Welcome New Patient

7695 Church Ranch Blvd, Westminster, CO 80021

PATIENT INFO

Today's Date: _____
Patient Name: _____
(first, last)
Date of Birth: _____
Age: _____
SS#: _____
Mailing Address: _____
City:_____ State:____ Zip:_____
Email:_____
Home Phone:_____
Cell Phone: _____
Work Phone: _____
Occupation: _____
Employer:_____
Employer Address:_____
City:_____ State:_____ Zip:_____
Occupation: _____
Status: (circle) Minor Single Married Divorced Widowed
Spouse's Name: _____
Have children? ___ No___Yes/How Many?___
Pregnant? ___ No ___ Yes/Weeks?_____
Nursing? ___ Yes ___ No

INSURANCE INFO

Ins Co. Name: _____
Address: _____
_____
Telephone #: _____
Insured's ID#: _____
Group #: _____
Insured's Name: _____
Relation to Patient: _____
Date of Birth: _____
Insured's Employer: _____

Chiropractors or Medical Doctors you have seen in the past year:
Name: _____ Specialty: _____
Date of last visit: _____ Phone #: _____

Name: _____ Specialty: _____
Date of last visit: _____ Phone #: _____

Were either seen as a result of current condition/accident? Y/N

How did you hear about our clinic? _____
_____
_____

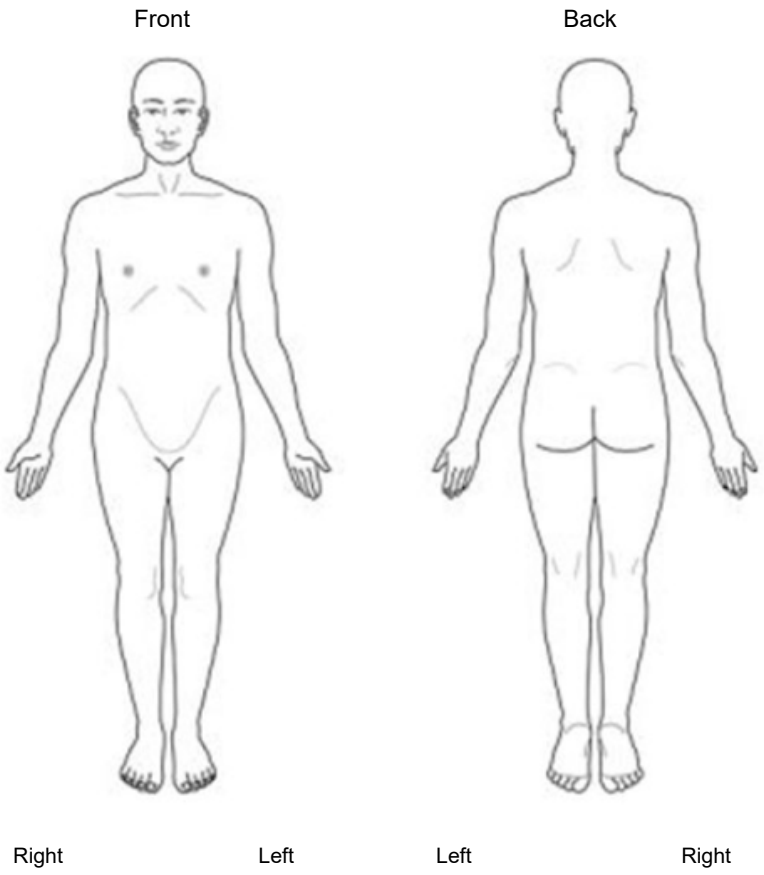
In the Event of an Emergency:
Whom should we contact? _____ Relationship: _____
Their Home#: _____ Their Cell#: _____ Their Work#: _____
Who is your Medical Doctor: _____ Office #: _____

How may we contact you for appointment reminders and diagnostic results?
___ Phone Only ___ Email ____ Text Message ____ All methods of contact are okay

Reason for your Visit:

Describe the pain & its location: _____
_____
How did it happen? _____ Auto _____ Work _____ Other: _____
_____
When did the condition begin? _____
Have you reported a condition/accident to anyone? If yes, to whom? _____
Is the condition getting worse? ___ Yes ___ No Is the condition constant ___ Yes ___ No
Does the condition come and go? ___ Yes ____ No
Is the condition interfering with your: ____ Work ___ Sleep ___ Daily Routine
If so, explain: _____

Name: _____



Complete the following diagram **drawing** the symbols below to show your typical pain:

Ache >>>>

Numbness - - - - -

Pins/Needles 0000

Burning XXXX

Stabbing / / / /

Circle ALL words describing your pain:

