medication ○ Surgery ○ Ice
- ○ Over-the-counter drugs ○ Acupuncture ○ Heat
- ○ Homeopathic remedies ○ Chiropractic Other _____
- ○ Physical therapy ○ Massage _____

11. What else should Dr. DenBleyker know about your current condition? _____

_____

12. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

_____

Doctor's Notes Only:

Consultation Notes

Doctor's Initials _____

Fluid Chiropractic
Dr. Jennifer DenBleyker, D.C.

PLEASE FILL OUT THIS PAGE FOR EVERY SYMPTOMATIC AREA:

1. The symptom(s) that have prompted me to seek care today include: _____

_____

Patient name _____

2. And are the result of (darken circle): ○ An accident or injury
○ Work ○ Auto ○ Other _____
○ A worsening long-term problem
○ An interest in: ○ Wellness ○ Other _____

3. Onset (When did you first notice your current symptoms?)

_____

4. Intensity (How extreme are your current symptoms?)

0○-○-○-○-○-○-○-○-○-○10
Absent Uncomfortable Agonizing

5. Duration and Timing (When did it start and how often do you feel it?)

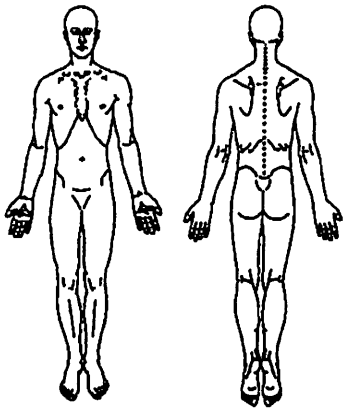
○ Constant ○ Comes and goes. How Often? _____

_____

6. Quality of symptoms (What does it feel like?)

- ○ Numbness
- ○ Tingling
- ○ Stiffness
- ○ Dull
- ○ Aching
- ○ Cramps
- ○ Nagging
- ○ Sharp
- ○ Burning
- ○ Shooting
- ○ Throbbing
- ○ Stabbing
- ○ Other _____

7. Location (Where does it hurt?)
Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)

_____

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem? _____

What tends to lessen the problem? _____

10. Prior interventions (What have you done to relieve the symptoms?)

- ○ Prescription medication ○ Surgery ○ Ice
- ○ Over-the-counter drugs ○ Acupuncture ○ Heat
- ○ Homeopathic remedies ○ Chiropractic Other _____
- ○ Physical therapy ○ Massage _____

11. What else should Dr. DenBleyker know about your current condition? _____

_____

12. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

_____

Doctor's Notes Only:

Consultation Notes

Doctor's Initials _____

Fluid Chiropractic
Dr. Jennifer DenBleyker, D.C.

CHIROPRACTIC HISTORY

Previous Chiropractic care? ❑ Yes ❑ No If yes, Doctor's name:_____

Date of last chiropractic visit: _____/_____/_____ Date of last chiropractic X-rays:_____/_____/_____

Reason for care:_____ How long were you under care?: _____

Were you satisfied with the previous chiropractic care you received? ❑ Yes ❑ No

Are other family members under chiropractic care? ❑ Yes ❑ No Who?: _____

Are you open to looking at new ideas in health and wellness? ❑ Yes ❑ No

HEALTH HABITS and STRESS LEVELS

Height:_____ft. _____in. Current Weight:_____ lbs. Have you recently lost or gained more than 10 lbs.? Y N

Mental Work: ❑ Heavy ❑ Moderate ❑ Light Hours per day:_____

Physical Work: ❑ Heavy ❑ Moderate ❑ Light Hours per day:_____

Exercise: ❑ Heavy ❑ Moderate ❑ Light Hours per week:_____ Type:_____

Smoking: ❑ Never ❑ Currently ❑ Previously Packs/day:_____, Pack/week:_____ How long?:_____

Alcohol: Beer/week:_____, Liquor/week:_____, Wine/week:_____ How long?:_____

Caffeine: Cups/day:_____ How long?:_____ Aspirin: No./day:_____ How long?:_____

Water Intake: _____Cups/day Soft Drinks: _____Cups/Day

Recreational Drugs: ❑ Never ❑ Currently ❑ Previously Type:_____ How Long?_____
Amount per day:_____ per week:_____

