Integrative Health Inc
Experts Providing Healthcare

Auto Injury Intake Form

5191 S. Yosemite St., Suite B, Greenwood Village, CO 80111

Please complete all areas as completely and accurately as possible. ALL AREAS ARE VALID. All information is private.

Patient Contact Information

Name: _____ Today's Date: _____

Address:_____ City:_____ State:____ Zip:_____

DOB ___/___/_____ Age: ____ □ Male □ Female □ Other _____ SSN: _____

If minor, name of parents: _____

E-mail address: _____ Cell Phone: (_____)_____

Employer: _____ Occupation:_____ How long? _____

Married or have a life partner? Yes No Significant other's name: _____

Emergency Contact: _____ Relationship: _____ Phone:(_____)_____

Auto Accident Information

Insurance Carrier: _____ Claim Number: _____

MedPay Coverage on Policy: $_____ Estimate of MedPay used so far? _____

Adjustor Name: _____ Phone Number: _____

Where did you go after the accident? □ Home □ Ambulance □ Urgent Care □ Doctor's Office □ Work

If you were treated at a clinic or hospital:

Hospital/Clinic Name: _____ Name of Doctor : _____

Treatment received: □ Medication for pain □ Medication for muscle spasm □ Medication for pain or spasms
□ X-rays □ CT scan □ MRI □ Ice □ Stitches □ Emergency life-saving procedures □ Other: _____

Medical providers seen since the accident:

Provider 1: _____ Date(s): _____
Reason for visit: □ Consult □ Follow up □ Consult and medication □ Surgical consult □ Orthopedic consult □ Neurologic consult
Still under care? □ Yes □ No

Provider 2: _____ Date(s): _____
Reason for visit: □ Consult □ Follow up □ Consult and medication □ Surgical consult □ Orthopedic consult □ Neurologic consult
Still under care? □ Yes □ No

Provider 3: _____ Date(s): _____
Reason for visit: □ Consult □ Follow up □ Consult and medication □ Surgical consult □ Orthopedic consult □ Neurologic consult
Still under care? □ Yes □ No

List any diagnosis given: _____

Current Care

On a scale of 1-10, rate your commitment to get rid of problem(s) and feel better? _____

Any concerns or fears about chiropractic, acupuncture or massage? _____

If yes, which service(s) and what concerns? _____

What are your top goals from these visits?

1. _____ 2. _____ 3. _____

Auto Accident Information

Accident Information:

Date _____ Time _____ AM PM Was it reported to the police? □ YES □ NO

Was a traffic violation issued? □ YES □ NO To whom? _____

1. Accident Location: _____
2. Position in vehicle: □ Driver □ Front Occupant □ Front Middle □ Left Rear Occ. □ Right Rear Occ. □ Middle Rear
3. Seat Belt: □ None □ Lap Harness □ Shoulder Harness □ Both Lap and Shoulder Harness

Your vehicle:

4. Vehicle Type: □ Small Car □ Mid-Size Car □ Full-Size Car □ Van □ Station Wagon □ Pickup Truck □ Large Truck □ Bus □ Other
5. Was struck: □ Back End □ Left Back □ Right Back □ Front End □ Left Front □ Right Back □ Driver's side Body □ Passenger's side Body
6. Other Vehicle Involved: □ Small Car □ Mid-Size Car □ Full-Size Car □ Van □ Station Wagon □ Pickup Truck □ Large Truck □ Bus □ Other
7. What was your vehicle doing at the time of the accident?
   □ Stopped at intersection □ Stopped in traffic □ Slowing down □ Accelerating □ Making a left turn □ Making a right turn
   □ Traveling in traffic □ Stopped at light □ Attempting to change lanes □ Other: _____
8. Secondary Impact Reported: □ Yes □ No
   If yes, with what? □ Vehicle stopped in front □ Moving vehicle in front □ Guard rail □ Sign post □ Tree
   □ Pedestrian □ Roadside debris □ Other: _____
9. Est. speed of initial impact: □ 1-5mph □ 5-10mph □ 10-20mph □ 20-30mph □ 30-40mph □ 40-50mph □ 50-60mph
   □ 60-70mph □ 70-80mph □ 80+mph
10. Vehicle Damage: □ Minimal □ Moderate □ Severe □ Totaled
11. Equipped with airbag system: □ Yes □ No
12. Airbags deployed: □ Driver Front □ Passenger Front □ Driver Side □ Passenger Side □ Not Deployed
13. Visibility: □ Poor □ Fair □ Good □ Excellent
14. Driving Conditions: □ Dry □ Wet □ Icy □ Snowy
15. 15. Did you see the accident coming? □ Yes □ No
16. Your position at time of the accident: □ Relaxed physical state □ Tense state □ Clenching the steering wheel
17. What was the direction of your head at the time of the impact?
    □ Facing straight forward □ Turned to the right □ Turned to the left □ Facing up □ Facing down
18. What was the position of your headrest at the time of impact?
    □ Even with top of head □ Even with bottom of head □ Middle of neck □ Absent

