John Zimmerman, D.C.

2629 Redwing Road Suite 200 . Fort Collins Colorado 80526
Phone (970)672-0789 . Fax (970)672-0884

PATIENT INTAKE FORM

Today's Date:_____

Please fill out all information completely. This is a requirement, prior to being seen for your appointment.

PATIENT INFORMATION

Last Name:_____ First Name:_____ Middle Initial:_____
Date of Birth:_____ Sex: [ ] M or [ ] F E-mail Address:_____
Mailing Address:_____ City:_____ State:_____ Zip Code:_____
Home Phone:_____ Cell Phone:_____ Work Phone:_____

EMERGENCY CONTACT INFORMATION

Contact Name:_____ Relationship:_____
Home Phone:_____ Cell Phone:_____ Work Phone:_____

RESPONSIBLE PARTY (legal guardian information – IF PATIENT IS A MINOR)

Last Name:_____ First Name:_____ Middle Initial:___ Date of Birth:_____ Sex: [ ] M or [ ] F
Mailing Address:_____ State:_____ Zip Code:_____

BILLING INFORMATION (Who are we billing for you?)

Please choose one of the following options:

Self Pay [ ] Insurance or Medicare [ ] Work Comp [ ] Motor Vehicle Accident [X]

Insurance Company Name: See Attached MVA page ID#_____ GRP#_____

IS THE PATIENT THE POLICEY HOLDER OF THE INSURANCE? YES [ ] OR NO [ ]
(If you selected **NO**, complete the policy holder information section below)

POLICY HOLDER INFORMATION (If the patient is NOT the policy holder)

Last Name:_____ First Name:_____ Middle Initial:_____
Date of Birth:_____ Sex: [ ] M or [ ] F E-mail Address:_____
Mailing Address:_____ City:_____ State:_____ Zip Code:_____
Home Phone:_____ Cell Phone:_____ Work Phone:_____

(If we are billing insurance we require a copy of the card, in addition to the other information provided)

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PRACTICE POLICIES

Thank-you for choosing us to participate in your health care. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial policy, which we require you to sign prior to any treatment.

Financial Policy: Payment is due in full at time of service, including co-payments and/or deductibles. We accept cash, checks, money orders, Discover, Visa, and Master Card. We ask that you please keep your account current. Any balance that remains unpaid after 30 (thirty) days may begin to accrue late charges. If your account remains in a delinquent status for over 3 (three) months it can be placed with our collection agency and you waive your right to confidentiality. A delinquent account can be the basis for termination of your care from our office. There will be a $50.00 charge for all returned checks and we will no longer accept personal checks from you as a form of payment.

Insurance: Thank you for being responsible and taking the time to know the terms and coverage of your insurance policy prior to appointments with this office or with locations we refer you to. A discount will be given to patients without insurance or with non-participating insurance who pay in full at the time of service.

In- Network: We are contracted with most major insurance companies. It is your responsibility to know if you have chiropractic coverage and what the benefits are for treatment. It is also your responsibility to provide us with accurate and current insurance information: we cannot bill insurance for you unless you bring in all current insurance information.

Out-of- Network: If we do not participate with your insurance, we require payment in full at the time of service. We will provide you with a copy of your super bill to send to your health plan for possible reimbursement. Our practice is committed to providing the best treatment possible to our patients and we believe our charges are reasonable for this area. You are responsible for full payment regardless of any insurance determination of usual and customary rates. In addition, some and perhaps all of the services provided may be determined "non-covered" services and not considered reasonable and necessary under the Medicare program and/or other medical insurance.

Paperwork/Information verification: We understand that filling out paperwork or verifying your information upon "check in" may seem repetitive and unnecessary. Please understand that in order to ensure our information is accurate and up to date and to meet federal regulations, we do have to ask for your cooperation with keeping our records accurate and current. Your refusal to fill out paperwork/verify information or refusal to fill out paperwork completely and accurately will be interpreted by us as a decision on your part not to be seen at our office and may result in termination from our practice

NOTICE OF PRIVACY PRACTICES (HIPAA)

This summary describes how we use and share information about you. This summary describes how you may see and get copies of this information.) This notice includes all occupants of John Zimmerman, DC.

