

## ***ERIN L. ELSTER, D.C.***

4880 Riverbend Road ▪ Boulder, CO 80301 ▪ (303) 442-5911 ▪ FAX (303) 442-5343  
erin@erinelster.com ▪ www.erinelster.com

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**Welcome!** Thank you for your interest in Dr. Elster's upper cervical chiropractic care. The evaluation and care you will undergo will be performed in accordance with the guidelines of the International Upper Cervical Chiropractic Association (IUCCA). Very few IUCCA-trained practitioners exist worldwide and Dr. Elster is currently the only practitioner in Colorado.

### BRIEF CONSULTATION (15 minutes):

For those patients wishing to undergo a preliminary discussion about their cases, your case will be discussed and a determination will be made as to whether you may benefit from Dr. Elster's care.

### INITIAL EVALUATION (Approximately two hours):

During your evaluation, your health history and health complaints will be discussed. Any previous medical records including x-rays, MRI's, lab tests, etc. will be reviewed. Dr. Elster will perform two state-of-the-art diagnostic tests to examine your spine: Paraspinal Digital Infrared Imaging (PDII) and Laser-aligned Radiography (X-rays).

- PDII is a non-invasive, painless, computerized, thermographic (heat-measuring) instrument used to detect irritation to the central nervous system (brain and spinal cord) and is performed by moving a sensitive scanning device along the sides of the spine.
- Precision laser-aligned x-ray (standard x-rays are inadequate) incorporates non-invasive laser technology into the alignment of the machine to ensure accuracy and to eliminate image distortion.

After Dr. Elster completes the analysis of your x-rays, the x-ray findings and your treatment plan will be discussed. This report of findings occurs as soon as possible after Dr. Elster has had ample time to analyze your x-rays and examination findings.

### CARE PLAN:

After the initial adjustment has been performed, multiple check-up visits will be required to ensure your spine and health problems heal and stabilize as quickly as possible. On average, these visits occur more frequently during the first month of care and taper down the subsequent months as healing occurs. The care plan is determined on a case by case basis and varies per person due to several factors: severity of the condition, length of time the condition has been present, and age of the patient. Please be advised that the care plan recommended by Dr. Elster should be followed for best results.

### OTHER HEALTH CARE PROVIDERS:

Dr. Elster's care is consistent with other forms of health care (procedures, treatments, therapies, medications, etc.) except for other chiropractic adjustments. **To achieve the best results, other adjustments and/or osteopathic manipulations should be avoided.** You should not discontinue any other health care and/or medications without consulting with your other providers. Dr. Elster encourages you to continue to consult with any such providers to coordinate your health recovery and maintenance.

### CONSENT FOR CARE:

While Dr. Elster has achieved a high percentage of results with a variety of conditions, I understand that there is no guarantee of benefit. Individual results may vary depending upon several factors including age, severity, and length of time the condition has been present. I understand that Dr. Elster will discuss with me any limitations my case might present as well as the probability for successful results. I understand that to achieve the best results, I should follow Dr. Elster's treatment plan recommendations.

**I understand all of the above information and give consent for the chiropractic evaluation and care to be performed by Dr. Elster.**

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Patient (or legal guardian) Signature

Date

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**PATIENT INFORMATION**

NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY, STATE, ZIP: \_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_  
HOME PHONE: \_\_\_\_\_  
CELL PHONE: \_\_\_\_\_  
EMAIL ADDRESS: \_\_\_\_\_  
OCCUPATION: \_\_\_\_\_  
SPOUSE'S NAME / PHONE: \_\_\_\_\_  
PARENTS' NAMES /PHONES (for minors): \_\_\_\_\_  
REFERRED BY: \_\_\_\_\_

**HEALTH HISTORY**

PRIMARY HEALTH COMPLAINTS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

WHEN DID COMPLAINT(S) START? DATE(S) OF DIAGNOSIS? \_\_\_\_\_  
\_\_\_\_\_

PLEASE LIST TRAUMAS & THEIR DATES: (AUTO, SPORTS, WHIPLASHES, CONCUSSIONS, FALLS, BIRTH TRAUMA, ETC): \_\_\_\_\_  
\_\_\_\_\_

PLEASE LIST CURRENT MEDICATIONS & DOSAGES / FREQUENCY OF USE (PRESCRIPTION & OVER THE COUNTER): \_\_\_\_\_  
\_\_\_\_\_

PREVIOUS TREATMENTS / THERAPIES YOU HAVE TRIED FOR YOUR COMPLAINT(S):  
Medications? No \_\_\_ Yes \_\_\_ Which? \_\_\_\_\_  
Chiropractic? No \_\_\_ Yes \_\_\_ Doctor \_\_\_\_\_  
Massage Therapy? No \_\_\_ Yes \_\_\_ Therapist \_\_\_\_\_  
Physical Therapy? No \_\_\_ Yes \_\_\_ Therapist \_\_\_\_\_  
Special Diets / Nutrition? No \_\_\_ Yes \_\_\_ What kind? \_\_\_\_\_  
Other? \_\_\_\_\_

YOUR CURRENT PHYSICIAN(S) / THERAPIST(S): \_\_\_\_\_  
\_\_\_\_\_

PLEASE LIST BROKEN BONES, SURGERIES: \_\_\_\_\_  
\_\_\_\_\_

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**FEES & INSURANCE INFORMATION**

Dr. Elster does not bill insurance companies but she will provide you with an insurance receipt that you can send directly to your company for reimbursement. Fees are payable in the form of cash, check, or credit card (visa / mastercard) when service is rendered unless other arrangements have been made in advance. Please be advised that insurance coverage for chiropractic varies and your company may or may not cover chiropractic services, may have limitations on the number of paid visits, and may have a deductible or exclusions. **Dr. Elster is not a participating provider with any insurance companies including PPO's, HMO's, Kaiser or Medicare.**

WILL YOU BE FILING AN INSURANCE CLAIM? NO \_\_\_\_\_ YES \_\_\_\_\_  
NAME OF INSURED: \_\_\_\_\_  
INSURANCE COMPANY: \_\_\_\_\_  
INSURED'S POLICY NUMBER: \_\_\_\_\_  
CLAIM NUMBER (for auto accident claims): \_\_\_\_\_  
ACCIDENT DATE (for auto accident claims): \_\_\_\_\_

**RELEASE OF INFORMATION:** (For insurance purposes)

I authorize Erin Elster, D.C. to release any information or office records necessary to process insurance claims.

\_\_\_\_\_  
Patient (or legal guardian) Signature

\_\_\_\_\_  
Date

**FEES FOR SERVICES RENDERED** (Effective August 1, 2011 & subject to change)

<b>Brief Consultation</b>	No charge
<b>New Patient Evaluation</b> -- includes all diagnostic tests	\$275.00
<b>New Patient Evaluation plus first adjustment</b>	\$355.00
<b>Routine Office Visit</b>	\$80.00

**CANCELLATION POLICY:**

Your time is invaluable as is Dr. Elster's. Please give 24 hours notice for cancelled or rescheduled appointments or fee may apply.

**I understand the above information and acknowledge that I am responsible for the payment of all charges.**

\_\_\_\_\_  
Patient (or legal guardian) Signature

\_\_\_\_\_  
Date