Shaar Chiropractic & Neurology, P.C.

Dr. Tricia A. Shaar, D.C., D.A.C.N.B.

ARPwave/MASSAGE ONLY PATIENT INFORMATION

PRINTED NAME____ DATE_________________
(Last) (First) (M.I.)

ADDRESS____

CITY____ STATE_____________ ZIP______________________

HOME #__________________ CELL # _________________ WORK # _______________________

DATE OF BIRTH_____________________ AGE ________ SOCIAL SECURITY #__________________________

Male Female / Single Married Divorced Widowed NAME OF SPOUSE___________________________

NAMES OF CHILDREN____

NAME OF EMPLOYMENT____

OCCUPATION____________________________________ DRIVERS LICENSE #___________________________

HOW DID YOU HEAR OF DR. SHAAR? ____

EMERGENCY INFORMATION

NAME____ RELATIONSHIP_____________________________

HOME #________________________ CELL # ____________________ WORK #_____________________________

PAYMENT OPTIONS:

****PLEASE fill-in ALL the CURRENT billing choices for your case below.****

1) Billing Information

(List information of responsible party, if different from above.)

PRINTED NAME____
(Last) (First) (M.I.)

ADDRESS____

CITY____ STATE______________ ZIP_________________

HOME PHONE____________________________________ WORK PHONE___________________________________

RELATIONSHIP TO INSURED: (please circle one) SELF SPOUSE CHILD OTHER__________________

PAYMENT OPTIONS: ☐ CASH ☐ PERSONAL CHECK ☐ VISA ☐ MASTER CARD

2) Major Medical Insurance Information

(* Please provide your insurance card when you arrive at the office ***)**

PRIMARY POLICY HOLDER (Name of insured)____

INSURED'S DATE OF BIRTH: _______________________ INSURED'S SS#: ________________________________

INSURED'S EMPLOYER: ________________________

POLICY ID#: ____ GROUP #: __________________________________

INSURANCE COMPANY: ______________________________ INS PROVIDER PHONE #: ___________________

NAME____ DATE___________________

3) Auto Insurance Information

PRIMARY POLICY HOLDER (Name of insured)____

INSURANCE COMPANY ____________________ AGENT_______________ AGENT'S #______________

POLICY NUMBER___________________________ DATE OF ACCIDENT: ___________________________

CLAIMS AGENT NAME: _____________________ AGENT #/ EXT #: ___________________________

FAX #: __________________________ CLAIM NUMBER: ________________________

HISTORY OF CHIEF COMPLAINT

1st) Please describe your WORST/Major/Present complaint (another section for another complaint to follow)**:**
____
____

What activities AND/OR movements CAN'T you do anymore or lately ?________________________
____
____

Result of Auto Accident: ___________ **On the Job Accident**: ___________ **Date of Accident:** ____________

Have you ever experienced this complaint before? _____________________________________

When:____

Where:____

How:____

Why:____

What Caused It: ____

What Type of Treatment Received:____

Diagnosis:____

When did this current complaint start?
____
____

Has it become better, worse, or changed in any way since it started?
____
____

Describe what makes it better:
____
____

Describe what makes it worse:
____
____

NAME____ DATE_________________

How would you describe the complaint? (mild, moderate, severe, extreme, painful, numb, stiff, achy, burning, sharp, dull, shooting, discomfort, tight, spasms, etc.)

____

____

Does it radiate spreading into other areas? (Please describe where.)

____

____

Do you have any numbness, tingling, burning, dizziness, nausea, headaches, memory loss, mood changes?

____

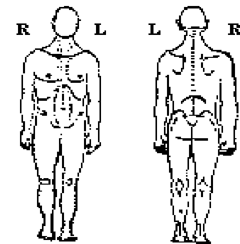
____

Have you ever sought chiropractic health care before? (Dr.'s name, city or state, length of care, conditions treated, x-rays taken, etc.)

____

____

Please indicate on the diagrams below where your area of chief complaint is:



Is it worse:

_____ In the morning

_____ In the mid-day

_____ In the evening

_____ Following:

- _____ Routine activity
- _____ Moderate activity

Does it interfere with:

______ Work ______ Days missed

_____Sleep

_____ Personal activities (describe)_________________________

_____ Activities of daily living (describe)____________________

____

_____ Other (describe) ___________________________________

____

How frequent it? (i.e. daily, twice daily, three times weekly, occasional, intermittent, frequent, constant, etc.)