OUR COMMITMENT TO RESPECT PRIVACY:

John Zimmerman, DC is required to:

- Keep your information private
- Let you know if we cannot do what you have asked us to do with your information.
- Try to reach you at another location or phone number, if you ask us to do so.
- Use and/or give out your information as listed below and as the law permits, unless we have your permission to do more.

WE MIGHT USE OR SHARE INFORMATION ABOUT YOU FOR:

- Treatment: Such as when our providers and employees discuss your care.
- Payment: Such as when we bill your insurance company for services provided to you.
- Other Ways: Such as when we share information to protect the health and safety of others or you; when we send disease reports to county and state health offices as required by law; when we provide information to researchers, organ donation groups, or funeral directors; and when we respond to court requests. We may also send you appointment reminders, greeting cards, and newsletters.

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NOTICE OF PRIVACY PRACTICES **(HIPAA)**

CONTINUED

HOW YOU MAY SEE AND GET COPIES OF THIS INFORMATION:

You have the right to:

- Ask for restrictions on the ways we use and give out your information. However, we are not required to do what you ask, where the law requires otherwise.
- Get and inspect a copy of your health record. Add information to your health record. Ask that your health information be sent to a different address or that we call you at a different phone number
- Change your mind if you told us we could use or share your information for reasons other than those listed above.
- Get a list of the times we gave out your information (this will be a list of the times the law requires us to keep a record of releasing your information). As we serve our clients, we may modify what we do with your information. If we make a change, we will give you a new notice the next time you visit us. You may call or write us to inquire about any changes.

COMPLAINTS: If you think your privacy rights have been violated, you may complain to John Zimmerman, DC. You will not be mistreated for filing a complaint.

PLEASE SELECT ONE OF THE FOLLOWING TWO OPTIONS THAT APPLY TO YOU AND INITIAL, TO INDICATE YOUR SELCTION.

FINANCIAL POLICY: FOR INSURANCE PATIENTS **ASSIGNMENT OF BENEFITS/ RELEASE OF INFORMATION**

I Hereby assign to John Zimmerman, DC all coverage or other benefits available under any government program, insurance policy, worker's compensation claim, or other benefit program, and I direct that benefits be paid directly to John Zimmerman, DC. I agree that John Zimmerman, DC may receive benefits directly, which will discharge the insurer or benefit program to the extent of such payments. I agree to pay promptly and fully all charges for services provided by, according to the rates and terms of my insurance company. I hereby personally obligate the patient and myself, if signing as a spouse of the patient or as a parent or guardian of a minor patient, to payoff all such charges. No extension or forbearance, no attempt to obtain payment from insurance or other sources, and no delay or lack of diligence in collection of such charges shall waive or release these personal financial obligations** I hereby authorize John Zimmerman, DC to release information as necessary to obtain benefits from this policy. If needed, I also authorize this clinic to file a complaint with the Colorado division of insurance on my behalf for nonpayment of claims by my insurance company.

-OR- **INITIAL _____**

FINANCIAL POLICY: FOR SELF PAY PATIENTS **SELF PAY AGGREEMENT**

I am not covered by any form of health insurance or am covered by an insurance company that is non- par with this facility and will be considered a self-pay patient. I understand that I will receive a discount for paying in full at the time of service. I understand that payment in full is due at the time of service unless prior arrangements have been made with the billing department.

INITIAL _____

I have read, understand and agree to all of John Zimmerman, *DC's* practice policies, privacy practices (HIPAA), and the financial Policy. I understand that this authorization will remain in effect for as long as I, and/or my dependent, remain a patient. I understand that these may be subject to change periodically without notice. I verify that all the above information is true and accurate to the best of my knowledge.

NAME:

DOB:

DATE:

SIGNATURE:

Office Use Only

1
2-5
>5

WILTSE et. al.

Patient #: _____

PAIN DRAWING

Name: _____ Todays Date: _____

Date of Birth: _____ Examiner: _____

TELL US WHERE YOU HURT.

Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbols(s) listed below.