Deep	Superficial	Dull	Aching	Sharp	Stabbing	Shooting
Electrical	Throbbing	Constant	Intermittent	Burning	Numbness	Weakness
Punishing	Knife-like	Cruel	Radiating			

	Hardly Noticeable						**Noticeable & Wearing**			**Barely Tolerable**
At BEST, my pain is:	1	2	3	4	5	6	7	8	9	10
At WORST, my pain is:	1	2	3	4	5	6	7	8	9	10
CURRENTLY, my pain is:	1	2	3	4	5	6	7	8	9	10

Things that make my pain better include:

_____

_____

Things that make my pain worse includes:

_____

_____

HEALTH HISTORY
Confidential

Patient Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for visit? _____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

CONDITIONS Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

MEDICATIONS List medications you are currently taking.

_____

_____

_____

_____

_____

Pharmacy Name Phone

ALLERGIES To medications or substances

All information is strictly confidential

FAMILY HISTORY Fill in health information about your immediate family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (✓) if, your blood relatives had any of the following: Disease	Relationship to you
Arthritis, Gout	
Asthma, Hay Fever	
Cancer	
Chemical Dependency	
Diabetes	
Heart Disease, Strokes	
High Blood Pressure	
Kidney Disease	
Tuberculosis	
Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates. _____

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications if any

HEALTH HABITS Check (✓) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

OCCUPATIONAL CONCERNS

Check (✓) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

_____ _____

Reviewed By — Date

Patient Authorization

Health Restoration Inc.

Patient Name: _____

Consent to Treat

I hereby consent to evaluation and treatment by **Health Restoration Inc.** and/or its clinical staff for either my dependent or myself. I understand that there are certain risks associated with an examination and treatment and those risks will be presented and explained to me.

Release of Information

I give permission to **Health Restoration Inc.** to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, attorney, employer, school related health care provider, assignees and/or beneficiaries and all other related persons as it relates to my treatments.

I authorize **Health Restoration Inc.** to obtain medical records and/or professional information from my physician or other medical professional, attorney and insurance company as it relates to my treatment and claim.

I have read and understand the above release.

Patient/Guardian Signature: _____ Date: _____

Assignment of Benefits

I authorize payment directly to **Health Restoration Inc.** for services.
This is a direct assignment of my rights and benefits under this policy.
A photocopy of this assignment shall be considered as effective and valid as the original.

Patient/Guardian Signature: _____ Date: _____

Payment Guarantee

I agree to immediately forward to **Health Restoration Inc.** any reimbursements, which I may receive, which are issued for the purpose of payment for my treatment.

I understand that any information obtained by **Health Restoration Inc.** for the purpose of payment of claims is not a guarantee of coverage and/or benefits.

If any law or insurance contract prohibits payment for services, I will cooperate and assist in the provision of information, authorizations, release and any other type of information necessary to allow for speedy collection from any third-party payer. Where the law or insurance contract does not prohibit payment by me.
I acknowledge responsibility for any and all account balances.

I further understand that this agreement is legal and binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatment unless agreed to in writing by myself and the representative of **Health Restoration Inc.**

Patient/Guardian Signature: _____ Date: _____

Notice of Privacy Practices

Our Practice **Health Restoration Inc.** is committed to maintaining the privacy of your protected health information known as (**PHI**) which is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and the care and treatment you receive from our practice. In addition, this NOTICE describes your rights to access and control your PHI. This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please read this NOTICE carefully and if you should have any questions or concerns about this PRIVACY NOTICE, please do not hesitate to contact our privacy officer, Shane R. Kokoszka at: 7695 Church Ranch Blvd. Suite 200, Westminster, CO 80021 or 303-635-2273.

This office is required by law to abide by the terms of this NOTICE OF PRIVACY Practices as well as abiding by any other applicable state laws that may govern privacy practices and/or the scope of the practice of physical medicine and rehabilitation. Our office may change and/or modify the terms of this NOTICE at any time and the new NOTICE will be effective for all PHI that we obtain at that time. Our office and/or acknowledgement of our NOTICE no later than the date of your first service. We will also keep you notified of any changes to our NOTICE of PRIVACY Practices and if requested by you our office will provide you with an updated copy.

