Auto Injury Management
@ Complete Care Health Services
3600 S Wadsworth Blvd Lakewood, CO 80235
Office: (303) 985-0646 Fax: (303) 985-3834
www.abetterbackclinic.com

AUTO COLLISION / PERSONAL INJURY INTAKE FORM

*(**Fill-in, Circle**, or Mark a ✓on each that applies, **N/A** if does not applicable, **Blank** if don't know)*

Today's Date: ____________

Your Full Name: ____

Gender: ☐M ☐F **Marital Status**: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Birth Date: _____/_____/_____ Age: _________

Height _________ **Weight** _____________ **Handed:** RT: ___ LT: ____

Address: ____

City: _______________________________________ **State**: __________ **Zip**: __________

Social Security No.: _________-________-_________ **Driver's License No**.:___________________

Home Phone: (____) _______________________ **Cellular Phone**: (_____)__________________

E-Mail: _______________________________ **Work Phone:** (_____) ___________________

Occupation: ____

Employer: ____

Employer Address: ____

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YOUR AUTO'S INSURANCE INFORMATION:

Insured's Name (name the policy is under): ______________________/_________________________
(Last) (First)

Relationship to patient (if policy is not under your name): _______________

Insurance Company Name:____

Auto Agents' Name: ___________________________________

Agent's phone Number: ________________________________

Do you have Med-Pay coverage? ☐Yes ☐No **Amount of Coverage**? : _____________

Do you have under-insured / un-insured coverage? ☐Yes ☐No

Have you been issued a Claim# for this accident? ☐Yes ☐No

Claim#: __________________________________

Were you at fault for this accident? ☐ Yes ☐ No

Other Party's AUTO INSURANCE INFORMATION (IF APPLICABLE)

Other party's Name: ______________________________

Insurance Company name of other person: ______________________________

Insurance Company Address: ______________________________

City: ______________________________ State: __________ Zip: ___________

Claim Number: ______________________________

Have you retained an attorney? ☐ Yes ☐ No
Your Attorney's Name: ______________________________

Your Attorney's Phone#: (_____) ____________________ Fax (_____) ____________________

Your Attorney's Address: ______________________________

City: ______________________________ State: _________ Zip: ___________

COLLISION INFORMATION:

Date of Collision: ________/________/________ **Time of Collision**: ____________ a.m. / p.m.

The Weather Conditions were they: ☐ Sunny ☐ Raining ☐ Snowing ☐ Foggy

The Road was: ☐ Dry ☐ Wet ☐ Icy **Light of Day:** ☐ Dawn ☐ Day ☐Dusk ☐ Night

Your Vehicle: Year _____________ Make ____________________ Model____________________

Your Estimated speed: ______________________

Collision Type: ☐Rear ended ☐Head-on ☐Broad-sided ☐ Side swiped

Did your car Spin / got Spun? ☐ Yes ☐ No

Did your car get pushed from the point of impact? ☐ Yes ☐ No (IF Yes, how far Feet__________)

After being hit did you hit something else? ☐ Yes ☐ No (IF Yes, What______________________)

Car was ☐ **Drivable OR** ☐ **Towed away** **Damage to Your Vehicle**: $ _________________

Have you had your car repaired yet? ☐ Yes ☐ No

(if applicable)

Other Vehicle: Year _____________ Make ____________________ Model____________________

Other Vehicle Damage: ☐ Mild ☐ Moderate ☐ Severe ☐ Drivable OR ☐ Towed away

Other vehicle's occupant(s) injured: ☐ Yes ☐ No ☐ Unsure ☐ Taken by Ambulance

Unusual circumstances: (please note)

(i.e.: was anyone drunk, under the influence, emotionally unstable, speeding, out of control etc.)

