PERSONAL AND FAMILY HEALTH HISTORY ***Today's Date*** _____

Legal Name: Last _____ First _____ MI _____

Name Preferred to be called _____ Sex M F Age _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Cell _____

SS# _____ Drivers License # _____ E-Mail _____

Who referred you to our office? _____

Occupation _____ Employer _____

Marital Status S M D W Spouse's Name _____ Their Occupation _____

Current Health Condition

Is your visit today due to an accident? Y N If so, Date of Accident _____

Present Complaint/Reason For Your Visit Today

Major _____

Pain or Problem started on _____

Pains are: □ Sharp □ Dull □ Constant □ Intermittent

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is this condition worse during certain times of the day? Y N If yes, when _____

Is this condition interfering with: Work? _____ Sleep? _____ Routine? _____ Other?_____

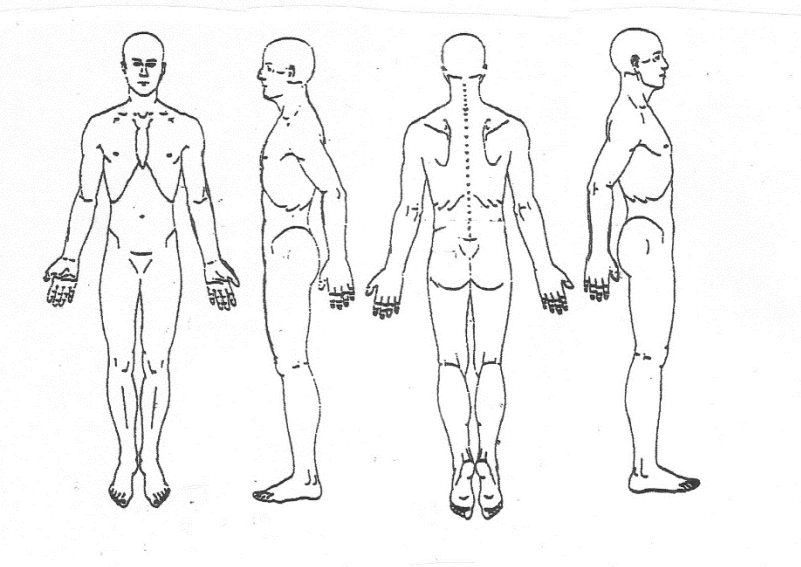
Is this condition getting progressively worse? _____

Other Doctors seen for this condition _____

Any home remedies? _____

Names of your medical providers _____

Mark the area(s) on the body where you feel the described sensation(s):
Use the appropriate symbol(s). Include all affected areas:
Aches ^^^^ Numbness oooo Pins/Needles ●●●● Stabbing ////



Indicate the severity of your symptoms by marking an "X" on the lines below:

How bad are your symptoms now?

_____

None Most Severe

How bad have they been in the past?

_____

None Most Severe

Please indicate whether you have any of these **symptoms**:

Constitutional
- ☐ Fever
- ☐ Fatigue
- ☐ Sleep Issues
- ☐ Loss of Appetite
- ☐ Excessive Hunger
- ☐ Weight Gain
- ☐ Unexplained Weight Loss
- ☐ Night Sweats
- ☐ Check here if none of above.

Eyes
- ☐ Wear Glasses or Contacts
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Pain
- ☐ Redness
- ☐ Halos/Flashes
- ☐ Check here if none of above.

Ears
- ☐ Ringing in Ears (Tinnitus)
- ☐ Pressure in Ears
- ☐ Pain in the Ear
- ☐ Ear Discharge
- ☐ Hearing Loss
- ☐ Check here if none of above.

Mouth, Nose & Throat
- ☐ Nasal Congestion
- ☐ Nose Bleeds (Epistaxis)
- ☐ Sinus Problems
- ☐ Dry Mouth
- ☐ Throat Sores
- ☐ Hoarseness
- ☐ Sore Throat
- ☐ Difficulty Swallowing
- ☐ Seasonal Allergies
- ☐ Check here if none of above.

Respiratory
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Congestion
- ☐ Sputum
- ☐ Wheezing
- ☐ Check here if none of above.

