Rockrimmon Integrated Medical

425 W. Rockrimmon Blvd. Suite 100, Colorado Springs, CO 80919

Patient Name:_____ Date: _____ Email: _____

SS #/SIN:_____ DOB:_____ ☐ Male ☐Female Home phone:_____ Cell Phone: _____

Check appropriate Box**:** ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Are you: ☐Active Military ☐Ministry ☐Medicare ☐Medicaid

Patient's Address: _____City: _____ State:_____ Zip:_____

Employer Name: _____

Spouse or Patient's Guardian name:_____ Spouse's Employer:_____

Whom may we thank for referring you?_____ ☐Facebook Ad ☐Google Ad ☐Google Search Other:_____

Person to contact in case of an emergency:_____ Phone:_____

In case of a medical emergency, if the patient is of school age 15+, is ok to treat in my absence.

_____ _____

Parent or Guardian Date

Responsible Party

Name of The Person responsible for this account: _____Relationship to Patient: _____

Address: _____ Cell Phone: _____

Home phone:_____ SS #/SIN: _____ Date of Birth: _____

Is the person currently a patient at our office? □ Yes □ No

Do you have any Medical insurance? □ Yes □ No if yes, complete the following:

Name of the insured:_____ Relationship to patient:_____

Insurance Company:_____ ID #:_____

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE
AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Rockrimmon Integrated Medical, LLC** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled,

including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 ____. X_____ (SEAL)
(patient signature)

X_____(SEAL)
(signature of Guardian if applicable)

X_____
(please print patient name)

Past Medical History

(Have you ever had the following: (circle "yes" or "no"/ leave blank if you are uncertain.)

AIDS & HIV……NO YES
Chicken Pox……NO YES
Diphtheria……NO YES
Hepatitis……NO YES
Infectious Mono……NO YES
Measles……NO YES
Mumps……NO YES
Pneumonia……NO YES
Polio……NO YES
Rheumatic Fever……NO YES
Scarlet Fever……NO YES
Small pox……NO YES
Tuberculosis……NO YES
Venereal Disease……NO YES

Whooping Cough……NO YES
Cancer……NO YES
Anemia……NO YES
Bleeding Tendency……NO YES
Blood Plasma
Transfusion……NO YES
Chest Pain/Angina……NO YES
Heart Attack……NO YES
Heart Murmur……NO YES
High Blood Pressure……NO YES
Low Blood Pressure……NO YES
Mitral Valve
Prolapse……NO YES
Diabetes……NO YES

Thyroid Disease……NO YES
Frequent Diarrhea……NO YES
Gallbladder Dz……NO YES
Heartburn……NO YES
Hemorrhoids……NO YES
Hernia……NO YES
Ulcer……NO YES
Hives or Eczema……NO YES
Arthritis……NO YES
Back Trouble……NO YES
Epilepsy……NO YES
Migraine Headache……NO YES
Stroke……NO YES
Glaucoma……NO YES

Kidney Disease……NO YES
Asthma……NO YES
Bronchitis……NO YES
Bladder Infection……NO YES
Loss of Urine……NO YES
Date of Last Chest X-Ray
_____
Any Other Disease……NO YES
List:_____
_____
_____
_____
_____

Previous Hospitalizations/Surgeries/Serious Illnesses When? Hospital, City, State

_____ _____ _____
_____ _____ _____
_____ _____ _____

Medication: (include nonprescription)

_____
_____

Are you taking any medications for acid indigestion? O yes O no if yes what type: _____
Supplements: _____

Patient Social History:

Use of Alcohol Never: _____ Rarely: _____ Moderate: _____ Daily: _____
Use of Tobacco Never: _____ Rarely: _____ Moderate: _____ Daily: _____
Use of Drugs Never: _____ Type/Frequency:_____
Excessive Exposure
At home or at work to: Fumes: _____ Dust: _____ Solvents: _____ Airborne Particles: _____ Noise: _____

Family Medical History:

	Age	Disease	If Deceased, Cause Of Death
Father			
Mother			
Siblings			
Spouse			
Children			

Indicate which of the below you have experienced in the last 1-2 months
1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes/Ears/Nose/Throat/Respiratory

Asthma	1 2 3 4 5
Chest Congestion	1 2 3 4 5
Chronic Cough	1 2 3 4 5
Drainage	1 2 3 4 5
Earache or Ear Infection	1 2 3 4 5
Frequent Sneezing	1 2 3 4 5
Hay Fever	1 2 3 4 5
Hoarseness	1 2 3 4 5
Itching	1 2 3 4 5
Itchy/Watery Eyes	1 2 3 4 5
Shortness of Breath	1 2 3 4 5
Sore throat	1 2 3 4 5
Stuffy Nose	1 2 3 4 5
Wheezing	1 2 3 4 5

