Dr. Jeanette Reed, D.C.
Colorado Healing Hands

NEW PATIENT PAPERWORK

Be sure to complete every line throughout the paperwork.

Name: ____ **Nickname:** ___________________________

Birth Date: _________________ **Age:** _____ **Gender:** ☐ M ☐ F **Address:**

____ **City:** _____________________________ **State:**

_______ **ZIP:** __________________ **Email:** ____ **Phone**

Number: ________________________ ☐ Mobile ☐ Home ☐ Work ☐ Other ___________________

Phone Number: ________________________ ☐ Mobile ☐ Home ☐ Work ☐ Other ___________________

Permanent Address: ____

Communication Preference: ☐ Mobile Phone ☐ Home Phone ☐ Work Phone ☐ Email ☐ Mail (Post)

Please circle how we may contact you (mark all that apply):

Leave message with detailed information	☐ Cell ☐ Home ☐ Work ☐ None
Leave call-back number only	☐ Cell ☐ Home ☐ Work ☐ Non
Text message ***(required for reminders)***	
Send electronic mail (email)	☐ Yes ☐ No
Social Media Platforms/Website	☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other **Number of Children:** _____

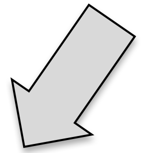
Employment Status: ☐ Employed ☐ Unemployed ☐ Student ☐ Retired ☐ Military ☐ Other

How did you hear about us? ☐ Insurance ☐ Sign ☐ Website ☐ Online ☐ Doctor __________________

☐ Family/Friend _____________________ ☐ Other ____________________

Emergency Contact Name: ________________________________ **Phone:** _______________________

Employer: ____ **Phone:** _______________________



Does your work environment require: ☐ Lifting ☐ Sitting ☐ Standing ☐ Computer/Deskwork
Do you exercise? ☐ No ☐ Yes ☐ Avoid due to pain

Are you pregnant? ☐ No ☐ Yes *Due Date* ________
Height/Weight: _____/_____
I am here for:

☐ Acute Pain ☐ Maintenance Care
☐ Chronic Pain ☐ Rehabilitation
☐ Well Care ☐ Other _______________

My pain interferes with the following:

☐ Sleeping ☐ Bending
☐ Sitting ☐ Lying Down
☐ Standing ☐ Working
☐ Walking ☐ Other _______________

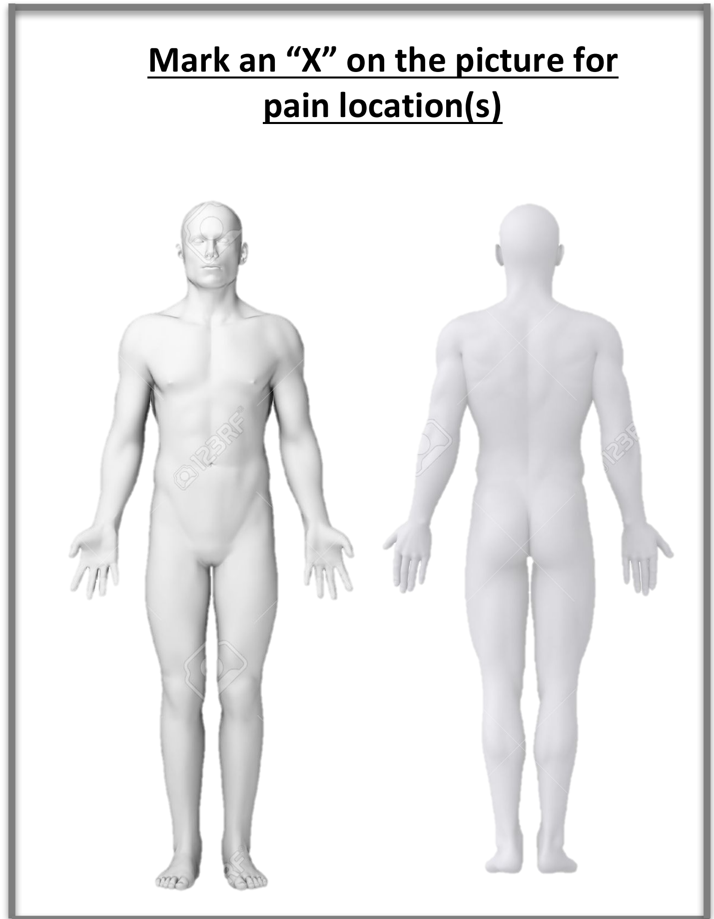
What is your type of pain?