____

Did you take Pictures? : ☐ Yes ☐ No

(If so, of what) ☐ My car ☐ Other car(s) ☐ Accident scene ☐ Injured body part(s)

COLLISION SPECIFICS:

Were you the: ☐ Driver ☐ Passenger

If passenger, where **were you** sitting: ☐ Front Seat OR ☐ Back Seat
☐ Right Side OR ☐ Left Side

Were you wearing your seatbelt: ☐ Yes ☐ No

Did the airbag deploy: ☐ Yes ☐No

Impending Collision, were you: ☐ Aware OR ☐ Unaware
☐ Braced OR ☐ Not brace

Right hand: ☐ Steering wheel ☐ Center console ☐ In Lap ☐ Door ledge ☐ Other: ___________

Left hand: ☐ Steering wheel ☐ Center console ☐ In Lap ☐ Door ledge ☐ Other: ___________

Right foot: ☐ Gas ☐ Brake ☐ Floor board ☐ Fire wall ☐ Other : _______________

Left Foot: ☐ Gas ☐ Brake ☐ Floor board ☐ Fire wall ☐ Other : _______________

Head position: ☐ Straight ahead ☐ turned left ☐ turned right ☐ bent down ☐ bent back

Torso position: ☐ Straight ahead ☐ turned left ☐ turned right ☐ bent down ☐ bent back

Head rest position: ☐ lowest positon ☐ middle position ☐ highest position

Seatback position: ☐ straight up-right ☐ slight recline ☐ full recline

Did you feel your body being jarred / jerked? ☐ Yes ☐ No

Did you feel your seat belt restrain you / engage? ☐ Yes ☐ No

Any bruising from the seat belt? ☐ Yes ☐ No (If yes, where on your body; ____________________)

Did any part of your body strike anything inside of your car: ☐ Yes ☐ No

If Yes what body part / what area of the car? ______________________ / _________________________

Were any inside parts of your vehicle displaced or broken: YES ☐ NO ☐
If yes list:

____

Were any personal items displaced or broken: YES ☐ NO ☐
If yes list:

____

Were you able to get out of the car? YES ☐ NO ☐ (if YES Circle) On your own OR Assisted

Did you experience: ☐Shock ☐Loss of Consciousness ☐Whiplash ☐ Dizziness ☐Other ______

Describe Collision: ____

____

____

____

____

____

____

Draw a picture / Diagram of collision:

IMMEDIATE LAW ENFORCEMENT FOLLOWING THE COLLISION: *(Mark a ✓on each that applies)*

☐ Police were called
☐ No police, we just exchanged information
☐ I was ticketed for the accident
☐ A Police report was done at the scene
☐ I have copy of the police report
☐ Police showed to the scene
☐ Hit & Run, no information to exchange
☐ Other party was ticketed
☐ I filed a police report on my own

Police Department: ______________________ Officer's name: ____________________________

Witnesses:

Was anyone else in the car with you: ☐ Yes ☐ No (If yes Who?):_______________________________

Did any other person witness the accident? ☐ Yes ☐ No: (if Yes who?):

____

IMMEDIATE MEDICAL HELP FOLLOWING THE COLLISION: *(Mark a ✓on each that applies)*

☐ Ambulance / Paramedics were called

☐ I was treated at the scene

☐ I was transported to Hospital by Ambulance

☐ Even though offered transport I opted not to: Why?_______________________________________

____

☐ I went to the Hospital (circle) on my own / via friend / via family. When?_____________________

☐ (circle) X-rays /Cat scan/ MRI were done at Hospital: What body area:

____

____

☐ Medication was prescribed by the Hospital: What; ____

____

☐ Follow-up care was recommended: What: ____

Name of Ambulance: ____

Name of Hospital; ____

****

FOR THIS CAR COLLISION AND BEFORE COMING TO THIS OFFICE, OTHER DOCTORS SEEN:

☐ Orthopedist ☐ Neurologist ☐ Psychiatrist ☐Physiatrist ☐ Chiropractor
☐ Acupuncturist ☐ General Practitioner ☐ Physical Therapist ☐ Massage Therapist
☐ Xray / MRI ☐Other: ____

If so give:
Clinic name Practitioner's Name Phone number Approximate Date(s) seen __

