



WELCOME TO PEAK PERFORMANCE CHIROPRACTIC

Todd Stevenson, DC-Amy Sasseen, DC

APPLICATION FOR TREATMENT

Date _____

Please Print Legibly

Name _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Gender _____ Contact Phone Number _____

E-Mail Address _____

(we will never give out your e-mail to a 3rd party. Your e-mail address will *only* be used for the front desk staff or your doctor to contact you)

How were you referred to our office? _____

Employer _____

Occupation _____ Work Duties (i.e. Desk Work, On Feet, Driving, ...) _____

Insurance Information (please provide card to front desk and this section can be skipped)

Primary Insurance _____

ID # _____ Group # _____

Emergency Contact

Name _____ Relation _____

Contact Phone Number _____

Minor Authorization - ** Skip if patient is over 18

If Patient is under the age of 18, Parental/Guardian Consent is Required for Treatment

Person Ultimately Responsible for Account (Parent or Legal Guardian)

Name _____ Relation _____

Contact Phone Number Cell, Home, or Work (circle one) _____ Signature _____

Parent or Legal Guardian Signature

REASON FOR TODAY'S VISIT

Patient Name: _____

- New Injury Old Injury Chronic Pain Wellness

Where are your major areas of complaint? Neck Midback Low Back Other _____

Rate Pain on Scale of 1 (mild discomfort) to 10 (severe discomfort) _____

Did your injury occur during: Work Sports/Play Auto Accident Routine/Home Activity

When and where did your condition/injury/accident occur? _____

Any further details of reason for visit: _____

Is your condition getting worse? Yes No Constant Comes and Goes

Is your condition interfering with your: Work Sleep Daily Routine? If so, how? _____

Has this or something similar happened in the past? Yes No If yes, please explain _____

Health History

Have you been treated by a Medical Physician for this condition? Yes No

If yes, where? _____

Are you taking any medications related to your injury? Yes No

If yes, indicate list _____

Please list any surgeries with dates and/or and other serious medical conditions:

Have you been treated by a Chiropractor before? Yes No If yes, please indicate Dr. or Clinic's name and approximate time since last visit _____

Please list any other major health problems or medical procedures you have or have had in the past: _____

Any further health information you would like to discuss with your doctor? _____

For Women: Are you pregnant? Yes No If yes, estimated due date _____

Are you nursing? Yes No Breast Augmentation? Yes No

Doctor Notes

Peak Performance Chiropractic

3735 Lakeside Dr., Ste A

Reno, NV 89509

(775) 786-7325

To Our Patients:

Please contact our office if you have any questions about a bill or Explanation of Benefits that you may receive from your insurance company. When dealing with insurance companies, it can be difficult to interpret the information they return to you.

Financial Policy

Non-insurance Patients:

Payment is due in full at the time of service. Our out-of-pocket rate is \$75 for the first visit, \$50 for any subsequent visit. You may request a super bill or receipt with information regarding your payment, diagnosis, and treatment at any time, including for past visits.

Insurance Patients:

Please provide a copy of your insurance card and identification for completion of your file. Our front desk staff will verify your coverage and deductible information, but ultimately, you are responsible for knowing if you have chiropractic coverage and whether or not your deductible has been met.

Nevada State Insurance Laws require health insurance companies to pay medical claims within 60 days of receipt of the claim. Our office submits claims generally within 2 days of services being rendered. We highly recommend that you keep in touch with your insurance company to ensure that timely and proper payments of your medical claims are made. Your insurance coverage is a contract between the employer/patient and your insurance company, and regardless of insurance coverage, the patient is ultimately responsible for the billed charges.

Anthem Blue Cross/Blue Shield Patients:

Your plan only covers treatment of 1-2 regions of the spine and does not include any additional therapy. Treatments at our office are typically full spine and do include multiple therapies that we charge an additional \$16 on top of your insurance copay. You may elect to not have any full spine treatment or therapy, but this is not our preferred method of treatment. Please let us know if further clarification is needed prior to your treatment.

Medicare Patients:

We will bill Medicare directly. Medicare typically forwards the claim to your secondary insurance. If either deductible has not been met, you are responsible for this amount. Please review your Medicare and secondary insurance information for further details.

Medicare only allows 12 visits per year. Any visit after 12 will be charged as a \$50 cash visit.

Personal Injury Patients: Please make front desk aware of accident prior to appointment

We accept patients with motor vehicle claims, either Med-Pay, attorney lien, or third party at fault. Please be aware, that you, the patient, are ultimately responsible for your bill if payment is not made by an insurance company or an attorney. You are also responsible for payment in full if the at-fault insurance company pays you directly at the final settlement of your claim.