Job Pressure / Stress: ❑ Heavy ❑ Moderate ❑ Light _____
Financial Peace: ❑ Yes ❑ No Prayer / Meditation: ❑ Yes ❑ No

ACTIVITIES OF DAILY LIVING (How does this condition currently interfere with our life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting					Grocery Shopping				
Rising out of a Chair					Household Chores				
Standing					Lifting Objects				
Walking					Showering or Bathing				
Lying Down					Dressing Myself				
Bending Over					Reaching Overhead				
Climbing Stairs					Hold a cup				
Using a computer					Finger/Hand Strength				
Getting in and out of a car					Getting to Sleep				
Driving a car					Staying Sleep				
Looking over your shoulder					Love Life				
Stoop					Exercising				
Crouch					Yard Work				
Kneel					Push				
Crawl					Pull				
Balance					Carry				
Concentration					Memory				

CONFIDENTIAL PATIENT CASE HISTORY

Patient Name:_____ Date:_____

REVIEW OF SYSTEMS (NOW=within the past 1 year; PAST=over one year ago)

GENERAL	Now	Past
Weakness	❑	❑
Fatigue	❑	❑
Fever	❑	❑
Chills	❑	❑
Night Sweats	❑	❑
Fainting	❑	❑
SKIN		
Color Changes	❑	❑
Nail Changes	❑	❑
Hair Changes	❑	❑
Moles	❑	❑
Rashes	❑	❑
Sores	❑	❑
Weakness	❑	❑
HEAD & EYES		
Headaches	❑	❑
Injuries	❑	❑
Bumps	❑	❑
Last Eye Exam	❑	❑
Glasses	❑	❑
Contacts	❑	❑
Cataracts	❑	❑
EARS		
Hard of Hearing	❑	❑
Deafness	❑	❑
Ringing	❑	❑
Discharge	❑	❑
Earache	❑	❑
Itching	❑	❑
Dizziness	❑	❑
Room Spins	❑	❑
NOSE		
Decreased Smell	❑	❑
Bleeding	❑	❑
Pain	❑	❑
Discharge	❑	❑
Obstruction	❑	❑
Post Nasal Drip	❑	❑
Deviated Septum	❑	❑
Runny Nose	❑	❑
Sinus Congestion	❑	❑
MOUTH		
Bleeding Gums	❑	❑
Sores	❑	❑
Dental Problems	❑	❑
Bad Breath	❑	❑
Loss of Taste	❑	❑
Dry Mouth	❑	❑
Ulcers	❑	❑
Blisters	❑	❑
THROAT		
Soreness	❑	❑
Bad Tonsils	❑	❑
Hoarseness	❑	❑
Pain	❑	❑
Trouble Swallowing	❑	❑
Recurrent Infections	❑	❑
NECK		
Neck Enlargement	❑	❑
Stiff Neck	❑	❑
Soreness	❑	❑
Lumps	❑	❑

BREASTS	Now	Past
Discharge	❑	❑
Lumps	❑	❑
Pain	❑	❑
Bleeding	❑	❑
Nipple Changes	❑	❑
Skin Changes	❑	❑
Bloated	❑	❑
RESPIRATORY		
Cough	❑	❑
Phlegm	❑	❑
Blood	❑	❑
Short of Breath	❑	❑
Wheezing	❑	❑
Pain	❑	❑
Congestion	❑	❑
Inhalant exposure	❑	❑
CARDIOVASCULAR		
Murmur	❑	❑
Palpitations	❑	❑
Rapid Heartbeat	❑	❑
Swollen Extremities	❑	❑
Cold Extremities	❑	❑
Chest Pain,Pressure	❑	❑
Varicose Veins	❑	❑
Blood Clots	❑	❑
Blue Extremities	❑	❑
BLOOD		
Anemia	❑	❑
Low Blood Iron	❑	❑
Easy Bruising	❑	❑
Easy Bleeding	❑	❑
Swollen Nodes	❑	❑
Painful Nodes	❑	❑
Sugar in Blood	❑	❑
Red Spots	❑	❑
GASTROINTESTINAL		
Abdominal Pain	❑	❑
Nausea	❑	❑
Bloated	❑	❑
Belching	❑	❑
Heartburn	❑	❑
Indigestion	❑	❑
Irreg. Bowel Habits	❑	❑
Constipation	❑	❑
Diarrhea	❑	❑
Gas	❑	❑
Hemorrhoids	❑	❑
Poor Appetite	❑	❑
Food Intolerance	❑	❑
Bloody Stools	❑	❑
Black Stools	❑	❑
GENITOURINARY		
Urgency	❑	❑
Incontinence	❑	❑
Straining	❑	❑
Back Pain	❑	❑
Frequent Voiding	❑	❑
Stones	❑	❑
Burning	❑	❑
Bed Wetting	❑	❑
Small Stream	❑	❑
Discharge	❑	❑
Impotence	❑	❑