☐ Sharp ☐ Throbbing
☐ Dull ☐ Cramping
☐ Aching ☐ Shooting
☐ Burning ☐ Numbness
☐ Tingling ☐ Stiffness
☐ N/A ☐ Other _______________

Is your pain constant, or does it come-and-go?

☐ Constant ☐ Come-and-go

When did your symptoms begin? ____/____/_____
____



Rate your pain level from 1 (least pain) to 10 (worst pain): 1—2—3—4—5—6—7—8—9—10

List anything that makes your condition **feel *better***. ____

List anything that makes your condition **feel *worse*.** ____

Please share **additional information** you think would help the doctor better diagnose and/or treat you.
____
____
____

Doctor's Notes:

Diagnosis:

Treatment Plan:

GENERAL SYMPTOMS

	Current	Past		Current	Past		Current	Past
Shoulder Pain (R/L)	☐	☐	Neck Pain	☐	☐	Numbness	☐	☐
Upper Arm Pain (R/L)	☐	☐	Upper Back Pain	☐	☐	Muscle Soreness	☐	☐
Hand/Wrist Pain (R/L)	☐	☐	Mid-Back Pain	☐	☐	Loss of Bladder Control	☐	☐
Upper Leg/Hip Pain (R/L)	☐	☐	Low Back Pain	☐	☐	Tinnitus (Ear Noise)	☐	☐
Knee Pain (R/L)	☐	☐	Chest Pain	☐	☐	Fainting/Dizziness	☐	☐
Stiff Joints	☐	☐	Abdominal Pain	☐	☐	Convulsions	☐	☐
Lower Leg Pain (R/L)	☐	☐	Headache	☐	☐	Rapid Heart Rate	☐	☐
Foot Pain (R/L)	☐	☐	Migraines	☐	☐	Visual Disturbances	☐	☐

☐ Medications (*Please list*): ____

☐ Chiropractic (*Doctor & When*): ____

☐ Physical Therapy (*Provider & When*): ____

☐ Surgery (*Type & When*): ____

☐ Other: ____

HEALTH HISTORY/INFORMATION

	Self	Parent	Sibling		Self	Parent	Sibling		Self	Parent	Sibling
AIDS/HIV	☐	☐	☐	Epilepsy	☐	☐	☐	Parkinson’s	☐	☐	☐
Anemia	☐	☐	☐	Fainting Spells	☐	☐	☐	Pinched Nerve	☐	☐	☐
Anxiety/Stress	☐	☐	☐	Fractures	☐	☐	☐	Prosthesis	☐	☐	☐
Arthritis	☐	☐	☐	Gout	☐	☐	☐	Psychiatric Care	☐	☐	☐
♿Blood Pressure	☐	☐	☐	Heart Disease	☐	☐	☐	Sciatica	☐	☐	☐
△Blood Pressure	☐	☐	☐	Herniated Disc	☐	☐	☐	Scoliosis	☐	☐	☐
Bursitis	☐	☐	☐	Herpes	☐	☐	☐	Skin Rash	☐	☐	☐
Cancer	☐	☐	☐	Multiple Sclerosis	☐	☐	☐	Stroke	☐	☐	☐
Circulation Issues	☐	☐	☐	Neuralgia	☐	☐	☐	Tumors/Growths	☐	☐	☐
Diabetes	☐	☐	☐	Osteoporosis	☐	☐	☐	Weight Issues	☐	☐	☐

Please list any additional information below:

____

____

____

Smoking Status: ☐ Never Smoker ☐ Current Every Day Smoker ☐ Former Smoker *(Date you quit)* ___________

I understand this information and guarantee I completed this form to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Patient Name (print) ____ Date ______________

Patient Signature ____ Date ______________

☐ Adult Patient ☐ Parent or Guardian

CONSENT TO RECEIVE CHIROPRACTIC CARE

I consent to the performance of examination, diagnosis, adjustments, and/or other chiropractic procedures on me (or the patient named above for whom I am legally responsible) by Jeanette Reed, D.C., and/or other professionals working at or associated with his office.