____

____

____

____

____

____

____

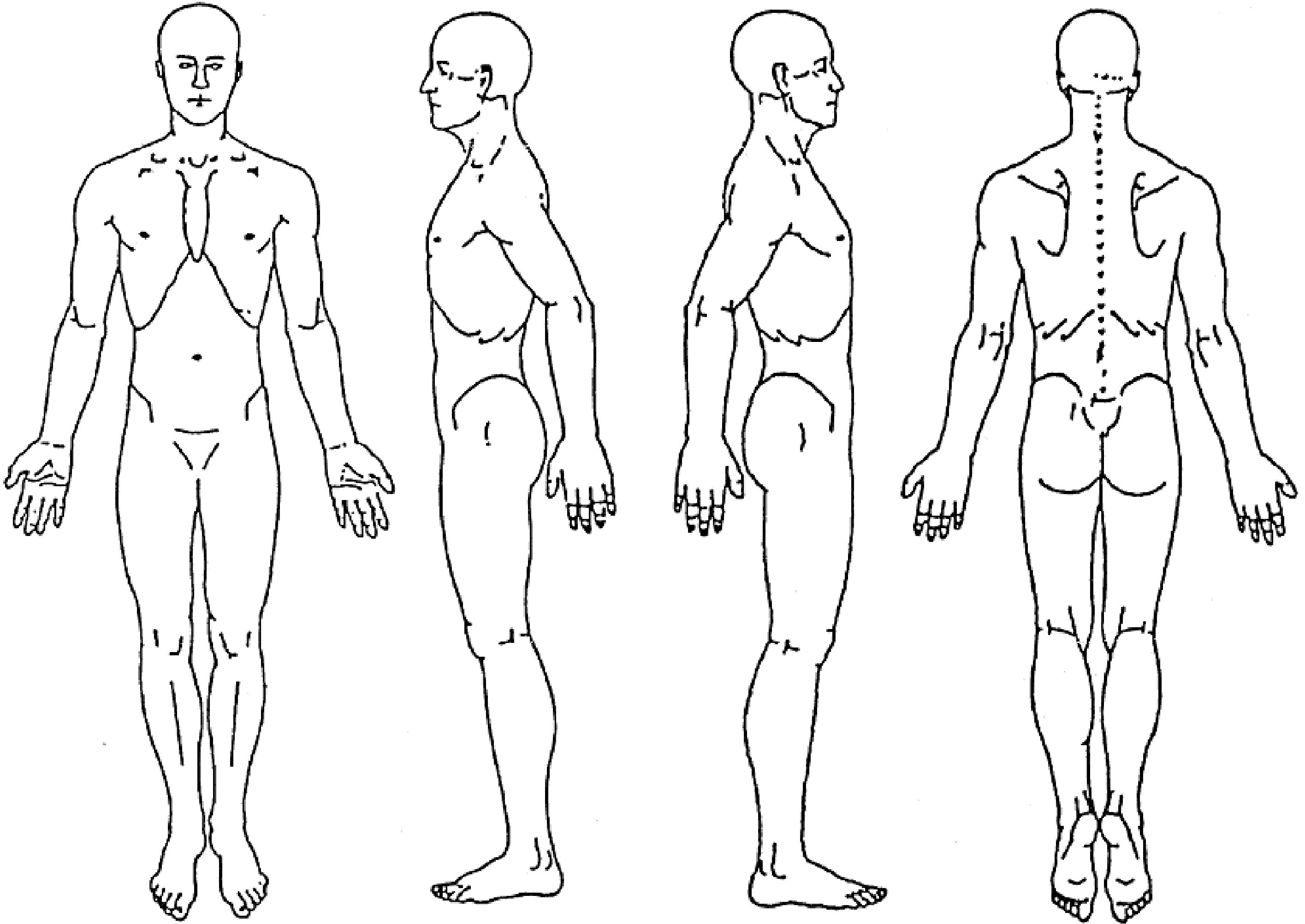
SYMPTOMATOLOGY: (Pain / Complaints) FROM THIS COLLISION, even if only felt momentarily

(Muscle – Skeletal):

Your Overall Body Picture:

Please use the legend symbols below to accurately mark the areas in which you feel:

Stabbing: SSSS   Tingling: TTTT   Burning: BBBB   Cramping: CCCC
Numbness: NNNN   Dull: DDDD   Achy: AAAA   Pin/ Needles: PPPP



