



LIFETIME

HEALTH AND WELLNESS

8155 W.94th Avenue • Westminster, CO 80021 • (303) 423-4610- Fax (303)431-8658

=====
Your Name: _____ **Today's Date:** _____
Date of Birth: ___ / ___ / ___ **Age:** _____ Female Male Prefer Not To Answer
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Phone Number: _____ Cellular Home
Alternative Telephone: _____ **Email:** _____
Marital Status: Single Married Divorced Widowed
Spouse Name: _____
Who Referred To Our Office : _____
Insurance Company: _____
Emergency Contact (Name): _____
Telephone: _____ **Patient Relationship:** _____

Your Employer: _____ **City:** _____

Your Occupation: _____

Type of Work: Office Manual Travel Homemaker

Work Requirements: Lifting Bending Back Loaded Lifting Children

Data Entry Cradling Telephone Sitting Prolonged Prolonged Standing

Primary Provider Name: _____ **Telephone:** _____

Which of the Following Statements Describe Better Your Attitude About Your Healthcare and Your Health: (Mark with an X)

- I seek medical attention only when it is totally necessary
- My primary health goal is that symptom-free star. I take care of my symptoms when they are minor.
- I am inclined to prevent future health problems through my lifestyle choices such as exercise, nutrition, and other health abuses.

Tell Us What Is Bothering You

To give the doctor a clear understanding of your case, we would like you to answer a few simple questions. Please be as specific as possible in the questions and body diagrams. If you have any questions about any part of this form do not hesitate to ask for help, especially from the doctor.

What Health Problem Brings You To Our Office: _____

When did the problem begin? (If you have had this problem for a long time, from the date when you finally decided you were in care):

Is it due to a recent accident or injury: Yes No Do not know

If "Yes", was it? Car Work Other (Describe): _____

Date of Accident: _____ **Time:** _____ AM PM

Have your injuries been reported? Yes No If "Yes" to whom? _____

Have you seen another doctor or been treated as a result of this condition /accident? Yes No

Names and Specialties: _____

What did the other doctor(s) / Specialist(s) do: Examination X-ray Traction Injections
 Physiotherapy (how long?): Other

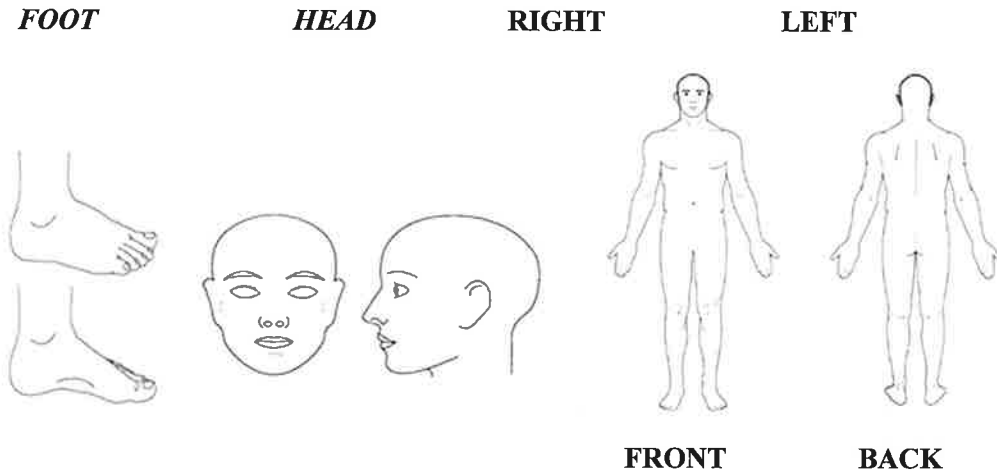
What is the main area of complaint? (Ex. neck pain, headache, lower back, arms / legs pain):

How long has it been since you felt good? _____

How long have you been in the care of a doctor? _____

Are you still under a doctor's care? Yes No

Please mark the area of your main discomfort in the following diagram. If you have pain that goes up or down to another part of the body please indicate where you are traveling.