Ache > > > >
> > > >

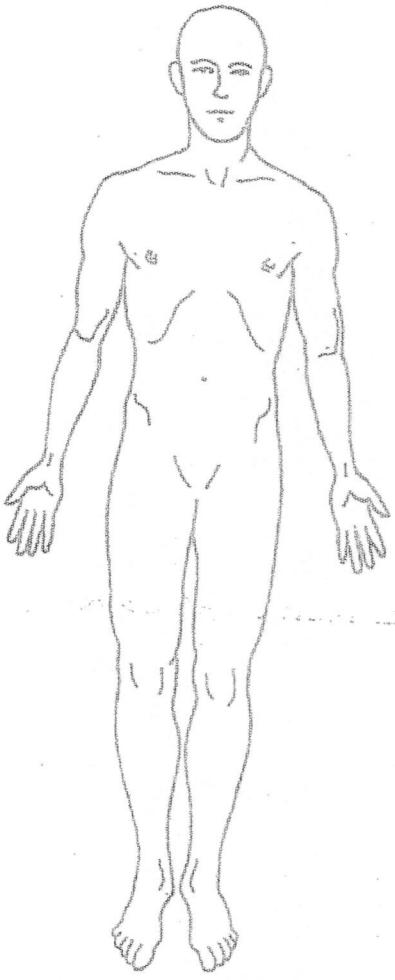
Numbness = = = =
= = = =

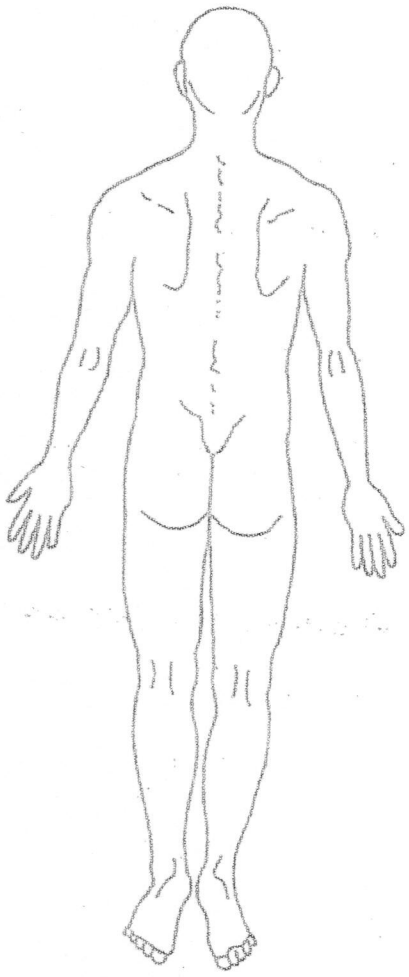
Pins and Needles o o o o
o o o o

Burning x x x x
x x x x

Stabbing / / / /
/ / / /

Throbbing ~ ~ ~ ~
~ ~ ~ ~





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AUTO ACCIDENT CLAIMS STATEMENT OF UNDERSTANDING

On July 1, 2003 Colorado state law regarding payment of medical expenses for auto accident injuries changed from "PIP- no fault" (personal injury protection) system to a "tort" system. Below is some information about how this law pertains to any medical services you received at our office for auto accident injuries. This information came the Deputy Commissioner of Consumer Affairs, Colorado Division of Insurance.

PRIMARY MEDICAL COVERAGE:

The auto insurance policy for the vehicle you were in is PRIMARY to all other insurance coverage- regardless of who was at fault for the accident. If the vehicle you were in had MedPay benefits on the date of the accident, we must bill this insurance company first, and it should pay up to the limits of the policy. If the vehicle you were in did NOT have MedPay, we must have written notice from this company that MedPay benefits are not available.

SECONDARY MEDICAL COVERAGE:

Your Private health insurance policy is SECONDARY to the above. If the vehicle you were in did NOT have MedPay, OR if the available MedPay benefits have been used up, we will bill your private health insurance policy next.

FINAL RESPONSIBILITY:

You are responsible for any amounts NOT covered by the above two policies. The at-fault party's auto insurance will only pay once all treatment is completed, and only at final settlement of the claim. The at-fault party's auto insurance will likely send any settlement money directly to you, and probably will not make any payments to this office. If you are unable to pay us for any amounts you are responsible for, we require that you sign a separate assignment of benefits/ medical lien. By signing this assignment of benefits/ lien you are promising to pay us from any money's you receive at the settlement of your injury claim with the at-fault party's auto insurance. We recommend that you go over this lien with an attorney. If you do not sign a lien, we must collect payments at the time of service.