Cardiovascular
- ☐ Chest Pain
- ☐ Chest Tightness
- ☐ Palpitations/Skipped Beats
- ☐ Heart Rhythm Problems
- ☐ Swelling in the Legs (Edema)
- ☐ Fainting (Syncope)
- ☐ Check here if none of above.

Gastrointestinal
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bowel Control Problem
- ☐ Indigestion
- ☐ Blood in Stool
- ☐ Heartburn
- ☐ Check here if none of above.

Genitourinary
- ☐ Incontinence
- ☐ Frequent Urination
- ☐ Urgent Urination
- ☐ Painful Urination
- ☐ Excessive Urination
- ☐ Blood in Urine
- ☐ Check here if none of above.

Skin/Integumentary
- ☐ Rash
- ☐ Skin Sores or Ulcers
- ☐ Itching
- ☐ Dry Skin
- ☐ Hair or Nail Changes
- ☐ Check here if none of above.

Musculoskeletal
- ☐ Joint Swelling
- ☐ Redness of Joints
- ☐ Stiffness
- ☐ Muscle Spasms
- ☐ Neck Pain
- ☐ Shoulder or Arm Pain
- ☐ Low Back Pain
- ☐ Hip Pain
- ☐ Ankle Pain
- ☐ Check here if none of above.

Neurologic
- ☐ Headaches
- ☐ Migraines
- ☐ Dizziness
- ☐ Nerve Pain
- ☐ Tingling or Numbness
- ☐ Seizures
- ☐ Tremor
- ☐ Difficulty of Speech
- ☐ Balance Problems
- ☐ Frequent Falls
- ☐ Coordination Problems
- ☐ Check here if none of above.

Endocrine
- ☐ Heat/Cold Insensitivity
- ☐ Breast Changes
- ☐ Hair Changes
- ☐ Excessive Thirst
- ☐ Check here if none of above

Hematologic/Lymphatic
- ☐ Ease of bruising
- ☐ Ease of bleeding
- ☐ Swollen Lymph Nodes
- ☐ Check here if none of above.

Allergic/Immunologic
- ☐ Environmental Allergies
- ☐ Food Sensitivities/Allergies
- ☐ Frequent Colds/Infections
- ☐ Check here if none of above

Psychological
- ☐ Depression
- ☐ Irritable/Mood Swings
- ☐ Memory Loss
- ☐ Anxiety
- ☐ Foggy Thinking
- ☐ Stress
- ☐ Check here if none of above.

Women
- Pregnant? ☐ Yes ☐ No
- ☐ Hot Flashes
- ☐ Breast Lump(s)
- ☐ Check here if none of above

What medications are you taking? _____

_____

How Long? _____ Are you allergic to any medicine(s)? _____

Have you had surgery? Y N What? _____ When? _____

_____

What side effects have you experienced from the drugs and surgery? _____

Are you allergic to anything else? Y N If so, what: _____

Females only: Are you currently pregnant or think you may be: _____ Date of Last Menstrual Period _____

Please indicate whether you have a history of any of the following common conditions:

Constitutional ❑ Overweight ❑ Obese	**Cardiovascular** ❑ Hypertension ❑ Hypotension ❑ Hyperlipidemia ❑ Heart Disease ❑ Myocardial Infarction ❑ Atrial Fibrillation ❑ Stroke ❑ Varicose Veins ❑ Deep Vein Thrombosis ❑ Pulmonary Embolism	**Musculoskeletal** ❑ Degenerated Disc ❑ Bulging/Herniated Disc ❑ Osteoarthritis ❑ Rheumatoid Arthritis ❑ Gout ❑ Osteoporosis	**Hematologic** ❑ Anemia ❑ Clotting Disorder
Eyes ❑ Wear Corrective Lenses ❑ Glaucoma ❑ Macular Degeneration ❑ Cataracts			**Allergic** ❑ Autoimmune Disease
Ears ❑ Hearing Aid		**Neurologic** ❑ Peripheral Neuropathy ❑ Vertigo ❑ Epilepsy ❑ Multiple Sclerosis ❑ Parkinson's Disease	**Men** ❑ Erectile Dysfunction ❑ Enlarged Prostate
Respiratory ❑ Asthma ❑ COPD ❑ On Oxygen ❑ Bronchitis	**Gastrointestinal** ❑ GERD/Heartburn ❑ Ulcer ❑ Diverticulitis ❑ Liver Disease	**Endocrine** ❑ Hypoglycemia ❑ Diabetes I (Childhood) ❑ Diabetes II (Adult Onset) ❑ Hypothyroidism ❑ Hyperthyroidism	**Female** ❑ Breast Cancer **Psychiatric** ❑ Dementia ❑ Psychiatric Care ❑ Psychiatric Illness ❑ Alcoholism
	Genitourinary ❑ Kidney Disease ❑ Kidney Stones		