19. Did your body strike the inside of your vehicle? □ Yes □ No

    Areas that impacted: _____

Patient Condition

1. Were you unconscious after the accident? □ Yes □ No If yes, for how long? _____

   _____
2. Could you move all parts of your body? □ Yes □ No If no, which parts couldn't you move and why?

   _____
3. Were you able to get out of the car and walk unaided? □ Yes □ No
4. Did you get any bleeding cuts? □ Yes □ No If yes, where? _____
5. 5. Did you get any bruises? □ Yes □ No If yes, where? _____
6. Please describe how you felt,
   i. Immediately after the accident? _____
   ii. Later that day? _____
   iii. The next day? _____

7. Since the accident your condition has:
   □ Not changed □ Slightly improved □ Significantly improved □ Become worse □ Become much worse

8. Your condition interferes with: □ Sleep □ Work □ Exercise □ Activities of daily living □ Driving □ Other: _____

Please explain the accident in your own words:

_____

_____

_____

_____

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_____

Patient Condition

Please describe the location of your main symptom: _____

When did this appear? _____

Describe the symptoms: dull/achy, sharp/stabbing, tightness, etc. _____

Do you feel symptoms down your arms or legs (which)? _____

Does anything go numb, tingly or have weakness? Where? _____

Is this condition getting: □ better □ worse □ same Is it progressively getting worse? □ Yes □ No

Please rate the intensity from 1 to 10 (10=Worst) Now: _____ Average: _____ At it's worst: _____

How often do you feel symptoms? Constant (100%) Frequent (75% of the time) Intermittent (50%) Occasional (25%)

When (morning, night, after work, etc.) is it the worst? _____

What makes it better? _____

What makes it worse… sitting, standing, bending ? _____

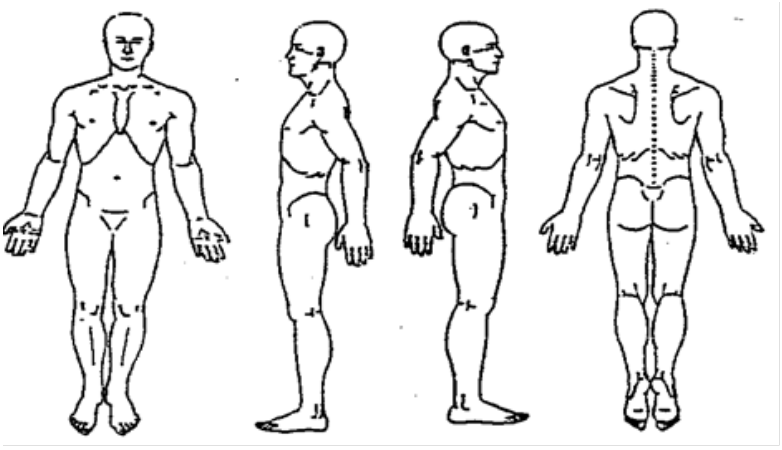
_____

Does it interfere with your…… work, sleep, daily routine, recreation? _____

Additional Complaints: _____

_____

Please draw where you feel symptoms:



Stress Habits

□ Smoking Packs/day: _____

□ Alcohol Drinks/wk: _____

□ Coffee/Caffeine Cups/day: _____

Exercise Habits

□ Exercise per wk: None 1-3x 4-6x

□ Favorite activities: _____

Sleeping Habits

Position: □ Face down □ Face up □ R / L side

How many hours? _____

□ Straight through □ Wakes Up, # of times:

What causes you to wake? _____

Global Systems Chart

Please indicate frequency of occurrence per day, week, month, or other.
Example: “Headaches: 2x daily” or “Neck Pain: 1x per month”