- ☐ Headaches/ Migraines
- ☐ Neck Pain
- ☐ Top of Shoulder Pain
- ☐ Mid-Back Pain
- ☐ Along Shoulder Blades
- ☐ Low Back Pain
- ☐ Sacrum Pain
- ☐ Wrist/ Carpal Tunnel
- ☐ Inside the Shoulder Pain
- ☐ Elbow/ Arm Pain
- ☐ Hand / Fingers Pain
- ☐ Hip Pain
- ☐ Knee Pain
- ☐ Foot/ Ankle/ Toes
- ☐ Leg/ Calf Pains
- ☐ Chest Pain
- ☐ Abdomen Pain
- ☐ Problem Sleeping
- ☐ Numbness in Arms/ Hands
- ☐ Numbness in Legs/ Feet
- ☐ Jaw Pain / clicking

☐ Other: ______________________________

DO NOT FILL OUT

REFER / USE THIS PAGE AS A REFERENCE GUIDE FOR QUESTIONS TO COME

Intensity:	None	(= 0 on a scale of 0 to 10)
	Low	(= 1 to 3 on a scale of 0 to 10)
	Moderate	(= 4 to 6 on a scale of 0 to 10)
	Intense	(= 7 to 9 on a scale of 0 to 10)
	Emergency	(= 10 on a scale of 0 to 10)

Timing:
- Daily (7 out of 7 days a week)
- Random (off and on during the week, yet not every day)

Frequency:	Intermittent	(Occurs 0 to 25% of the day)
	Occasionally	(Occurs 26 to 50% of the day)
	Frequently	(Occurs 51 to 75% of the day)
	Constantly	(Occurs 76 to 100% of the day)

DO NOT FILL OUT

REFER / USE THIS PAGE AS A REFERENCE GUIDE FOR QUESTIONS TO COME

Type of Discomfort:	Dull	Aching	Burning
	Tingling	Numbness	Sharp
	Shooting	Throbbing	Spasm

Referring:
- None (Discomfort is contained to the area of compliant)
- Discomfort Radiates to the Left: (body area)
- Discomfort Radiates to the Right: (body area)
- Discomfort Radiates Bilaterally to: (body area)

Aggravated: / Relieved
- Upon awakening*
- In the evening*
- Upon doing; *
- Brought on by: *
- Relieved by: *

(*examples
Any movement | Repeated movement
Bending (Forward / Backwards) | Side Bending (Left / Right)
Turning (Left / Right) | Twisting (Left / Right)
Sitting | Arising | Standing Still
Walking | Lifting | Breathing
Grabbing | Pushing | Straining
Heat/Ice | Medication | Rest

DO NOT FILL OUT

REFER / USE THIS PAGE AS A REFERENCE GUIDE FOR QUESTIONS TO COME

Prioritize Your Symptoms / Conditions
(related to prior page and your overall body picture)

(1st) First Body Area/Location/Condition: ______________________________
(Were you ever treated professionally for this, PRIOR to this car crash? Yes / No)

(2nd) Second Area/Location/Condition: ______________________________
(Were you ever treated professionally for this, PRIOR to this car crash? Yes / No)

(3rd) Third Area/Location/Condition: ______________________________
(Were you ever treated professionally for this, PRIOR to this car crash? Yes / No)

(4th) Fourth Area/Location/Condition: ______________________________
(Were you ever treated professionally for this, PRIOR to this car crash? Yes / No)

(5th) Fifth Area/Location/Condition: ______________________________
(Were you ever treated professionally for this, PRIOR to this car crash? Yes / No)

(6th) Sixth Area/Location/Condition: ______________________________
(Were you ever treated professionally for this, PRIOR to this car crash? Yes / No)

(Additional) Body Area/Location/Condition: ______________________________
(Were you ever treated professionally for this, PRIOR to this car crash? Yes / No)

(Additional) Body Area/Location/Condition: ______________________________
(Were you ever treated professionally for this, PRIOR to this car crash? Yes / No)

(Additional) Body Area/Location/Condition: ______________________________
(Were you ever treated professionally for this, PRIOR to this car crash? Yes / No)

(Additional) Body Area/Location/Condition: ______________________________
(Were you ever treated professionally for this, PRIOR to this car crash? Yes / No)

(Additional) Body Area/Location/Condition: ______________________________
(Were you ever treated professionally for this, PRIOR to this car crash? Yes / No)

(Additional) Body Area/Location/Condition: ______________________________
(Were you ever treated professionally for this, PRIOR to this car crash? Yes / No)

(Additional) Body Area/Location/Condition: ______________________________
(Were you ever treated professionally for this, PRIOR to this car crash? Yes / No)

