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

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

(702)880-5335

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

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
Las Vegas NV 89134

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
2085 Village Center Circle #110
Las Vegas, NV. 89134
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

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

CHIROPRACTIC HISTORY

PATIENT'S NAME _____

SOCIAL SECURITY # _____

Have you previously seen a chiropractor in the last twelve (12) months?

Yes _____ No _____

If yes: Who did you see? _____

When did you receive treatment? _____

For how long? _____

For what condition or area of body? _____

Were X-rays taken? Yes _____ No _____

Signed: _____

Date: _____

Name_____Age_____Date of injury_____

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

Please briefly describe your condition:

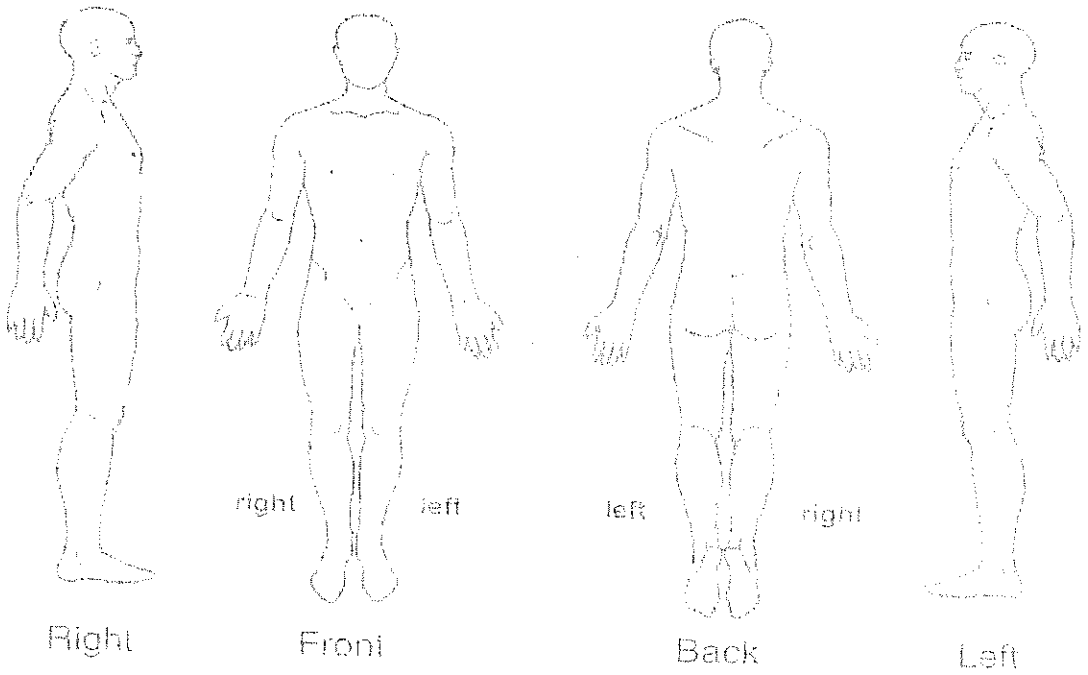
_____

_____

Patient Signature_____**Date**_____

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

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



Please circle your estimated level of pain, in your opinion

0 1 2 3 4 5 6 7 8 9 10

Doctors notes:_____

_____

_____

Chiropractor Name and Address that Patient/Attorney is Authorizing Lien with.
DR. MARGARET R. COLUCCI
Red Rock Chiropractic & Wellness Center
2085 Village Center Circle #110 Las Vegas NV 89134 (702)880-5335

LIEN AUTHORIZATION
TO PAY CHIROPRACTIC FEES
-and Constructive Trust for the Chiropractor-

ATTORNEY NAME/ADDRESS:
Date of Injury:

PATIENT NAME/ADDRESS:
Social Security No:

PATIENT AGREEMENT

I hereby authorize the above Chiropractor to furnish you, my attorney, a full report of his/her examination, diagnosis, treatment, and prognosis of my injuries, arising from the accident in which I was involved.

I further authorize and irrevocably direct you, my attorney, **to pay directly to above Chiropractor** such billings and fees as may be due and owing to him for these chiropractic services/treatment, X-rays, reports, all deposition time, court appearances, transcription time, and costs rendered to me by reason of this accident. You, my attorney, are further irrevocable directed to pay such billings and fees from funds held for me in your client trust account, or to withhold such sums from any settlements, judgments, dispositions, proceeds, payments or verdicts received by you on my behalf as may be necessary to adequately protect above Chiropractor. I hereby further, irrevocably, give a lien on my case to above Chiropractor against any and all proceeds of any settlements, judgments, dispositions, proceeds, payments, payments or verdicts which may be paid to you, my attorney, or myself, as a result of the injuries which necessitated diagnostic testing, examination, and treatment.