Cervical (Neck) Area

Headaches or Migraines: _____
Dizziness/Lightheaded: _____
Blurred/Loss of Vision: _____
Sinus Congestion/Pain: _____
Ringing in ears (Which?): _____
Brain Fogginess: _____
Neck Tension/Pain: _____
TMJ/Jaw Tension/Pain: _____
Shoulder Tension/Pain: _____
Elbow Tension/Pain: _____
Wrist Stiffness/Pain: _____
Hand Stiffness/Pain: _____
Tingles/Numb Hands: _____
Swollen Hands: _____
Cold Hands: _____

Thoracic Area

Difficulty Swallowing: _____
Voice Change/Hoarseness: _____
Allergies (to what): _____
Asthma/breathing issues: _____
Chest pressure/Pain: _____
Heartburn/Reflux: _____
Gas/ Belching: _____
Nausea/Vomiting: _____
Pain between sh. Blades: _____

Lumbar/Low Back Area

Low Back Pain: _____
SI/Pelvis/Hip Pain: _____
Thigh/IT Band Pain: _____
Knee Pain (which?): _____
Sciatica (which leg?): _____
Calf Pain/Restless legs: _____
Ankle or Foot Pain: _____
Cold Feet (even w/ socks): _____
Tingling/Numbness in legs: _____
Constipation/Hard Stool: _____
Diarrhea/Rectal Bleeding: _____
Cannot fully void bladder: _____
Dribbles when cough/sneeze: _____
Bladder wakes from sleep: _____
Menstrual Cramping/PMS: _____
Infertility or Impotence: _____

Patient Health History Please check any of the following you have had:

□ Diabetes
□ Cancer
□ High/low Blood Pressure
□ Depression
□ Anxiety
□ Arthritis
□ Chronic fatigue
□ Concussion
□ Disc Herniation
□ Other: _____
□ Epilepsy
□ Heart disease
□ Thyroid Problems
□ AIDS/HIV
□ Kidney problems
□ High Cholesterol
□ Osteoporosis
□ Stroke
□ Weight Loss/Gain

Accident History Everything is relevant.

Date: _____ Front / Side / Rear Impact traveling _____ MPH. Any treatment? _____

Date: _____ Front / Side / Rear Impact traveling _____ MPH. Any treatment? _____

Date: _____ Front / Side / Rear Impact traveling _____ MPH. Any treatment? _____

Surgical History

Year	Type/Area
_____	_____
_____	_____
_____	_____
_____	_____

Current Medications

Name	Purpose
_____	_____
_____	_____
_____	_____
_____	_____

Traumas (fractures, stitches, etc.)

Year	Type/Area
_____	_____
_____	_____
_____	_____
_____	_____

Supplements/Herbs

Name	Purpose
_____	_____
_____	_____
_____	_____
_____	_____

Female patients: Please mark any additional conditions you've had:

□ Menstrual Problems / Pain □ Infertility □ Uterine fibroids □ Endometriosis □ PCOS

Start date of last period: _____ Have you ever been pregnant? □Y □ N # of times ____

Is there anything else which may help us to understand you and your needs which has not been discussed?

_____

_____

Please read the statements below and check the boxes next to those with which you agree:

□ I have been offered to view a copy of Integrative Health's HIPPA guidelines and privacy policies.
□ I certify that information provided to this office is up to date and correct to the best of my knowledge.
□ I authorize the release of any medical information necessary to process claims submitted to my insurance carrier.
□ I authorize payment of any medical benefits directly to this clinic for any services rendered to me.
□ I am the authorized parent or guardian of this child (if applicable) and authorize this office to treat my child.

Signature: _____ Date: _____

Signature of Parent: _____ Date: _____

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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

Integrative Health Inc
5191 S Yosemite St, Suite B
Greenwood Village, CO 80111
303.577.9977

AUTO INJURY, WOMRKMAN'S COMPENSATION AND PERSONAL INJURY

Patient Name: _____ **DOB:**_____

Claim Number: _____ **Date of Injury:** _____

Insurance Company Name: _____

Phone Number: _____

Adjustor's Name: _____

Adj. Direct Phone Line or Extension: _____

Insurance Billing Address:_____

Insurance Fax: _____

Medpay: ☐ **Yes** ☐ **No** **If Yes, Medpay in the amount of: $**_____

Attorney's Law Firm: _____

Attorney's Contact Name: _____

Attorney Phone: _____ **Attorney Fax:** _____

Employer: **(if Workman's Compensation)** _____

Referring Doctor's Name: _____ **Doctor's Phone:** _____

I certify that the information provided to Integrative Health is correct and up to date to the best of my knowledge. If any of the provided information shall change, Integrative Health is be provided with an updated form.

