WASHINGTON PARK CHIROPRACTIC
heal thrive evolve

1313 S. Clarkson St. Unit 1, Denver, CO 80210 P: 303-744-7100 F: 303-744-7109 washparkchiro.com

Auto Financial No-Show/Cancellation Policy

To better serve our patients and assure that they have a fair opportunity to have an appointment as promptly as possible, please observe our cancellation policy for chiropractic, massage, and acupuncture appointments.

We require a minimum 24-hour notice to cancel or reschedule massage, acupuncture, and new patient chiropractic appointments. We also require at least 2 hours notice for follow up chiropractic appointments.

Authorization for Credit Card Use
(All information will be kept confidential)

Cardholder Name: _____
Billing Address: _____
_____

Card Number: _____
Expiration Date (mm/yy): _____
CCV: _____

I, _____ authorize Washington Park Chiropractic to charge my card for any late cancellations or missed appointments.

_____ _____
Signature Date

Fees

Chiropractic: no-shows/late cancels will be billed $25 for the first missed appointment and full price for subsequent missed appointments.

Massage, Acupuncture & Nutrition: no-shows/late cancels will be billed for half of the price of the appointment for the first miss and full price for any subsequent missed appointments.

Please arrive on time for your appointment. If you know you will be late, please call to verify that the doctor will be able to devote your full scheduled time to you. If it is best, we will reschedule your appointment.

_____ _____
Parent/Guardian Signature Date

_____
Parent/Guardian Name (print)

WASHINGTON PARK
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Informed Consent

I, the undersigned, have voluntarily requested that the Doctors and/or other providers at Washington Park Chiropractic assist me in the management of my health concerns. I understand and agree to all policies and terms provided in the Office Policies and Procedures.

Meet the Doctors

Dr. Lisa Goodman, DC, CCSP, CACCP
2006 Graduate of Palmer College of Chiropractic West, San Jose, CA
Certified Chiropractic Sports Physician
Certified by the Academy Council of Chiropractic Pediatrics
Webster, Prenatal Certified
Graston Certified (Instrument Assisted Soft Tissue Mobilization)
Functional and Kinetic Treatment with Rehab (FAKTR)

Dr. Chad London, DC, CCSP
2012 Graduate of Palmer College of Chiropractic, Davenport, IA
Webster, Prenatal Certified
Certified Chiropractic Sports Physician
Functional and Kinetic Treatment with Rehab (FAKTR)

Dr. Katherine Mullen, DC, MS
2019 Graduate of University of Western States, Portland, OR
Masters of Sports Medicine
Pre-Participation Physical Examination Certified

Chiropractic

Chiropractic healthcare is primarily concerned with the relationship between structure (primarily of the spine) and function (primarily of the nervous system). The Doctor of Chiropractic evaluates the patient using standard examination and testing procedures, such as orthopedic and neurologic evaluation and possibly x-rays, along with specialized chiropractic evaluation including observation, inspection, auscultation and palpation. The chiropractic examination focuses on structural or functional abnormalities called segmental dysfunction. Segmental dysfunction exists when one or more vertebrae in the spine or bones in the extremities are fixated sufficiently to result in damage or irritation to either nearby nerves, joints, and/or tissues such as muscles and ligaments. The primary goal of chiropractic treatment is to remove the segmental dysfunction. This is accomplished by performing a procedure unique to chiropractic called an adjustment. An adjustment involves the application of a quick, precise force directed over a very short distance to a specific vertebrae or bone. Adjustments are usually performed by hand, but may use a hand-guided instrument. In addition to adjustments, other treatments used by chiropractors include physiotherapy modalities (ice, heat, soft tissue manipulation), nutritional recommendations and rehabilitative procedures.

As is the case with all health care interventions, the benefits of care must be weighed against the inherent risks and limitations of receiving treatment. Chiropractic treatments are one of the safest interventions available to the public as evidenced by malpractice statistics. While there are risks involved with treatment, these are seldom great enough to contraindicate care.

