WELCOME

Red Rock Chiropractic & Wellness Center
2085 Village Center Circle #110
Las Vegas NV 89134

(702)880-5335

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with

_____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to

_____
Name of Doctor or Clinic

for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____
Signature of Beneficiary, Guardian or Personal Representative

_____
Please print name of Beneficiary, Guardian or Personal Representative

_____ _____
Date Relationship to Beneficiary

3 PHONE NUMBERS

Home (_____) _____ Cell (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

4 FAMILY HISTORY

Date of last physical examination _____

What is your reason for visit? _____

	FATHER	Present health or cause of death	MOTHER	Present health or cause of death	SPOUSE	Present health or cause of death
ALIVE	☐		☐		☐	
DECEASED	☐		☐		☐	
BROTHERS	NO. ALIVE	HEALTH		NO. DECEASED	CAUSE OF DEATH	
SISTERS	NO. ALIVE	HEALTH		NO. DECEASED	CAUSE OF DEATH	
CHILDREN	NO. ALIVE	AGES & HEALTH		NO. DECEASED	AGES & CAUSE OF DEATH	

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR **BLOOD RELATIVES**

☐ Diabetes ☐ Cancer ☐ Bleeding tendency ☐ Kidney disease ☐ Tuberculosis
☐ Heart disease ☐ Stroke ☐ High blood pressure ☐ Nervous illness ☐ Allergy ☐ Other _____

E MEDICAL HISTORY All information is strictly confidential.

Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression/Nervousness
- ☐ Dizziness/Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High/Low blood pressure
- ☐ Irregular/Rapid heart beat
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache/Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes/Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching/Rash
- ☐ Change in moles
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

Check (✓) conditions you have or have had in the past.
- ☐ AIDS
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

Describe serious illnesses or operations _____

MEDICATIONS/ALLERGIES

List medications you are currently taking _____

_____

Pharmacy Name _____

Phone (____) _____

List allergies to medications or substances _____

_____

_____

HEALTH HABITS

Check (✓) which you use and how much:
- ☐ Caffeine _____
- ☐ Street Drugs _____
- ☐ Tobacco _____
- ☐ Other _____

Check (✓) if your work exposes you to:
- ☐ Stress
- ☐ Heavy Lifting
- ☐ Hazardous Substances
- ☐ Other _____

Your occupation _____

F SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

_____ _____
Reviewed By — Date

Name_____Age_____Date of injury_____

What is your current weight_____lbs., and height,_____ft ____in.?

Please briefly describe your condition:

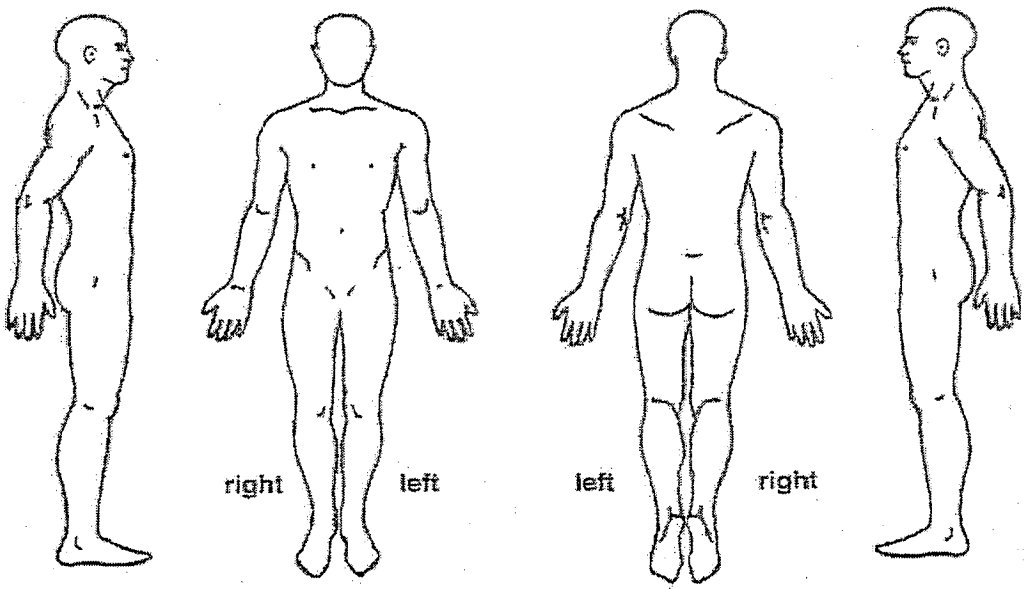
_____

_____

Patient Signature_____**Date**_____

Please mark the area(s) of injury or discomfort using the symbols below.