I understand and am informed that, in the practice of chiropractic there is the unlikely possibility of adverse events from examination and treatment including, but not limited to, soreness, fractures, disc injuries, strokes, dislocations, sprains, increased symptoms & pain or no improvement of symptoms/pain.

I agree that if I suspect any adverse effects I will inform Dr. Reed and will not take any legal action against her or her staff. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest.

I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatments. I intend this consent form to cover the entire course of treatment of my present condition and for any future condition(s) for which I seek treatment.

I understand that I may refuse treatment at any time and that
I am responsible for my healthcare choices.

By signing below, I understand the terms above and agree to the Consent to Receive Chiropractic Care.

Patient Name (print) ____ Date ______________

Patient Signature ____ Date ______________

☐ Adult Patient ☐ Parent or Guardian

ASSIGNMENT OF INSURANCE PAYMENTS

I instruct and direct my insurance company, or their intermediaries, to pay for services rendered to the order of Jeanette Reed, D.C., 1901 Kipling, Suite 140, Lakewood, CO 80215, for the professional medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment towards the total charges for services provided.

This is a direct assignment of my insurance benefits. This payment will not exceed indebtedness to Dr. Reed. I agree to cooperate with the office of Dr. Reed to pursue any third party that is responsible for any balance of said professional service charges. A photocopy of this Assignment shall be considered as effective and valid as the original document.

I understand there is no guarantee that my insurance companies or pre-paid health plan will cover or pay for all of my charges. Notwithstanding denial, reduction of benefits or failure to pay for any reason,
I understand that I am responsible for all remaining charges.

By signing below, I understand the terms above and agree to the Assignment of Insurance Payments.

Patient Name (print) ____ Date ______________

Patient Signature ____ Date ______________

☐ Adult Patient ☐ Parent or Guardian

PAYMENT & BILLING OPTIONS

Please note that filing insurance is a courtesy we extend to all new personal injury or workman's compensation patients; however, it is your responsibility to know the coverage and benefits of your policy.

Please read the following information carefully. Feel free to ask questions if necessary.

1. Payment may be made by cash, check, debit, or credit card (VISA, MasterCard, American Express or Discover).
2. As a benefit to you, we will accept assignment from your insurance company(s). This means we will bill your insurance company(s) charges incurred at our office and apply their payment(s) to your balance. After your insurance has responded, **any remaining amount is your responsibility**.
3. If you would like us to bill your insurance, we ***must*** have a copy of your insurance card. Without your insurance card, you will be required to pay the applicable charges. You will be reimbursed when you bring your insurance card to our office unless your benefits indicate a payment is necessary. You agree to pay any balance owed.
4. We allow 30-days for the payment after the 1st statement has been sent to you. If at any time you feel there is a discrepancy or we have made an error in posting, please bring it to our attention immediately so we can remedy the potential problem.
5. **Any co-pays or co-insurance must be paid at the time of your visit.**
6. If the patient/insurance portion is undefined at the time of service, **you will be responsible for a minimum of $45/appointment** (deductibles may also apply).
7. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the office manager. If your account is not paid within 90-days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges, and any other expenses incurred on collecting your account.
8. If after several attempts to collect payment or establish a payment plan agreement and your account becomes delinquent, and it is necessary for you to be sent to collections, you will be responsible for full payment in addition to the expenses associated with collections.
9. It is your responsibility to inform us of any changes in your contact, insurance, and/or account information.

You will be responsible for charges your insurance does not cover, such as, but not limited to your deductible, co-payment, co-insurance, uncovered services, and/or any service beyond your benefit allowance. Your insurance policy is an agreement between you and your insurance company, and a quote of benefits is not a guarantee or payment.