Manual Therapy

A large part of our treatment involves manual therapy performed by hand or by using instruments. Manual Therapy is generally performed to increase range of motion, reduce scar tissue and treat sprains and strains. Some common side effects of Manual Therapy include soreness and bruising.

K-Laser Therapy

Laser therapy is a safe and effective therapy that is FDA cleared for the temporary relief of pain and reduction of symptoms associated with mild arthritis and muscle pain. Laser also promotes relaxation of muscle spasms and promotes vasodilation. Adverse effects from laser therapy are normally rare and temporary.

Pain relief from laser therapy may be dramatic and substantial, lasting for hours, days or weeks. However, your results may be minimal or insignificant. Adverse effects of laser therapy may occur from multiple causes including hypersensitivity, preexisting health conditions, thermal effects, excessive pressure from the probe, and laser over-stimulation. Laser light can damage the retina in your eye. Always wear the laser protective glasses provided.

Most common side effects are:

1. Temporary increase in pain during application of laser.
2. Temporary increase in pain the following day after laser therapy.
3. Mild bruising from vasodilation or direct pressure of laser tip.
4. Temporary dizziness.
5. Reactions when photosensitizing drugs are used with laser therapy.

Stretching

The use of gentle force to stretch muscles, which may alleviate sore muscles and increase range of motion. This involves the provider moving joints through their full range of motion and holding the position for an amount of time. The provider may ask the patient to meet their full resistance to activate muscles, which is called PNF (Proprioceptive Neuromuscular Facilitation).

Results from Treatment

I understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasms. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine as well as chiropractic is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

Possible Risks & Side Effects from Treatment

One research study indicated that within the first 2 months of care, approximately half of patients report some "reaction" to chiropractic treatment. Of those who reported a reaction, the following were the most commonly reported reactions to initial chiropractic treatment:

Local Discomfort (53%)
Headache (12%)
Tiredness (11%)
Radiating Discomfort (10%)
Most appeared within 4 hours of treatment and resolved within 24 hours.

Rare, yet possible side-effects / Complications

Rib Fracture
Disc Herniation
Cauda Equina Syndrome (1 case per 100 million adjustments)
Compromise of the vertebrobasilar artery (ie. Stroke) (1 case per 400,000 to 1 million cervical spine adjustments)

Stretching & Exercise Disclaimer

Additional risks are present with stretching and exercise. These risks are increased if you have had surgery or have had a surgical implant or device or history of dislocation. Please consult your treating and/or operating physician prior to engaging in any stretching or exercise program.

Alternative Treatments Available

Reasonable alternatives to these procedures have been explained to me including:
Medications: I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, create undesirable side-effects, produce physical or psychological

dependence, and may have to be continued indefinitely. Some medications may involve serious risks that I should discuss with my medical doctor.

Rest/Exercise: Simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of value but are not corrective of injured nerve and joint tissues.

Surgery: Surgery may be necessary for conditions such as joint instability or serious disk rupture, among others. Surgical risks may include unsuccessful outcomes, complications, pain or reaction to anesthesia, and prolonged recovery.

Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

PLEASE CIRCLE the answer to all questions below to help us determine possible risk factors:

1.	Have you ever had an adverse (ie. bad) reaction to or following chiropractic care?	**Y N**
2.	Have you ever been diagnosed with osteoporosis or osteopenia?	**Y N**
3.	Do you take corticosteroids (ie. Prednisone)?	**Y N**
4.	Have you ever been diagnosed with a fracture of the spine?	**Y N**
5.	Have you ever been diagnosed with cancer?	**Y N**
6.	Do you take Warfarin (coumadin), heparin or other "blood thinners?"	**Y N**
7.	Have you ever had a stroke or TIA (transient ischemic attack)?	**Y N**
8.	Have you ever been diagnosed with any of the following?	
	a. Rheumatoid Arthritis	**Y N**
	b. Reiter's Syndrome, Ankylosing Spondylitis, Psoriatic Arthritis	**Y N**
	c. Ligamentous Hypermobility (Marfans, Ehlers, Danlos)	**Y N**
9.	Have you ever become dizzy while turning your head?	**Y N**
10.	Have you ever had spinal / back surgery?	**Y N**
11.	Have you ever been diagnosed with spinal stenosis?	**Y N**
12.	Have you ever had any of the following problems?	
	a. Sudden weakness in the arms of legs?	**Y N**
	b. Numbness in the genital area?	**Y N**
	c. Recent inability to urinate or lack of control when urinating?	**Y N**
13.	Are you currently pregnant or potentially pregnant?	**Y N**
14.	Have significant bruising throughout the body?	**Y N**
15.	Undergoing chemotherapy?	**Y N**

