



**Welcome to Elevation Now, P.C.! Please thoroughly complete all questions. Thank you.**

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_

E-Mail: \_\_\_\_\_ Phone: Home \_\_\_\_\_ Work: \_\_\_\_\_

Cell #: \_\_\_\_\_ Marital status: M/W/D/S Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

Your prior Doctor of Chiropractic and address: \_\_\_\_\_

Chiropractic techniques you've had success with: \_\_\_\_\_

Last Visit with Chiropractor: \_\_\_\_\_ General Practitioner name: \_\_\_\_\_

Other Specialists you are currently under care with:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer name: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer's address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Spouse's name: \_\_\_\_\_

Spouse's employer: \_\_\_\_\_

Children's names & ages: \_\_\_\_\_

\_\_\_\_\_

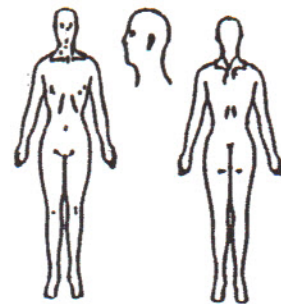
Favorite hobbies or interests: \_\_\_\_\_

\_\_\_\_\_

Method of payment for first visit:

\_\_\_\_ Cash \_\_\_\_ Check \_\_\_\_ MAC \_\_\_\_ Credit Card

**Mark area(s) of Health Concerns**



Health reasons for consulting our office:

1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_

Have you had same or similar problem(s) before?  Yes  No How long?: \_\_\_\_\_  
Please explain:

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

Father/Mother/Brother/Sister/Children, with similar problems? \_\_\_\_\_

Is this the result of an auto or work injury? \_\_\_\_\_ If so, when? \_\_\_\_\_

Other doctors who have treated this problem: \_\_\_\_\_

Surgery you have had: \_\_\_\_\_

Medication(s) you currently take: \_\_\_\_\_

Is there any chance you are pregnant? Yes  No

What have you heard about chiropractic care?

\_\_\_\_\_

Do you know what a subluxation is? If yes, please describe

\_\_\_\_\_

What daily rituals for spinal health do you presently practice?

\_\_\_\_\_

Have you ever been diagnosed with cancer?  If so, what type?

\_\_\_\_\_

Do you have insurance that covers Chiropractic?  Yes  No  Unsure

Name of insurance company: \_\_\_\_\_

What is your level of commitment to yourself, your life and well-being?  High  Medium  Low

Additional Comments: \_\_\_\_\_

\_\_\_\_\_

The above information is true and accurate to the best of my knowledge. My reason for consultation with Dr. Nick Sechrist is for evaluation of my physical health and the potential for improvement.

Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



Elevation Now, P.C.

Patient Authorization Form

Patient Authorization for:

- \* Contact regarding appointment reminders, scheduling related and account balance matters, birthday greetings, chiropractic care, related health services and/or related health products
- \* Sign-In Sheet
- \* Testimonials / Success Stories

It is our desire for the staff to use your name, address and/or telephone number for the purpose of contacting you to remind you about scheduled appointments, re-evaluations, birthday greetings or other appointment related or account balance issues and also to advise you about health related meetings, workshops and products. We also display your name on our sign-in sheet and any testimonials/success stories we receive from you.

The use of this information is intended to make your experience with our office more efficient and productive. If you choose to not authorize this information use, your decision will have no adverse effect on your care from Dr. Nick Sechrist or on your relationship with our staff.

Your signature indicates authorizations of this activity.

\_\_\_\_\_  
Name (Printed)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system.

**Elevation Now, P.C.**

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a member of Elevation Now, P.C., we may use or disclose your personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer (if they are or may be responsible for your services).
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, to provide information about alternatives to present care or to other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose of your health information without your consent or authorization in the following circumstances:

- If we are providing health care services to you based on the orders of another health care provider
- If we provide health care services to you in an emergency
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care
- If we are ordered by the courts or another appropriate agency

Any use of disclosure of your protected health information, other than as described in the example outlined above will only be made upon your written authorization.

We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and or/copy your health information for seven years from the date that the record was created or for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Request to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your member file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information files.

Information that we may use or disclose based on this privacy notice may be subject to re-disclosure by the person or persons to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities, you should direct your complaint to our office manager at (970) 263-9100. If you would like further information about our privacy policies and practices please contact our office manager at (970) 263-9100.

This notice is effective as of the date signed below. This notice and any alterations or amendments made hereto, will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

Name	Signature	Date

If you are a minor or if you are being represented by another party

Representative Signature	Date	Representative Printed	Relationship