Is there a family history of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's side	□	□	□	□	□
Mother's side	□	□	□	□	□

Do You : Smoke?: Y N Amount per day:_____

Drink alcoholic beverages?: Y N □ Light □ Medium □ Heavy

Exercise: □ Never □ Sometimes □ Frequently □ Regularly

Upon the completion of your first visit, you will receive a Chiropractic Report to discuss the different types of Active Life Plans that are available to you. Chiropractic Active Life Plans are designed to help get you feeling better quickly and to help you and your family be as healthy as possible. Please review the explanations of the Chiropractic Active Life Plans prior to your Chiropractic Report appointment so you can choose the level of participation that supports you in reaching all of your health goals.

As a result of my chiropractic care, I would like to

(Please check all that apply)

□ Feel better quickly
□ Have a healthier body by keeping my nerve system healthy
□ Have a healthier spine
□ Live a healthier lifestyle

I attest that the above information is true and correct to the best of my knowledge. I further understand that any charges incurred by me in this office are my responsibility, despite any insurance plan, legal involvement, or settlement.

Patient's Signature: _____ Date: _____

Parent or Guardian: _____

Signature: _____ Date: _____

Insurance Information

Primary

Insurance Carrier: _____ Phone: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Policy Holder SS#: _____ Policy Number: _____

Group Number: _____ This is: Health Insur Auto Workers Comp Other _____

Secondary

Insurance Carrier: _____ Phone: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Policy Holder SS#: _____ Policy Number: _____

Group Number: _____

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION:
I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

CONSENT FOR TREATMENT
I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

RELEASE OF INFORMATION:
By signing this form, you are granting consent to Colorado Health and Wellness, Inc. to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at 719-576-2225. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

I have received, read and understand Colorado Health and Wellness Notice of Information Practices containing a complete description of the uses and disclosures of my health information. I understand that Colorado Health and Wellness has the right to change its Notice of Information Practices from time to time and that I may contact CHW at any time to obtain a current copy of the Notice of Information Practices. I have also read and voluntarily consent to treatment and release of information as indicated above.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

COLORADO HEALTH AND WELLNESS CONSENT FOR TREATMENT

Please initial each line that you have read and understand pour office policies

_____NOTICE OF INFORMATION PRACTICES:

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures. Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment. You may inspect and receive copies of your records within 30 days of a request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation. You may request changes to your records. Our practice has the right to accept or deny your request. We maintain a history of protected health information disclosures that is accessible to you. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office. You may file a complaint about privacy violations by contacting our Office Manager. Name: John Warner; Phone: 719-576-2225. The effective date of this Notice of Information Practices is 04/13/03.

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

_____FINANCIAL POLICY :

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care.

1. **If You Do Not Have Insurance:** All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $100 at any time or care may be terminated. Our payment plans make care an affordable part of your family budget.
2. **If You Have Insurance:** All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed $100 or care may be terminated. Our payment plans make care an affordable part of your family budget.

You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage. We do not accept assignment for secondary insurance carriers, but will be happy to provide you with a claim form for your secondary carrier.

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

When your schedule of visits is once per month or longer, you will not be eligible for insurance assignment. Charges for services rendered will be due as they are rendered. We will continue to provide you with an insurance claim form.

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full, regardless of any claim submitted.