I have read, understand, and agree to the PEAK PERFORMANCE CHIROPRACTIC Financial Policy.

Patient Name (Printed)

Patient Signature

Date



Informed Consent Form

Our office requires that every patient be informed of the risks of treatment and the alternatives to treatments prior to the beginning of care. The following is Peak Performance Chiropractic's informed consent for treatment. We intend this consent form to cover the entire course of treatment for your present condition and for any conditions for which you seek treatment at this clinic.

The nature of chiropractic treatment: The doctor will use his/her hands in order to adjust/manipulate your joints. You may hear a "click" or "pop", similar to when a knuckle is "cracked" and you may feel movement of the joint. Various ancillary procedures, such as a hot or cold packs, soft tissue treatments, mechanical traction as well as exercise instruction may also be used.

Possible risks and probability: There are inherent risks any treatment derived by any health care provider ranging from taking a single aspirin to a complicated brain surgery. Chiropractic care is no exception. Although we take every precaution, there are indeed some slight risks to chiropractic adjustments/manipulations. The risk is very minor to non-existent in any treatment of the extremities. The risks involved in treatment to the spine excluding the neck are several. A list from the least to the most serious would include muscular strain (rare), ligamentous sprain (rare), fractures (rare), and injury to the intervertebral discs, nerves, or spinal cord (very rare). The risk involved in the treatment of the neck would include any of the preceding list but also include the remote possibility of cerebrovascular injury, or stroke (very rare: incident rate is one in ten million). A minority of patients may notice a stiffness or soreness after the first few days of treatment (common). The ancillary physical therapy procedures could produce skin irritations or other minor complications (rare).

Other treatment options, not provided by this clinic, which could be considered, may include the following:

Over-the-counter analgesics. The risks of these medications include irritations to the stomach, liver and kidneys and other side effects in a significant number of cases.

Medical care, typically anti-inflammatory drugs, tranquilizers and analgesics. Risks of these drugs include numerous undesirable effects, usually more serious than those listed above and patient dependence in a significant number of cases. Surgery in conjunction with medical care adds the risks of adverse reactions to anesthesia (which include death), as well as extended convalescent period in a significant number of cases.

Risks of remaining untreated. Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and include chronic pain cycles. It is quite probable the delay of treatment will complicate the condition, and make further rehabilitation more difficult.

Concerns or questions. Please ask your Doctor of Chiropractic. Peak Performance Chiropractic has gone to great lengths to make your health and safety a top priority. Our doctors will be glad to explain any concerns about treatment you may have. Suffice to say we will only recommend treatment for you that we would feel comfortable having performed on ourselves.

I have read the above explanation of chiropractic care. I also had the opportunity to ask questions and have them answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

Printed Name _____ Signature _____ Date _____



NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES-HIPPA

This notice describes how your health information about you may be used and how you can get access to this information. Please review it carefully. The privacy of your health is very important to our office.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect on 1-1-2021 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted and applicable by law. We reserve the right to make changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we can make a significant change in our privacy practices, we will change the notice and make the new notice available upon request. You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of the notice.

Used and Disclosures of Health Information

We may use and disclose health information about you for treatment, payment, and healthcare operations,
For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use or disclose health information to obtain payment for services we provided you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualification of healthcare professional, evaluating practitioner and provided performance, conducting training programs, accreditation, certification, licensing, or credentialing activities. Peak Performance Chiropractic provides quality healthcare and semi-open environment. During your treatment, incidental details about your care may be disclosed to others in the open environment in which we provide care. The doctors, office staff, and massage therapists are committed to protecting your health information.

Your Authorization: In addition to our use of our health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your health information for any reason except those described in the notice.

To Your Emergency Contact Listed on File: We may use this contact person as a means to reach you or to alert this contact of any significant issues that may arise from your care or account.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, or your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the persons involvement in your health care. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or similar forms of health information.

Peak Performance Chiropractic

3735 Lakeside Drive, Suite A Reno, NV 89509 (775) 786-7325

- ▶ We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between doctor and patient.
- ▶ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- ▶ Peak Performance Chiropractic provides quality healthcare in a semi-open environment. During your treatment, incidental details about your care may be disclosed to others in the semi-open environment in which we provide care. The doctors, staff, and massage therapists are committed to protecting your health information.
- ▶ I have read a copy of the Notice of Health Information Privacy Practices- HIPPA form. I have been given the opportunity to keep this form and have had any questions I may have answered for me by the front desk staff.
- ▶ I have read, signed, and understand the Informed Consent form provided.
- ▶ I understand the forms I have completed and answered correctly to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes to the information I have provided.

_____ Signature

_____ Printed Name

_____ Date