____

____

Please rate the intensity <u>at its WORST</u> on the scale below:

0____10
(absent) (extreme)

Please rate the intensity <u>RIGHT NOW</u> on the scale below:

0____10
(absent) (extreme)

How long does it last? (i.e. # of seconds, # of minutes, # of hours, all day, # of continuous days, etc.)

____

____

NAME____ DATE________________

2nd) Please describe any other chief complaints or problems: ____

____

Result of Auto Accident: ____________ **On the Job Accident**: ____________ **Date of Accident:** ____________

Have you ever experienced this complaint before? ____

When:____

Where:____

How:____

Why:____

What Caused It: ____

What Type of Treatment Received:____

Diagnosis:____

Additional symptoms noticed since the onset of this problem that you feel could be related?

____

____

Additional complaints you would like to discuss today: ____

____

____

Please list any quantifying and qualifying information about the above additional complaints? ____________

____

____

Have you sought treatment elsewhere for this condition? (name(s), diagnosis, how it was treated, x-rays taken)____

____

PATIENT PAST HEALTH HISTORY

Prior conditions requiring surgeries/operations/hospitalizations (include year**):**

____

____

Prior fractures/broken bones/sprained ankles (bone(s) and year)**:** ________________________________

____

Serious Adult or Childhood Diseases or Health Conditions: ____

____

Automobile or motorcycle injuries (injury and year)**:** ____

____

Anomalies (explain/describe):____

____

NAME____ DATE________________

Significant falls/accidents/closed head trauma/concussions (injury and year): ________________________

____

Present health problems (currently under treatment): ____

____

Vitamins/Supplements (indicate purpose/condition): ____

____

All Current Medications (indicate purpose/condition/self-medicated/prescribed): ______________________

____

____

FAMILY HEALTH HISTORY

Please indicate WHO and WHEN in your family has or had the following conditions:

Arthritis or Bone Conditions (dx/type):____

____

Blood Pressure (high or low): ____

____

Cancer/Tumors (location): ____

____

Diabetes (type or age or onset): ____

____

Epilepsy (type): ____

____

Strokes (specify): ____

____

Genetic Problems (specify): ____

____

Heart or Vascular Conditions (specify): ____

____

Headaches (i.e. migraines, cluster, etc.): ____

____

Lung Conditions (specify): ____

____

Alcoholism/Drug Dependency: ____

Other (specify): ____

I have completed the above survey to the best of my ability.

Signature: ____ **Date:**____________________

Shaar Chiropractic & Neurology, P.C.

Dr. Tricia A. Shaar, D.C., D.A.C.N.B.

TREATMENT AUTHORIZATION RECORD

Consent for Release of Information & Patient Notification Statement

I,_____________________________, hereby authorize Dr. Shaar, and/or her employees, to release to employer groups, insurance companies, government agencies or other third party payers, and their agents, information concerning health care, advice, treatment, supplies or other information that may be necessary for the purpose of determining eligibility, available benefits and obtaining payment on the behalf, for the Chiropractic health care provided to me. This authorization may be revoked in writing at any time, however, revocation will not apply to the previous dates of service. I understand that the care and service I will receive are subject to review by health care professionals, third party payers and review agencies.

I understand that I will be financially responsible for all charges incurred for my treatment if I revoke or refuse to authorize the disclosure of my medical records to a third party payer, and payment denial of my insurance claims results.

Patient/Guardian Signature __________________________________ Date: ___________________

CANCELLED OR NO SHOW APPOINTMENTS

All appointments that are cancelled with **less than a 24 hour prior** notice will be subjected to a **$25.00 fee** for that appointment time slot. An appointment that a **patient fails to show** will be **charged in full**. Payment will be required at the following scheduled appointment.

Initial ___________

TERMS OF ACCEPTANCE

Thank you for asking us to support you on your way to optimum health. Cooperation and compliance from both the patient and the doctor will give us the best probability of success of a conservative health care program of a non-drug/surgery approach. This form of teamwork can only be positive when both parties give their honest effort towards the same goal. We at Shaar Chiropractic Health Care are giving our word to do our part of this teamwork goal for the most optimum level of health for you.

Here are some of the quality of life improvements that you will be asked to implement and/or add into your activities of living:

- Attending scheduled appointments, or re-scheduling when necessary.
- Communicating with the office and/or the doctor when necessary.
- Getting quality sleep.
- Increasing water intake.
- Practicing breathing and doing appropriate exercises when necessary.
- Doing an exercise/stress management program.
- Doing prescribed exercises.
- Decreasing junk food snacks.
- Decreasing sugar, soda and caffeine intake.
- Stopping ALL intake of nutra-Sweet and sugar substitutes.
- INCREASING TIME LAUGHING, FRIENDS/FAMILY AND QUALITY OF RELATIONSHIPS!!

