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Lovett Family Chiropractic
12201 E Arapahoe Rd, #B-10
Centennial, CO 80112

## ABOUT THE PATIENT

Name _____ Preferred Name _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Primary Phone _____ (cell / home / work) Alternate Phone _____ (cell / home / work) Gender ❑ M ❑ F

e-Mail Address _____ Preferred Method of Contact ❑ Email ❑ Text ❑ Phone (cell / home / work)

Referred By _____ Have you been to a chiropractor before? ❑ No ❑ Yes

Significant Other's Name _____ Kid's Names and Ages _____

Your Employer _____ Type of Work _____

Emergency Contact _____ Relationship _____ Phone Number _____

Will you be working with Insurance ❑ No (self pay) ❑ Yes Is today's visit the result of an accident? ❑ No ❑ Auto ❑ Work

Primary _____ ID #_____ Secondary _____ ID #_____

Name of Primary Care Physician _____

- I authorize Lovett Family Chiropractic to request records from other providers as may be necessary.
- Person responsible for this account if other than the patient?_____
- I understand that after any initial promotional services all care is rendered at usual and customary fees.

_____ _____

Patient / Parent Signature (This represents a long term authorization for all occasions of service) Date

## REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

2. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

3. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

4. _____ How long has this been an issue? _____

Is it: ❑ Dull ❑ Sharp ❑ Ache ❑ Numb / Tingle ❑ Stabbing ❑ Constant ❑ Occasional ❑ Staying the same ❑ Getting worse ❑ Mild ❑ Moderate ❑ Severe ❑ Worse in the morning ❑ Worse in evening ❑ Pain radiates to_____

5. Does your condition affect: ❑ Sleep ❑ Work ❑ Daily Routine ❑ Sitting ❑ Driving

6. What makes it better?_____

7. What makes it worse? _____

8. What Doctor's have you seen for this?_____

_____

9. Type of treatment:_____

10. Results: _____

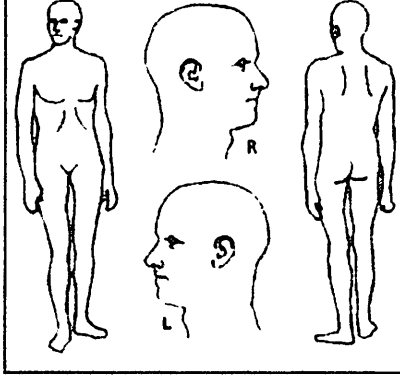
NOTES: _____

_____

_____

Are you pregnant?
❑ Yes ❑ No

Please mark all areas of concern.



# GENERAL HEALTH HISTORY

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Patient Name_____ *Mark the conditions that apply to you.*

| Past | Present | | Past | Present | |
|---|---|---|---|---|---|
| ❑ | ❑ | Headaches | ❑ | ❑ | Urinary Problems |
| ❑ | ❑ | Migraines | ❑ | ❑ | Easy Bruising |
| ❑ | ❑ | Shortness of Breath | ❑ | ❑ | Tobacco Use |
| ❑ | ❑ | Allergies / Asthma | ❑ | ❑ | Dental Problems |
| ❑ | ❑ | Medication Side Effects | ❑ | ❑ | Fibromyalgia |
| ❑ | ❑ | Diabetes | ❑ | ❑ | Blood Thinner use |
| ❑ | ❑ | Hands or Feet cold | ❑ | ❑ | HIV Positive |
| ❑ | ❑ | Muscle aches | ❑ | ❑ | Cancer |
| ❑ | ❑ | Trouble Walking | ❑ | ❑ | Depression |
| ❑ | ❑ | Leg / Foot Numbness | ❑ | ❑ | Alcohol Use |
| ❑ | ❑ | Fainting | ❑ | ❑ | ___High or ___Low Blood Pressure |
| ❑ | ❑ | Gall Bladder Trouble | ❑ | ❑ | Stroke History |
| ❑ | ❑ | Ringing in Ears | ❑ | ❑ | High Cholesterol |
| ❑ | ❑ | Ear Problems | ❑ | ❑ | TMJ |
| ❑ | ❑ | Sleeping Problems | ❑ | ❑ | Digestive Problems |
| ❑ | ❑ | Vision Problems | ❑ | ❑ | Pain all Over |
| ❑ | ❑ | Thyroid Problems | ❑ | ❑ | Tension / Irritability |
| ❑ | ❑ | Liver Disease | ❑ | ❑ | Chest Pains |
| ❑ | ❑ | Kidney Problems | ❑ | ❑ | Heart Pacemaker |
| ❑ | ❑ | Light Bothers Eyes | ❑ | ❑ | Heart Problems |
| ❑ | ❑ | Other | | | |