STATEMENT OF UNDERSTANDING:

I Acknowledge that I have read the above information. I understand that Auto Insurance companies do not guarantee payment. I also understand that I am ultimately financially responsible to the office of John Zimmerman, D.C. For any financial balance that may occur due to my treatment.

_____ _____

Patient/ Insured Signature **Date**

_____ _____

Witness **Date**

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AUTO ACCIDENT (TORT)

* ALL of the following questions must be filled out COMPLETELY in order for us to bill insurance for you.*

PATIENT NAME:_____ DATE OF BIRTH: _____
last *First* *MI*

****

Accident Date: _____ Were you the: [ ]Passenger [ ]Driver [ ]Other_____
Who was the at fault party? [ ] Patient/driver of the car patient was in [ ] Other Person
Who got the ticket? [ ] Patient/ driver of the car the patient was in [ ] Other Person

****

AUTO INSURANCE FOR THE VEHICLE THE PATIENT WAS IN AT THE TIME OF THE ACCIDENT:

Insured Person's Name:_____ Relationship to the Patient:_____
Auto Insurance Company Name:_____ Phone:_____
Claims Mailing Address:_____ City:_____ Zip:_____
Auto Insurance Agent's Name:_____ Phone:_____
Claim #:_____ Adjuster's Name:_____ Phone:_____
Are there Medical Benefits (MedPAy)? [ ]YES [ ]NO If you have MedPay, How much? $_____

****

HEALTH INSURANCE FOR THE PATIENT: *Insurance card must be provided*

Do you Have Health Insurance? [ ]YES [ ]NO *(If yes complete the following)*
Health Insurance Company Name:_____ Phone:_____
Claims Mailing Address:_____ City:_____ Zip:_____
Insurance ID #:_____ Group#:_____
Insured's Name:_____Insured's Date of Birth:_____Insured's Social Security#:_____
Insured's Relationship to the Patient:_____ Insured's Phone:_____
Insured's Address:_____ City:_____ Zip:_____

****

AUTO INSURANCE FOR THE "AT FAULT" PARTY VEHICLE *(If different from above)*

Insured Person's Name:_____ Phone:_____
Mailing Address:_____ City:_____ Zip:_____
Auto Insurance Company Name:_____ Phone:_____
Claims Mailing Address:_____ City:_____ Zip:_____
Auto Insurance Agent's Name:_____ Phone:_____
Claim #:_____ Adjuster's Name:_____ Phone:_____

****

ATTORNEY FOR PATIENT:

Do you have an attorney [ ]YES [ ]NO *(If yes complete the following)*
Attorney's Name:_____ Phone:_____ E-mail:_____
Mailing Address:_____ City:_____ Zip:_____

**IF YOU DO NOT CURRENTLY HAVE AN ATTORNEY, WE ASK THAT IF/WHEN YOU DO RETAIN AN ATTORNEY, THAT YOU PLEASE PROVIDE US WITH THE ABOVE INFORMATION AS SOON AS POSSIBLE. THANK-YOU.*

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ASSIGNMENT, LIEN, RELEASE & POWER OF ATTORNEY

THIS AGGREEMENT, made and entered into this _____ day of_____, 20_____, by _____ referred to as "PATIENT" and the office of John Zimmerman, D.C., referred to as "John Zimmerman, D.C.", located at 2629 Redwing Road, Suite 200, Fort Collins, CO 80526.

WHEREAS PATIENT desires to receive services from the office of John Zimmerman, D.C. And desires to assign certain rights and benefits to John Zimmerman, D.C. Deferring their right to immediately file suit against PATIENT and for John Zimmerman, D.C awaiting payment of such benefits.

Accordingly, it is hereby agreed:

A. PATIENT hereby authorizes John Zimmerman, D.C. To furnish a full report and records regarding case history, examination, diagnosis, treatment and prognosis, z-rays, laboratory reports and results of all treatments of any type or character of PATIENT to such persons and/ or agencies as John Zimmerman, D.C deems appropriate.