GENITOURINARY	Now	Past
Dribbling	❑	❑
Cloudy Urine	❑	❑
Spotting	❑	❑
Menstrual Cramps	❑	❑
Painful Menses	❑	❑
Itching	❑	❑
Painful Intercourse	❑	❑
Irregular Periods	❑	❑
Hot Flashes	❑	❑
NEUROLOGICAL		
Seizures	❑	❑
Vertigo	❑	❑
Dizziness	❑	❑
Hand Trembling	❑	❑
Loss of Sensation	❑	❑
Incoordination	❑	❑
Loss of Facial	❑	❑
Weak Grip	❑	❑
Paralysis	❑	❑
Difficulty Speech	❑	❑
Tingling	❑	❑
Loss of Memory	❑	❑
Numbness	❑	❑
ENDOCRINE		
Weight Loss	❑	❑
Weight Gain	❑	❑
Extremely Thin	❑	❑
Heat Intolerance	❑	❑
Cold Intolerance	❑	❑
Hair Changes	❑	❑
Breast Changes	❑	❑
IMMUNIZATION/VACCINATION		
DPT	❑	❑
Mumps	❑	❑
Smallpox	❑	❑
Typhoid	❑	❑
Tetanus	❑	❑
Measles	❑	❑
Pneumococcal	❑	❑
Influenza	❑	❑
Polio	❑	❑
MMR	❑	❑
Flu	❑	❑
PSYCHIATRIC		
Hyperventilation	❑	❑
Insecurity	❑	❑
Depression	❑	❑
Trouble Sleeping	❑	❑
Irritable	❑	❑
Hallucinations	❑	❑
Loss of Memory	❑	❑
Alcoholism	❑	❑
Drug Addiction	❑	❑
Drug Dependent	❑	❑
Suicidal Thoughts	❑	❑
Extreme Worry	❑	❑
Sexual Problems	❑	❑
MUSCULOSKELETAL		
Muscle Pain	❑	❑
Muscle Weakness	❑	❑
Muscle Cramps	❑	❑
Muscle Stiffness	❑	❑
Joint Stiffness	❑	❑
Joint Pain	❑	❑

PAST MEDICAL HISTORY

Check only the ones **you** have had in the **past**.

Hay Fever	❑
Mumps	❑
Rheumatic Fever	❑
Allergies	❑
Angina	❑
Cancer	❑
Tumor	❑
Blood Disease	❑
Leukemia	❑
Heart Trouble	❑
Varicose Veins	❑
Phlebitis	❑
Hypertension	❑
Stroke	❑
Ulcers	❑
Jaundice	❑
Skin Trouble	❑
Gallstones	❑
Liver Trouble	❑
Hepatitis	❑
Parasites	❑
Epilepsy	❑
Paralysis	❑
Polio	❑
Mental Illness	❑
Alcoholism	❑
Depression	❑
Nervous Breakdown	❑
Migraine	❑
Gout	❑
Hemorrhoids	❑
Prostate Problems	❑
Sexual Problems	❑
Gonorrhea	❑
Syphilis	❑
Diabetes	❑
Bladder Trouble	❑
Kidney Stones	❑
Kidney Infections	❑
Dysentery	❑

ALLERGIES

List known allergies below

_____
_____
_____
_____
_____
_____
_____

If Female,
Are You Pregnant?