1. List any medications you are taking:_____

2. Please list all doctors you are currently seeing: _____

3. Has any Doctor or other professional advised you to "Go to a Chiropractor": ❑ No ❑ Yes, Name_____

# PAST HISTORY

4. List any past auto collisions:_____ Was any care received?_____
5. List any past work injuries: _____ Was any care received?_____
6. List any past sport, recreational, or home injuries_____
7. Please describe any past conditions and treatment received: _____
8. Please list any past hospitalizations and surgeries: _____

# FAMILY HISTORY

Father's side: ❑ Heart Disease ❑ Cancer ❑ Diabetes ❑ Heavy Medication use ❑ Arthritis ❑ Other_____

Mother's side: ❑ Heart Disease ❑ Cancer ❑ Diabetes ❑ Heavy Medication use ❑ Arthritis ❑ Other_____

Is there any other family history you want us to know?_____

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## COLLISION INFORMATION

Name: _____ Today's Date: _____
Where did the collision occur: Street: _____ City: _____ State: _____
Date when collision occurred: _____ AM or PM. Was the road: ❑ Dry ❑ Wet ❑ Snowy ❑ Icy
Where you the: ❑ Driver ❑ Front middle passenger ❑ Front right passenger ❑ Back left ❑ Back middle ❑ Back right
Describe what happened: _____

## CRASH DETAILS

❑ Yes ❑ No If driving, were both hands on the wheel at impact?
❑ Yes ❑ No If passenger, did your hands brace yourself?
❑ Yes ❑ No Did you have your seat belt and shoulder strap on?
❑ Yes ❑ No Was your seat up at the time of impact?
❑ Yes ❑ No Where you wearing a bulky coat or slippery pants?
❑ Yes ❑ No Did the seat belt engage?
❑ Yes ❑ No Did the airbag engage?
❑ Yes ❑ No Did you hit the dash, steering wheel or window?
❑ Yes ❑ No Did you know you were going to be hit?
❑ Yes ❑ No Did you brace yourself with hands or feet?
❑ Yes ❑ No If driving, was your foot on the brake at impact?
❑ Yes ❑ No Was your head turned at impact?
❑ Yes ❑ No Were you leaning forward?
❑ Yes ❑ No Did your glasses fly-off at impact?
❑ Yes ❑ No Was your body turned at the moment of impact?
❑ Yes ❑ No Did you get hit into another car, tree, railing, etc?
❑ Yes ❑ No Any damage or marks on your vehicle, the vehicle that hit you, or another object that was hit?
What part of the vehicle was hit? _____

1. What make and model of vehicle were you in? _____ The other vehicle? _____
2. What kind of seat were you in? __ Bucket __ Bench __ Fabric __ Leather/Vinyl
3. Did the car have headrests? ❑ Yes ❑ No
4. Did you hit your head on the headrest? ❑ Yes ❑ No On the back window if in a small truck? ❑ Yes ❑ No
5. Was the headrest positioned: __ below __ level with __ above the center of your head
6. Did your head hurt after the collision? ❑ Yes ❑ No Did your TMJ/jaw hurt after the collision? ❑ Yes ❑ No
7. How soon after the collision did you notice any pain? _____
8. Did the crash affect: ❑ dizziness ❑ memory ❑ concentration ❑ headaches ❑ balance ❑ nightmares ❑ breathing ❑ fatigue ❑ irritability ❑ ability to read ❑ ability to listen ❑ appetite ❑ nausea ❑ vision
9. Is there anything else you want us to know? _____

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## PROVIDERS SEEN

List **all** providers seen since injury occurred:

1. Clinic/Doctor/Hospital Name_____ City_____
2. Clinic/Doctor/Hospital Name_____ City_____
3. Clinic/Doctor/Hospital Name_____ City_____
4. Clinic/Doctor/Hospital Name_____ City_____
5. Clinic/Doctor/Hospital Name_____ City_____

❑ Yes ❑ No Do you have pictures of your vehicle? Where is it being repaired?_____

❑ Yes ❑ No Do you have a copy of the police report?