A thorough health history and physical examination will be performed on me to minimize the risk of any complications from treatment and I freely assume these risks.

I have read or have had read to me the above explanation of chiropractic treatment. The doctor has also asked me if I want a more detailed explanation; but I am satisfied with the explanation and do not want any further information. I have made my decision voluntarily and freely. To attest to my consent to these examination and treatment procedures, I hereby affix my signature to this Informed Consent document.

Signature of patient (or guardian) _____ Date_____

Doctor's Signature _____ Date_____

I explained the procedures, alternatives, and risks in conference with the patient.

WASHINGTON PARK
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HIPAA Privacy Practices – Patient Reception Form

I have received or reviewed the privacy practice notice for Washington Park Chiropractic, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially initiated care at this office on my first visit, whenever that may have occurred.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

_____ _____
Patient/Guardian Signature Date

_____
Print Patient Name

Exception and Records Release

I allow the doctors and staff at Washington Park Chiropractic to discuss my treatment and diagnosis with the following doctors, health care professionals, coaches, lawyers, spouses, etc.

Name Title

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____
Patient/Guardian Signature Date

_____
Print Patient Name

WASHINGTON PARK CHIROPRACTIC heal thrive evolve

Automobile Accident History Form

Patient Name: _____ DOB: _____ Date: _____

Accident Information

Date of Accident _____ Time of Accident _____
State/City of Accident _____ Street of Accident _____
Road conditions at the time of accident Wet Dry Icy Other _____
Did the Police come to the scene? Yes No Is there an accident report? Yes No
Were you working or in a work vehicle during the accident? Yes No If yes, have you notified your employer? Yes No

Treatment Information

Did you go to the Hospital? Yes No If Yes, name and city of hospital _____
Did you go via ambulance? Yes No Did you have X-rays? Yes No
If Yes, what body parts were X-rayed _____
What treatment did you receive at the hospital? _____
_____
How long did you stay at the hospital? _____
Have you been treated by any other health care professional regarding the accident? Medical Doctor Dentist Massage Acupuncture Chiropractic Other
Name of provider(s) and facility: _____

Injury Information

Did you break any bones? Yes No Did you have any cuts or bleeding? Yes No
Did you lose Consciousness? Yes No Did you have any bruises? Yes No
Did you become Dizzy Confused Nauseated Disoriented Lightheaded
Did you have Blurred vision/ Ringing in ears? Yes No

Accident Mechanism

Were you the Driver Passenger Did you see the accident coming? Yes No
Were you wearing a seat belt? Yes No
Were you Rear-ended T-boned Side-swiped Front-ended Other _____
How far is the headrest from the back of your head? _____ inches
Was your head pointing straight forward at impact? Yes No If no, what direction was it facing _____
Was the car stopped at impact? Yes No If yes, was the driver's foot on the brake? Yes No
If no, estimate the speed your car was going at impact _____ mph
Were you speeding up slowing down moving at a constant speed?
List the Year _____ Make _____ Model _____ of the vehicle you were in.
What is the estimated damage to the vehicle $_____

The Other Vehicle Information

Estimate the speed of the other car involved in the accident _____ mph
Were they speeding up slowing down moving at a constant speed
List the Year _____ Make _____ Model_____ of the other vehicle involved in the accident.