Numbness	Pins & Needles	Burning	Aching	Stabbing
-----	OOOOO	^^^^^	XXXXX	@@@@@



Right Front Back Left

Please circle your estimated level of pain, in your opinion

0 1 2 3 4 5 6 7 8 9 10

Doctors notes:_____

_____

_____

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Patient Name: _____ **Date of Birth:** _____ **Date:** _____

Social Security # _____ **Patient/Clinic ID#** _____ **Admit. Date:** _____

Patient Informed Consent

Congratulations on choosing chiropractic health care. This clinic believes it is the safest, most natural health care delivery system in the world today. Chiropractic adjustments (chiropractic manipulative therapy; C.M.T.) and other care procedures are safe and cost effective.

All health care professionals (anesthesiologists, chiropractors, dentists, medical doctors, osteopaths, pharmacists, surgeons, etc.) are regulated by laws and boards. These health care professionals are required to give you, the patient, advanced notice of any care risks, because health care is not an exact science. It is not reasonable to expect any doctor to foresee all risks and/or complications. Informed consent information regarding any risks such as: paraplegia, quadriplegia, brain damage, stroke, disc injury, breaks, fractures, dislocations, drug reactions, death or loss of function of any organ or limb, or disfiguring scars associated with physical care, drugs, surgery and/or treatment is an undesirable result, but it does not necessarily indicate an error in clinical judgement. No guarantee of cure or results has been made to you, the patient in this clinic. Your care may involve the making of recommendations based upon facts known to the doctor at this time. Chiropractic care does not use drugs or surgery, and does not diagnose internal and/or medical conditions.

For your information the following is furnished to all patients who request and/or accept chiropractic care in this clinic. Again, chiropractic care does not use drugs or surgery, and does not diagnose internal and/or medical conditions. This clinic is staffed with graduate chiropractors who are licensed and recognized by government agencies regulating all the aforementioned healing arts.

Chiropractic is the science that concerns itself with the relationship between the brain, central nervous system, spine, and the function of the body. Any alteration of this relationship can cause the biomechanical and neurophysiological dynamics of the contiguous spinal and paraspinal structures to be disrupted. This can cause neuronal disturbances in the form of the vertebral subluxation complex (V.S.C.) with its physical and chemical components, which can then interrupt the body's inherent recuperative powers.

The practice of chiropractic can include exams and diagnostic testing. In some cases, this includes the utilization of specialized instrumentation, lab tests, radiological exams, nutritional and/or physical therapy, and rehabilitation procedures, etc. There is a special procedure unique to chiropractic: the chiropractic adjustment (chiropractic manipulative therapy-C.M.T.). Adjustments are made by chiropractors to correct and/or reduce and/or stabilize vertebral or extremity subluxation complexes. The goal of chiropractic health care is to reduce and/or stabilize the nerve interference caused by the VSC and its component parts. There are over 200 different adjusting techniques, some using specialized equipment. Adjustments are usually performed by hand, but may be performed by hand-guided instruments. A C.M.T. is the application of a specific force, applied to a segmental contact point, usually on a vertebra, to reduce or stabilize the V.S.C. and its component parts.

You should understand the benefits of chiropractic health care, but you also need to be aware of some of the limited inherent risks. These occur seldom enough to contraindicate care, but should be considered in your informed decision to receive chiropractic care.

All health care procedures have some risks. With C.M.T.'S these risks may include musculoskeletal sprain/strain, disc injuries, dislocations, fractures, neurological deficits, Horner's Syndrome, Vertebral Artery Syndrome (V.A.S.), stroke, etc. The chances of this occurring have been estimated by experts to be approximately only 1 per 400,000 treatments, to 1 per 1,000,000 treatments.

Appropriate tests will be performed to identify if you may be susceptible to these risks, and you will be notified, in that case. If you have any questions about these issues, please do not hesitate to speak with your doctor of chiropractic.

I have read (or have had read to me) the above information. I wish to rely on the doctors judgement during my course of care, based on the facts then known. I have also had opportunity to ask questions regarding the above information and possible consequences and risks. By signing below, I now agree to have the chiropractic care procedures recommended and performed. I have no questions, and I acknowledge no guarantee of cure has been made to me concerning results, care and treatment.

INFORMED CONSENT TO TREAT

The information I have given this office and my treating doctor is complete and true to the best of my knowledge. I understand the risks associated this form of treatment and I will take the responsibility to ask the doctor to clarify any of my considerations or areas of treatment that I do not completely understand. I authorize the doctors and staff to administer such procedures and treatment as they deem necessary. They have not stated or implied any guaranteed of cure. "24 Hour notice of cancellation is required to avoid a broken appointment charge of $40.00. I am responsible for payment of this charge.