We are committed to providing you with the best chiropractic care possible in a caring environment and have established our financial policies to achieve that goal. You will be expected to pay for your chiropractic care at the time the service is rendered unless you make arrangements in advance.

Health Insurance: I understand and agree that health and accident insurance policies are an agreement between myself and my insurance carrier. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this doctor's office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees or outstanding balances for services I have received will be immediately due and payable by me. **Remember, your agreement with your insurance company is between you and them.**

_____MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION:

I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this doctor's office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees or outstanding balances for services I have received will be immediately due and payable.

If you acquire insurance for a special situation such as an auto accident or a worker's compensation injury and choose to utilize that coverage, you will be charged our regular office fees until such claim is settled. We will help you get reimbursed quickly on these claims.

_____PATIENT INFORMED CONSENT STATEMENT FOR CONSULTATION AND/OR EXAMINATION AND/OR TREATMENT:

I hereby request and consent to a consultation as well as a physical examination and ensuring treatment relating to my condition and circumstances in the performance of diagnostic assessment procedures, chiropractic adjustments and other chiropractic manipulative and therapeutic procedures, including Trigenics and other various modes of manual medicine, physical and exercise therapy. Also, if necessary, requisition of diagnostic radiographs (x-rays), MRIs or ultrasound on me by any of the doctors or staff of Colorado Health and Wellness. Some procedures and testing may be experimental and non FDA approved.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other clinic doctors or office personnel, the nature and purpose of chiropractic treatment and other related manual medicine or therapeutic procedures deemed necessary for my care. I understand that results are not guaranteed and that any fees paid by me, as per the Colorado Health and Wellness Fee Schedule, will be strictly for products supplied or services rendered and not based on results. I further understand that, in certain cases, treatment may cause a worsening of my symptoms or condition which is usually, but not always, temporary.

I further understand and am informed that, as is all health care or medical procedures, in the practice of chiropractic, there are some risks to treatment including, but not limited to, residual or intractable pain in the area being treated or other associated areas, muscle spasm, bruising, sprains, fractures, dislocations, disc injuries, and strokes. I do not expect the doctor(s) to be able to anticipate and explain all risks and complications and I wish to rely on the doctor(s) to exercise judgment during the course of the procedure, which the doctor(s) feels at the time, based upon the facts then known, and is in my best interest.

I have read the above consent and I have also had an opportunity to ask questions about its content, and by signing below, I agree to the above-mentioned chiropractic and related manual medicine procedures. This consent form will cover my entire course of treatment.

_____RELEASE OF INFORMATION:

By signing this form, you are granting consent to Colorado Health and Wellness, Inc. to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at 719-576-2225. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we grant your request we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

I have received, read and understand Colorado Health and Wellness Notice of Information Practices containing a complete description of the uses and disclosures of my health information. I understand that Colorado Health and Wellness has the right to change its Notice of Information Practices from time to time and that I may contact CHW at any time to obtain a current copy of the Notice of Information Practices. I have also read and voluntarily consent to treatment and release of information as indicated above.

All payments and plans are non-refundable and non-transferable. If your treating physician is no longer available you will be given the option to see another doctor at CHW. If you choose not to see anyone else in the office, you will forfeit any prepayments made.

_____MISSED APPOINTMENT OFFICE POLICY:

It is our office policy that if you do not call 24 hours ahead of your scheduled appointment time to cancel or reschedule, we reserve the right to charge you for the missed appointment valued at up to fifty dollars.

I have read and I understand all of the above policies.

Print Patients Name **Signature of Patient (or Parent/Guardian)**

_____

Agreement of Financial Responsibility

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

• Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider and are the designated Primary Care Provider (PCP), if applicable.

• It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.

• We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.

• If we have a contract with your insurance company, we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.

• If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.

• Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.

• Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In Network rate.

• If you are unable to keep your appointments, please call 24 hours in advance to cancel your appointment. We will charge a fee of $50 for no show appointments.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

_____ _____

Signature of Patient /Responsible Party Date

_____ _____

Name of Patient/Responsible Party (please print) Relationship to Patient