(Additional) Body Area/Location/Condition: ______________________________
(Were you ever treated professionally for this, PRIOR to this car crash? Yes / No)

(Additional) Body Area/Location/Condition: ______________________________
(Were you ever treated professionally for this, PRIOR to this car crash? Yes / No)

(If you have additional body areas/locations, please ask for an additional page)

Will be reviewed with your examiner

(Cognitive / Emotional/ Sensory):

Mark a ✓ on symptoms that have resulted DUE TO THIS COLLISION
Mark a X on symptoms that you had PRIOR but made WORSE DUE TO THIS COLLISION

☐ Ringing in Ear ☐ Vertigo/ Dizziness ☐ Loss of Balance ☐ Fatigued
☐ Black outs ☐ Difficulty Concentrating ☐ Loss of memory ☐ Vison changes
☐ Reading Problem ☐ Sensitivity to Light ☐ Sensitivity to Sound ☐ Anxiety
☐ Highly Emotional ☐ Irritability ☐ Apathy ☐ Depression
☐ Social withdrawn ☐ Loss of Taste ☐ Loss of Smell ☐ Loss of Hearing
☐ Difficulty in Speech ☐ Night mares ☐ Sensitivity Hot / Cold
☐ Loss of Libido ☐ Thoughts of Suicide ☐ Typing / Writing Problems

(Systemic):

Mark a ✓ on symptoms that have resulted DUE TO THIS COLLISION
Mark a X on symptoms that you had PRIOR but made WORSE DUE TO THIS COLLISION

☐ Asthma ☐ Digestive Problems ☐ Allergies ☐ Shortness of Breath ☐ Extreme Thirst
☐ Weight Loss /Gain ☐ Nausea / Vomiting ☐ Menstrual Irregularities ☐ High Blood Pressure

(Miscellaneous):

☐ Other ____________________
☐ Other ____________________

****

Self-Care:

What do you do or have done for yourself to relieve any the symptoms? ((*Mark a ✓ that applies)*

☐ Take Non-Prescription / over the counter Medications
☐ Take prescription Medications
☐ Recreational drugs
☐ Use ice
☐ Use heat
☐ Get extra Rest / sleep
☐ Do Stretches
☐ Do Exercises
☐ Massage self
☐ Massage from family member / friend
☐ Other:____________________

Effects of your injuries / symptoms:

Please mark a ✓on each that applies to your activities affected by ***injuries*** ***due to this collision:***

- ☐ Have to hold onto something to sit or stand from a chair.
- ☐ Stay at home most of the time.
- ☐ Have to sit most of the day.
- ☐ Stays in bed most of the day.
- ☐ Change position frequently to try and get comfortable.
- ☐ Have difficulty turning over in bed.
- ☐ Have to lie down and rest frequently.
- ☐ Have to get other people to do things for me.

Please mark a ✓on each that applies to Difficulties you are having in your daily activities ***affected by injuries*** ***due to this collision:***

☐ Driving the car	☐ Bathing self	☐ Going to Restroom
☐ Climbing Stairs	☐ Walking	☐ Dressing Self
☐ Brushing teeth	☐ Combing Hair	☐ Shaving
☐ Doing Laundry	☐ Ironing	☐ Cooking
☐ Vacuuming	☐ Washing Dishes	☐ Dusting
☐ Movie going	☐ Dining Out	☐ Shopping
☐ Kneeling	☐ Social events	☐ Going to Church.
☐ Sexual relationships	☐ Reading	☐ Watching TV
☐ Child care	☐ Using phone	☐ Computer work
☐ Mowing Lawn	☐ Gardening	☐ Washing Car
☐ Outside House Maintenance	☐ Landscaping	☐ Taking out Trash
☐ Aerobic exercising	☐ Backpacking	☐ Basketball
☐ Bowling	☐ Boxing	☐ Bicycling
☐ Basketry	☐ Baseball	☐ Fishing
☐ Fencing	☐ Dancing	☐ Camping
☐ Card Playing	☐ Handball	☐ Golf
☐ Football	☐ Judo	☐ Hunting
☐ Hockey	☐ Health Club	☐ Gymnastics
☐ Yoga	☐ Petitioning	☐ Karata
☐ Ice Skating	☐ Horseback riding	☐ Sailing
☐ Rafting	☐ Racquetball	☐ Photography
☐ Jogging	☐ Swimming	☐ Snow Skiing
☐ Sewing	☐ Weightlifting	☐ Water sports

Other: ____

How do the following positions or motions affect your pain?