Patient's Signature:_____ **Date:**_____

Witness:_____ **Date:**_____

INFORMED CONSENT TO TREAT A MINOR CHILD

The information I have given this office and my treating doctor pertaining to _____ is complete and true to the best of my knowledge. I understand the risks associated with this form of treatment and will take the responsibility to ask the doctor to clarify any of my considerations or areas of treatment that I do not completely understand. I authorize the doctors and staff to administer such procedures and treatment as they deem necessary to my **child/ward** in my legal custody. They have not stated or implied any guaranteed of cure.

Parent/Guardian Signature:_____ **Date:**_____

Relationship to Minor:_____

Witness:_____ **Date:**_____

Signature of Chiropractic Representative *Patient Signature* *Date*

I CERTIFY THAT I AM THE PARENT OF THE MINOR CHILD, THE GUARDIAN, OR OTHER LEGAL REPRESENTATIVE OF THE PATIENT INVOLVED.

_____

Parent/Guardian/Legal Representative Signature *Date*

RED ROCK
CHIROPRACTIC
& WELLNESS
CENTER

Dr. Margaret R. Colucci
& Associates

Office 702 880.5335
Fax 702 880.5336

www.redrock
chiropractic.com

2085 Village Center Circle
Suite 110
Las Vegas, Nevada 89134

Consent To X-Ray

Patient Name:_____

Date:_____

FEMALES - I UNDERSTAND THAT IF I AM PREGNANT AND HAVE X-RAYS TAKEN WHICK EXPOSE MY LOWER TORSO TO RADIATION, IT IS POSSIBLE TO INJURE THE FETUS. I AHEV BEEN ADVISED THAT 10 DAYS FOLLOWING ONSET OF MENSTRUAL PERIOD ARE GENERALLY CONSIDERED TO BE SAFE FOR X-RAY EXAMS.

WITH FULL UNDERSTANDING OF THE ABOVE, I DO HEREBY STATE THAT, TO THE BEST OF MY KNOWLEDGE, I AM NOT PREGNANT, NOR IS PREGNANCY SUSPECTED OR CONFIRMED AT THIS TIME AND I WISH TO HAVE XRAYS EXAMINATION PERFORMED NOW.

MALES - I DO HERBY GIVE MY PERMISSION TO HAVE AN X-RAY EXAMINATION PERFORMED ON ME.

_____

Patient's Signature

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Financial Policy

Thank you for choosing us as your Chiropractic provider. Our main concern is that you receive the proper chiropractic care as needed to maintain optimum spinal health. If you have any questions , Please do not hesitate to ask our staff and/ or doctor.

Our practice firmly believes that a good doctor/ patient relationship is based upon understanding and open communication. The following information is designed to provide you with detailed information about our policies and financial policies to allow a better understanding of your financial liabilities for our professional services.

*Payments for services are due at the time services are rendered. We accept cash, checks, and for your convenience, MasterCard and Visa.

Please read the following and initial each line:

_____ 1.All co- pays and deductible are due at the time of your visit. Payment for services for cash visits are due " In Full" at the time of your visit. We accept cash Checks and Master Card.

_____ 2.We will submit an insurance claim on your behalf as a courtesy, if we have a provider contract with your Insurance Company. However, it is your responsibility to follow up with your insurance company in the event that your claim is unpaid. If any of your personal information changes, it is your responsibility to notify us and provide a copy of the new insurance card to us immediately. (WE DO NOT BILL SECONDARY INSURANCE).

_____ 3.Your insurance policy is a contract between you, your employer and your insurance company. We are Not a party to that contract. Our relationship is with you and not your insurance company. You are ultimately responsible for any services provided, regardless of your insurance coverage.

_____ 4.Your insurance company does not cover all services that are provided .It is your responsibility to know the limitations and benefits. Fees for no-covered services are due at the time they are rendered.

_____5. If your insurance company requires a referral from your Primary Care Physicians (PCP), it is your responsibility to have this with you at the time of your visits or your will be responsible for payment of the service.

_____ 6 If your insurance does not pay within 60days from your visit, we reserve the right to begin billing you directly and that you contact your insurance carrier. Accounts will be considered delinquent after 90 days . Deliquent accounts will be placed with a private collection agency. Any and all accounts placed with the collection agency will be subject to all reasonable collection, interest and filing fees and court cost.

_____ 7 Should you receive payment from your insurance company or lien for services provided by Red Rock Chiropractic & Wellness Center, You have 10 days to forward the said monies to our office. Should you fail to carry out this, we will report it to the Internal Revenue Services (IRS) as an income and not a reimbursement and we will place the account with the collection agency.

_____ 8. Returned Checks are subject to a $25.00 returned check fee. of any services you receive. .

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_____ 9 A charge of $40.00 will be assessed for any missed and cancelled appointments without 24-hour notice. This is to the patient's personal responsibility: we can not bill this to the insurance
You will be responsible to make up any missed appointment with in the week in order not to be charged the missed appointment fee.

