CJ Chiropractic, LLC
Dr. Christopher Eddy | Dr. Jenna Bridgewater
2155 Hollow Brook Drive, Suite 70
Colorado Springs, CO 80918
Phone: (719) 445-0806 Fax: (719) 445-0998
www.cjchiropractic.com

Patient Demographic Information

Name: _____
Birth Date: M_____ D_____ Y_____ Gender: ☐ Male ☐ Female
Home Address: _____
City: _____ State: _____ Zip: _____
Home Phone: (_____)_____ May we leave a message? ☐ Yes ☐ No
Cell Phone: (_____)_____ May we leave a message? ☐ Yes ☐ No
Work Phone: (_____)_____ May we leave a message? ☐ Yes ☐ No
Email: _____
May we add you to our email newsletter & calendar of events? ☐ Yes ☐ No (Your e-mail will not be shared)
Spouse's Name: _____
Name(s) and age(s) of children: _____
Occupation: _____
Do you primarily: ☐ Sit ☐ Stand ☐ Perform repetitive tasks
How did you hear about us? _____

Emergency Contact Information

Name: _____
Home Phone: (_____)_____
Cell Phone: (_____)_____
Work Phone: (_____)_____
Relationship to you: _____
May we disclose necessary medical information to this person? ☐ Yes ☐ No

Healthcare History

Have you had previous chiropractic care? □ Yes □ No

Who was your previous Chiropractor? _____

Where? _____ When? _____

Were x-rays taken in the last 6 months? □ Yes □ No

What was the primary reason for consulting that office?

□ Relief Care – Symptom relief of pain or discomfort

□ Corrective Care – Correcting, relieving, and stabilizing spinal, joint, and postural issues

□ Wellness Care – Maximizing the body's ability for optimal healing and function

Do you feel your previous chiropractic care was effective? □ Yes □ No

Please explain: _____

Are you wearing: □ Heel Lifts □ Custom Orthotics

Family Doctor: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (_____)_____

Date and reason of last visit: _____

May we contact your family doctor regarding your care at our office if necessary? □ Yes □ No

Other specialists and healthcare professionals:

Name: _____

Professional Designation: _____

Date and reason of last visit: _____

Name: _____

Professional Designation: _____

Date and reason of last visit: _____

Name: _____

Professional Designation: _____

Date and reason of last visit: _____

By signing below, I acknowledge that the information I provided above is true and accurate to the best of my ability.

_____ _____

Patient Signature Date

Notice of Privacy Practices Acknowledgement

CJ Chiropractic, LLC

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian (print) Date

_____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date_____ Attempt_____

Staff Name_____

Informed Consent Document

Patient Name:_____

To the Patient: Please read this entire document prior to signing it. IT is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

The nature of the chiropractic adjustment.

The primary treatment used by doctors of chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click". You may feel a sense of movement.

Analysis/Examination/Treatment

As part of the analysis, examination, and treatment, you are consenting to the following procedures:

1. Spinal, cranial, and extremity manipulative therapy
2. Palpation and leg length analysis
3. Vital Signs
4. Range of motion testing
5. Provocative orthopedic testing
6. Basic neurological testing
7. Muscle strength testing
8. Postural and gait analysis testing
9. Hot/Cold therapy
10. Acupressure therapy
11. Nutritional counseling
12. Neuro- Emotional Technique

The material risks inherent in chiropractic adjustment

As with any healthcare procedure, there are certain complication which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. The doctor will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to the doctor's attention it is your responsibility to inform the doctor.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and possible x-rays. Stroke and/or vertebral artery dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate. The most current research of the topic is inconclusive as to a specific incident of this complication occurring. If there is a causal relationship at all it is extremely rare and

remote. Unfortunately, there is no recognized screening procedure to identify patients with neck pain who are at risk of a vertebral artery stroke.

