

# Shaar Chiropractic & Neurology, P.C.

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

## PRE-EXISTING ADULT 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**

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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.)

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

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

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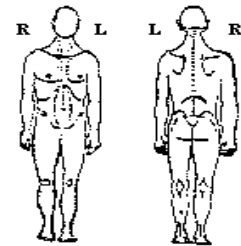
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**Have you ever sought chiropractic health care before?** (Dr.'s name, city or state, length of care, conditions treated, x-rays taken, etc.)

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**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.)

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**Please rate the intensity at its WORST on the scale below:**

0 \_\_\_\_\_ 10  
(absent) (extreme)

**Please rate the intensity RIGHT NOW 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.)

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NAME \_\_\_\_\_ DATE \_\_\_\_\_

**2<sup>nd</sup>) Please describe another chief complaint or problem:** \_\_\_\_\_

**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 \_\_\_\_\_

# 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 all 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 5<sup>th</sup> light onto W. Chatfield Ave.
- (go through 2 lights)
- Turn **Right** (south) at 3<sup>rd</sup> 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 3<sup>rd</sup> light onto Platte Canyon Rd.
- (go through 6 lights)
- Turn **Left** (south) at the 7<sup>th</sup> 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 3<sup>rd</sup> 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.