_____ 10. Insurance companies do not cover supplement' and or supplies such as: neck and back support pillows. They are the patient's responsibility. Please consult with our front office regarding products and prices.

_____ 11.For any unpaid past due balances over 30 days old, a late fee of 1.5% per month will be assessed. Unpaid balances over 30 days are subject to further collection actions by an outside agency , unless payment arrangements have been made in writing.

_____ 12. All Returns on supplies and supplements are subject to a restocking fee and must be returned within 10 days from the date of purchased. All special orders are subject to a shipping fee.. No cash refunds will be issued only a credit will be applied to your account. After 10 days all sales are final.

_____ 12.All returns on Spinal Pelvic Stablizers (Orthotics) are subject to a non- refundable $50.00 molding fee. I understand I am responsible for all shipping fees to return the product. You have 30 days from the date of receipt to receive a refund. After 30 days all sales are final.

_____ 14. I understand I am responsible to follow up with my insurance company as to when I reach my maximum benefit. (We are not always notified by all insurance carriers in a timely manner).

_____. 15. I understand I am responsible to follow up with my insurance company as to when I reach my maximum benefit. (We are not always notified by all insurance carries in a timely manner)

_____ 16). Effective as of August 17, 2015 all credit cards and debit cards will have a service charge of $1.00 per each transaction as a service fee. We accept Visa, Master card and Discover . We do not accept American Express .

We do understand that temporary financial problems may affect timely payments of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

_____ _____
Signature of Patient/ Guarantor **Date**

_____ _____
Witness **Date**

RED ROCK
CHIROPRACTIC

Dr. Margaret R. Colucci
Chiropractic Physician

Office 702 880.5335
Fax 702 880.5336
redrockchiropractic@yahoo.com

Red Rock Chiropractic & Wellness Center
2085 Village Center Circle #110
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AUTHORIZATION

FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

This Authorization authorizes the release of Protected Health Information pursuant to 45 CFR Parts 160 and 164.

1. The undersigned authorizes the above-named provider ("Provider") to release the following information: (describe specifically)

2. The information may be disclosed by employees or business associates of (Provider).

3. The information may be disclosed to: _____(insert name or other specific identification of the persons or entities to which the disclosure will be made)

4. The disclosure may be made for the following purpose _____(describe specifically. If disclosure is at patient's request, "Patient request" will suffice)

5. This authorization will expire on (date) _____. (or when - describe occurrence).

6. I acknowledge: (i) that I have the right to revoke the authorization at any time, and (ii) that I understand that once the information is disclosed, it may no longer be protected by federal privacy law.

You may revoke this authorization only in a writing sent by certified mail to (the Provider) at the address above. The revocation will be effective only upon receipt, except (1) to the extent (the Provider) has acted in reliance on the authorization, or (2) the authorization was obtained as a condition of obtaining insurance coverage and the insurer wishes to use to the protected health information to lawfully contest a claim.

7. I understand that treatment by (the Provider) is not conditioned on my signing this authorization, although exceptions will be made for (a) research-related treatment, (b) for treatment the purpose of which is creating protected health information for a third party, such as pre-employment physicals, and (c) except for psychotherapy notes, for health plans who condition enrollment or on an authorization requested prior to enrollment, or where payment is conditioned on an authorization to use PHI to determine payment.

8. If this authorization is for a marketing use or disclosure of my information, (the Provider):

8.1 [ ] will be remunerated by a third party.

8.2 [ ] will not be remunerated by a third party.

Date:_____

Signed by_____

Print Patient's Name:_____

If person signing is other than patient, state authority under which signature is made:

Red Rock Chiropractic & Wellness Center
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Office (702) 880-5335
Fax (702) 880-5336

Authorization to Release Medical Information

Patient Name _____ Nick Name/ Maiden / Other _____

SS#_____ Date of birth _____/_____/_____

Home phone _____ Phone Number (Cell / Pager/ Other)_____

Work phone_____ ext._____ Best times to call _____

Address_____

City_____ State_____ Zip_____

Please obtain information from the following:

Name of Physician_____Facility_____

Address_____

City_____ State_____ Zip_____

Phone _____ext._____ Fax _____

Please send my medical information to:

Red Rock Chiropractic & Wellness Center
2085 Village Center Circle #110
Las Vegas, NV 89134
702-880-5336

All pertinent medical records :_____

Specific Information as indicated:_____

By initialing, I specifically authorize the release of the following confidential information.

_____ HIV test, test results, and related information
_____ Drug/Alcohol diagnosis, treatment and referral information
_____ Mental health treatment information
_____ Other (specify)_____

I understand that my consent may be revoked at any time. The only exception is when action has already occurred as instruction in the consent. Unless revoked earlier, this consent will expire in four months from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

_____ _____
Signature (Patient-Parent- Guardian) Date