I fully realize and understand that I am directly and fully, personally responsible to the above Chiropractor for all chiropractic billing and that ***this obligation is not contingent upon my receiving any settlement for my claim.*** With this in mind, I agree to give the above Chiropractor all information concerning any and all insurance policies which may cover my chiropractic treatment and diagnosis. I further agree to notify the said Chiropractor's office and to pay his/her billings at such time as I may personally receive payments made directly to myself from any of the involved insurance carriers.

Should I receive payment for the above Chiropractic fees and have not turned said monies over to the above Chiropractor within thirty (30) days, or should I fail to perform my obligation to pay these fees, then the entire amount of the Chiropractors billing shall bear interest at the highest rate permitted by law from the date chiropractic services were first rendered.

In the event I discharge my present attorney, or change or substitute another attorney, at any time, prior to payment in full for all chiropractic billing and other charges, the new attorney shall honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him/her. I agree to notify said Chiropractor if any change in attorney status within two weeks. If my new attorney does not honor this lien for any reason, or if I have no legal representation for any reason, then I will pay all of said Chiropractor bills in full within thirty (30) days.

(Continued on Other Side-Page 2)

Lien Authorization-(Continued from Side One)

Chiropractor's Name: Dr. Margaret R. Colucci D.C.

PATIENT AGREEMENT CONTINUED (PAGE 2)

I agree to be responsible for any legal fees, court, or collection agency costs incurred, which are necessary to enforce this agreement. Those additional expenses for legal or collection agency fees or court costs, will be added on top of the billings and/or fees of said Chiropractor along with the highest interest rate permitted by law, calculated from the date chiropractic services were first rendered. I understand that, in view of the protracted time for cases to be tried, I waive any right to statute of limitations for collections.

I hereby appoint the said Chiropractor at the address on this lien as my Attorney-in-Fact, to act in my name and place, and on my behalf with authority to endorse any checks issued to me in payment for Chiropractic fees.

This contract is binding upon me, whether or not signed by my attorney.

A photocopy reproduction of this authorization and signature may be used in place of the original.