❑ **Yes**
❑ **No**

CONFIDENTIAL PATIENT CASE HISTORY

Patient Name:_____ Date:_____

FAMILY HISTORY - List any of the diseases listed previously which run in your family

Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses (if any)
Father:	_____	_____	_____	_____	_____
Mother:	_____	_____	_____	_____	_____
Brother(s):	_____	_____	_____	_____	_____
Sister(s):	_____	_____	_____	_____	_____
Grandfather (Mat):	_____	_____	_____	_____	_____
Grandmother (Mat):	_____	_____	_____	_____	_____
Grandfather (Pat):	_____	_____	_____	_____	_____
Grandmother (Pat):	_____	_____	_____	_____	_____

Spouses Health Status: ❑ Poor ❑ Fair ❑ Good ❑ Excellent

Children's ages and health status:_____

_____

FINANCIAL POLICY:

Fluid Chiropractic offers multiple payment options. ChiroHealth USA (CHUSA) Medical Discount Rates are the preferred method for maximum discounts. We look forward to going over all your options in person when we know your treatment needs. Please see the attached CHUSA brochure and fee structure.

AGREEMENTS and AUTHORIZATION

Patient Name:_____ Date:_____

Consent To Health Care Services/Release of Health Care Information

You, (the undersigned Patient, or undersigned person responsible for consenting on Patient's behalf), hereby request and consent to Patient health care services from this office. The Patient health care services will be provided by and overseen by licensed, treating physicians. Health care services will also be provided by non-physician health care professionals and assistants employed or otherwise retained by this office. Medical, nursing, and other health care personnel who are in training may also participate in the Patient's care as part of their education.

_____ initial

Payment Guarantee

In consideration of the services provided by this office, Provider to Patient, you agree to; I) guarantee payment of all charges incurred by Patient in connection with such services ("Patient Charges"); II) irrevocably assign and transfer to this office, all right, title and interest to medical reimbursement benefits to which Patient is entitled for the purpose of payment of Patient Charges; and III) authorize payment of such benefits directly to this office. You also agree to be fully responsible for the payment of any and all Patient Charges to the extent that these charges are not satisfied by the assigned benefits.

_____ initial

Patient Right To Restrict Disclosure of Protected Health Information (PHI)

For any service in which you pay for 100% out-of-pocket, you have a right to restrict the disclosure of that healthcare information for that particular service to any health insurance entity. This is according to your HIPAA privacy rights established under the American Recovery and Reinvestment Act (ARRA) of 2009. For services that are non-covered under your insurance plan and that you pay for in-full out-of-pocket, you understand and request that this office does not bill for any of these non-covered services or items on my behalf and that you wish to restrict the disclosure of PHI of these services from your insurance company.

_____ initial

Responsibility For Personal Property

You accept sole responsibility for all Patient property, except for property expressly accepted by this office for safekeeping under its sole care and custody.

SIGNATURE of Patient, Parent or Guardian: _____

PRINTED Name of Patient, Parent or Guardian: _____

Date: _____ Relationship to Patient: _____

Witness Signature: _____ Date: _____

(A scanned copy of this document shall serve as the original.)

AUTHORIZATION and HIPAA PRIVACY NOTICE

Patient Name:_____ Date:_____

Consent To Release Information

Here at this office, we do not sell or release your information to third parties. There will be cases along the course of your care where information will need to be released in certain circumstances. You authorize this office to release to employer groups, government agencies (Medicare, Medicaid, Champus, State or Federal government, etc.), insurance companies, or other third-party payers and their agents, and its collection representatives and attorneys, the following "Patient Information": medical history, diagnosis and procedures performed, course of treatment , plan of care, prognosis, supplies and/or such other information that may be requested for the purpose of determining eligibility and availability of Patient's benefits, obtaining authorization/payment for Patient's health care services, or billing and collection of amounts due to this office for services rendered. In the case of Patient Information released for purposes of payment of Patient Charges, this authorization shall be valid only for the period of time necessary to process payment claims. You agree to pay any Patient Charges that are denied or are ineligible for medical reimbursement benefits as a result of your refusal or revocation of consent to disclose Patient Information.