- **If you have financial difficulties,** please contact us to schedule a payment plan.
- **Past due accounts will be charged a late fee (18%).**
- **Bring us insurance checks/payments** you directly receive to see if they need to be applied to your account.

We encourage you to contact your insurance company to verify your deductible, co-pay, and chiropractic benefits.

Call the number on the back of your card; follow the prompts. Ask the rep. to verify your coverage for chiropractic care. An Insurance Verification Form is available upon request to assist you when calling to verify your benefits.

By signing below, I understand the terms above and agree to the Payment & Billing Options.

Patient Name (print) ____ Date _____________

Patient Signature ____ Date _____________

☐ Adult Patient ☐ Parent or Guardian

PRIVACY NOTICE

This notice describes how Colorado Healing Hands may use or disclose your protected health information (PHI). PHI is individual identifiable health information, including actual medical information, your name, address, phone number, identification number, insurance information or other identifiers.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandates that patients be provided with advance written notice of the practice's policies regarding the use/and or disclosure of protected health information. This notice took effect April 14, 2003.

A patient's information may be used and/or disclosed for the following reasons:

- **Treatment –** We may use PHI to provide you with medical treatment or services. This includes communications between other healthcare professionals, and other healthcare facilities, and other providers for administering treatment.
- **Payment –** We may use and/or disclose your PHI so the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party. This includes typical payment activities, such as verification of coverage, pre-certifications, referrals, and claims processing.
- **Administrative or Healthcare Operation Activities –** We may use and/or disclose medical information about you for certain administrative, healthcare and management activities, such as compliance monitoring, quality improvement, and business planning. These uses and/or disclosures are necessary to run the practice and to ensure that our patients receive quality care and services.
- **For Communicable Diseases/Public Health Safety –** We may disclose your PHI, if authorized by law, if the public may have been exposed to a communicable disease.
- **For Legal Proceedings –** We may disclose PHI in response to a court order.

The patient reserves the right to request restrictions on the policies listed in this notice, and receive a copy of all information used and/or disclosed. Requests for the patient's own PHI will be provided only with a photo proof of identification from the patient. The patient has the right to designate a personal representative to authorize the disclosure of protected health information.

Colorado Healing Hands **reserves the right to contact patients regarding appointments and accounts.**

If you believe your PHI privacy rights have been violated, please contact us in writing.

I acknowledge I was offered a hard copy of the Notice of Privacy Practices document.

I understand and accept this Privacy Notice.

Patient Name (print) ____ Date _______________

Patient Signature ____ Date _______________

☐ Adult Patient ☐ Parent or Guardian

RECORDS RELEASE AUTHORIZATION

At times it is necessary to request records such as examination results, x-rays, MRI reports, progress notes, etc. from other healthcare providers. We also send reports to your primary care physician and specialists upon request to keep them informed of your current condition(s) and response to care. Also, your insurance company, attorney, or other third party may request your records to assist in processing your insurance claims.

By signing below, I understand the above terms and allow the release of my medical records for the purpose of communication between Dr. Thalman, my other healthcare providers, attorneys/representatives, insurance company(s), and/or other third party.

Name: ____ **Date of Birth:** __________________

I, ____, hereby authorize the release of ANY medical records to:

Colorado Healing Hands
1901 Kipling, Suite 140
Lakewood CO 80215
(303) 862-2181
doctorjetreed@gmail.com

I understand and accept to the release of my records.

Patient Name (print) ____ Date _______________

Patient Signature ____ Date _______________

☐ Adult Patient ☐ Parent or Guardian

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**You may Refuse to Sign This Acknowledgement **

I have received/been offered a copy of this office's Notice of Privacy Practices.

_______________________________________ _______________________________________ _____________

Print Patient's Name/Parent or Legal Guardian if Patient is a Minor | **Patient Signature/Parent or Legal Guardian if Patient is a Minor** | **Date**

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ○ Individual refused to sign
- ○ Communications barriers prohibited obtaining the acknowledgement
- ○ An emergency situation prevented us from obtaining acknowledgement
- ○ Other (Please Specify):

____ ________________________

Signature of Staff Member Completing This Section **Date**