Dated:_____ Patient's Signature:_____

Print Name: _____

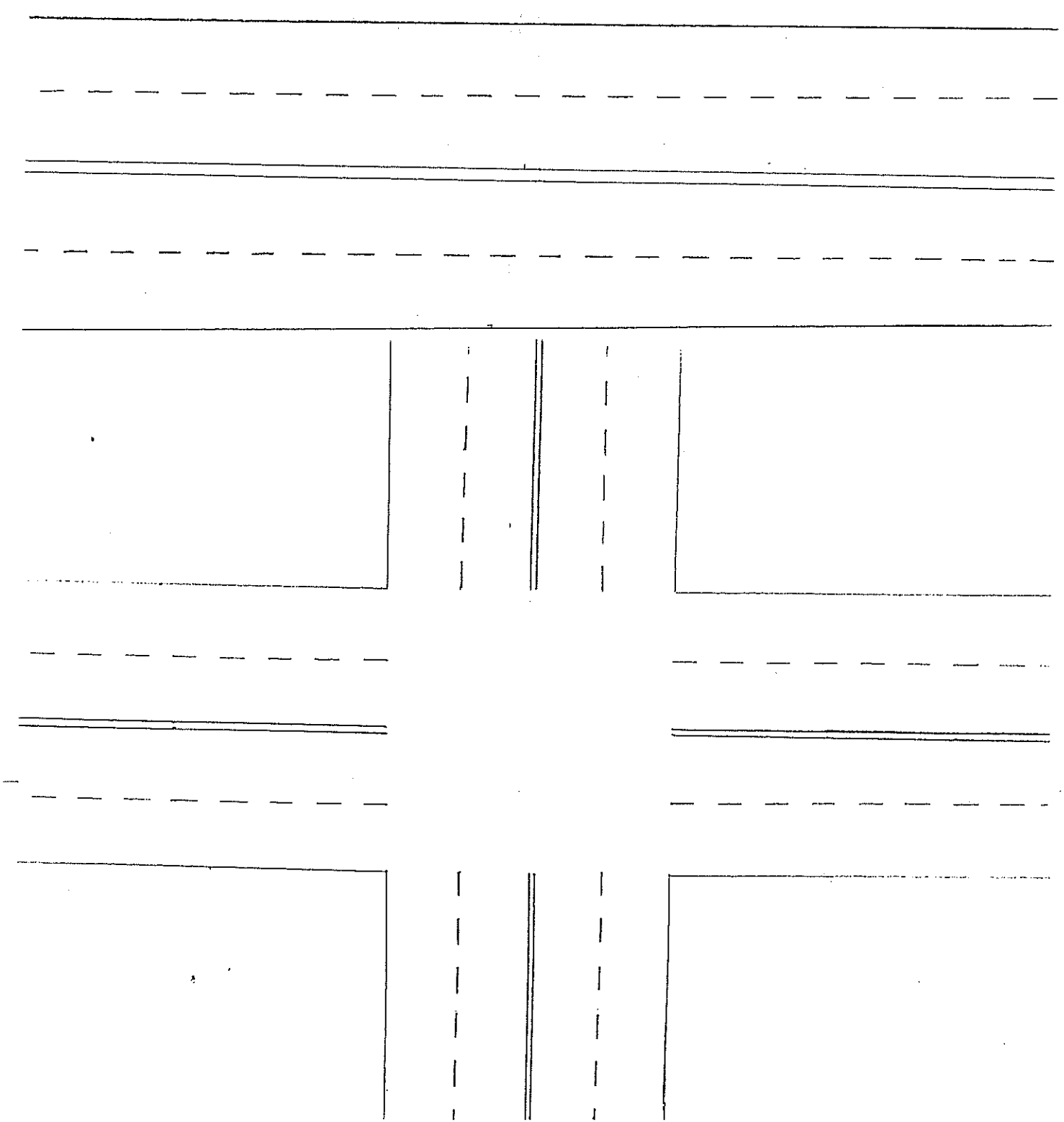
ATTORNEY AGREEMENT

The undersigned, being the attorney of record for the above-mentioned patient, does hereby agree to observe all the terms of the above **Chiropractic Lien and agrees to withhold such sums In Trust** from any payments, proceeds, dispositions, settlements, judgments, or verdicts as may be necessary to adequately protect said Chiropractor. This lien is given with the understanding that it applies only to the net proceeds received, after deduction of attorney's fees and costs of suit. Furthermore, this lien is to be treated on a pro rata basis, with all other liens of equal stature. Counsel further agrees to notify said Chiropractor in writing, at such time as this patient's case is surrendered to the patient/client or is transferred to a new attorney. The undersigned also represents and warrants to said Chiropractor that he/she has explained fully to his/her client, all of the legal ramifications of the foregoing chiropractic lien for services rendered including, but not limited to, its irrevocability, its waiver of the defense of the statute of limitations and its provision for direct payments of chiropractic billings. Furthermore, counsel agrees that after receiving monies to send payment to said Chiropractor within thirty (30) days or be charged an additional 2% per month at the highest interest rate permitted by the law for every month that the suit has been settled and/or chiropractic payments have been received and said Chiropractor remains unpaid. Counsel agrees to pay all legal fees and court costs should this lien necessitate enforcement through the legal process.

Dated:_____ Attorney Signature:_____

Print Name:_____

Attorney, please date, print and sign your name, and then promptly return this form to said Chiropractor's office after making a copy for your own records.



ACCIDENT QUESTIONNAIRE

PATIENT'S NAME_____ DATE_____

Date of Injury:___/___/___ Attorney:_____

Date of Exam:___/___/___

ACCIDENT HISTORY:

_____

_____

_____

_____

Type of vehicle driving:_____(car, truck, motorcycle, other....)
Type of vehicle hit:_____(car, truck, motorcycle, other....)
Impact collision: ___Head on ___Driver side ___Passenger side
Rear-end collision_____
Did your vehicle hit other vehicles: yes____ no____
Were you a : driver____ passenger:____ front:____ back:____
Where there any other passengers in the vehicle? yes___ no___ If so, how many?_____ Who were your passengers?_____.
Was your car: stopped____ moving____
Estimated speed your car was traveling:_____m.p.h.
Estimated speed of other vehicle:_____m.p.h.
Were you braced for impact: yes___ no___
Were your brakes applied: yes___ no___
Were you wearing: lap belt___ shoulder harness___
Does your seat have a head restraint: yes___ no___
Were you looking : straight ahead____ left___ right___
Were you knocked unconscious: no___ no sure___
If knocked unconscious: few seconds____ few minutes___ an hour___
a few hours___
List any part of your body that made contact with vehicle parts:_____

_____

_____

What happened at the moment of impact: tensed body___ neck whiplash___
thrown from side to side____ bruised____ cut____
thrown over the seat___
Immediately after the accident did you feel: stunned____ frightened___ dazed___
confused____ dizzy____ shocked____ shaken____
nauseous____
Did you receive medical aid at the accident site: yes____ no____