Describe your pain: Sharp Dull Ache Deep Stabbing Burning Other

Intensity Of Pain _____ 0-10 (10 being the worst) Frequency Of Pain: _____ (# times / week)

Mark the following symptoms related to your condition:

- | | | |
|--|---|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Tiredness on Head/ Shoulders | <input type="checkbox"/> Head seems heavy |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Tension | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Fainting | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Visual Fatigue | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Pain in Joints |
| <input type="checkbox"/> Paleness | <input type="checkbox"/> Pain behind the Eyes | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Lack of Breathing | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Excessive Sweat |
| <input type="checkbox"/> Nausea or Vomiting | <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Muscle jerking |
| <input type="checkbox"/> Nasal Problem | <input type="checkbox"/> Leg Problems | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Extremely Nervous (a) | <input type="checkbox"/> Stress Fatigue | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Difficulty Sitting Remained | <input type="checkbox"/> Digestive Disorder | <input type="checkbox"/> Anxiety |

Date of last: Physical Exam _____ Spinal X-ray _____ Spinal Exam _____
Chest X-rays _____ Blood Test _____ Dental X-rays _____ Urine Exam _____

You take: Nerve pills Muscle relaxants Analgesics Tranquilizers
 Insulin Birth Control Other: _____

Take vitamins and / or minerals: Yes No Which?: _____

Habits (please say the amount): Tobacco ____ (packs / day) Alcohol ____ (drinks / day)
 Caffeine (coffee / tea / soda) _____ Exercise out of work _____ (hours / week)
 Sleep ____ (hours / night) Do you sleep on: Back Side Stomach
 Do you use a bed board? Yes No Is your bed comfortable? Yes No

Do you wear: Heel lift Sole lift Insoles Arch support Back support Prescribed orthotics

Mark the diseases you have had:

- | | | | |
|---|---|--|---------------------------------------|
| <input type="checkbox"/> AIDS / HIV | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Arthritis | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Cancer / Tumors | <input type="checkbox"/> Malaria |
| <input type="checkbox"/> Smallpox | <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Measles | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Typhoid Fever | <input type="checkbox"/> Diphtheria |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Eczema | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Other: _____ | |

Are you aware of any diseases that run in your family: Yes No

Please describe: _____

Do any family members have similar health problems: Yes No (Please describe):

For Women Only:

Date of Last Normal Period: _____ **Menstrual cycle:** _____ days

First period at the age of: _____ **Date of last visit to the gynecologist:** _____

Is there a possibility of pregnancy? Yes No

Indicate all that apply:

- | | | |
|--|---|---|
| <input type="checkbox"/> Cycles irregular | <input type="checkbox"/> Cramps or Back Pain | <input type="checkbox"/> Menopause Symptoms |
| <input type="checkbox"/> Premenstrual Stress | <input type="checkbox"/> Excessive Flow | <input type="checkbox"/> Conjugated Breasts, Breast Lumps |
| <input type="checkbox"/> Pain During | <input type="checkbox"/> Other Menstrual Symptoms | |



Consent for the Purpose of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by C.E.O. Westminster for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or for carrying out health care operations. I understand that the analysis, diagnosis or treatment of me by C.E.O. Westminster may be subject to my consent as evidenced by my signature below.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. C.E.O. Westminster is not required to agree to the restrictions they I may request. However, if C.E.O. Westminster agrees to a restriction that I request, the restriction is binding. I have the right to revoke this consent, in writing, at any time, except to the extent that C.E.O. Westminster has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me, created or received by my doctor, another health care provider, a health plan, my employer or a health care compensation center. This protected health information relates to my past, present or future health or physical or mental condition and identifies me, or there is a reasonable basis to believe that you can identify me.

I have been provided a copy of the Notice of Privacy Practices of CEO Westminster. I understand that I have the legal right to review the Notice of Privacy Practices of CEO Westminster before signing this consent and we encourage you to read it in its entirety. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations in our clinic. The Notice of Privacy Practices for CEO Westminster is also posted in the waiting room at 8155 W. 94th Ave Broomfield, CO 80021.

The Notice of Privacy Practices for CEO Westminster is subject to change. I may obtain a revised notice of privacy practices by calling our clinic and requesting that a copy be sent by mail or requesting one at the time of my next appointment.

Signature of Patient or Personal Representative

Printed Name of Patient

Date of Signing

Description of Authority of Personal Representative



Lifetime Health & Wellness

WWW.LTHAW.COM

8155 W. 94th Avenue • Westminster, CO 80021 • Phone: 303-423-4610 • Fax: 303-431-8658

ACKNOWLEDGMENT OF RECEIPT OF HIPPA PRIVACY NOTICE

I, _____, have been offered/provided a copy of the Notice of Privacy Practices from this office. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in the provision of my treatment.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and accreditation.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations. The practice of C.E.O. Westminster is not required to agree to the restrictions that I may request.

I understand that my “protected health information” means health information including my demographic information collected from me, created or received by my doctor, another health care provider, a health plan, my employer, or a health care compensation center. This protected health information relates to my past, present, or future health or physical or mental condition and identifies me, or there is a reasonable basis to believe that you can identify me.