B. PATIENT assigns John Zimmerman, D.C. any and all benefits payable by PATIENT'S insurance company or health care plan(s) as a result of charges incurred by PATIENT for services rendered by John Zimmerman, D.C. PATIENT also assigns John Zimmerman, D.C. any and all contractual rights PATIENT has against any insurance company, health care benefit plan, or any other party possibly liable to PATIENT for payment of health care costs incurred by PATIENT as a result of services rendered by John Zimmerman, D. C

C. PATIENT fully understands that PATIENT is directly and fully financially responsible to John Zimmerman, D. C. for all bills submitted for services rendered and that this agreement is made solely for additional protection and consideration for awaiting payment. PATIENT further understands that such payment is not contingent upon any settlement, claim, judgment, or verdict which PATIENT may eventually recover. In the event of non- payment or reduced payment by any insurance company, health care benefit plan, or any other party possibly liable to PATIENT for payment of health care costs incurred by PATIENT as a result of services rendered by John Zimmerman, D.C., PATIENT agrees to be responsible for any such outstanding balance, including interest at a rate of 18% APR, and reasonable attorney's fees and costs.

D. PATIENT fully understands that the assignment and lien given to John Zimmerman, D.C herein is irrevocable.

E. By executing this agreement, PATIENT hereby instructs and directs any attorney representing PATIENT to honor the above assignment and lien and make payment under the assignment and lien directly to John Zimmerman, D.C. PATIENT directs that attorney be bound by this lien and treat it, irrevocably, as an assignment due to John Zimmerman D.C. John Zimmerman, D.C. is relying upon the assignment, lien and directive to any attorney, and as a result of such reliance, John Zimmerman, D.C. is providing care for which this assignment, lien and directive provides security for payment. Moreover, PATIENT agrees that John Zimmerman, D.C. is to be viewed as a third party beneficiary of this direction to PATIENT'S attorney and it is PATIENT'S intent to impost upon PATIENT'S attorney an obligation to comply with the terms of this directive.

F. PATIENT hereby directs all insurers and other persons possibly responsible for Patient's healthcare costs to make all payments for health care services rendered by John Zimmerman, D. C. directly to John Zimmerman, D.C.

G. PATIENT agrees that in the event PATIENT receives any check, draft, or other payment subject to this

agreement, PATIENT agrees to act as fiduciary agent for John Zimmerman, D.C. and will immediately deliver said check, draft, or payment to John Zimmerman, D.C. to be applied to Patient's debt for services rendered.

H. PATIENT hereby appoints John Zimmerman, D.C. as PATIENT'S true and lawful attorney, irrevocably, and with full power f substitution, for PATIENT and in PATIENT'S name, to ask, demand, sue for, collect, endorse, sign, and receive proceeds from insurance, other health benefits, and third party claims relating to services rendered to PATIENT by John Zimmerman, D.C. John Zimmerman, D.C. is not obligated or compelled to exercise such powers but may do so in John Zimmerman;s sole discretion. PATIENT agrees to fully cooperate with John Zimmerman, D.C. in collecting said amounts.

I. John Zimmerman, D.C. agrees to submit a copy of this agreement with the initial claim form(s) which John Zimmerman, D.C submits to third party payor(s) as notice to the third party payor(s) of this assignment and other agreements contained herein. At the time each claim is submitted, a copy of the claim will be stored for safekeeping in OATIENT'S file and may be picked up by the PATIENTS, upon reasonable request and during normal business hours, or upon written requests by PATIENT, be mailed to the designated address.

J. PATIENT hereby authorized John Zimmerman, D.C. to receive a complete copy of PATIENT'S insurance policy, including and endorsements, conditions, limitations, or exclusions.

K. A copy of this document shall be a binding as the document bearing the original signatures.

_____ _____

Patient's Signature Date

_____ _____

John Zimmerman, D.C. Date

AKNOWLEDGEMNT OF ATTORNEY

The undersigned being attorney of record for the above PATIENT does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect John Zimmerman, D. C. as above. Any settlement of this claim without honoring this assignment/ lien will cause the undersigned attorney to be responsible to John Zimmerman, D.C. for payment. The prevailing party in any litigation resulting from enforcement of this assignment/lien shall be entitled to actual attorney's fees and court costs.

_____ _____

Attorney's Signature Date

**Attorney: Please sign, date and return one copy to John Zimmerman, D.C. as above at once.*
Keep one copy for your records.