Where did you go right after the accident: hospital____ emergency treatment center____ home ____ family physician____ this office____ work____ _

How did you get there: ambulance____ drove myself___ walked___ someone drove me____

Did your symptoms develop: immediately____ hours later____ next day____ over the next few days____ over the next few months____

Since the accident have your symptoms: gotten better____ gotten worse____ same____

Where did you have pain: neck____ shoulders____ arm ____ hand ____ upper back____ mid back ____ low back____ leg____ knee____ foot____ headaches____ other_____

Have you seen any other Doctors for this condition: yes___ no___
If so, Name_____ D.C.___, DO.___, M.D.____ PAT.___

Test performed: Exam____ X-ray____ CT Scan____ MRI____ EGG____
Prescription received: pain killers____ muscle relaxers____ anti-inflammatory____

WORK HISTORY:

Have you missed any days from work? yes____ no____
If so how many? _____Last day worked? _____
Have you returned to work? ___Yes ___ NO If so, when? ____/____/____
What type of work do you do?_____
_____
_____

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 STE 110
LAS VEGAS, NV 89134-6263

PATIENT TRACKING

Patient name: _____ **Date of accident/injury**_____
Address: _____
_____
Phone: ( ) _____ **Home**
( ) _____ **Other**
Insurance: _____
Address: _____
_____
Phone: ( ) _____
Contact: _____
Attorney: _____
Address: _____
_____
Phone: ( ) _____
Contact: _____

ACTIVATOR METHODS, INC., P.O. Box 80317, Phoenix, AZ 85060-0317
(602) 224-0220 Fax: (602) 224-0230