The Notice of Privacy Practices for C.E.O. Westminster is also posted in the waiting room at 8155 W. 94th Ave., Broomfield, CO 80021. The Notice of Privacy Practices is subject to change and a revised version may be requested and mailed to me or provided for me at the time of my next appointment.

Patient Name (printed): _____ Date: _____

Patient Signature: _____

Please check here to authorize our office to release records to you Primary Care Physician.

For Official Use Only

We attempted to obtain written Acknowledgement of Receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented our office from obtaining acknowledgment
- Other (please specify): _____

Staff Signature: _____ Date: _____

Chiropractic Disclaimer

To the patient: Please read the document in its entirety prior to signing it. It is important that you understand the information explained below. If you have any questions please ask before you sign.

Nature of Chiropractic Treatment

Prior to beginning treatment, you will be given a physical examination that can include taking vital signs, range of motion testing, muscle strength testing, palpation, orthopedic testing, and neurological testing. Once your condition has been diagnosed, the primary method of treatment will be spinal manipulation, also known as spinal adjustment. An adjustment is a quick, precise movement of the spine over a short distance. Adjustments are usually performed by hand but may be performed by hand-guided mechanical instruments. In addition to spinal manipulation, treatment can also involve other forms of therapy including electrical stimulation, traction, cold packs, hydrotherapy, infrared heat, exercise, acupuncture, dry needling, massage, A.R.T., cranial therapy, rapid release, and nutritional supplements.

Risks of Chiropractic Treatment

All health care procedures carry some degree of risk. The most common side effect of spinal manipulation is short-term muscle soreness. More serious side effects can include bone fractures, muscle strain, ligament sprain, joint dislocation and injury to the discs, nerves or spinal cord. Some manipulations of the upper spine have been associated with injury to the arteries in the neck, which could cause or contribute to stroke. However, documented cases are exceedingly rare, and it has been estimated by researchers that the probability of a spinal adjustment causing a stroke is one in several million. Compared to other forms of health care, chiropractic is extremely safe, and complications are generally rare.

Treatment Options Other Than Chiropractic

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics;
- Medical care and prescription drugs such as muscle relaxers, pain killers and drugs to reduce inflammation;
- Surgery;
- Remaining untreated.
- Physical therapy

If you decide to pursue other treatment options, you should discuss the risks and benefits with your medical physician. Remaining untreated carries its own risks and may allow the formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce mobility and induce chronic pain cycles.

I have read above the explanation and risks of Chiropractic treatment and possible therapies. By signing below, I state that I have weighted the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient/Guardian Signature

Date

Witness

Date

OFFICE POLICIES

Please read our policies and acknowledge by initialing next to each statement and sign the bottom

_____ All payments are **DUE AT TIME OF SERVICE** including co-pays, co-insurance, deductible amounts, and/or non-covered procedures. If payment is not made at time of service, a **\$10 billing fee** will be applied to your balance.

_____ Insurance cards presented are current and accurate. We will contact your insurance to verify benefits, however, this is not a guarantee of coverage or payment. Ultimately, it is the patient's responsibility to know insurance coverage. We know your claim is processed once we receive payment and an explanation of benefits (EOB).

_____ Insurance companies have 45 days to approve or deny a claim. In some cases, this may take longer if extra information is requested.

_____ For any balance remaining after insurance has paid, you will be mailed a statement. Please contact your insurance company if you feel insurance has paid incorrectly.

_____ If bill is not paid within 30 days of receiving statement or billing department is not contacted, a **\$15 billing fee** will be applied each billing thereafter.

_____ We understand there are times where you are unable to keep an appointment. We request 24-hour notice for cancelling an appointment. A **\$20 fee** may be assessed if we are not contacted in time. You may leave a voicemail if the office is closed.

_____ In accordance with the State of Colorado statutes, no doctor shall engage in a personal relationship with any patient outside the parameters of normal conduct of doctor-patient interaction.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize CEO Westminster Inc. to release any appropriate information concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered and hereby release CEO Westminster Inc. of any consequences thereof. I authorize my insurance and/or attorney to pay by check made out and directly mailed to CEO Westminster Inc. Further, I agree to pay CEO Westminster Inc. the difference, if any, between the total amount of charges and the amount paid by the insurance carried and/or attorney. A photocopy of this document will be deemed as valid and binding on all parties involved.

I have read and have full understanding of all policies and HIPPA agreement of Lifetime Health & Wellness.

Patient Name: _____

Patient Signature: _____

Date: _____

OR

Legal Guardian Signature: _____

Date: _____

Relationship to Patient: _____

Witness Initials: _____