PRIMARY CARE	Patient Information Sheet	CONFIDENTIAL

5191 S. Yosemite, Suite B. Greenwood Village, CO 80111 Phone: (303) 577-9977 www.integrativehealthinc.com

Important: Complete this document as thoroughly as possible. Some questions may seem unrelated to your condition, but they may affect your diagnosis and treatment. All information is confidential.

Date _____ / _____ / _____	First Name	Last Name	Social Security Number — —
Marital Status **Single Married Divorced**	Date of Birth _____ / _____ /	Age	Gender ☐ **Male** ☐ **Female** ☐ **Non-binary** ☐ **Other:**___________________ ☐ **Prefers not to say**
Street Address	City	State	Zip
Phone (Daytime) – **Home Work Mobile** *Circle One* ( )	Alternate Phone # – **Home Work Mobile** *Circle One* ( )		
Place of Employment --- Occupation ------------------------	Phone Numbers of Emergency Contact Primary ( ) Alternate ( )		
Circle Insurance Coverage (Please circle one) None Workers' Comp Auto Injury Health Insurance Company Name:______________________________			
E-Mail: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐			
How did you hear about us? *Please circle one and write the name* Current Patient's Name: __________ Doctor: __________Advertisement: __________ Friend/Family's Name: ________Insurance: ___________ Other: ____________			

Chief complaint: ____
How long? ______________________________ How often: ______________________________
What caused this (accident, lifestyle, drug, etc.)? ______________________________
Describe the worst it can be: ______________________________
What treatments have you tried? ______________________________
Get temporary relief? _______ Fixes problem? _______ Causes side effects? ______________________
How does this affect your life? ______________________________
Affect your family? ______________________________ Affect your sleep? ______________________
Affect your work? ______________________________ Affect your hobbies? ______________________
What is your goal/plan if the problem continues 5/10/20 years? ______________________________

Complaint #2: ____
How long? ______________________________ How often: ______________________________
What caused this (accident, lifestyle, drug, etc.)? ______________________________
Describe the worst it can be: ______________________________
What treatments have you tried (ice/heat/rest/over-the-counter/prescription meds), other? _________________
Get temporary relief? _______ Fixes problem? _______ Causes side effects? ______________________
How does this affect your life? ______________________________
Affect your family? ______________________________ Affect your sleep? ______________________
Affect your work? ______________________________ Affect your hobbies? ______________________
What is your goal/plan if the problem continues 5/10/20 years? ______________________________

Other Complaints:

3) ______________________________________ 4) ______________________________________

SYMPTOMS – ****NOTE**: For each symptom you currently have, rate its severity from 1- 5 (5 being the worst). LEAVE BLANK IF NOT APPLICABLE.**

_____ Irritability / Anger
_____ Depression / Stress
_____ Headaches / Migraines
_____ Visual Problems
_____ Red / Dry / Itchy Eyes
_____ Gall Stones
_____ Dizziness
_____ Blurred Vision
_____ Feeling of Lump in Throat
_____ Clenching of Teeth at Night
_____ Muscle Cramping / Twitching
_____ Tension
_____ Joints/Neck/Shoulder Pain/Tight
_____ Poor Circulation
_____ Soft / Brittle Nails
_____ Emotional Eater

_____ Urinary Problems
_____ Bladder Infection
_____ Lack of Bladder Control
_____ Weakness / Pain in Lower Back
_____ Decrease Bone Density
_____ Feel Cold Easily
_____ Low Sex Drive
_____ Excess Sexual Desire
_____ Poor Memory
_____ Loss of Hair
_____ Hearing Problems
_____ Cavities
_____ Craving / Avoiding Salty Foods
_____ Fear
_____ Hot Flush / Night Sweating

_____ Heart Palpitations
_____ Chest Pain
_____ Insomnia / Sleep Problems
_____ Easily Startled
_____ Restlessness / Agitation
_____ Vivid Dreams
_____ Lack of Joy in Life

_____ Dry Cough
_____ Cough with Sputum
_____ Nasal Discharge
_____ Post-Nasal Drip
_____ Sinus Infection / Congestion
_____ Itchy, Red or Painful Throat
_____ Dry Mouth / Throat / Nose
_____ Skin Rashes / Hives
_____ Snoring
_____ Grief / Sadness
_____ Shortness of Breath
_____ Allergies / Asthma
_____ Low Resistance to Colds or Flu
_____ Sneezing
_____ Mild Fever Comes & Goes
_____ Smoke Cigarettes

_____ Heaviness Anywhere in Body
_____ Fatigue / Worse After Eating
_____ Hard to Get Up in the Morning
_____ Edema (Swelling)
_____ Muscles Feel Tired Often
_____ Easily Bruising & Bleeding
_____ Bad Breath
_____ Decreased / Increased Appetite
_____ Crave Sweets
_____ Hypoglycemia
_____ Difficulty Digesting Oily Foods
_____ Nausea / Vomiting
_____ Gas / Belching
_____ Insulin Sensitivity
_____ Hemorrhoids
_____ Constipation
_____ Diarrhea
_____ Abdominal Pain
_____ Indigestion / Heartburn
_____ Over-Thinking
_____ Tendency to Gain Weight
_____ Brain Foggy

MEDICAL CONDITIONS
Please list conditions & surgeries you have had and year diagnosed.