REVISED OSWESTRY CHRONIC LOW BACK PAIN DISABILITY QUESTIONNAIRE

NAME (Please Print): _____ DATE: _____

AGE: _____ DATE OF BIRTH: _____ OCCUPATION: _____

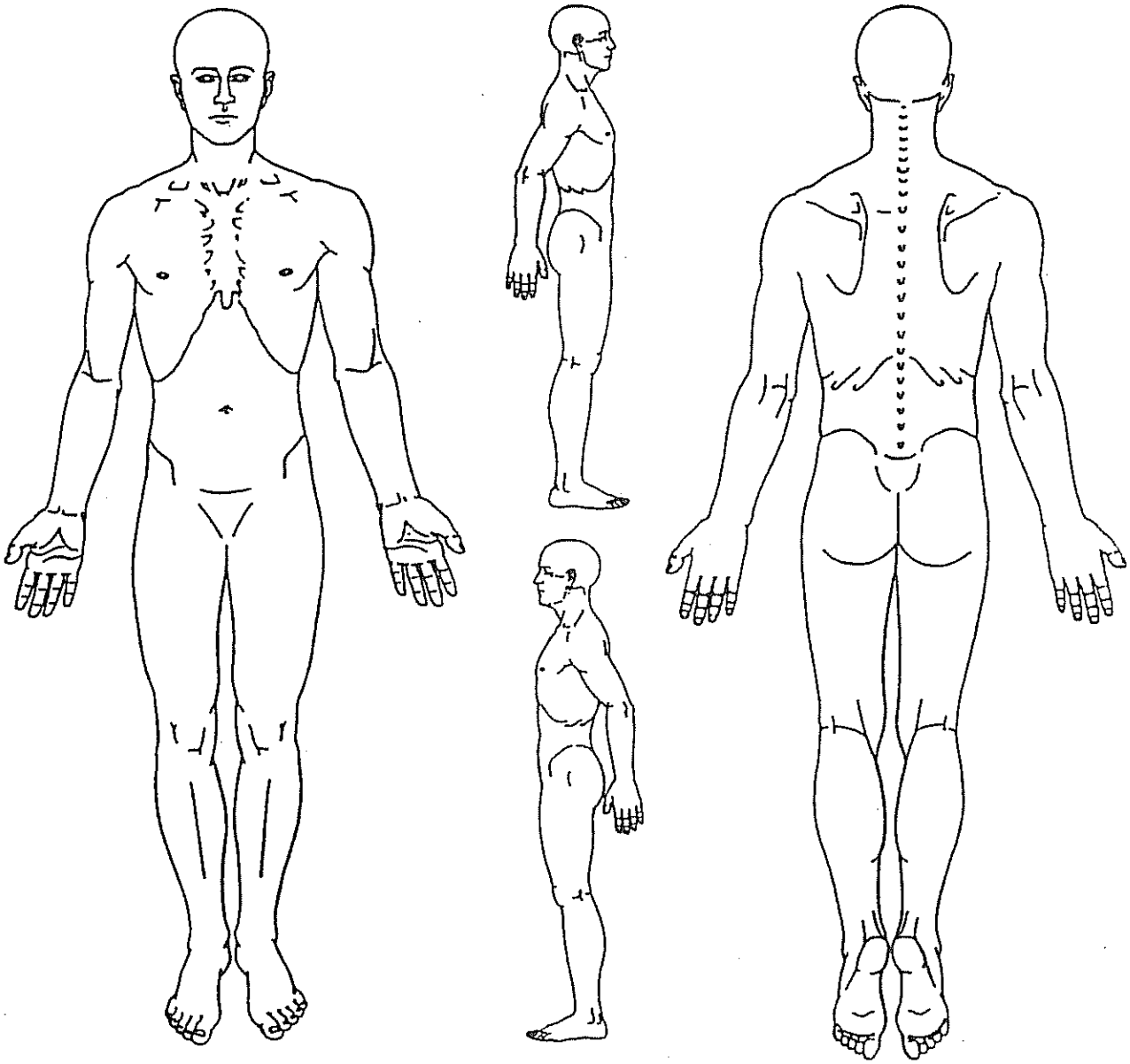
HOW LONG HAVE YOU HAD LOW BACK PAIN? ___YEARS ___MONTHS ___WEEKS

IS THIS YOUR FIRST EPISODE OF LOW BACK PAIN? ___YES ___NO

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW

(Please remember to complete both sides of this form.)

KEY: **A**=ACHE **B**=BURNING **N**=NUMBNESS
P=PINS & NEEDLES **S**=STABBING **O**=OTHER



OVER PLEASE

REVISED OSWESTRY CHRONIC LOW BACK PAIN DISABILITY QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

SECTION 1 -- Pain Intensity

A The pain comes and goes and is very mild.
B The pain is mild and does not vary much.
C The pain comes and goes and is moderate.
D The pain is moderate and does not vary much.
E The pain comes and goes and is severe.
F The pain is severe and does not vary much.

SECTION 2 -- Personal Care

A I would not have to change my way of washing or dressing in order to avoid pain.
B I do not normally change my way of washing or dressing even though it causes some pain.
C Washing and dressing increases the pain, but I manage not to change my way of doing it.
D Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E Because of the pain, I am unable to do some washing and dressing without help.
F Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 -- Lifting

A I can lift heavy weights without extra pain.
B I can lift heavy weights, but it causes extra pain.
C Pain prevents me from lifting heavy weights off the floor.
D Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
E Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F I can only lift very light weights, at the most.

SECTION 4 -- Walking

A Pain does not prevent me from walking any distance.
B Pain prevents me from walking more than one mile.
C Pain prevents me from walking more than 1/2 mile.
D Pain prevents me from walking more than 1/4 mile.
E I can only walk while using a cane or on crutches.
F I am in bed most of the time and have to crawl to the toilet.

SECTION 5 -- Sitting

A I can sit in any chair as long as I like without pain.
B I can only sit in my favorite chair as long as I like.
C Pain prevents me from sitting more than one hour.
D Pain prevents me from sitting more than 1/2 hour.
E Pain prevents me from sitting more than ten minutes.
F Pain prevents me from sitting at all.

From: N. Hudson, K. Tome-Nicholson, A. Breen; 1989

REVISED 9/11/92

SECTION 6 -- Standing

A I can stand as long as I want without pain.
B I have some pain while standing, but it does not increase with time.
C I cannot stand for longer than one hour without increasing pain.
D I cannot stand for longer than 1/2 hour without increasing pain.
E I cannot stand for longer than ten minutes without increasing pain.
F I avoid standing, because it increases the pain straight away.

SECTION 7 -- Sleeping

A I get no pain in bed.
B I get pain in bed, but it does not prevent me from sleeping well.
C Because of pain, my normal night's sleep is reduced by less than one-quarter.
D Because of pain, my normal night's sleep is reduced by less than one-half.
E Because of pain, my normal night's sleep is reduced by less than three-quarters.
F Pain prevents me from sleeping at all.

SECTION 8 -- Social Life

A My social life is normal and gives me no pain.
B My social life is normal, but increases the degree of my pain.
C Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
D Pain has restricted my social life and I do not go out very often.
E Pain has restricted my social life to my home.
F I have hardly any social life because of the pain.