Please sign below if you are in agreement to do your part in this goal of optimum level of health care.

Patient/Guardian Signature ________________________________ Date: __________________

Doctor Signature ____ Date: __________________

Shaar Chiropractic & Neurology, P.C.

Dr. Tricia A. Shaar, D.C., D.A.C.N.B.

OFFICE FINANCIAL POLICIES

To prevent any misunderstandings about your insurance coverage and our billing/collections procedures, we like to inform our patients that we can not render services on the ASSUMPTION that the patient care given will be paid for by an insurance company. You will be fully responsible for all professional services furnished that your insurance company does not pay.

For certain insurance plans that we do not participate in, we do reserve the right to NOT bill your insurance company. We will provide you with a receipt so you can submit your own bills.

It is our Office Policy to:

1. To collect full payment for cash patients the day services are rendered. If payment is not collected on day of service the cash discount will no longer apply and you will be billed our full standard fee.
2. Collection of deductibles payments and/or co-pays is done at the time of serves rendered.
3. We will accept your insurance office visit co-pay as our in-office co-pay after each treatment, when deductibles have been met, in all cases. If your insurance company does not have a designated co-pay our in-office co-pay is $25.00.
4. If your insurance company payment plus your in-office co-pay does not meet Shaar Chiropractic discounted cash rate patient will be responsible and billed for the difference plus 15% insurance billing processing fee.
5. You will be charged a late fee of 21% APR, if payment is not received by the due date on the statement.
6. To collect full payment for any nutritional supplies, supports, and any therapeutic appliances the day they are prescribed.
7. We will charge a $35.00 fee for any returned checks.
8. Phone consultations over 10 minutes have a charge of $35.00 per 15 minutes.
9. If your major medical insurance policy is a split percentage, ____%/ ____%, we will set a payment to be collected at the time of service that will go towards your deductible. In doing this, we agree to write off any balance (except nutritional supplies, supports, treatment instruments, pillows/wedges or deductibles) not covered by your insurance company. If however, you do not pay this set fee at the time of service, we will bill you for the full percentage as stated in your policy.
10. Patients who have Blue Cross/Blue Shield (BC/BS) out of state insurance **please be advised** that you will received a check from your insurance company in the mail. This check will be in your name however this check is not for you. This is our check and needs to be signed over to Shaar Chiropractic. We are not contracted, in-network with BC/BS and therefore they will pay the patient for the services we have provided. Failure to turn over the check and pay us for the services we have provided will result in the file going to collections.

You signature will signify your understanding and compliance with our policies. Thank you.

PATIENT SIGNATURE:____ Date:________________

Directions to Shaar Chiropractic & Neurology, P.C.

at Wells Fargo Bank Building
10288 W. Chatfield Ave., Suite 305
Littleton, CO. 80127
303-980-3009

From the North or West:

- **South** C-470 (travel towards DTC).
- Exit Ken Caryl Ave. go **East** (left).
- (go under over pass of C-470)
- (go through 4 lights)
- Turn **Right** (south) at 5th light onto W. Chatfield Ave.
- (go through 2 lights)
- Turn **Right** (south) at 3rd light onto Sangre de Cristo Rd.
- Turn an immediate **Left** into Wells Fargo Bank Parking lot.
- Park on the West side of the building.

From Downtown:

- **South** on Sante Fe.
- (look for Aspen Grove on the right and Light Rail walking bridge above Santa Fe)
- Turn **Right** (west) at the light onto Mineral Ave **OR** continue straight to C-470 and follow the South or East directions (below) heading West on C-470.
- (go through 2 lights)
- Turn **Left** (south) at 3rd light onto Platte Canyon Rd.
- (go through 6 lights)
- Turn **Left** (south) at the 7th light onto Sangre de Cristo Rd.
- Turn an immediate **Left** into Wells Fargo Bank Parking lot.
- Park on the West side of the building.

From the South or East:

- **West** on C-470 (traveling towards the mountains).
- Exit Kipling Pkwy go **North** (right).
- (go through 2 lights)
- Turn **Left** (west) at 3rd light onto Chatfield Ave.
- Turn **Left** (south) from the second left turn lane onto Sangre de Cristo Rd.
- Turn an immediate **Left** into Wells Fargo Bank Parking lot.
- Park on the West side of the building.

AFTER HOURS ACCESS:

Please use the silver box on the west side entrance to the Wells Fargo Bank Building. Pick up the phone, scrolling through the directory, find our name and calling our office. Through this process we can allow you access.