

WELCOME TO PEAK PERFORMANCE CHIROPRACTIC

APPLICATION FOR TREATMENT

Please Print Legibly

Name _____ Date _____
Address _____ City _____ State _____ Zip _____
Date of Birth _____ Gender _____ Name you prefer to be called _____
Contact Phone Number Cell, Home, or Work (circle one) _____ Add'l Number Cell, Home, or Work (circle one) _____
Marital Status _____ Spouse's Name _____ # Children _____
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, ...) _____
Is your insurance through your employer? Yes No
.....

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

Primary Insurance _____
Address _____
Phone Number _____ ID # _____ Group # _____
Insured's Name _____ Insured's Date of Birth _____
Relation _____ Insured's Employer _____
.....

Emergency Contact

Name _____ Relation _____
Contact Phone Number Cell, Home, or Work (circle one) _____
Do you have a primary M.D.? If so, please list doctor and/or office : _____
.....

** Skip this section if patient is over 18

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

Account Information Person Ultimately Responsible for Account (Parent or Legal Guardian)

Name _____ Relation _____
Address _____ City _____ State _____ Zip _____
Contact Phone Number Cell, Home, or Work (circle one) _____ Signature _____
Parent or Legal Guardian Signature

REASON FOR TODAYS VISIT

Patient Name: _____

Date: _____

- ☐ Emergency ☐ New Injury ☐ Old Injury ☐ Chronic Pain ☐ Wellness

Are you in Pain ☐ Yes ☐ No Rate Pain on Scale of 1 (discomfort) to 10 (intense) _____

Did your injury occur during: ☐ Auto Accident— please let front desk know for additional forms
☐ Sports/Play ☐ Work ☐ Routine/Home Activity ☐ Other

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When did your condition/accident occur? _____ Where did your injury occur? _____
Please explain what happened: _____

Please explain what happened: _____

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

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

Is your condition interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Exercise

If so, how?

If so, how? _____

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

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

If yes, where? _____

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 _____

Health History

Are you taking any medications? ☐ Yes ☐ No If yes, indicate type and reason

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

For Women: Are you pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No If so, list activities

Which side is your more dominant side? ☐ Left ☐ Right

Please mark any other of the following diseases, health problems, or medical procedures you have or have had in the past:

- ☐ Heart Attack/Stroke ☐ Heart Surgery/Pace Maker ☐ Heart Murmur ☐ Congenital Heart Defect
☐ HIV+/AIDS/ARC ☐ Degenerative Joint Disease ☐ Arthritis ☐ Gout
☐ Shingles ☐ Diabetes ☐ High/Low Blood Pressure ☐ Kidney Problems
☐ Ulcers/Colitis ☐ Fainting/Seizures/Epilepsy ☐ Difficulty Breathing
☐ Artificial Bones/Joints/Limbs - please list _____ ☐ Cancer, type? _____ ☐ Chemotherapy

Other Valid and/or Important Health History to Discuss?

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

For Office Use Only



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 is 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

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

Cash Patients: Payment is due in full at the time of service. 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 attempt to identify 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. Please ask the front desk if we can assist in explaining your particular insurance plan to the best of our knowledge.

Your co-pay is due at the time of service. As a courtesy, we bill your insurance for you; however the Patient/Responsible Party is also responsible for 100% of any services they may have that are not authorized or limited by your particular insurance plan.

If your insurance requires authorization for office visits, it is the patient's responsibility to contact their Primary Care Physician (PCP) for proper referral/authorization. If we do not have an authorization at time of visit your appointment can be rescheduled, or you can become a cash patient.

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.

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.

Personal Injury Patients:

We accept patients with motor vehicle claims, including (but not limited to) those represented by an attorney, third party claims, and med-pay. 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. You will be sent to collections if payment is not made in 30 days after settlement.

Initial Here _____ Date _____

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- ▶ 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