Your Account of the Accident

Were you at fault? Yes No
If yes, did you brace yourself for it? Yes No If yes, was it a Lap belt or Shoulder harness?_____

WASHINGTON PARK
CHIROPRACTIC

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Please describe your account of the accident:

List symptoms that you noticed immediately after accident:

List symptoms that you have noticed since the accident:

WASHINGTON PARK
CHIROPRACTIC
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Auto Accident Office Policy

Our office policy and recommendation is as follows:

1. Medical Payments Coverage on your Auto Insurance

Often called "*med-pay*" for short, Medical Payments Coverage is a type of insurance which provides at least $5,000 coverage for the insured driver and passengers to pay for injuries sustained in a car accident, **regardless of who is at fault**. Although the coverage is mandatory, there is a provision for consumers who do not want med-pay coverage to opt-out in writing.

If you have Med Pay, our office policy is to submit your bills and treatment notes to *your* insurance company if you are making a claim. If the other party has taken responsibility we will still send all claims to your insurance company and they can recover costs independently.

Source: Colorado Department of Regulatory Agencies. *http://www.dora.state.co.us/insurance/consumer/Med- Pay%202009.html*

2. No Medical Payments Coverage on your Auto Insurance If you don't have Medical Payments Coverage or have opted-out your other options are as follows:

a. **Health Insurance** We are happy to verify your health insurance to determine if you have coverage in our office. We are an out-of-network provider which means you may have a deductible to meet before your benefits begin. Once your insurance has been verified we will handle all billing and collections from your health insurance carrier.

b. **Pay at the Time-Of-Service** Many patients chose to benefit from our time-of-service discount by paying for treatment as they go. Our office will not bill your claims to any insurance company and you will be responsible for payment. However, you are eligible to send in receipts and possible be reimbursed from the At-Fault Auto Insurance company if they deem your treatment 'medically necessary'

c. **Lien** A Lien is a loan provided by the health care provider, in this case by our office. A Lien is offered when a patient is unable to afford the necessary treatment after an auto accident. In this case the health care provider will not be reimbursed until after the case settles. Because there is risk involved with offering a Lien, our office policy is to require that an attorney handle your case and work with our office.

Please contact our office with any further questions or if you need help determining which of the above payment methods will be best for you.

Please Note: *if you do not have Med Pay on your auto insurance or we have not verified it prior to your first appointment, all payments for your first visit will be due at the time of service.*

_____

Parent/ Guardian Initial

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Automobile Accident Financial Summary Form

Patient Name: _____ DOB: _____ Date: _____

Date of Accident: _____

1. Have you made a vehicle claim? □ Yes □ No Estimated Damage to your Vehicle $_____

2. Have you made a medical or injury claim? □ Yes □ No If yes, which insurance company □ Mine □ The other person's

3.Were you at fault? □Yes □ No

4. Do you have an attorney? □ Yes □ No

Attorney _____ Phone _____
Email _____

5. Do you have Medical Payments Coverage on your Auto Insurance: □ Yes □ No

6. Have you received a coverage confirmation letter from your insurance? □ Yes □ No If so, *please bring us a copy.*

Your Insurance Company_____
Agent/Adjuster Name:_____ Phone Number:_____
Policy Number_____ Claim Number _____

Medical Payments Coverage (MedPay) Summary

Our office policy is to submit your bills and treatment notes to your insurance company if you are making a claim. If you are not making a claim, you will be considered a Self-Pay patient and payment will be due at the time of service. If the other party has taken responsibility we will still send all claims to your insurance company and they can recover costs independently. Often called "med-pay" for short, Medical Payment Coverage is a type of insurance which provides at least $5,000 coverage for the insured driver and passengers to pay for injuries sustained in a car accident, regardless of who is at fault. Although the coverage is mandatory, there is a provision for consumers who do not want med-pay coverage to opt-out in writing.

Source: Colorado Department of Regulatory Agencies. *http://www.dora.state.co.us/insurance/consumer/Med-Pay%202009.html*

_____ _____

Parent/Guardian Signature *Date*