	No Change	Relieves	Increased	**If increases**, Duration limited to #?
Sitting	☐	☐	☐	________ hours / minutes
Walking	☐	☐	☐	________ hours / minutes
Standing	☐	☐	☐	________ hours / minutes
Lying Down	☐	☐	☐	________ hours / minutes
Looking up	☐	☐	☐	________ hours / minutes
Looking Down	☐	☐	☐	________ hours / minutes
Lifting	☐	☐	☐	________ weight / repetitions
Bending	☐	☐	☐	________ ________ / ________

EMPLOYMENT HISTORY / CHANGE

WERE YOU EMPLOYED AT THE TIME OF THE COLLISION?: YES ☐ NO ☐
DID YOU LOOSE YOUR JOB DUE TO THIS COLLISION?: YES ☐ NO ☐

Employer: ____________________
Company name: ____________________
Supervisor / Boss name; ____________________

Your job Title: ____________________
Your job Duties:
____
____

Loss time from work due to this collision?: YES ☐ NO ☐

If yes:
Day: Date: Amount of time:
____
____
____
____

Has /Have you and or your Boss modified any your work responsibilities due to the effects of this collision? YES ☐ NO ☐
IF SO EXPLAIN:
____
____
____

****

PRIOR MEDICAL HISTORY: (YOU HAVE BEEN TREATED FOR, BEFORE/ OUTSIDE THIS CAR CRASH):

OTHER DOCTORS SEEN FOR HEALTH CONDITIONS (BEFORE OR NOT FROM THIS CAR CRASH),

☐ Orthopedist ☐ Neurologist ☐ Psychiatrist ☐ Physiatrist ☐ Chiropractor
☐ Acupuncturist ☐ General Practitioner ☐ Physical Therapist ☐ Massage Therapist
☐ Xray / MRI ☐ Other: ____________________

If so give:
Clinic name Practitioner's Name Phone number Date(s) seen
____
____
____
____
____

Personal Medical History & Review of Systems:

Please indicate with an "X" any medical problems that you currently have or have had in the past.

Lungs / Pulmonary – breathing disorders OR ☐ NO problems in this area

- ☐ asthma
- ☐ COPD
- ☐ emphysema
- ☐ pulmonary embolism
- ☐ pneumonia
- ☐ tuberculosis
- ☐ respiratory arrest
- ☐ sleep apnea
- ☐ other: ____________________

Cardiac / Heart and peripheral vascular disease OR ☐ NO problems in this area

- ☐ chest pain / angina
- ☐ heart attack
- ☐ congestive heart failure
- ☐ bleeding problems
- ☐ high blood pressure
- ☐ heart murmur, valve disorder
- ☐ mitral valve prolapse
- ☐ other: ____
- ☐ irregular heartbeat, arrhythmia
- ☐ peripheral vascular disease
- ☐ deep vein thrombosis

Neurologic Disorders OR ☐ NO problems in this area

- ☐ stroke or TIA
- ☐ peripheral neuropathy
- ☐ other: ____
- ☐ Parkinson's
- ☐ MS
- ☐ cerebral palsy
- ☐ polio

Bone & Joint Disorders OR ☐ NO problems in this area

- ☐ osteoarthritis
- ☐ rheumatoid arthritis
- ☐ other: ____
- ☐ gout
- ☐ lupus
- ☐ osteomyelitis
- ☐ ankylosing spondylitis

Gastrointestinal Disorders OR ☐ NO problems in this area

- ☐ peptic ulcer or stomach ulcer
- ☐ acid reflux, GERD
- ☐ GI bleed
- ☐ other: ____
- ☐ diverticulitis
- ☐ irritable bowel
- ☐ inflammatory bowel disease
- ☐ hepatitis - Type ______
- ☐ liver disease

Genitourinary Disorders OR ☐ NO problems in this area

- ☐ urinary tract infection
- ☐ bladder problems
- ☐ kidney problems
- ☐ kidney stones
- ☐ dialysis, kidney failure
- ☐ other: ______________________________