You further authorize any individual health care professional, including treating physician(s), to provide this office or its designee with Patient Information for quality assurance and, or risk management purposes. Finally, in the event that the Patient's employer, or an insurance company representing such employer, requests Patient Information relating to healthcare services provided for worker's compensation injuries, it is understood and agreed that this office is required, under state law, to release copies of such information to such employer or insurance company without the authorization of Patient or Patient's representative. Again, here at this office, we strive to provide you with the best care possible and in order to do that this consent is necessary.

_____ initial

HIPAA Privacy Notice Patient Acknowledgment

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

I hereby state that by signing this Consent I acknowledge and agree as follows:

1) The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request and that a copy of it is always available at the Front Desk.
2) The Practice's Privacy Notice brochure is in reception and has been available to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations.
3) The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law and Federal Law.
4) The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
5) The Practice's "Notice of Privacy Practices" is also provided in the reception area display table and on the Practice's web site. I may also request a copy from this office at any time via US Mail.

This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.

_____ initial

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

PRINTED Name of Patient, Parent or Guardian: _____

SIGNATURE of Patient, Parent or Guardian: _____

Date: _____ Relationship to Patient: _____

Witness Signature: _____ Date: _____

(A scanned copy of this document shall serve as the original.)

CONSENT TO EXAMINATION AND TREATMENT

I hereby request and consent to the necessary recommend examination the performance of chiropractic manipulation and manual therapy techniques and other chiropractic procedures, including various modes of physical therapeutic modalities and procedures and diagnostic X-rays, where warranted, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below.

I have had an opportunity to discuss with the doctor of chiropractic named below the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment and diagnostic services including but not limited to:

Manipulation: increased pain or discomfort, fractures, spinal or disc injuries, strokes, dislocations, strains, sprains, increased and/or unchanged symptoms or pain, and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

Therapeutic Modalities and procedures: additional pain, skin discoloration and discomfort. Endurance exercise may cause increased risk of acute Myocardial Infarction (heart attack) in patients with known or possible cardiac conditions.

Radiographs: ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. The doctor named below has additionally explained the risks associated with my refusal of treatment. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT Print Name:_____ **Patient Signature:**_____ **Date Signed:** _____

FEMALE PATIENTS: By my initials here _____ on this form, I do hereby state that to the best of my knowledge, I AM NOT PREGNANT, nor is pregnancy suspected or confirmed at this particular time and. I consent to X-rays if the doctor deems them necessary for the evaluation of my condition. First Day of Last Menstrual Period: ____/____/_____. Patient Signature:_____ Date Signed:_____

If Patient is a Minor: Print Name of Patient's Representative: _____
Relationship to Patient: _____
Signature of Patient's Representative: _____ Date Signed: _____

DOCTOR OR STAFF:

Witness of Patient's Signature: _____ Date Signed: _____

(A scanned copy of this document shall serve as the original.)

Dr. Jennifer DenBleyker
1720 S. Bellaire St. #906
Denver, CO 80222 (720) 383.7536 FrontDesk@FluidChiro.com

Pt Name _____ DOB_____ Date _____

FLUIDCHIROPRACTIC

Fluid Chiropractic: Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature:_____ Date:

Witness Name: _____ Signature:_____ Date:

FLUID CHIROPRACTIC PAYMENT AUTHORIZATION FORM

If you would like to enjoy the convenience of automatic billing, simply complete the Credit Card Information section below and sign the form. All requested information is required. Upon approval, we will automatically bill your credit card at the end of every Chiropractic Visit for the amount of services and products provided that session. An invoice will be emailed to you with the service and product details and the total charges. Your total charges will appear on your credit card statement.

You may cancel this authorization at any time by contacting us in writing. All payments will still be required in full on the date of your visit and this will take time out of your appointment for billing if you choose to cancel automatic payments.

Credit card authorizations will be kept in Chase Paymentech Merchant services encrypted system.