Name of your Attorney if you have one:_____

Name of Your Car Insurance Co._____ Claim #:_____

Your Health Ins. Co. _____

Name of the Other Divers Car Insurance if Applicable_____ Claim #:_____

## Functional Rating Index

**Patient Name:** _____ **D.O.B.:** _____

For each item below please circle the number which best describes your condition right now.

**1. Pain Intensity**

| | | | | |
|---|---|---|---|---|
| 0- No pain | 1- Mild Pain | 2-Moderate Pain | 3- Severe Pain | 4- Worst Possible Pain |

**2. Sleeping**

| | | | | |
|---|---|---|---|---|
| 0- Perfect Sleep | 1-Mildly Disturbed | 2- Moderately Disturbed | 3- Greatly Disturbed | 4- Totally Disturbed |

**3. Personal Care (washing, dressing, etc.)**

| | | | | |
|---|---|---|---|---|
| 0- No pain No Restrictions | 1- Mild Pain No Restrictions | 2-Moderate Pain Go Slowly | 3- Moderate Pain Some Assistance | 4- Severe Pain 100% Assistance |

**4. Traveling (flying, driving, etc.)**

| | | | | |
|---|---|---|---|---|
| 0- No pain on Long Trips | 1- Mild Pain on Long Trips | 2- Moderate Pain on Long Trips on | 3- Moderate Pain Short Trips | 4- Severe Pain on Short Trips |

**5. Work (job, chores, etc.)**

| | | | | |
|---|---|---|---|---|
| 0- Usual Work + Extra Work | 1- Usual Work No Extra | 2- 50% of Usual Work Only | 3- 25% of Usual Work | 4- Cannot Work at all |

**6. Recreation (exercising, playing, T.V., etc.)**

| | | | | |
|---|---|---|---|---|
| 0- Can do All Activities | 1- Can do Most Activities | 2- Can do Some Activities | 3- Can do Few Activities | 4- Cannot do Any Activities |

**7. Frequency of Pain**

| | | | | |
|---|---|---|---|---|
| 0- No Pain | 1- Occasional (25%) | 2- Intermittent (50%) | 3- Frequent (75%) | 4- Constant (100%) |

**8. Lifting**

| | | | | |
|---|---|---|---|---|
| 0- No Pain with Heavy Weight | 1- Increased Pain with Heavy Weight | 2- Increased Pain with Moderate Weight | 3- Increased Pain with Light Weight | 4- Increased Pain with Any Weight |

**9. Walking**

| | | | | |
|---|---|---|---|---|
| 0- No Pain with Any Distance | 1- Increased Pain after 1 Mile | 2- Increased Pain After ½ of a Mile | 3- Increased Pain After ¼ of a Mile | 4- Increased Pain After Any Distance |

**10. Standing**

| | | | | |
|---|---|---|---|---|
| 0- No Pain with Any Time | 1- Increased Pain After Several Hours | 2- Increased Pain After 1 Hour | 3- Increased Pain After Half an Hour | 4- Increased Pain After Any Time |

Patient Signature: _____ Date: _____ Total

_____ ( /4 x 10) = Functional Rating Score _____ %

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# INFORMED CONSENT FOR CHIROPRACTIC SERVICES

**I have been informed of the following:**

That the process of delivering a "Chiropractic Adjustment (manipulation)" may be performed manually or with an instrument to the vertebra(e) of the spine and/or associated structures (legs, arms etc.), often resulting in an audible pop or click sound; As an addition to the Chiropractic Adjustment "Supportive Therapies" may be applied by the chiropractor or by staff under their direction or supervision incorporating the use of light, sound, vibration, electricity, traction, motion, bracing, nutritional advice, heat, or cold;

I have been informed on occasion some temporary soreness and/or stiffness may occur; less frequently aggravation of presenting symptoms or initiation of new symptoms; rarely bruising, swelling, even more rare separation/fracture; and extremely rare, nerve or vascular injury may occur in conjunction with the process of a Chiropractic Adjustment. The listed possible consequences and possible complications have been explained to me by the chiropractor;

I acknowledge that the chiropractor has made no guarantee of a positive outcome from treatment; I have been afforded ample opportunity for questions and answers; and the condition, possible benefits, risks of the treatment procedures, options, and financial obligations have been explained to me by the chiropractor.