The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [] or have had read to me [] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Christopher Eddy/Dr. Jenna Bridgewater and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated:_____ Dated:_____

_____ _____

Patient or Parent/Guardian's Signature Doctor's Signature

_____

Patient's Name Printed

PATIENT FINANCIAL RESPONSIBILITY

This office will provide you with a superbill in order to send claims to your insurance, if you so desire, as a courtesy. **Remember that you are ultimately responsible for any charges incurred in this office. Our office's policy is to collect full payment the same day services are rendered. Due to this policy we offer a prompt pay discount to you. This is only applicable if full payment is received within 24 hours of services rendered. Your signature on this document indicates that you agree to pay for any charges incurred in this office.**

Patients who do not have health insurance:

Since we will not need to pay staff to bill and follow up with insurance companies, we pass the savings on to you. We offer EVERYONE our Prompt Pay rates when their accounts are paid in full on each visit. A written copy of our fee schedule is available upon request.

Patients with Insurance:

You can pay our Time of Service fees, which are significantly less than our regular fees. However, YOU will then be responsible for submitting all services you have paid for to your insurance for reimbursement. We will not be billing on your behalf. We will supply you with all of the necessary paper work to submit to your insurance company.

Anthem BCBS:

Our office is In-network with Anthem BCBS. Your chiropractic coverage can vary depending on your individual plan. This information will be gone over with you before the start of treatment. REMINDER: BCBS chiropractic coverage is only for Acute Musculoskeletal Pain main complaints. If other procedures are needed that are necessary for your care you will be financially responsible for that treatment. Your

We will strive to work out feasible payment options for anyone who is in need of care. Unless other prior written agreements have been made, any outstanding balance more than 60 days old is considered delinquent. A re-billing fee of 1% of the outstanding balance will occur per month and will also be added to all accounts that fit this criterion. Office policy dictates that delinquent accounts may be referred to a collection agency for collection which may include possible blemishes on your credit record. If this happens, an administrative collection fee of $50 (minimum) may be added to your account to cover our costs and you specifically authorize us to run your credit report.

By signing below, I have read and understand that I am responsible for payment at the time of service. I authorize CJ Chiropractic, LLC to include necessary health information to complete the proper superbills so that I may submit them to my insurance. I also authorize the doctor to release all information necessary to communicate with personal physicians, other healthcare providers, collection agencies, and payers to secure the payment of benefits or inform them of concurrent treatment. By signing below I indicate that I have read, understand, and agree with the terms on this page.

_____ _____

Signature of responsible party (Patient, Parent, or Legal Guardian) Date

Cancellation/Missed Appointment Policy

Our goal at CJ Chiropractic is to provide quality chiropractic care in a timely manner. In order to do so, we have had to implement an appointment/cancellation policy. This policy enables us to better utilize available appointments for our patients in need of chiropractic care.

Cancellation of an Appointment:

In order to be respectful of the needs of other patients, please be courteous and call CJ Chiropractic promptly if you are unable to attend your appointment. This time will be reallocated to someone who is in need of treatment that day. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the opportunity to have access to timely care.

How to Cancel Your Appointment:

To cancel appointments, please call CJ Chiropractic office at 719-445-0806 at least 24 hours prior to your scheduled appointment. If you do not reach someone within the office, you may leave a detailed message on the voice mail. If you would like to reschedule your appointment, please be sure to leave us your phone number and we will return your call as soon as possible. Late cancellations will be considered as a "no-show".

No-Show Policy

A "no-show" is a missed appointment without 24 hours' notice. "No-shows" inconvenience other patients who may need access to chiropractic care in a timely manner. A failure to present at the time of a scheduled appointment without adequate notice will be recorded in the patient's chart as a "no-show". There will be no charge to the patient for the first event. Any additional "no-shows" will result in a fee of $40.00 charged to the patient and must be paid prior to your next appointment. Any further "no-show" appointments may result in the termination of the patient from the practice.

I have read the above policy completely. I agree to all of the terms and understand that if I violate this policy it may result in the termination of my doctor/patient relationship.

Signed: _____ Date: _____

Printed Name: _____

Effective on 9/18/2017