

Shaar Chiropractic & Neurology, P.C.

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

CHILD PATIENT REGISTRATION INFORMATION

PATIENT NAME _____ DATE _____
(Last) (First) (M.I.)

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME # _____ CHILDS CELL # _____ PARENTS CELL # _____

PARENTS WORK # _____ AGE: _____ SOCIAL SECURITY# _____

DATE OF BIRTH _____

FEMALE ____ MALE ____ SIBLINGS: _____

PARENTS NAME _____
(Last) (First) (M.I.)

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____

DATE OF BIRTH _____ AGE _____ SOCIAL SECURITY # _____

Male Female / Single Married Divorced Widowed NAME OF SPOUSE _____

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: _____

CONSENT TO TREATMENT OF MINOR

I (WE) BEING THE PARENT OR GUARDIAN OF _____, A MINOR, THE AGE OF _____ DO HEREBY CONSENT, AUTHORIZE AND REQUEST Dr. _____ TO ADMINISTER SUCH TREATMENT DEEMED ADVISABLE, NECESSARY OR REQUESTED ON THE ABOVE MINOR.

I (WE) AGREE TO HOLD HIM FREE AND HARMLESS FROM ANY CLAIMS, SUITS FOR DAMAGES OR COMPLICATIONS WHICH MAY RESULT FROM SUCH TREATMENT.

SIGNED _____
(PARENT OR GUARDIAN)

DATE _____

WITNESS _____

NAME _____ DATE _____

HISTORY OF CHIEF COMPLAINT

1st) Please describe the WORST/Major/Present complaint (another section for another complaint will follow):

Result of an Accident (car or injury): _____ **Birth Trauma:** _____ **Date of Incident:** _____

How long has the situation been going on?

Have you ever experienced this complaint before? _____

If so, please describe by answering the next 7 questions below. If not over look the next 7 questions:

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 _____

2nd) Please describe any other complaints or problems not mentioned above?

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

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

PAST HEALTH HISTORY

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

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

Serious illnesses/disease/anomalies (condition and year): _____

Automobile/motorcycle injuries (injury and year): _____

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

Present health problems (currently under medical treatment): _____

Vitamins/Supplements (indicate purpose/condition): _____

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

NAME _____ DATE _____

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): _____

Patient Instructions: Please **check any significant condition** that you have ever had in the past or that you are **currently experiencing**. Please **only acknowledge** what you would consider to be **significant conditions to your health history and/or chief complaints**.

1.	General	<input type="checkbox"/> Fever <input type="checkbox"/> Weight Loss or Gain <input type="checkbox"/> Sweats <input type="checkbox"/> Low Grade Fever	<input type="checkbox"/> Chills <input type="checkbox"/> Fatigue <input type="checkbox"/> Allergies <input type="checkbox"/> Frequent Illness	<input type="checkbox"/> Sleep Disturbances <input type="checkbox"/> Water Intake: _____ <input type="checkbox"/> Nausea <input type="checkbox"/> Normal
2.	Head	<input type="checkbox"/> Headache/Migraines <input type="checkbox"/> Trauma <input type="checkbox"/> Convulsions	<input type="checkbox"/> Dizziness <input type="checkbox"/> Loss of Consciousness <input type="checkbox"/> Fainting	<input type="checkbox"/> Pain/Discomfort <input type="checkbox"/> Lightheadedness <input type="checkbox"/> Normal