CUSTOMER BILLING INFORMATION:

Customer Name: (No Company Cards. This must be a personal card.) _____

Billing Address: _____

Email Address (legible): _____@_____ .com .net .org

Phone: _____

PAYMENT INFORMATION :

I authorize **FLUID CHIROPRACTIC** to automatically bill the card listed below as specified:

Product/Service description: **CHIROPRACTIC SERVICES, LAB TESTS, SUPPLEMENTS, ORTHOTICS, SHIPPING FEES AND ANY OTHER SERVICES/PRODUCTS FLUID CHIROPRACTIC OFFERS.**

The amount will depend on the services rendered and products purchased that day. Frequency of billing will be at the end of every day or within one week usually. Emails will be sent out showing invoice details and total credit card charges. If the security code & address don't match the card there is a 4% processing fee added.

CREDIT CARD INFORMATION (to be completed by customer legibly):

Card type: _____MasterCard _____Visa

3 Digit Security Code: _____

Cardholder Name: _____ **Cardholder ZIP Code:** _____

Card Number: _____ **Expires:** _____/_____

You will be notified via email when your credit card is charged. (Make sure email address above is correct.) X _____ _____

Customer signature **Date**

Fluid Chiropractic
FINANCIAL REPORT OF FINDINGS

ChiroHealthUSA
The Network That Works for Chiropractic!

Patient Name _____ **Date:** _____

fluid
Chiropractic

Fluid Chiropractic's Medical Discount Plan allows us to give you our discounted fees, instead of our Actual Fees. To access our medical discount fees you must become a member of ChiroHealth USA on your first visit. As a member of our Medical Discount Plan you will receive special discount pricing. This is not insurance and cannot be submitted to insurance.

We welcome you to our practice!

Patient Responsibility	Visits	Actual Fee	Actual Fee Total	CHUSA	CHUSA TOTAL
Initial Consultation	1	291.00	291.00	125.00	125.00
2nd Visit/Report of Findings	1	272.00	272.00	125.00	125.00
	SUBTOTAL	$	563.00		$ 250.00

Estimated Total for Treatment	
With CHUSA	**$ 250.00**
Without CHUSA / Actual Fees	**$ 563.00**

Total SAVINGS with ChiroHealthUSA (Minus $49 Membership) **$264.00**

I would like to enroll in CHUSA network for the Medical Discount Plan Rates. I understand the annual CHUSA membership fee is $49 basic/ $89 Plus and not included in Fluid Chiropractic fee. I understand that these are discount rates for self-pay patients and the receipts will be financial receipts only. The receipts can not be submitted to insurance. I agree to pay the CHUSA discount rate of $250 for the first and second visit, as well as the $49/$89 CHUSA membership fee.

Signature: _____ Date Signed:_____

I agree to pay the Actual Fees and I will receive insurance receipts upon request. I understand Fluid Chiropractic does not accept insurance and I will need to submit these receipts myself. I agree to pay for all services at the time of service and I will be re-imbursed by my insurance according to my insurance contract. I understand that often all of the services rendered are not covered and there is no guarantee of reimbursement. The contract with insurance is entirely between myself and the insurance company. I understand and acknowledge the above. Signature:_____Date Signed: _____

ChiroHealthUSA
The Network That Works for Chiropractic!

ChiroHealthUSA Plus

DISCOUNT MEDICAL PLAN APPLICATION

THIS FORM SHOULD NOT BE GIVEN TO PATIENTS UNLESS THEY ARE JOINING CHIROHEALTHUSA OR CHIROHEALTH PLUS
You must read important disclosures and sign the reverse side

Date:

Patient Name:

Primary Card Holder Gender: ◯ Male ◯ Female

Primary Card Holder Date of Birth:

Dependents' Names:
(Spouse, Domestic Partner, Dependent Children up to age 26, Parents in the Household over age 60, and any other IRS Dependent)

Patient Address:

City:

State: **Zip:**

Phone:

Email:
(Contact information will not be shared, sold or distributed)

FOR CLINIC USE ONLY

City:

Date entered in Online Membership Link:

By:

ChiroHealthUSA
120 Stone Creek Blvd., Suite 100, Flowood, MS 39232
1-888-719-9990

◯ *CHUSA PROCESSED*

PAYMENT INFORMATION

◯ **YES! I want ChiroHealthUSA PLUS for $89.00 for a ONE YEAR membership to include Chiropractic, Vision, Dental, Pharmacy, Lab and Imaging Discounts! NOTE: Not available in Alaska, California, Vermont and Washington.**

◯ **YES! I want ChiroHealthUSA for discounted Chiropractic Care Only for $49.00 for a ONE YEAR membership.**

You may renew your agreement by continuing annual payments as applicable for your plan. The brochure for your program contains a description of the benefits you will receive and is incorporated by reference and is a part of this document. PLEASE READ YOUR BROCHURE BEFORE SIGNING THIS DOCUMENT.