Metabolic & Other Disorders OR ☐ NO problems in this area

- ☐ Diabetes x ________ years
- ☐ thyroid problems
- ☐ sickle cell disease
- ☐ high cholesterol or lipids
- ☐ skin disorder _____________
- ☐ psoriasis
- ☐ any skin ulcer
- ☐ tooth abscess, gingivitis
- ☐ depression
- ☐ anxiety
- ☐ alcohol or drug dependency
- ☐ other: ________________

Cancer: any type -- please specify OR ☐ NO problems in this area

____

Allergies: *(please list all medications, food environmental issues that cause allergic reaction)*

___________________________ ___________________________ ___________________________
___________________________ ___________________________ ___________________________

Medications: *(please list all medications, social drugs and supplements that you currently take)*

_________________________ _________________________ _________________________
_________________________ _________________________ _________________________
_________________________ _________________________ _________________________

Surgical History: Please list ALL previous surgery / approximate date on which it was performed:

Surgery ______________________________ Date ____________________

______________________________ ____________________

______________________________ ____________________

______________________________ ____________________

Other medical problems NOT included above, Yes □ (Use back of sheet to explain)

Family Health History:

Please indicate with an "X" any significant family medical history or problems.

□ asthma □ tuberculosis □ sleep apnea
□ COPD or Emphysema □ other lung :________________________

□ heart attack, myocardial infarction □ congestive heart failure
□ irregular heartbeat, arrhythmia □ bleeding problems □ Peripheral neuropathy
□ MS or Parkinson's □ other neuro :__________________

□ osteoarthritis □ Lupus □ gout
□ rheumatoid arthritis □ Other bone & joint: ____________________

□ acid reflux, GERD □ inflammatory bowel disease □ hepatitis - Type _____
□ liver disease □ other GI :______________________

□ kidney problems □ dialysis, kidney failure □ diabetes □ psoriasis
□ high cholesterol or lipids □ thyroid problems □ sickle cell disease
□ any skin ulcer □ Malignant hyperthermia

Family Cancer: any type -- please specify

____

Other Family medical problems NOT included above (explain)

____

Social Habits: (regular "Pre"- Automobile crash)

Smoking: ___ Yes ___ No If yes, Ave:______ Packs per Day, for _____ years
Alcohol: ___ Yes ___ No If yes, Number of drinks per week ________
Caffeine: ___ Yes ___ No If yes, Number of drinks per day ________
Exercise: ___ Yes ___ No If yes, ________ time per week, ______% Aerobic / _____% Weights
Children: ___ Yes ___ No If yes, Ages : ______________________________
Sleep: Average _____ hours per Night
Hobbies/ Recreational Activities: ______________________________

****** I ATTEST THAT I, have reviewed pages 1 through 13 of this Auto Collision / Personal Injury Intake form and the information I have provided, is to the best of my recollections, Truthful / Factual / Accurate. ******

Name Printed:______________________________**(If for/minor's name**______________________**)**

______________________________ ____________________

Signature **Date**

Office Policies/Fees/Assignment of Benefits

Consent to Treatment or Testing with Liability Release:
You authorize Complete Care Health Services Inc (CCHS), and its authorized subsidiaries and technicians, to administer treatment and/or testing. Furthermore, while the chances of injury are slim, you agree to hold CCHS and its staff without fault for any injuries that may occur during the procedures or advice given to you. Special note to patients with breast augmentation: although rare, there may be risk of implant rupture. Please advise your chiropractic physician before any manipulation/adjustment procedure.

Verification of Non-Pregnancy:
You attest to the best of your knowledge that you are not pregnant, nor is pregnancy suspected at this particular time. If you think you might be pregnant, please advise your CCHS physician or CCHS technician.

Release of Patient Records:
You authorize CCHS to furnish your insurance carrier, attorney, and/or referring physician with documentation/reports relating to the case history, examination, diagnosis, treatment, and prognosis. This release of records is pursuant to the representative above as only for the accident/illness for which you are being treated for. Furthermore, CCHS has the right to release any and all records required for remuneration purposes. Fees relating to such records are the patient's responsibility. If requesting records and/or reports, fees for such records/reports must be prepaid.

