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.

Patient (or legal guardian) Signature    Date
PATIENT INFORMATION

NAME:___________________________________________________________________________
ADDRESS:_______________________________________________________________________
CITY, STATE, ZIP:_________________________________________________________________
DATE OF BIRTH:______________________________________AGE:_______________________
HOME PHONE: __________________________________________________________________
CELL PHONE: ___________________________________________________________________
BUSINESS PHONE:_______________________________________________________________
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: ____________________________________________
________________________________________________________________________________
________________________________________________________________________________
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 March 1, 2007 & subject to change)

<table>
<thead>
<tr>
<th>Service</th>
<th>Fee</th>
<th>CANCELLATION POLICY:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief Consultation</td>
<td>No charge</td>
<td></td>
</tr>
<tr>
<td>New Patient Evaluation</td>
<td>$425.00</td>
<td></td>
</tr>
<tr>
<td>-- includes all diagnostic tests</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Patient Evaluation plus first adjustment</td>
<td>$495.00</td>
<td></td>
</tr>
<tr>
<td>Routine Office Visit</td>
<td>$70.00</td>
<td></td>
</tr>
</tbody>
</table>

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

Patient (or legal guardian) Signature                                                Date