**Therefore, by signing below:**

I consent to the performance of the diagnostic and therapeutic procedures performed by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

I consent to the performance of other diagnostic and therapeutic procedures in the future that may be deemed reasonable and necessary by the doctor and or staff under the direction and supervision of the office chiropractor(s) involved in my case;

Patient Signature: _____ Date: _____

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**Guardian Consent to Treat a Minor:**

I hereby authorize Dr. Patrick Lovett and whomever he may designate as assistants to administer examinations and chiropractic care as deemed necessary to:

_____ _____
Minor's Printed Name Printed Name of Parent or Guardian

_____ _____
Signature of Parent or Guardian Date

# PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.
I acknowledge that I have been offered a copy of the *Notice of Privacy Practices for Protected Health Information.*

_____ _____ _____
Patient Signature Signature of Parent or Guardian Date

_____ _____ _____
Personal Representative Printed Personal Rep. Signature Relationship to Patient

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# AUTHORIZATIONS

Before this office begins any health care operations we require you to read and sign this form stating that you understand the below item. If you refuse to sign this form the doctor reserves the right to refuse care.

- ❑ AUTHORIZATION: By signing below you authorized this office/provider to complete a consultation and examination on the above.
- ❑ AUTHORIZATION FOR X-RAY WITH RELEASE: By signing below you have declared, to the best of your knowledge, that there is no chance you are pregnant at this time. By signing below you have declared that you have no known limitations that would be contraindicated for an x-ray evaluation. By signing below you consent to the taking of x-rays if there is a determined need.
- ❑ ACKNOWLEDGMENT OF ASSIGNMENT OF BENEFITS: By signing below you have acknowledged that you are fully responsible for all services rendered. By signing below you furthered acknowledge understanding that your health and accident insurance information policies are an arraignment between you and your carrier, and that you may be required to pay some or all of the fees charged to your account. By signing below you hereby assign benefits to paid directly to this office/provider by your third-party payer, e.g. insurance company, attorneys, etc. By signing below you agree that this is a non-rescindable agreement and failure to fulfill this obligation will be considered a breach of contract between you and this office.
- ❑ CMS-1500 HEALTH INSURANCE CLAIM FORM: By signing below you acknowledge and agree that the CMS-1500 Health Insurance Claim Form Box 12 and Box 13 will state "Signature on File". Box 12 Reads as follows: "PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below." Box 13 Reads as follows: "INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below."
- ❑ ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: We are very concerned with protecting your personnel health information. There may be times our office may need to contact you regarding office matters. By signing below you have authorized this office to contact you for office related matters in the following manner: phone-work-home or mobile, e-mail and regular mail. Messages may be left on an answering device/voicemail, or with the person answering your phone (home-work-mobile). Also in accordance with the Health Insurance Portability and Accountability act of 1996 (HIPAA), updated September 23, 2013, this office is obliges to supply you with a copy of the office privacy policies and procedures upon request. This document outlines the use and limitations of the disclosure of your personal health information and your rights as a patient. By signing below you have acknowledged that you have been offered a copy of this document.
- ❑ ACKNOWLEDGEMENT OF TREATMENT PLAN: By signing below I acknowledge that, if accepted for care, I may be presented with a chiropractic treatment plan resulting in one or more of the following services: chiropractic adjustments, examinations, and supportive therapies and procedures.
- ❑ PHOTO/NAME RELEASE: I grant to Lovett Family Chiropractic, its representatives and employees the right to use photographs of me. I authorize Lovett Family Chiropractic, its assigns and transferees to copyright, use and publish the same in print and/or electronically. I agree that Lovett Family Chiropractic may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content.
- ❑ ACKNOWLEDGEMENT: By signing below you have acknowledge that you understand and agree with the policies and procedures outlined in this TERMS of ACCEPTANCE form. By signing below you acknowledge and certify that all the information given to the office/provider in the INTAKE forms are a true and accurate to the best of you knowledge.