Missed Appointment Fees:
If you cannot make an appointment and need to cancel, we require a **minimum 24-hour** advance notice. Should we not receive such notice, a minimum $55 no show fee, or the equivalent of the service fee you missed, will be assessed to your account. This is a non-reimbursable fee that your insurance WILL not pay and is your sole responsibility.

Returned Checks/Insufficient Funds:
Returned checks, insufficient funds, or expired debit/credit cards have a $45 per incident fee.

Special Arrangements/Agreements:
Any special arrangements/agreements must be in writing. No verbal agreements.

Verification of Information/Financial Responsibility:
Any information asked of me will be accurately given. I understand that providing incorrect information can be dangerous to my health and possibly illegal. I also authorized payment to be made directly to CCHS in the amount due for all service charges for myself and my eligible dependents. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for all services rendered on my behalf or my dependents. Any collection fees, court costs, attorney fees, refund check fees, insufficient funds fees, and interest fees are the responsibility of the person(S), including parent and/or legal guardian, named on the account.

I certify that I have read and understand the above information to the best of my knowledge.

Name Printed:______________________________(If for a minor, minor's name:________________)

Signature:____Date:_________________________

HIPPA Laws:
This office follows HIPPA law standards described below. We cannot discuss any patients' care or even acknowledge if they are a patient, including family members, without written permission given first hand by the patient and/or legal guardian themselves.

HIPPA Notice of Information Practices

1. Complete Care Health Services (CCHS) may use and disclose protected health information for treatment, payment, and health care operations. Example of these include, but are not limited to, request (e.g. by preschool, life insurance, sports physical, referral to nursing homes, foster care homes, home health agencies, and/or referral to other health providers for treatment), payments (e.g. workers compensation, general insurance companies for claims including coordination of benefits with other insurers and collections agencies), healthcare operations (e.g. internal quality control and assurance).
2. CCHS is permitted or required to use or disclose protected health information without the individual's written consent or authorization in certain circumstances. Two examples: public health requirements or court orders.
3. CCHs will not make any other use or disclosure of a patient's protected health information without the individual's written authorization. Such authorization may be revoked at any time. Revocation must be done in writing.
4. CCHS may, at times, contact the patient to provide appointment reminders or information regarding treatment alternatives or other health related benefits and services that may be of interest to the individual patient.
5. CCHS will abide by the terms of this notice or the notice currently in effect at the time of the disclosure.
6. CCHS reserves the right to change the terms of its notice as to make any notice provision effective for all protected health information that it maintains.
7. CCHS will provide each patient with a copy of any revisions of its notice of information practice at the time of their next visit or at their last known address. If there is a need to use or disclose any protected health information of the patient, copies may also be obtained at any time from our office.
8. Any person/patient may file a complaint to the practice and to the Secretary of Health and Human Services if they believer their privacy rights have been violated. To file a complaint with the practice, please contact the Privacy Officer at the above address and or phone number. All complaints will be addressed and the results will be reported to the Corporate Compliance Office/Managing Physician Board of Directors.
9. It is CCHS's policy that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.
10. The name, title, and telephone number for the person in the office to contact for further information: Dr. Kevin Luck, President, (303) 985-0646
11. The effective date (cannot be earlier than the date on which the notice is printed or otherwise signed)

HIPPA Notice of Information Practices (Continued)

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as a part of my healthcare, CCHS originates and maintains helath records describing my health history, symptoms, examination w/test results, diagnosis, treatment, and any future plans for future care or treatment. I understand that this information serves as:

- A basis for planning care and treatment
- A means for communicating 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 provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures.
I understand that I have the right to review the notice prior to signing consent.
I understand that the practice reserves the right to changer their notice and practices, and prior to implementation, will mail a copy of any such revised notice to the address I have provided.
I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations and that the practice is not required to agree to the restriction request.
I understand that I may revoke this consent in writing, except to the extent that the practice has already taken action in reference thereon.

I request the following restrictions to the use or disclosure of my health information:
____
____

Please list any person you wish authorized to access your account:
(No information can be shared with anyone not listed on this form)

1. ____
2. ____
3. ____

Date:______________________________

Signature of Patient or Legal Representative:______________________________

(below this line for office use only)

______________________________Accepted ______________________________Denied

______________________________ ____________________ ______________
Signature Title Date