SECTION 9 -- Traveling

A I get no pain while traveling.
B I get some pain while traveling, but none of my usual forms of travel make it any worse.
C I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D I get extra pain while traveling which compels me to seek alternative forms of travel.
E Pain restricts all forms of travel.
F Pain prevents all forms of travel except that done lying down.

SECTION 10 -- Changing Degree of Pain

A My pain is rapidly getting better.
B My pain fluctuates, but overall is definitely getting better.
C My pain seems to be getting better, but improvement is slow at present.
D My pain is neither getting better nor worse.
E My pain is gradually worsening.
F My pain is rapidly worsening.

Comments: _____

Patient Signature: _____ Date: _____

For re-ordering information, contact:
ACTIVATOR METHODS, INC., P.O. Box 80317, Phoenix, AZ 85060-0317
Phone: (602) 224-0220; Facsimile (602) 224-0230

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

NAME (Please Print): _____ DATE: _____

AGE: _____ DATE OF BIRTH: _____ OCCUPATION: _____

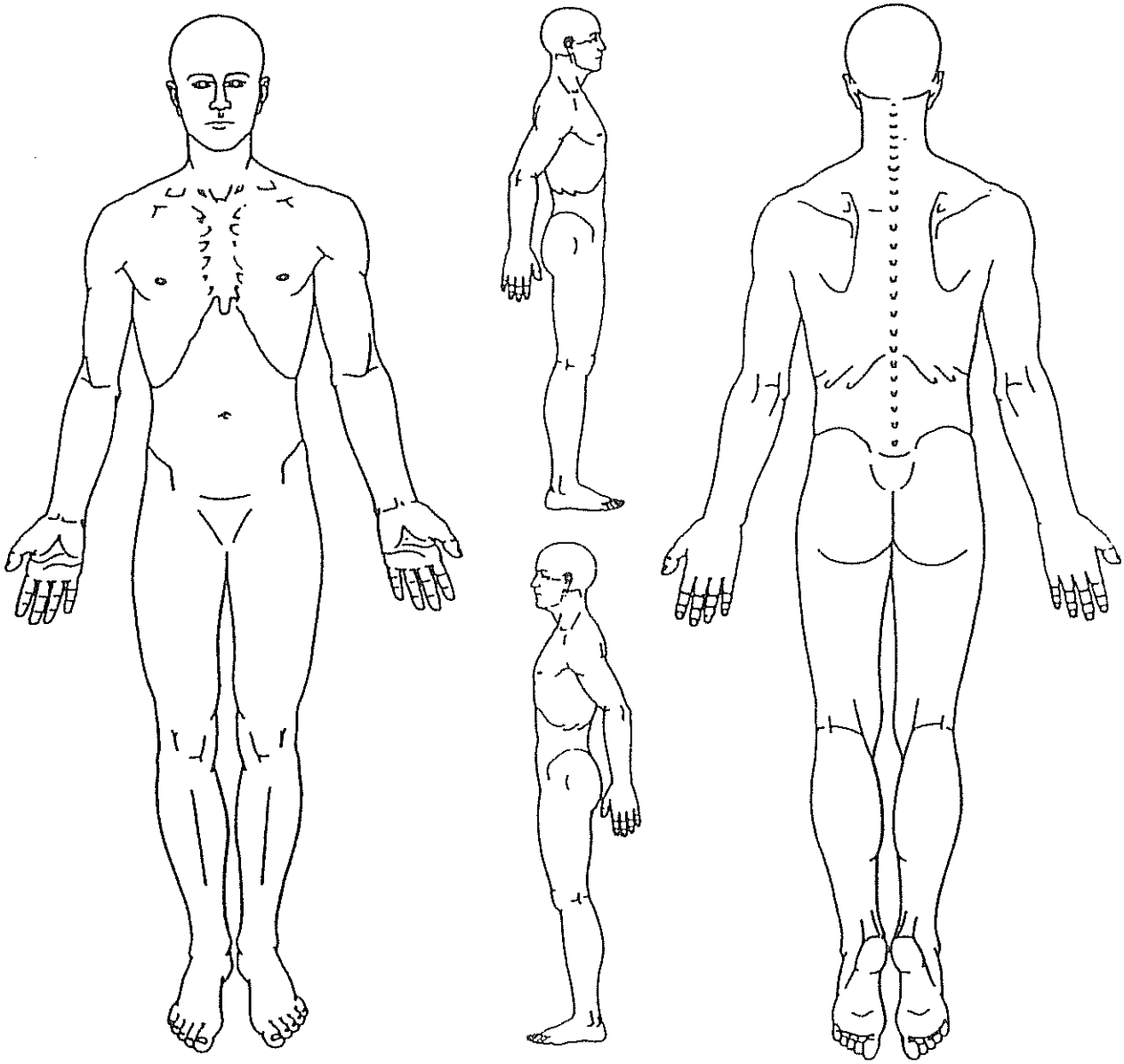
HOW LONG HAVE YOU HAD NECK PAIN? ___YEARS ___MONTHS ___WEEKS

IS THIS YOUR FIRST EPISODE OF NECK PAIN? ___YES ___NO

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW

(Please remember to complete both sides of this form.)