HSA and FSA accounts for payment of membership fees is not permissible.

Check and Credit card information will be destroyed once transaction is completed.

Check #:

Credit Card Type: ◯ Visa ◯ MC ◯ Amex ◯ Disc. **Card#:**

Card ID (CVV2/CID) Number: **Exp. Date:** **Billing Zip Code:**

Name on Card: **Signature:**

DISCLOSURES

These discount medical, health, and drug plans are NOT insurance, health insurance policies, Medicare Prescription Drug Plans or qualified health plans under the Affordable Care Act. These plans (The Plans) provide discounts for certain medical services, pharmaceutical supplies, prescription drugs or medical equipment and supplies offered by providers who have agreed to participate in The Plans (ChiroHealthUSA provides discounts only on chiropractic services). The range of discounts for medical, pharmacy or ancillary services offered under The Plans will vary depending on the type of provider and products or services. The Plans do not make and are prohibited from making members' payments to providers for products or services received under The Plans. The member is required and obligated to pay for all discounted prescription drugs, medical and pharmaceutical supplies, services and equipment received under The Plans, but will receive a discount on certain identified medical, pharmaceutical supplies, prescription drugs, medical equipment and supplies from providers in The Plans (ChiroHealthUSA provides discounts only on chiropractic services). Members will have free access to providers without restrictions such as waiting periods, notification periods, etc. except for hospital discounts. The Plans do not offer discounts on hospital services. The Discount Medical Plan Organization is Alliance HealthCard of Florida, Inc., P.O. Box 630858, Irving, TX 75063. ChiroHealthUSA members may call 1-888-719-9990 for more information or visit www.chirohealthusa.com for a list of providers. ChiroHealthUSA Plus members may call 1-800-220-7752 for more information or visit www.chirohealthusaplus.com for a list of providers. The Plans will make available before purchase and upon request, a list of program providers and the provider's city, state and specialty, located in the member's service area. Alliance HealthCard of Florida, Inc. does not guarantee the quality of the services or products offered by individual providers. The fees for The Plans are specified in the membership agreement. You have the right to cancel your membership at anytime. If you cancel your membership within 30 days of the effective date, you will receive a full refund of your membership fees other than money paid by you to a provider. To cancel your ChiroHealthUSA Plan you must, verbally or in writing, notify ChiroHealthUSA at 1-888-719-9990, 120 Stone Creek Blvd., Suite 100, Flowood, MS 39232. To cancel your ChiroHealthUSAPlus Plan you must, verbally or in writing, notify Alliance HealthCard of Florida, Inc. at 1-800-220-7752, P.O. Box 630858, Irving, TX 75063. Any complaints should be directed to Alliance HealthCard of Florida, Inc. at the address or phone number above. Upon receipt of the complaint, member will receive confirmation of receipt within 5 business days. After investigation of the complaint, Alliance HealthCard of Florida, Inc. will provide member with the results and a proposed resolution no later than 30 days after receipt of the complaint.

Note to DE, IL, LA, NE, NH, OH, RI, SD, TX and WV consumers: If you remain dissatisfied after completing the complaint system, you may contact your state department of insurance . You may contact Alliance HealthCard of Florida, Inc. for department of insurance contact information.

Note to MA consumers: The plan is not insurance coverage and does not meet the minimum creditable coverage requirements under M.G.L. c. 111M and 956 CMR 5.00

Signature:

ChiroHealthUSA
120 Stone Creek Blvd., Suite 100, Flowood, MS 39232
1-888-719-9990

SPACE INTENTIONALLY LEFT BLANK

Welcome to

ChiroHealthUSA

The Network That Works for Chiropractic!