| | |
|---|---|
| Printed Patient Name | Date |
| Patient Signature | Guardian Signature |

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Centennial, CO 80112

## Assignment of Benefits: Assignment of Cause of Action: Contractual Lien

The undersigned patient and / or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered assigns to Lovett Family Chiropractic, the following rights, power and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjuster for purposes of processing my claim for benefits and payment of services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owned by an insurance company in accordance with the Colorado Unfair Claims Practice Act, Revised Statute Section 10-3-1104 to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me / us for treatment rendered by the physician facility named above, you are hereby tendered demand to pay in full the bill for services rendered by the physician / facility named above within 30 days following your receipt of such bill for services to the extent such bills are payable under the terms of the policy. This demand specifically conforms to the Colorado Unfair Claims Practice Act, Revised Statute Section 10-3-1104, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. I further instruct the provider to make all checks payable to **Lovett Family Chiropractic**, and to send all checks to 12201 E. Arapahoe Rd, #B-10, Centennial, CO 80112.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the Liability carrier to cut a separate draft to pay in full all services rendered, payable to **Lovett Family Chiropractic**, and to send all checks to 12201 E. Arapahoe Rd, #B-10, Centennial, CO 80112.
STATUTE OF LIMITATIONS: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician / facility named above, in addition to reasonable cost of collection, including attorney fees and court cost incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician / facility named above the power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and healthcare rendered by the physician / facility named above. I agree that any insurance payment representing an amount in excess of the charges for

treatment rendered will be credited to my / our account or forwarded to my / our address upon request in writing to the physician / facility named above.

PATIENT RESPONSIBILITY: I understand and agree that I am 100% directly and fully responsible to said Medical Provider for all medical services rendered and bills issued pursuant to this Contractual Lien:
(a) Even if any insurance company denies payment in whole or part for such medical services;
(b) Even if patient is forced to file a lawsuit due to denial of payments by an insurance claims adjuster; and
(c) Even if a judge or jury renders a verdict in my lawsuit that the insurance company for said person or entity is not responsible for payment for Patient's medical bills.

REJECTION IN WRITING: I hereby authorize the physician / clinic named above to establish a MedPay or UM/UIM claim on my behalf. I also instruct my insurance carrier to provide upon request to the provider / clinic named above, any rejections in writing as they apply to my lack of MedPay or UM/UIM coverage. If my carrier is unable to provide said rejections in a timely manner, I acknowledge that I am entitled to minimum levels of coverage, as per section 10-4-635 of the Colorado Revised Statute, and further instruct my carrier to pay up to available limits directly to physician / clinic named above, and to send any and all checks or financial instruments to 12201 E. Arapahoe Rd, #B-10, Centennial, CO 80112.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, he / she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from any other doctor; I will notify this physician / facility immediately. I understand that failure to do so may jeopardize my case.

Signature of patient and / or responsible parties:

_____ _____

Patient Signature Date

_____ _____

Medical Provider Signature Date

_____ _____

Attorney Signature Date

# NOTICE OF DOCTOR'S LIEN

Doctor: ***Patrick Lovett, DC, CCCN***
**Lovett Family Chiropractic**
**12201 E Arapahoe Rd Ste B10**
**Centennial, CO 80112**

TO: Attorney _____
Address_____

RE: Medical Reports and Doctor's Lien

**Client Name:** _____ DOB: _____ DOI: _____

I do hereby authorize the above doctor to furnish you, my attorney, with a full report of his/her examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him/her for medical service rendered me by reason of this accident and by reason of any other bills that are due his/her office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical and/or surgical benefits, including major medical, submitted by him/her for service rendered me and that this Agreement is made solely for said doctor's additional protection and in consideration of his/her awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

Dated: _____ Patient's Signature: _____

Witness: _____

ACKNOWLEDGEMENT OF ATTORNEY

The undersigned being attorney or record for the above patient does hereby agree to observe all terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor above-named.

Dated: _____ Attorney's Signature: _____