_____
_____
_____
_____
_____
_____
_____

ALLERGIES

Seasonal, Environmental, Food, etc		

MEDICATIONS – Please list all prescription medications you use. Include those which you may only use occasionally. Remember inhalers, eye drops and nose sprays. NOTE: If need more space, or have a form the front desk can make a copy.

Prescription Name	Purpose	Started taking	Dose	How Often	Last Dose

PERSONAL MEDICAL & FAMILY HEALTH HISTORY

Please indicate health issues for yourself and your family with a "**C**" for current health issues. "**P**"will indicate a past problem. Leave blank those that do not apply. If you require more space, use the reverse side of this form.

	You	Father	Mother	Spouse	Brother(s)		Sister(s)		Children		
Age											
AIDS / HIV											
Alcohol Use											
Anxiety											
Arthritis											
Asthma / Hay Fever / Allergy											
Back Trouble											
Cancer											
Depression											
Diabetes/Prediabetes											
Digestive Trouble											
Headaches / Migraines											
Heart Attack											
Heart Disease or Surgery											
Hepatitis											
High Blood Pressure											
Immune Disorder											
Kidney Disease											
Liver Disease											
Low Blood Pressure											
Lung Disease											
Seizures											
Thyroid Disorder											
Tobacco Use											
Vascular Disease											
Weight Problem											
Other:_____											
Other:_____											

If any of the above family members are deceased, please list their age at death and cause.

_____

SOCIAL HISTORY

Smoker? ☐ NO ☐ YES How many per day?_____ How many years? _____

Alcohol? ☐ NO ☐ YES How many per day?_____ How many years? _____

Recreational drug(s)? ☐ NO ☐ YES How many per day?_____ How many years? _____

Exercise? ☐ NO ☐ YES How often?_____ Type? _____

Special Diet? ☐ NO ☐ YES Type of Diet? _____

Do you have little interest or pleasure in doing things?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Do you feel safe at home?

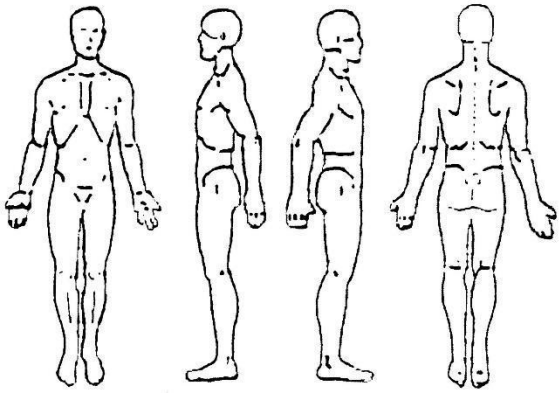
☐ YES ☐ NO

CURRENT SYMPTOMS

☐ Fainting/Dizziness	☐ Chest Pains/Shortness of Breath	☐ Palpitations/Rapid Heartbeat

☐ Known Heart Murmur ☐ Memory Concerns	☐ Fatigue ☐ Swelling	☐ Loss of Vision or Speech ☐ Pain

Please mark problem areas on diagram:



Describe Pain and Location

☐	Sharp	☐	Burning	☐	Aching
☐	Fixed	☐	Swelling	☐	_____

☐	Sharp	☐	Burning	☐	Aching
☐	Fixed	☐	Swelling	☐	_____

☐	Sharp	☐	Burning	☐	Aching
☐	Fixed	☐	Swelling	☐	_____

Any other information that you would like to share with me that can help with the care you are receiving?

_____

_____

_____

_____

_____

I hereby certify that all the above information is true to the best of my knowledge.

Patient/Parent/Guardian Printed Name _____

Patient/Parent/Guardian Signature _____ **Date:** _____

5191 S Yosemite St, Suite B
Greenwood Village, CO 80111
Phone: 303-577-9977
www.IntegrativeHealthInc.com

_____ (initial) I, hereby understand Integrative Health Wellness Center is a wellness building that houses a variety of health professional businesses. As a patient, I realize I am not being treated by Integrative Health Inc., but the specific provider's business seen by. Integrative Health is not your health care provider and cannot be held responsible to any harm or damages to your person. I, hereby release Integrative Health Inc. from any damages that could occur to my person.

Consent For Care

_____ (initial) I, herby authorize and request the provider(s) in which I scheduled with at 5191 S Yosemite St, Ste B, to perform such examinations and therapeutic treatments as in the judgement of the provider(s). I understand I am not forced to accept medical treatment.