Muscular/Skeletal

Ankle/Foot Pain	1 2 3 4 5
Arthritis	1 2 3 4 5
Elbow Pain	1 2 3 4 5
Fibromyalgia	1 2 3 4 5
Hip Pain	1 2 3 4 5
Joint Pain	1 2 3 4 5
Knee Pain	1 2 3 4 5
Low Back Pain	1 2 3 4 5
Muscle Aches	1 2 3 4 5
Neck Pain	1 2 3 4 5
Pain b/t shoulder blades	1 2 3 4 5
Shoulder Pain	1 2 3 4 5
Wrist/Hand Pain	1 2 3 4 5

Neurological

Dizziness	1 2 3 4 5
Headaches	1 2 3 4 5
Migraines	1 2 3 4 5
Numbness	1 2 3 4 5
Pins/needles in hands or feet	1 2 3 4 5
Tingling	1 2 3 4 5

General

Fatigue	1 2 3 4 5
Malaise	1 2 3 4 5
Weakness, tiredness	1 2 3 4 5
Lightheadedness	1 2 3 4 5
Irritability	1 2 3 4 5
Constipation	1 2 3 4 5
Diarrhea	1 2 3 4 5
Feeling foggy	1 2 3 4 5
Forgetfulness	1 2 3 4 5

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the provider's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of the Patient, Parent or Guardian Date

Provider's Review

_____ _____

Signature of Provider Date

ROCKRIMMON INTEGRATED MEDICAL
"SERVING GOD BY CARING FOR HIS PEOPLE"

CONSENT TO TREAT

I hereby request and consent to medical treatment and/or 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 medical provider or provider 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 can discuss with the medical provider or 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, in both the practice of medicine and the practice of chiropractic, there are some risks to treatment and diagnostic services including but not limited to:

Manipulation: increased pain or discomfort, fractures, disc injuries, strokes, dislocations and sprains.

Therapeutic Modalities and procedures: additional pain 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.**

Lab Draws: bleeding at site of draw, bruising, nausea.

Medical Prescriptions/Supplements: side effects, adverse events, allergic reaction, death

I do not expect the provider to be able to anticipate and explain all risks and complications, and I wish to rely upon the provider to exercise judgment during the course of the procedure which the provider feels at the time, based upon the facts then known to him or her, is in my best interest. The provider at the location named below has additionally explained the risks associated with my refusal of 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.

Rockrimmon Integrated Medical
425 W. Rockrimmon Blvd Suite 100
Colorado Springs, CO 80919
(719) 593-1969

Patient Signature_____ Date _____

Consent to evaluate and adjust a minor child

I, _____being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

X_____

Signature **Printed Name** **Date**

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Consent for Disclosure of Health Care Information

I,_____ understand that my personal health information is private and confidential. The HIPAA Privacy Rule gives individuals the right to request restrictions on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of that a communication of PHI be made by alternative means. The providers and staff at **Rockrimmon Integrated Medical, LLC,** work hard to ensure the privacy and confidentiality of my personal health information. I understand that providers and staff at **Rockrimmon Integrated Medical, LLC** work to disclose to me personal health information to help provide health care, handle billing and information, and to take care of other health operations. I understand that I have the right to ask my provider to limit how my personal information is used or disclosed to carry out treatment, payment, or other health care operations.

I wish to be contacted in the following manner (Check all that apply):

( )By telephone _____ ( ) Work ( ) Cell ( ) Home

( ) It is OKAY to leave detailed message ( ) Message with call back number ONLY

( ) Written communication

( ) Okay to send mail to my home address

( ) Okay to send email to the following address _____.

I hereby authorize **Rockrimmon Integrated Medical, LLC** to provide clinical information or answer questions regarding my care with (Check all that apply):

Name: _____ Relation to client: _____Phone Number:_____

( ) Information regarding treatment ( ) Lab results ( ) Appointment Information

Name: _____ Relation to client: _____Phone Number:_____

( ) Information regarding treatment ( ) Lab results ( ) Appointment Information

Name: _____ Relation to client: _____Phone Number:_____

( ) Information regarding treatment ( ) Lab results ( ) Appointment Information

_____ _____

Patient or Parent/Guardian Signature Date