If you are considering joining ChiroHealthUSA, you are among a growing number of people who are finding themselves uninsured, under-insured, or with limitations in their health plan.

Some state and federal regulations prohibit doctors from reducing fees or giving away services. Doctors are usually required to charge insurance companies and patients the same fees unless they are under a network contract for a lower fee. ChiroHealthUSA is a contracted network that allows doctors to set and accept discounts on their services for our members. When you join the ChiroHealthUSA Program, you are entitled to similiar "in-network" discounts just like the insurance companies. Your doctor is a member of this growing network of healthcare professionals who are dedicated to helping you get the care you need at a fee you can afford.

How does it work? Simple!

Your provider has entered into a contract with ChiroHealthUSA to accept discounted fees or charges from their "usual customary and reasonable" (UCR) charges. By joining the ChiroHealthUSA Program, you immediately become a member of ChiroHealthUSA and are eligible to enjoy these discounted fees. Your membership is just $49.00 a year and it includes you and your dependents.

Upon completion of the application, your provider will collect the enrollment fee and submit it to us for processing. You will receive a membershi

fluid
Chiropractic
FluidChiro.com
(720) 383.7536
MyChiroTown.com FC0059
DxWellness.org Provider#: DHW128-170
fluidchiro@ehealthpro.com: FLUID20
DFH Select @ Amazon: DFH18523

ChiroHealthUSA
The Network That Works for Chiropractic!

Questions? Give us a call or visit us online!

1-888-719-9990
www.chirohealthusa.com

Helping Doctors. Helping Patients.

Patient's guide to

ChiroHealthUSA

The Network That Works for Chiropractic!

PABR042015

Disclosures

This discount medical plan is NOT insurance, a health insurance policy, a Medicare prescription drug plan or a qualified health plan under the Affordable Care Act. This plan (The Plan) provides discounts only on chiropractic services offered by providers who have agreed to participate in The Plan. The range of discounts for the chiropractic services offered under The Plan will vary depending on the type of provider and products or services. The Plan does not make and is prohibited from making members' payments to providers for products or services received under The Plan. The member is required and obligated to pay for all discounted chiropractic services and equipment received under The Plan, but will receive a discount on certain identified chiropractic services from providers in The Plan. The Discount Medical Plan Organization is Alliance HealthCard of Florida, Inc., P. O. Box 630858, Irving, TX 75063. You may call 1-888-719-9990 for more information or visit www.chirohealthusa.com for a list of providers. The Plan will make available before purchase and upon request, a list of program providers and the providers' city, state and specialty, located in the member's service area. The fees for The Plan are specified in the membership agreement. The Plan includes a 30-day cancellation provision.

Note to MA consumers: The plan is not insurance coverage and does not meet the minimum creditable coverage requirements under M.G.L. c. 111M and 956 CMR 5.00.

Frequently asked questions.

Can I use ChiroHealthUSA with my insurance?

Yes, if permitted by your health plan, and only for non-covered services or when benefits are exhausted. Fees you pay for non-covered services do not typically apply to any deductible or any out of pocket maximums you may be subject to under your health plan. Refer to your insurance plan or administrator for more information.

Are there times when my ChiroHealth USA card reduces my out of pocket expenses?

Yes, but that will depend on your insurance policy.

- Your payment using your ChiroHealthUSA discount card may be lower than your insurance policy copayment.
- Payment using your ChiroHealthUSA discount card may be lower until you have met your insurance policy's yearly deductible. Payment using your ChiroHealthUSA discount card will not apply to your deductible.

Refer to your insurance plan or administrator for more information.

If I decide to change chiropractors, can I use ChiroHealthUSA in their clinic?

Your ChiroHealthUSA membership will be honored by any ChiroHealthUSA participating provider. Fees and discounts offered may vary.

Does ChiroHealthUSA membership include my family?

Yes. Your membership includes you and your dependents.

How will I know I have received the discounts allowable as a ChiroHealthUSA member?

Most providers bill their normal fees and show a "contractual discount" on their receipts or bills. Others may have the ChiroHealthUSA fee schedule and/or discounts posted in their clinic. Fees and discounts are explained at the time of enrollment. We maintain copies of our contracted providers' fees for verification of discounts upon member request.