Patient: _____

Date: _____

3.	Eyes	<input type="checkbox"/> Contacts and/or Glasses <input type="checkbox"/> Color Blindness <input type="checkbox"/> Eye Pain <input type="checkbox"/> Double Vision <input type="checkbox"/> Difficulty Reading	<input type="checkbox"/> Blurry Vision <input type="checkbox"/> Flashes in Front of Eyes <input type="checkbox"/> Spots in Front of Eyes <input type="checkbox"/> Dryness <input type="checkbox"/> Eye Fatigue/Strain	<input type="checkbox"/> Tearing <input type="checkbox"/> Sensitive to Lights <input type="checkbox"/> Crossed Eyes <input type="checkbox"/> Eye Twitching <input type="checkbox"/> Normal
4.	Ears	<input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Frequent/History Infections <input type="checkbox"/> Itching/Irritation	<input type="checkbox"/> Hearing Loss <input type="checkbox"/> Drainage <input type="checkbox"/> Ringing	<input type="checkbox"/> Pain/Earache <input type="checkbox"/> Loud Noise Sensitivity <input type="checkbox"/> Normal
5.	Nose	<input type="checkbox"/> Post-Nasal Drip <input type="checkbox"/> Sinus Infections <input type="checkbox"/> Changes in Smell	<input type="checkbox"/> Dryness <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Congestion Sidedness	<input type="checkbox"/> Anomaly <input type="checkbox"/> Nasal Obstructions <input type="checkbox"/> Normal
6.	Mouth/ Throat	<input type="checkbox"/> Gum bleeds <input type="checkbox"/> Increased Saliva <input type="checkbox"/> Changes in Taste <input type="checkbox"/> Speech Problems <input type="checkbox"/> Bite/Chewing Changes <input type="checkbox"/> Soft Teeth	<input type="checkbox"/> Cold sores and/or Canker Sores <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Sore Throat/Sidedness <input type="checkbox"/> Dental Changes <input type="checkbox"/> Dental Decay <input type="checkbox"/> Metal Taste in Mouth	<input type="checkbox"/> Jaw Pain /TMJ Problems <input type="checkbox"/> Gagging <input type="checkbox"/> Tongue Tied <input type="checkbox"/> Hoarseness <input type="checkbox"/> Stuttering <input type="checkbox"/> Normal
7.	Neck	<input type="checkbox"/> Masses <input type="checkbox"/> Swelling <input type="checkbox"/> Enlarged Glands <input type="checkbox"/> Muscle Spasm	<input type="checkbox"/> Stiffness <input type="checkbox"/> Swollen Glands <input type="checkbox"/> Enlarged Thyroid <input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Pain <input type="checkbox"/> Range of Motion Changes <input type="checkbox"/> Skin/Temperature Changes <input type="checkbox"/> Normal
8.	Lungs	<input type="checkbox"/> Asthma <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Chest Pain <input type="checkbox"/> Inhalation Pain <input type="checkbox"/> Exhalation Pain	<input type="checkbox"/> Pneumonia <input type="checkbox"/> Coughing Up Sputum <input type="checkbox"/> Coughing Up Blood <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Lightheadedness	<input type="checkbox"/> Wheezing <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Difficulty Breathing w/ Sports <input type="checkbox"/> Normal
9.	Vascular	<input type="checkbox"/> Pain Over Heart <input type="checkbox"/> Heart Palpitations <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Slow/Fast Heart Beats <input type="checkbox"/> Leg/Arm Heaviness/Ache	<input type="checkbox"/> Swelling <input type="checkbox"/> Leg Cramps <input type="checkbox"/> Calf Pain <input type="checkbox"/> Toe/Foot Temperature Changes <input type="checkbox"/> Finger/Hand Temperature Changes <input type="checkbox"/> Vascular Disease	<input type="checkbox"/> Skin Color Changes <input type="checkbox"/> Ankle Swelling <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Poor Circulation <input type="checkbox"/> Nail Bed Changes <input type="checkbox"/> Normal
10.	Gastro-Intestinal	<input type="checkbox"/> Blood in Stool <input type="checkbox"/> Diarrhea/Constipation <input type="checkbox"/> Hiatal Hernia <input type="checkbox"/> Bowel Movement <input type="checkbox"/> Distension of Abdomen <input type="checkbox"/> Falling/Dropped Bladders	<input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Vomiting of Blood <input type="checkbox"/> Difficult Digestion/Food Sensitivities <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Poor Appetite <input type="checkbox"/> Dropping Reproductive System	<input type="checkbox"/> Heartburn <input type="checkbox"/> Gas or Belching <input type="checkbox"/> Hemorrhoid <input type="checkbox"/> Indigestion <input type="checkbox"/> Liver/Gallbladder/Pancreas History <input type="checkbox"/> Normal
11.	Genito-Urinary	<input type="checkbox"/> Pain with Urination <input type="checkbox"/> Color: Dark Light Clear <input type="checkbox"/> Pus in Urine <input type="checkbox"/> Bedwetting	<input type="checkbox"/> Increased Urination <input type="checkbox"/> Decreased Urination <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Incontinence/Bowel Problems	<input type="checkbox"/> Foul Odor of Urine <input type="checkbox"/> Difficulty with Urination <input type="checkbox"/> Urinary Tract Infections (UTI) <input type="checkbox"/> Normal
12.	Skin	<input type="checkbox"/> Rash <input type="checkbox"/> Bruise Easily <input type="checkbox"/> Hair Loss <input type="checkbox"/> Dryness <input type="checkbox"/> Eczema <input type="checkbox"/> Body Odors	<input type="checkbox"/> Warts <input type="checkbox"/> Brittle Nails <input type="checkbox"/> Changes in Moles <input type="checkbox"/> Temperature/Pain Changes <input type="checkbox"/> Fever Blisters/Herpes Lesion <input type="checkbox"/> Pimples/Acne	<input type="checkbox"/> Itching <input type="checkbox"/> Healing Time <input type="checkbox"/> Boils/Ulcers <input type="checkbox"/> Hives <input type="checkbox"/> Ulcers <input type="checkbox"/> Normal
13.	Neurology	<input type="checkbox"/> Seizures/Epilepsy <input type="checkbox"/> Strokes <input type="checkbox"/> Tremors <input type="checkbox"/> Running into Things <input type="checkbox"/> Muscle Twitching	<input type="checkbox"/> Tingling Sensation <input type="checkbox"/> Numbness Sensation <input type="checkbox"/> Burning Sensation <input type="checkbox"/> Tripping Over Feet <input type="checkbox"/> Balance Problems	<input type="checkbox"/> Weakness <input type="checkbox"/> Difficulty walking <input type="checkbox"/> Fainting <input type="checkbox"/> Spinning/Dizziness <input type="checkbox"/> Normal
14.	Musculo-Skeletal	<input type="checkbox"/> Joint Pain/Swelling <input type="checkbox"/> Stiffness <input type="checkbox"/> Muscle Ache <input type="checkbox"/> Radiation Pain <input type="checkbox"/> Joint Popping/Moving	<input type="checkbox"/> Arthritis <input type="checkbox"/> Anomaly/Deformities <input type="checkbox"/> Bone Pain <input type="checkbox"/> Bone Disease <input type="checkbox"/> Weakness	<input type="checkbox"/> Fractures <input type="checkbox"/> Dislocations <input type="checkbox"/> Spasm/Cramps <input type="checkbox"/> Muscle Infection/Disease <input type="checkbox"/> Normal
15.	Psychiatric	<input type="checkbox"/> Depression <input type="checkbox"/> Concentration <input type="checkbox"/> Stress <input type="checkbox"/> Memory: Short Long <input type="checkbox"/> Head Trauma	<input type="checkbox"/> Mood Swings <input type="checkbox"/> Nervousness <input type="checkbox"/> Personality Changes <input type="checkbox"/> Learning Disabilities <input type="checkbox"/> ADHD/ADD	<input type="checkbox"/> Anxiety <input type="checkbox"/> Phobias <input type="checkbox"/> Aggressive Behavior/Tendencies <input type="checkbox"/> Autism/Asberger <input type="checkbox"/> Normal