Authorization To Release Information

_____ (initial) I AUTHORIZE the provider(s) seen at 5191 S Yosemite Street, Ste B, to release any information required to process this claim to any insurance company or attorney involved in my case. I also authorize any insurance company or medical provider to release my medical records to the provider(s) at 5191 S Yosemite St, Ste B. The information is to be used for the purpose of preceding my claim for benefits due.

_____ (initial) I understand that my record will be kept confidential and will not be released to others unless they are involved in my care plan. I understand that I may request a copy of my records at any time and a fee may apply.

Payment Agreement

_____ (initial) I assume full responsibility for and agree to pay all costs, charges and expenses for goods and services furnished by provider(s) seen at 5191 S Yosemite St, Ste B, at time of service.

_____ (initial) I hereby authorize my insurance benefits to be paid directly to the provider(s) seen at 5191 S Yosemite St, Ste B. I must pay charges and services not covered by any insurer third-party and/or paid to the providers(s) seen at 5191 S Yosemite St, Ste B, for any reason within a time period deemed reasonable by the provider(s). The amount of the bill shall be due and payable upon presentation to the patient, his/her agent, guardian, conservator or third party responsible for payment of the charges.

Cancellation Notice

_____ (initial) Kindly give 24 HOURS NOTICE for cancellations. Late cancellations are subject to 50% CANCELLATION FEE, no shows or cancellation with less than 2 hours before scheduled appointment are subject to a 100% CANCELLATION FEE. Cancellation fee is based on the cash rate of service. Call-backs or email reminders are a courtesy and I understand that I am responsible for my appointment and providing 24 hour notice for cancellations or reschedules.

_____

Your Printed Name

_____ _____

Signature Date

INTEGRATIVE HEALTH, INC.
WELLNESS CENTER
EXPERTS PROVIDING NATURAL HEALTHCARE
5191 S Yosemite St, Suite B, Greenwood Village, CO 80111
Phone: 303-577-9977 Fax: 303-694-4341
www.IntegrativeHealthInc.com

Consent for Purpose of Treatment and Healthcare Operations

In this document, "I" and "my" refer to the patient/client

I consent to the use or disclosure of my protected health information by the provider(s) seen at Integrative Health Inc, 5191 S Yosemite St, Ste B., for the purpose of analyzing, diagnosing and providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that analysis, diagnosis or my treatment may be conditioned upon my consent as evidenced by my signature below.

I understand 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, the provider(s) seen are not required to agree to the restrictions that I may request. However, if the provider(s) agrees to a restriction that I request, the restriction is binding on the provider(s). I have the right to revoke this consent, in writing at any time, except to the extent that the provider(s) has taken action in the reliance on the consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, health plan, my employer or a health care clearing house. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I may review the Notice of Privacy Practices online on the link provided below and understand that I have the right to read the Notice of Privacy Practices prior to signing this document. 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 of Integrative Health, as well as my rights and duties of the provider(s) seen at 5191 S Yosemite St, Ste B, with respect to my protected health information.

The Notice of Privacy Practices is available online at: https://www.hhs.gov/hipaa/for-individuals/index.html

_____

Your Printed Name

_____ _____

Signature Date

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INSURANCE BILLING INFORMATION

Dealing with insurance can be a complicated and confusing process. This information is meant to clear up any questions you might have when we are billing your insurance.

Each provider is their own independent business and therefore contracts individually with insurance. Confirm with your insurance or our front desk staff to see which providers are in-network and out-of-network with your insurance. Not all services are eligible under insurance.

The process to verify and bill insurance takes a few steps:

1. We will copy your insurance card, call and verify your benefits. We will find out if there is a deductible to be met prior to your insurance paying, or if you have a copay or coinsurance. To speed-up the verification process, contact your insurance prior to your appointment and we will honor benefits. Verification is never a guarantee of benefits. Your insurance will determine coverage upon receiving the claims.
2. When billing insurance, your provider will use specific legal codes designated to the service you received. These procedure codes, or CPT codes, have an assigned amount of time and fee attached to each. We must abide by these codes and they cannot be changed. The codes dictate the overall price at which the insurance company is charged, which is usually higher than the amount paid at time of service.
3. Once the insurance company receives the claim they will allow the full or a portion of the amount billed. For example, if the insurance company gets a bill for $250.00 they may decide to allow $60.00 or deny the claim. Usually a denial is based on a variety of reasons, when possible we submit corrected claims for approval. Insurance companies ask us to allow 60-90 days to process claims.
4. If your insurance benefits state that your insurance will only cover a percentage of the charges, you may be responsible for paying the difference.
5. We will do everything we can to get your claims processed and approved, however, if insurance does not pay for your service(s), you will be responsible for the billed amount. To avoid additional charges, payment must be made in a timely manner.

Your understanding of this process is critical in our working relationship of provider and patient. Thank you for taking the time to read this letter, for further questions please inquire at our front desk.

_____ _____

Signature Date

_____

Printed Name