Patient Signature: _____ **Date:**_____

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REQUIRED DISCLOSURES PURSUANT TO C.R.S. §38-27.5-104

Patient/Guardian: _____

Health-care provider(s): _____

Date of Injury: _____

Pursuant to Colorado law, Patient/injured person is provided with the following disclosures and advisements:

(1) Before a health-care provider lien is created, a health-care provider or its assignee must make the following disclosures and advisements to the injured person:

(a) The following are potential methods for payment of a health-care provider's billed charges:

I. The creation of a health-care provider lien;
II. The use of benefits available from any payer of benefits as defined in section 38-27-101(9) to which the injured person is a beneficiary, including that the injured party can obtain information about the payer of benefits' network from the payer of benefits or the health-care provider;
III. Any other payment method or arrangement agreed to in writing by both the health-care provider or its assignee and the injured person; or
IV. A combination of the payment methods specified in subsections (1)(a)(I) to (1)(a)(III) of C.R.S. 28-27.5-104, as set forth above.

(b) That the health-care provider or its assignee is not a heath insurer or payer of benefits.

(c) That, except in the event of fraud or misrepresentation by the injured person:

I. If the injured person does not receive a judgment, settlement, or payment on the injured person's claim against third parties or under an uninsured or underinsured motorist policy, the injured person is not liable to the holder of the health-care provider lien for any portion of the health-care provider lien.

II. If the injured person receives a net judgment, settlement, or payment that is less than the full amount of the health-care provider lien, the injured person is not liable to the holder of the health-care provider lien for any amount beyond the net judgment, settlement, or payment, and the holder of the health-care provider lien may not file a complaint or counterclaim against the injured person directly to be reimbursed for any amount beyond the net judgment, settlement, or payment. Nothing in this section prevents a health-care provider or its assignee from initiating a declaratory judgment action or participating in an interpleader action or claim pursuant to the Colorado Rules of Civil Procedure, or any other similar action or claim, to

determine the health-care provider's or its assignee's share of the injured person's net judgment, settlement, or payment.

III. The health-care provider or its assignee may not assign a health-care provider lien to a collection agency or debt collector.

(d) That a health-care provider's assignee's compensation from the injured person is based on the difference between the health-care provider's usual and customary billed charge and the amount that the assignee pays to purchase the health-care provider lien;

(e) Of any common ownership interest between the holder of the health-care provider lien and the injured person's legal counsel. No such relationship exists.

(f) Of any common ownership interest between the assignee of a health-care provider lien and any health-care provider who is providing treatment or who may provide treatment to the injured person under the terms of the health-care provider lien; and

(g) That if the injured person has obtained health insurance even after a health-care provider lien has been created, and the injured person or the injured person's legal counsel so informs the holder of the health-care provider lien, all future care may be billed to the health insurance carrier at the injured person's discretion.

(2) Nothing in C.R.S. 38-27.5-101, *et. seq.* changes any obligation of the health-care provider or its agents under the "Colorado Medical Assistant Act", Articles 4 to 6 of Title 25.5

(3) Upon request by the injured person or the injured person's legal counsel, the holder of a health-care provider lien shall provide in writing to the injured person an itemized statement of all the billed charges for treatment comprising the total value of the health-care provider lien as the billed charges are accrued, to the extent practicable, and when the health-care provider lien is final. The final itemized statement must include a summary of all treatments provided, the total amounts billed for each treatment, and the total amount of the health-care provider lien due and owning.

I acknowledge receipt of the foregoing disclosures and advisements as required by Colorado law.

Dated this ____ day of _____, 20____.

