Invictus Chiropractic
7936 E Arapahoe Ct Suite 2400
Centennial, CO 80112
(303) 993-8845

Introduction

Thank you for choosing us at Invictus Chiropractic. We know you have many options for health care providers in the area to trust with your health. We strive to be the best chiropractic facility in town. In order to help make your experience with us smoother, please fill out the following forms to the best of your abilities at least 24 hours prior to your first appointment. We look forward to serving you.

Contact

First Name_____ Last Name_____

Address _____

City_____ Prov_____ Postal_____

Gender Male Female Date of Birth_____

Height _____ Weight _____

Parent/Guardian

First Name_____ Last Name_____

Home Phone_____ Cell Phone_____ Email_____

How did you hear about us? Location Patient Physician Advertisement Attorney

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History

Complications during pregnancy? Yes No

Ultrasounds during pregnancy? Yes No

Medications during pregnancy? Yes No

Cigarette/alcohol use during pregnancy? Yes No

Location of Birth: Hospital Home Other

Birth intervention performed: Forceps Vacuum Ex. C-Section None

Delivery Medication? _____

Delivery Complications? Yes No

Birth Weight _____ Birth Length_____ APGAR Scores_____

Breast Fed? Yes No

Formula Yes No

Name of Pediatrician _____ Date of Last Visit _____

Reason for Visit_____ Treatment_____

At what age, in months, was the following introduced?

Solids:_____ Cows's Milk:_____

At what age, in months, was your child able to?

Respond to Sound: _____ Respond to Visual Stimuli: _____ Hold Head Up: _____

Stand Alone: _____ Crawl:_____ Walk Alone:_____

Sit:_____

Personal Illness History ADHD Falling Allergies Asthma Auto Accident Bed Wetting Chronic Colds Colic Constipation Diarrhea Digestive issues Ear Infections Headaches Recurring Fevers Scoliosis Seizures Temper Tantrums Traumat. Birth Vaccine Reaction Other

Vaccination history_____

Family History_____

Please list any vitamins, herbs, or minerals the child takes:_____

Childhood Diseases

Chicken Pox Yes No

Rubeola Yes No

Whooping Cough Yes No

Rubella Yes No

Mumps Yes No

Other Yes No

Childhood Injuries

Fractures Yes No

Auto Accident Yes No

Spinal Injury Yes No

Hospitalization Yes No

Surgery Yes No

Number of doses of antibiotics your child has taken:

Last 6 months: _____ Since birth: _____

Number of doses of other prescription medications your child has taken:

Last 6 months: _____ Since birth: _____

Child's daily habits (skip any questions that do not apply):

Hours of sleep per night (1-24)_____

Child's exercise Heavy Daily Moderate None

Average amount of time spent watching TV, playing video games, or using a computer per day: None 1-3 4-6 7-12 Over 12

How often does this child consume:

Caffeine Drinks: Never Occasionally Daily

Sugar/sweets: Never Occasionally Daily

Dairy Products: Never Occasionally Daily

Wheat Products: Never Occasionally Daily

Fruits/Vegetables: Never Occasionally Daily

Water as a beverage: Never Occasionally Daily

Condition

Present problem:_____ First occurrence of condition:_____

Did something specific cause this condition? (please describe)_____

Since the problem started, is it: Improving Same Worse

Does anything make it better? Yes No

_____

Does anything make it worse? Yes No

_____

Other health professionals seen for this problem (please list name and dates if applicable)

Chiropractor _____

Medical Doctor_____

Other_____

Finalize

Please Read the following carefully before signing.

Please read this entire document prior to signing it. Please ask questions before you sign if there is anything that is unclear.

*Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as ?informed consent? and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care. We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

spinal manipulative therapy palpation vital signs

range of motion testing orthopedic testing basic neurological testing

muscle strength testing * postural analysis testing

movement pattern assessment

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being. You may feel a sense of movement or hear an audible ?pop? or ?click,? much as you have experienced when you ?crack? your knuckles. Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an ?arterial dissection? that typically is

caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and X-ray. Stroke and /or vertebral artery dissection caused by chiropractic manipulation of the neck has been the subject of ongoing medical research and debate.

Other treatment options for your condition may include:

? Self-administered, over-the-counter analgesics and rest

? Medical care and prescription drugs such as anti-inflammatory, muscle

relaxants and pain-killers

? Hospitalization

? Surgery

If you chose to use one of the above noted ?other treatment? options you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

FINANCIAL POLICY

We understand that the cost of healthcare is a key concern for our patients. Your care is our main priority, but we hope that you will assist us by understanding your responsibility as it relates to our Financial Policy. If you have any questions regarding our policy a member of our staff will be glad to assist you. We are out of network with all health insurance providers including Medicare and Medicaid. We are able to provide you with a written summary statement of your charges so that you may submit directly to your insurance company (aka the Superbill). You are expected to pay in-full at the time of your visit and to assist this we accept cash, HSA/FSA accounts, credit cards (MasterCard, Visa, Debit) and personal checks. Please understand that we work on an appointment basis so it is important for you to uphold your appointments with the office. Late notice cancellations within 24 hours of the appointment time and/or a no-call/no-show situation without a reschedule for the same visit are subject to a $25 fee due upon your next visit to the office in addition to any regular fees for your visit(s).

When you pay by check you expressly authorize this office (Cuiffo Chiropractic, PLLC), if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check, plus a processing fee of $25 and any applicable sales tax. The use of a check for payment is your acknowledgment and acceptance of this policy and its terms. Financial arrangements are valid under your present condition. Should changes arise in your medical or financial situation that would affect your current financial agreement, you must notify this office prior to your care. Should you discontinue care or be released from further service, at this office, all outstanding balances are due upon notification. Any past due balance not paid within 90 days will be reported to the credit bureau and turned over to an attorney or agency for collections. You will be held liable for up to 50% of the balance owed for the collection fees associated with past due accounts. Please keep your account current to avoid any action or blemish on your credit history.

Privacy Policy

This practice is committed to maintaining the privacy of your Protected Health Information (PHI), which includes information about your health condition and the care you receive from the practice. This notice details how this information may be used in this office. With consent from you, it is the policy of this office to use the your PHI in the following manners:

Treatment: Your PHI will be given to those professionals that require it to provide care.

Appointment reminders: Our staff may call/text/email from time to time to remind you of appointments

Sign-in Log: We maintain a log of incoming patients for our own statistical use

Referral board: We keep a board to thank member of our practice who have referred others

Medical Doctors: It is the policy of this office to share our findings with your regular medical doctor. This helps build a better understanding of how we may work together to improve your health.

Email: We have compiled a database of email addresses and we will add you immediately to this list for you and your convenience. We will use email to convey important announcements, specials, and office closures. We never Spam in fact we dislike it as much as you. You have the right to easily unsubscribe from future emails with a one-click option from any previous email.

In special circumstances, your PHI may be disclosed as in the following:

Personal Representative: In accordance with applicable law that may represent you.

Emergency situations

Abuse, Neglect, or Domestic Violence

Law Enforcement issues

Worker''s Compensation claim

Avert a health threat

Your rights regarding your health information:

Inspect and copy your records: A written request must be submitted and cost of copying may be applied to such a request

Amend your PHI by submitting a written request with an explicit reason or request restrictions on your PHI. However, this practice is not obligated to agree to any such restrictions.

You may revoke consent at any time or complain to the practice

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE. PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW.

I have read or have had read to me the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Andrew Cuiffo and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo care in this office.

I have read and agree to the terms outlined in the above financial and privacy policies.

**After agreeing, please sign and click Submit below.

Relationship to patient _____

Parent/Guardian Signature: