Heritage Health Inc.
7555 E. Arapahoe Rd, Suite 2, Centennial, CO 80112
Phone: (303) 694-1245 Fax: (303) 694-1254

Office Use Only	
DR: TN PM MS	
Dxl	Dx2
Dx3	Dx4

Confidential Patient Information

Patient's Full Name: ____ Date: _____/_____/________

Home Phone: ___________________________ Cell Phone: ___________________

Mailing Address: ______________________________________City:______________ State: ______ Zip: ___________

E-Mail:____ Male Female Age: ________

Your email will be used only for office updates and newsletters (it will not be sold or distributed for any other purpose)

Date of Birth: _____/____/________

Occupation: _________________ Hours/Week____ Employer: ____________________ Business Phone: ____________

Spouse's Name: ____________________ Employer: _______________________ Business Phone: __________________

Emergency Contact: _____________________________ Relationship: _________________ Phone: ________________

How did you hear about our office? ________________________ If referred, by whom? _________________________

Is Today's Visit Due To a Work Related Injury? Y / N **Auto Accident:** Y / N

Date of Injury: __________

If yes to either question above, please check with receptionist, additional information is needed

Have you had previous Chiropractic/Physical Therapy care: Y / N If Yes, for what Problems: ________________

____

____

____

Which best describes your health care goals:

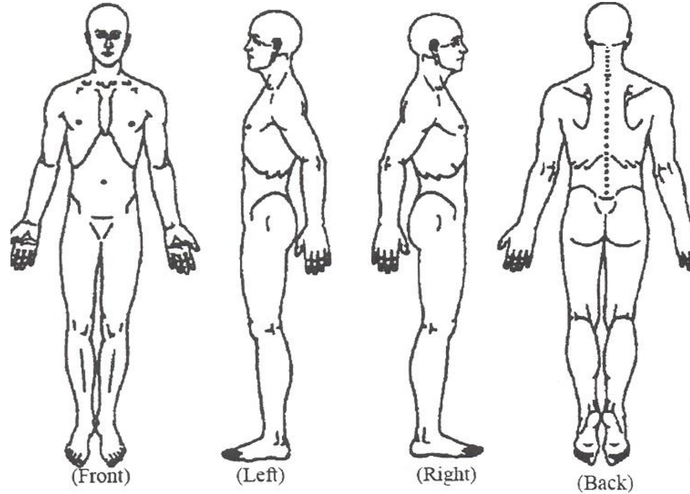
______ Pain relief only (not interested in correction of problem)

______ Would like to find the cause of this problem and have it improved or corrected

______ Wellness / preventative care - just want to stay well and be at optimal health.

Patient Signature: ________________________________ Date: _____________________________

PLEASE MARK AN X ON THE AREAS OF YOUR CONCERNS



Please describe your main problem:____
____

Circle the number which best describes your pain level, with 0 being no pain and 10 being severe:
0 1 2 3 4 5 6 7 8 9 10

Circle the choice which best describes the percentage of time that you are awake and experiencing these symptoms:
0% 25% 50% 75% 100%

Have you had the same or similar symptoms before? Y / N
If yes, please describe: ____
____

Describe the quality of the main problem/pain
(circle):
Sharp / Shooting Dull / Aching Burning
Tingling Numbness Stabbing
Radiating Throbbing Localized
Other: ______________________

Does any of the following make your main problem worse?
(circle):
Lifting Bending Pushing Pulling
Coughing Sneezing Bowel Movement
Driving Sitting Working Walking
Prolonged Standing Twisting Home Activities
Other: ___________________________

Does any of the following make your main problem better?
(circle):
Rest Laying down Sitting
Walking Exercise Moving About
Heat / Ice Stretching Medications
Massage Treatments Nothing
Other: _____________________________

When is your main problem the worst?
(circle):
Morning Afternoon Evening
Middle of Night While working At End of work day
While Driving After Traveling After Exercising
After Sports
Other: ________________________

Does your main problem interfere with your daily activities?
____ Minimal (causes pain but doesn't prevent you from doing any of your normal activities)
____ Mild (causes pain and prevents you from doing a few of your normal activities)
____ Moderate (causes pain and prevents you from doing some of your normal activities
____ Severe (causes pain and prevents you from doing most or all of your normal activities)

What activities are affected by your main problem? i.e. (sleeping, working, walking, exercising, family activities, household activities, etc.)

____

____

____

Describe your <u>secondary</u> or related problem, if any: ______________________________

____

Circle the number which best describes your pain level, with 0 being no pain and 10 being severe:

0 1 2 3 4 5 6 7 8 9 10

Circle the choice which best describes the percentage of time that you are awake and experiencing these symptoms:

0% 25% 50% 75% 100%

Have you had the same or similar symptoms before? Y / N

If yes, please describe: ____

____

Describe the quality of the secondary problem/pain (circle):

Sharp / Shooting	Dull / Aching	Burning
Tingling	Numbness	Stabbing
Radiating	Throbbing	Localized

Other: ______________________

Does any of the following make your secondary problem <u>worse?</u> (circle):

Lifting	Bending	Pushing	Pulling
Coughing	Sneezing	Bowel Movement	
Driving	Sitting	Working	Walking
Prolonged Standing		Twisting	Home Activities

Other: ___________________________

Does any of the following make your secondary problem <u>better</u>? (circle):

Rest	Laying down	Sitting
Walking	Exercise	Moving About
Heat / Ice	Stretching	Medications
Massage	Treatments	Nothing

Other: _____________________________

When is your secondary problem the worst? (circle):

Morning	Afternoon	Evening
Middle of Night	While working	At End of work day
While Driving	After Traveling	After Exercising
After Sports		

Other: ________________________

Does your secondary problem interfere with your daily activities?

____ Minimal (causes pain but doesn't prevent you from doing any of your normal activities)

____ Mild (causes pain and prevents you from doing a few of your normal activities)

____ Moderate (causes pain and prevents you from doing some of your normal activities)

____ Severe (causes pain and prevents you from doing most or all of your normal activities)

What activities are affected by your secondary problem? i.e. (sleeping, working, walking, exercising, family activities, household activities, etc.)

____

____

____

Describe your <u>other</u> problems, if any:____

____

Circle the number which best describes your pain level, with 0 being no pain and 10 being severe:

0 1 2 3 4 5 6 7 8 9 10

Circle the choice which best describes the percentage of time that you are awake and experiencing these symptoms:

0% 25% 50% 75% 100%

Have you had the same or similar symptoms before? Y / N
If yes, please describe: ____
____

Describe the quality of the other problem/pain (circle):
Sharp / Shooting   Dull / Aching   Burning
Tingling   Numbness   Stabbing
Radiating   Throbbing   Localized
Other: ____________________

Does any of the following make your other problem worse? (circle):
Lifting   Bending   Pushing   Pulling
Coughing   Sneezing   Bowel Movement
Driving   Sitting   Working   Walking
Prolonged Standing   Twisting   HomeActivities
Other: _________________________

Does any of the following make your other problem better? (circle):
Rest   Laying down   Sitting
Walking   Exercise   Moving About
Heat / Ice   Stretching   Medications
Massage   Treatments   Nothing
Other: ___________________________

When is your other problem the worst? (circle):
Morning   Afternoon   Evening
Middle of Night   While working   At End of work day
While Driving   After Traveling   After Exercising
After Sports
Other: ______________________

Does your other problem interfere with your daily activities?
____ Minimal (causes pain but doesn't prevent you from doing any of your normal activities)
____ Mild (causes pain and prevents you from doing a few of your normal activities)
____ Moderate (causes pain and prevents you from doing some of your normal activities)
____ Severe (causes pain and prevents you from doing most or all of your normal activities)

What activities are affected by your other problem? i.e. (sleeping, working, walking, exercising, family activities, household activities, etc.)
____
____
____

Concurrent Health Care:

Are you currently receiving treatment for these problems? Y / N If yes, with whom and what is being done?
____
____

Present & Past Health, Social and Family History

1. Have you **ever** had any **major illness, injuries, broken bones, hospitalizations, or surgeries**? If yes list them:
____
____
____
____
____

2. Is there any history of significant family health problems? If yes list them:
____
____
____
____
____

3. Weight ____________lbs. Have you recently lost or gained weight? Y / N Height ___________

4. Do you exercise regularly? Y / N If yes, how many hours a week and what activities:

____

____

5. Please place a check mark for **symptoms/diseases** you have had in the present/past.

GENERAL SYMPTOMS
__ Chills
__ Cold hands/feet
__ Confusion
__ Convulsions
__ Depression/Anxiety
__ Fainting/Dizziness/Vertigo
__ Fatigue
__ Fever
__ Forgetfulness
__ Headaches
__ Loss of sleep/Insomnia
__ Loss of weight
__ Migraines
__ Motion Sickness
__ Nervousness
__ Numbness
__ Paralysis
__ Sweating
__ Tremors
__ Other

EYES, EARS, NOSE, THROAT
__ Allergies
__ Asthma/Bronchitis/Pneumonia
__ Blurry vision
__ Cataracts
__ Color blindness
__ Cross eye
__ Deafness
__ Dental decay
__ Difficult speech
__ Difficult swallowing
__ Ear discharge
__ Ear noises/ringing
__ Earache
__ Enlarged/swelling glands
__ Eye inflammation
__ Eye pain or sensitivity
__ Eye strain
__ Failing vision
__ Frequent colds/flu
__ Glaucoma
__ Gum problems
__ Hay fever
__ Hoarseness
__ Loss of hearing
__ Loss of smell
__ Loss of taste/change in tastes
__ Nasal drainage
__ Nasal obstruction
__ Nose bleeds
__ Sinus infection
__ Sore throat
__ Spots/lines in vision
__ Tonsillitis
__ Thyroid problems
__ Other

SKIN, HAIR, NAILS
__ Boils
__ Cuts heal slowly
__ Finger/Toenail problems
__ Hair problems
__ Hives or allergy
__ Moles/warts
__ Rashes
__ Sensitive skin
__ Skin eruptions
__ Other

RESPIRATORY
__ Chest pain
__ Chronic cough
__ Difficulty breathing
__ Spitting up blood
__ Spitting up phlegm
__ Wheezing
__ Other

CARDIOVASCULAR
__ Anemia
__ Hardening of arteries
__ Heart Disease
__ High blood pressure
__ High cholesterol
__ Irregular heat beat
__ Low blood pressure
__ Low cholesterol
__ Pacemaker
__ Pain over heart
__ Paralytic stroke
__ Poor circulation
__ Previous stroke
__ Rapid heart beat
__ Slow heart beat
__ Swelling of ankles
__ Varicose veins
__ Other

MUSCLE and JOINTS
__ Arthritis/osteoarthritis
__ Backache
__ Disc Problems
__ Faulty posture
__ Fibromyalgia
__ Finger, hand or wrist problems
__ Hernia
__ Pain between shoulders
__ Painful joints
__ Painful tailbone,
__ Sciatica
__ Sore muscles
__ Spinal curvature
__ Stiff joints
__ Stiff neck or neck pain
__ Swollen joints
__ Toe, foot or heel problems
__ Walking problems
__ Weak muscles
__ Other

GENITOURINARY
__ Bed wetting
__ Bladder problems
__ Blood in urine
__ Discolored/cloudy urine
__ Foul smelling urine
__ Frequent urination
__ Inability to control urine
__ Kidney infection/stones
__ Painful urination
__ Pus in urine
__ Scanty urine
__ Urinary tract infections
__ Venereal disease
__ Other

GASTROINTESTINAL
__ Anal problems
__ Bad breath
__ Belching
__ Black stool
__ Blood in stool
__ Colitis
__ Colon problems
__ Constipation
__ Diarrhea
__ Difficult chewing
__ Distention/bloating
__ Eating disorder
__ Excessive hunger
__ Gallbladder problems/stones
__ Gas
__ Heartburn
__ Hemorrhoids
__ Indigestion
__ Intestinal worms
__ Jaundice
__ Liver problems
__ Mucous in stool
__ Nausea
__ Pain in abdominal area
__ Poor appetite
__ Ulcer/Gird
__ Undigested food in stool
__ Vomiting
__ Vomiting of blood
__ Weight problems
__ Other

FEMALE
__ Abnormal bleeding
__ Abnormal Pap test
__ Breast pain
__ Excessive flow
__ Hot flashes
__ Irregular cycle
__ Lumps in breast
__ Menopausal symptoms
__ Painful menstrual periods
__ Period cramps or Backache
__ PMS
__ Pregnancy
__ Pregnancy complications
__ Previous miscarriage
__ Reduced sex drive
__ Vaginal discharge
__ Vaginal pain
__ Yeast infections
__ Other

MALE
__ Discharges
__ Genital pain or problems
__ Impotence
__ Premature ejaculation
__ Prostate problems
__ Reduced sex drive
__ Seminal emission
__ Other

OTHER
__ Alcoholism/substance abuse
__ Cancer
__ Diabetes
__ Edema Hepatitis
__ Hepatitis A/B/C
__ Herpes
__ HIV+/AIDS
__ Mental/Emotional disorder
__ TB Epilepsy

___ **NONE OF THE ABOVE**

6. Do you smoke? Y / N If yes, how many packs / day? ____

7. Do you drink alcohol?   None   Light   Moderate   Heavy

8. Have you had any diagnostic imaging i.e. X-RAYS, MRI, CT scan, Bone Scan, etc. in the past five years? Y / N

If yes, what did you have done?
____

9. Have you detected any possible relationship of your current complaint with any of the following (circle)?

Muscle Weakness   Bowel / Bladder problems   Digestion   Cardiac / Respiratory
Other: _____________________

10. Have you tried any self-treatment or taken any medication (over the counter or prescription): Y / N
____
____

11. Women only: Are you pregnant? Y / N If yes, how far along are you? ____________________________

12. Do you have health insurance? Y / N Insurance Company Name: _______________________________________

***There may be some things that your insurance company does not cover, but we have many reasonable and affordable payment options. If you have a problem that we can help, and we decide to accept your case, are you willing to pay out of pocket to reach your health care goals? _____ Yes _____ No**

_________________________________   _____________________________   __________

Patient or Legal Guardian Printed Name   Patient or Legal Guardian Signature   Date

PATIENT PAYMENT OPTIONS

Our experience has shown that it is wise to have an understanding with our patients as to our office policies and fees. Therefore, this form has been prepared for your convenience and information. We offer several methods of payment for your care in our office (if you are accepted as a patient) and you may choose the plan which best fits your needs. Please read carefully and choose the plan you prefer. This information will enable us to better serve you and help avoid any misunderstandings in the future. If special arrangements are necessary, please consult with the Doctor. Our main concern is your health and well being, and we will do our best to help you!

PLAN l: PROMPT PAY- Fees are to be paid at the time services are rendered (every visit), unless special arrangements have been made in advance. Cash, Check, Visa or MasterCard.

PLAN 2: WEEKLY or MONTHLY CASH PAYMENT AGREEMENT- For that non-transient, but active patients who qualify, we will extend knowledgeable credit through this plan; however, should you become inactive by discontinuing your care, your entire unpaid balance will be due immediately. This plan applies to all cases, except work injury or auto injury claims.

PLAN 3: INSURANCE- If you have insurance that covers Heritage Health Services and we are willing to accept your insurance, we can bill your insurance directly. Please provide us with your current health insurance card, on or before your second visit. Until we have the completed, correct, and necessary information regarding coverage, you will be required to pay for your care. Most patients are required to pay a co-pay/co-insurance in addition to their yearly deductible. In the event that a payment should come to you, you are expected to bring the endorsed check to us along with the EOB's. The contracted insurance plan is yours, not ours; therefore you are always responsible for your account with us. If you become inactive by discontinuing your care, your account balance is due immediately.

PLAN 4: AUTO/PERSONAL INJURY- You need to supply us with the accident report, your auto insurance information, your health insurance information, liable party's insurance information, accident claim number, accident adjustor contact information, and attorney information if applicable. Until necessary information is gathered and verified or you have retained an attorney, you will be required to pay for your care. If we can accept your case, we will bill your insurance directly. In the event that payment comes to you from the insurance company, or your attorney achieves a settlement, then we expect payment immediately. If you are released from care or non-compliant with the medical recommendations, the account balance is due within 90 days. You are responsible for payment of all services on your account. If payment on your account is not made, the balance will be submitted to a collection agency.

______________________________	______________________________	__________
Patient or Legal Guardian Printed Name	Patient or Legal Guardian Signature	Date

Authorization to Release Information

If I am accepted as a patient, I authorize this healthcare facility to release all information related to the care I receive to my primary care physician, insurance company, third party payor, attorney, or their designee, as may be necessary for the coordination of care, payment of my bill, determining benefits, or for quality review.

Privacy and Confidentiality

I understand that this healthcare facility is making extensive efforts to protect my personal privacy and information. I understand that there are some treatments and procedures that are not in a private setting, such as therapy tables and exercise rehabilitation. If I am uncomfortable with that setting, I will notify the staff and they will try to accommodate me as much as possible. I also give permission for the office to leave messages regarding future appointments and information related to my care. A Federal and State law (HIPPA) requires all healthcare facilities to adhere to their policies regarding the release and disclosure of medical records. Records and x-rays are the property of this facility. Copies of records may be received only by authorization of the patient or guardian, request must be in writing, and charges for those copies follow the usual/customary costs. 7-10 business days is required to process request. I have received a copy of the privacy protection policy.

Authorization for Examination, Diagnostic Testing, and Treatment

If, after consultation and deemed appropriate, I authorize the performance of examination, diagnostic tests, procedures, and treatment deemed necessary by personnel in this office regarding my care. Necessary procedures will be discussed with the doctor/therapist on a case by case basis. I give the office staff permission to use their best clinical judgment regarding what is necessary to handle my case. I understand that occasionally it may be necessary for another doctor/therapist to treat me.

I understand that the doctor/therapist will explain the risks/benefits, the prognosis of my condition, and refer me to another provider if needed. I understand that it may not be possible for every risk factor to be explained to me. I expect the doctor/therapist to use their best judgment in the management of my care. I also understand that the intent of this facility is to facilitate healthy body function relating to musculoskeletal conditions and some individuals may need another medical provider to diagnosis and treat certain diseases.

Assignment of Benefits

I assign to Heritage Health Inc. and all affiliates of Heritage Health Inc. all benefits payable to me for my care. If I ask this facility to handle my insurance claims for me, I authorize this healthcare facility to be paid directly by the insurance company or other third party payor. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

Guarantee of Payment

I guarantee payment of all charges incurred for evaluation and treatment in accordance with the rates and terms of this healthcare facility. I understand that this agreement will start once I am accepted as a patient and my care plan and responsibilities are discussed.

Payment for all services is required on the same day and may be paid by cash, check, VISA, MasterCard, and Care Credit unless other arrangements have been previously made. If we are submitting claims for your insurance to pay, then your co-insurance and payment toward your annual deductible is also required at the time of service.

****Payment discount plans are available; please ask if you are interested, i.e. Care Credit and ChiroHealth USA****

We are happy to file claims for you if appropriate. However, disputes regarding coverage, benefits, payments, etc. are strictly between the patient and the insurance company. Most insurance claims involve delay before we receive payment. Please keep in mind that we can't guarantee payment from the insurance company, your insurance is your responsibility, and insurance company contracts are between the company and the insured individual(s). We may need your help to collect payment for your claims. Ultimately, you are responsible for payment of any services.

Method of Payment for charges:

_____ Cash _____ Credit Card
_____ Check _____ Credit Card on File

I certify that I understand the above office policies and agree to abide by the same.

_______________________________ __________ ________________________________
Signature of patient or responsible party Date If, under 18 years old, relationship to patient

Please read and Sign the below form before examination and treatment

INFORMED CONSENT

Medical doctors, chiropractic doctors, osteopaths, and physical therapists that perform manipulation are required by law to obtain your informed consent before starting treatment.

I do hereby give my consent to the performance of conservative non-invasive treatment of the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used. Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware the there are possible risks and complications associated with these procedures as follows:

Soreness/Bruising: I am aware that like exercise it is common to experience muscle soreness and occasionally bruising in the first few treatments.
Dizziness: Temporary symptoms like dizziness and nausea can occur, but are relatively rare.
Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disc, or other abnormality is detected, this office will proceed with extra caution.
Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.
Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn occurs, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor/therapist. Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

TREATMENT RESULTS

I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate that there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic, physical therapy, and acupuncture is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor/therapist and such other persons of the doctor's/therapist’s choosing.

ALTERNATIVE TREATMENTS AVAILABLE

Reasonable alternatives to these procedures have been explained to me including, rest, and home applications of therapy, prescription or over-the counter medications, exercises and possible surgery.
Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.
Rest/Exercise: I understand that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness.
Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.
Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar tissue/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or had read to me the above explanation of chiropractic/physical therapy/acupuncture treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

______________________________ __________ ______________________________

Signature of patient or responsible party Date If, under 18 years old, relationship to patient

Privacy Protection Policy

This page describes how medical information about Heritage Health's patients may be used and disclosed and about how you can access this information. If, after reviewing this information, you have any questions, please contact front desk.

Heritage Health is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of the legal duties and privacy practices regarding such protected health information.

Disclosure of Your Health Care Information

Treatment
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

Payment
We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

Workers' Compensation
We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies
We may disclose your health information to notify a family member, or anyone else responsible for your care, in the event of an emergency.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Public Safety
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Change of Ownership
In the event that Heritage Health is sold or merged with another organization, your health information/record will become the property of the new owner.

You're Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that Heritage Health amend your protected health information.
- You have a right to receive an accounting of disclosures of your protected health information made by Heritage Health.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.