KEY: A=ACHE B=BURNING N=NUMBNESS
P=PINS & NEEDLES S=STABBING O=OTHER



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Phone: (602) 224-0220; Facsimile (602) 224-0230

NECK PAIN DISABILITY INDEX QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE, JUST CIRCLE THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

Section 1 — Pain Intensity

A I have no pain at the moment.
B The pain is very mild at the moment.
C The pain is moderate at the moment.
D The pain is fairly severe at the moment.
E The pain is very severe at the moment.
F The pain is the worst imaginable at the moment.

Section 2 — Personal Care (Washing, Dressing, etc.)

A I can look after myself normally without causing extra pain.
B I can look after myself normally, but it causes extra pain.
C It is painful to look after myself and I am slow and careful.
D I need some help, but manage most of my personal care.
E I need help every day in most aspects of self care.
F I do not get dressed, I wash with difficulty and stay in bed.

Section 3 — Lifting

A I can lift heavy weights, without extra pain.
B I can lift heavy weights, but it gives extra pain.
C Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
D Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E I can lift very light weights.
F I cannot lift or carry anything at all.

Section 4 — Reading

A I can read as much as I want to with no pain in my neck.
B I can read as much as I want to with slight pain in my neck.
C I can read as much as I want with moderate pain in my neck.
D I cannot read as much as I want because of moderate pain in my neck.
E I cannot read as much as I want because of severe pain in my neck.
F I cannot read at all.

Section 5 — Headaches

A I have no headaches at all.
B I have slight headaches which come infrequently.
C I have moderate headaches which come infrequently.
D I have moderate headaches which come frequently.
E I have severe headaches which come frequently.
F I have headaches almost all the time.

After Vernon & Mior, 1991
Reprinted by permission of the Journal of Manipulative and Physiological Therapeutics

Section 6 — Concentration

A I can concentrate fully when I want to with no difficulty.
B I can concentrate fully when I want to with slight difficulty.
C I have a fair degree of difficulty in concentrating when I want to.
D I have a lot of difficulty in concentrating when I want to.
E I have a great deal of difficulty in concentrating when I want to.
F I cannot concentrate at all.

Section 7 — Work

A I can do as much work as I want to.
B I can only do my usual work, but no more.
C I can do most of my usual work, but no more.
D I cannot do my usual work.
E I can hardly do any work at all.
F I cannot do any work at all.

Section 8 — Driving

A I can drive my car without any neck pain.
B I can drive my car as long as I want with slight pain in my neck.
C I can drive my car as long as I want with moderate pain in my neck.
D I cannot drive my car as long as I want because of moderate pain in my neck.
E I can hardly drive at all because of severe pain in my neck.
F I cannot drive my car at all.

Section 9 — Sleeping

A I have no trouble sleeping.
B My sleep is slightly disturbed (less than 1 hour sleepless).
C My sleep is mildly disturbed (1-2 hours sleepless).
D My sleep is moderately disturbed (2-3 hours sleepless).
E My sleep is greatly disturbed (3-5 hours sleepless).
F My sleep is completely disturbed (5-7 hours sleepless).

Section 10 — Recreation

A I am able to engage in all of my recreational activities, with no neck pain at all.
B I am able to engage in all of my recreational activities, with some pain in my neck.
C I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
D I am able to engage in a few of my usual recreational activities because of pain in my neck.
E I can hardly do any recreational activities because of pain in my neck.
F I cannot do any recreational activities at all.

REVISED January 1, 1995

Comments: _____

_____

Patient Signature: _____ Date: _____

ROLAND MORRIS DISABILITY INDEX

Name _____ **Date** ____/____/____ **File#**_____
(Please Print)

When your back hurts, you may find it difficult to do some of the things you normally do. Check the box before each sentence that describes you today. Leave the box blank if the sentence does not describe you.