Patient: _____

Date: _____

16.	Social History	<input type="checkbox"/> Medical Behavioral Meds <input type="checkbox"/> Consume Caffeine <input type="checkbox"/> Stress (Home or School) <input type="checkbox"/> Drugs/Alcohol	<input type="checkbox"/> Exercise Regularly <input type="checkbox"/> Consume Diet Foods <input type="checkbox"/> Stress Level 1- 10: <input type="checkbox"/> Hobbies/Sports/Activities	<input type="checkbox"/> Processed/Dairy/Carbohydrate Food <input type="checkbox"/> Consume Soft Drinks/Coffee <input type="checkbox"/> Nervous Habits: <input type="checkbox"/> Normal
17.	Female ONLY OB-GYN	<input type="checkbox"/> Vaginal Discharge <input type="checkbox"/> Itching/Irritation <input type="checkbox"/> Age period Began: <input type="checkbox"/> Length of Periods:	<input type="checkbox"/> PMS <input type="checkbox"/> Last PAP date: <input type="checkbox"/> Breast Exam date: <input type="checkbox"/> Discharge from Nipples	<input type="checkbox"/> Are You Pregnant <input type="checkbox"/> Due Date: <input type="checkbox"/> Dr. Name & Number: <input type="checkbox"/> Normal
18.	Male ONLY	<input type="checkbox"/> Discharge <input type="checkbox"/> Pimples/Acne	<input type="checkbox"/> Hernia History/Surgeries <input type="checkbox"/> Pain/Irritation	<input type="checkbox"/> Genetic History <input type="checkbox"/> Normal
19.	Pregnancy/Birth	<input type="checkbox"/> Uneventful Pregnancy <input type="checkbox"/> Complicated Pregnancy <input type="checkbox"/> Problems 1 st Trimester <input type="checkbox"/> Problems 2 nd Trimester <input type="checkbox"/> Problems 3 rd Trimester <input type="checkbox"/> Problems Getting Pregnant <input type="checkbox"/> Ultrasound Qty:	<input type="checkbox"/> Amniocentesis <input type="checkbox"/> Blood Work Problems <input type="checkbox"/> Prenatal Vitamins <input type="checkbox"/> Stress Level 1 to 10: <input type="checkbox"/> Did Mom Work <input type="checkbox"/> Pregnancy Go Full Term <input type="checkbox"/> Labor Induced	<input type="checkbox"/> Drugs Administered w/Delivery <input type="checkbox"/> Duration of Labor: <input type="checkbox"/> Natural Birth <input type="checkbox"/> Epidural <input type="checkbox"/> Forceps <input type="checkbox"/> Vacuum Extraction <input type="checkbox"/> Normal

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 does not show** will be **charged in full**. Payment will be required at the following scheduled appointment.

Initial _____

Shaar Chiropractic & Neurology, P.C.

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

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. Collect 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.

Parent/Guardian 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.