_____ _____

Signature of Patient/Guardian Printed Name

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Irrevocable Lien, Assignment of Benefits, and Security Interest

Patient/Guardian: _____ (hereafter "patient")

Date of Injury: _____

Provider(s): _____

Patient, in order to receive care, treatment, products, and services (collectively referred to hereafter as "Services") from Provider or Provider's Assignee (hereafter collectively referred to as Provider), hereby executes this Irrevocable Lien, Assignment of Benefits, and Security Interest (hereafter "Document") in favor of Provider, and any Assignee designated at Provider's discretion. Patient agrees as follows:

1. Provider, shall have an irrevocable lien against, and a security interest in, any settlement, award, judgment, verdict, or recovery arising out of the injury sustained by patient on the above-referenced Date of Injury. Patient assigns, to Provider, the proceeds from any such settlement, award, judgment, verdict, or recovery in an amount equivalent to Patient's outstanding balance for Services with Provider.

2. Patient assigns to Provider, in an amount equivalent to Services provided, any benefits or legal or contractual rights to payment that patient may have under any insurance, uninsured/underinsured motorist coverage, third-party liability coverage, and auto med-pay coverage. Patient authorizes Provider to receive a full copy of Patient's, or any third-party's insurance policy, including policy limits or declarations pages.

3. Patient understands that this Document is valid, secured, and enforceable upon execution and shall remain valid even if Provider's rights are assigned. Patient agrees to assignment at the discretion of Provider. Patient agrees that Provider may file this, and any other Document, with the appropriate court, any insurance carrier, with Patient's attorney, or the Colorado Secretary of State. Patient authorizes Provider to provide copies of Patient's medical records and bills to Patient's attorney and any insurance carrier who may be responsible for payment of Services, through contract or due to a third-party's liability. Patient acknowledges receipt of Disclosures/Advisements pursuant to C.R.S. 38-27.5-104, *et. seq.*

4. This Document is intended to be valid and enforceable, even if not signed by Patient's attorney. Patient's attorney is advised, that by execution of this Document, that Patient recognizes that Provider is a third party with an undisputed interest in Patient's claim/case as anticipated by Colorado Formal Ethics Opinion 94. Patient's attorney is instructed to honor this Document and issue payment.

5. Patient authorizes and directs Patient's attorney, Patient's insurance company, or any third-party insurance company to disclose all insurance benefits, offers, status of negotiations, and any final settlement or judgment amount, along with date of settlement, all provider or insurer lien reductions, and disbursement amounts to others (actual or proposed).

6. Provider shall not be responsible, in part, or in whole, for payment of attorney's fees, expenses, or costs which Patient may incur for the collection of funds due from third parties or insurance benefits. Patient understands that Provider is not subject to either the "made-whole rule" or the "common fund doctrine."

7. If Patient or Patient's representative request that Provider bill health or other insurance, such request shall be in writing. This document does not create a continuing obligation to provide Services. Provider may decline any request to bill insurance and decline to provide future services. If Provider agrees to bill insurance, Patient shall be responsible for all co-payments or deductibles at the time of service. Any request to bill insurance shall only be effective prospectively and will not affect any duties hereunder for services previously provided. Patient warrants that Patient is NOT eligible for Medicaid for Services rendered by Provider. Patient will immediately advise Provider, in writing, upon becoming Medicaid eligible.

8. This Document applies to amounts currently owed by Patient to Provider and to amounts which may be incurred in the future for treatment and services related to injuries sustained on the Date of Injury.

9. Patient agrees that this document shall be governed by the laws of Colorado and any dispute under this document, or for Services provided, shall be brought in the county where Patient received Services. If any provision of this agreement is deemed to be unenforceable for any reason, the remaining portions shall still be enforceable and have binding effect.

10. In the event Patient has made any misrepresentations, or committed fraud, Patient shall be responsible for any balance due and Provider's reasonable attorney's fees and costs should collection efforts be undertaken by Provider, whether or not a lawsuit is undertaken.

Dated this ____ day of _____, 20____.

_____ _____

Signature of Patient/Guardian Printed Name

_____

Address

_____

City, State, Zip

ACKNOWLEDGEMENT

I, the undersigned attorney, am the attorney of record for Patient named above. I hereby acknowledge receipt of the foregoing Irrevocable Lien, Assignment of Benefits, and Security Interest. **I provide this acknowledgement with the understanding that attorneys' fees and costs shall be deducted BEFORE payment of any Services pursuant to this Lien**.

_____ _____

Attorney Signature Attorney Printed Name

_____

Firm Name