- ❑ I stay home most of the time because of my back.
- ❑ I change positions frequently to try and get my back comfortable.
- ❑ I walk more slowly than usual because of my back.
- ❑ Because of my back , I am not doing any of the jobs that I usually do around the house.
- ❑ Because of my back, I use a handrail to get upstairs.
- ❑ Because of my back, I lie down to rest more.
- ❑ Because of my back , I have to hold on to something to get out of an easy chair.
- ❑ Because of my back, I try to get other people to do things for me.
- ❑ I get dressed more slowly because of my back.
- ❑ I only stand up for short periods of time because of my back.
- ❑ Because of my back, I try not to bend or kneel.
- ❑ I find it difficult to get out of a chair because of my back.
- ❑ My back is painful almost all of the time.
- ❑ I find it difficult to turn over in bed because of my back.
- ❑ My appetite is not very good because of my back.
- ❑ I have trouble putting on my socks (stockings) because of my back.
- ❑ I only walk short distances because of my back pain.
- ❑ I sleep less well because of my back pain.
- ❑ Because of my back pain, I get dressed with help from someone else.
- ❑ I sit down for most of the day because of my back.
- ❑ I avoid heavy jobs around the house because of my back.
- ❑ Because of my back pain, I am more irritable and bad tempered with people than usual.
- ❑ Because of my back, I go upstairs more slowly than usual.
- ❑ I stay in bed most of the time because of my back.

Form by Roland M, Morris R. Spine 1983;8(2):141-144. Lippincott-Raven Publishers

RADIOLOGY CONSULTATION

An Informed Consent: To insure the highest quality of interpretation, the services of Ammon G. Strehlow, DC, DACBR / STREHLOW Radiology Consulting are being utilized to obtain a secondary opinion on my x-rays or other advanced imaging study. I understand that there is a separate fee for this service and that this fee may be billed directly by SCRC. In accordance with the Medicare Act, this is to advise you that this is a non-covered service.

Release of Information: I do hereby authorize the above doctor / consultant to obtain from and to furnish to my physician, attorney, and or insurance carrier a full report of my case history, examination, diagnosis, treatment and prognosis in regard to my accident and / or illness.

Doctors Lien: I do hereby give a lien to the above doctor / consultant on any settlement, claim, judgment, or verdict as a result of the accident and or illness, and authorize and direct you, my attorney / insurance carrier to pay directly to the said doctor / consultant (STREHLOW Radiology Consulting @ 141 W. Brigham Rd., Suite D - St. George, UT 84790) such sums as may be due and owing him for the services rendered me, and to withhold such sums from the settlement, claim, judgment, verdict as may be necessary to pay said doctor / consultant . I UNDERSTAND THAT I AM DIRECTLY RESPONSIBLE TO SAID DOCTOR / CONSULTANT FOR ALL CHIROPRACTIC - RADIOLOGY BILLS SUBMITTED BY HIM FOR SERVICES RENDERED ME, and that this agreement is made solely for said doctor / consultant additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover. I further agree never to rescind this agreement and instruct my attorney that any attempted rescission on my part shall be null and void. I also agree that this agreement shall be binding upon any substitute counsel retained by me and that I will promptly notify the said doctor / consultant of any substitution of counsel or changes in my home address.

Signatures & Copies: I do hereby grant power of attorney to the said doctor / consultant for the discrete sole purposes of signing two-party checks received in the STREHLOW Radiology Consulting name and or when dual signatures are required for payment on a check from an insurance company, and with the signing privilege related to insurance benefit applications in lieu of habeas corpus and forms related to the stated injury for which services have been rendered to facilitate the completion of insurance for processing the claim. I do hereby state and agree that a photocopy or facsimile of this document will be as valid and binding on all parties involved as the original document.

Patient Signature Date

The undersigned, being the attorney of record or an authorized representative for the above patient does hereby acknowledge this lien and does agree to honor the same to protect adequately said above named doctor / STREHLOW Radiology Consulting.

Attorney Signature Date

Patient Name (printed) ☐ F ☐ M

Home Address

City, State & Zip Code

Patient Social Security # Patient Date of Birth

Patient Home Phone # Date of Injury

Referring Physician : _____

PATIENT HISTORY

☐ MVA ☐ Acute Injury ☐ Insidious Onset ☐ Other

☐ Malignancy ☐ Surgeries ☐ Congenital Anomalies

Explanation : _____

☐ See attached patient history paperwork

BILLING INFORMATION

☐ Attorney ☐ Insurance ☐ Physician ☐ Patient

Name of Attorney / Insurance Carrier

Address of Attorney / Insurance Carrier

City, State & Zip Code

Insurance Policy #

Accident Claim #

Phone # Adjuster

STREHLOW Radiology Consulting

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Dr. Margaret R. Colucci
& Associates

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Las Vegas, Nevada 89134

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. .

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

_____ 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**