Uses and Disclosures of PHI

Our office may use and disclose of your PHI for healthcare delivery purposes, which is known as treatment, payment and healthcare operation (TPO) Your PHI may be used and disclosed by your doctor, our office and staff and others outside of our office that are involved in you care and treatment for the purpose of providing healthcare service to you. Your PHI may also be used and disclosed to pay your healthcare bills and to support the operation of the doctors' practice. It should be noted that even though our list of uses and disclosures of your PHI is fairly comprehensive, it is difficult to take into account each and every single possibility of how your PHI may be used or disclosed. We can assure you that your doctor and his office staff will do everything possible to maintain the confidentiality of your PHI. LIsted below are some of the more common types of uses and disclosures of your PHI that our office is allowed to make without your consent and/or authorization. Any other uses, and/or disclosures other than those listed below will only be made with your written authorization.

TreatmentL Your PHI may be used and disclosed for the coordination or management of your healthcare and related services among healthcare providers or by a healthcare provider from a third party, consultation between healthcare providers regarding you or the referral of you from one healthcare provider to another.

Payment- Your PHI may be used and disclosed for payment which encompasses the various activities of healthcare providers to obtain payment to be reimbursed for their services and of a health plan to obtain premiums to fulfill their coverage responsibilities and proved benefits under the plan and to obtain reimbursement for the provision of healthcare.

Healthcare Operation: Your PHI may be used and disclosed for healthcare operations for certain administrativ, financial, legal and quality improvement activities that are necessary to run its business and to support the core functions of treatment and payment.

Emergency Situations: Our office an/or doctors may use of disclosure your PHI in an emergency treatment situation. IF an emergency situation happens, to arise we are not required to obtain a written acknowledgement from you of our Notice of Privacy Practices until after the emergency situation has ended.

Minimum Necessary Standard: Our office and/or staff will make reasonable efforts to limit the use and disclosure of an request for your PHY to the minimum necessary to accomplish the intended purpose.

Employee Limitations: Your doctor will also limit the use and disclosure of your PHI to members of his or her workforce to those who may need access to your PHI for treatment, payment and healthcare operations.

Public Health Purposes and Activities: Your PHI may be disclosed to public health authorities who are legally authorized to receive such reports for the purpose of preventing or controlling disease, injury or disability which would include reporting of disease or injury, reporting vital events like births or deaths and conducting public health surveillance, investigations or effectiveness of a productor activity regulated by the FDA and persons at risk of contracting or spreading disease as well as workplace medical surveillance. Again, this information will be limited to the minimum amount necessary to accomplish the public health purpose.

Business Associate Contract: A business associate is a person or entity that performs certain functions or activities that involve the use or disclosure of PHI on behalf of, or provides serves to, a covered entity, i.e.- healthcare provider, healthcare plan or clearing house. Your PHI may be used or disclosed to a business associate provided we obtain satisfactory assurances from the business associates that the business associate will safeguard your PHI it receives or creates from any misuse and will use the information only for the purposes, for which it was engaged to do and not for the business associates independent use or purposes, except as needed for proper management and administrations of the business associate.

Research Purposes-Your PHI may be used or disclosed for research purposes which has been de-identified and/or you have authorized the use and disclosure or your PHI.

Workers' Compensation Purposes- Due to the variability among State laws the Privacy Rule permits disclosure of your PHI for purposes as authorized by and to the extent necessary to comply with workers' compensation laws without your authorization and no minimum necessary determination is required.

Marketing Purpose: Your PHI may be used and disclosed for marketing purposes if it is in the form of a face-to-face communication or a communication involving a promotional gift of nominal value by the covered entity i.e. healthcare provider, healthcare plan or clearinghouse. Marketing is defined as making a communication about a product or services that encourages recipients of the communication to purchase or use the product or service. This type of marketing has certain exceptions, which do not require authorization for the use and disclosure of your PHI and are listed as follows;

1.) Communication is not marketing if it is made to describe a health-related product or service that is provided by or included in a plan of benefits of the covered entity making the communication.
2.) Communication is not marketing if it is made for treatment for an individual.
3.) Communication is not marketing if it is made for case management or care coordination for an individual or to direct or recommend alternative treatment, therapies, healthcare providers, or settings of care to the individual.

Personal Representative-Your PHI may be used and disclosed under state law to a person who is authorized to act upon your behalf in making your healthcare related decisions.

Miscellaneous uses and disclosures of PHI- The clinic may use sign-in sheets at our front desk so our staff can easily see who is seeking care. We are allowed to use and disclose your name in the waiting room when your doctor is ready to see you. We may use an address to send you a newsletter, or communication about our practice and services we offer. In addition, we may send you information about products or services that we feel may benefit you.

Patient Rights to Access and Control Their PHI:

The Privacy Rule allows you certain rights with regards to your records, which are as follows: You have the right to review and receive copies of your records as it relates to your own care. Your request would have to be put in writing and the law requires that your doctor respond within 30 days of your request. In addition, your dotore is allowed to deny your access to your records, but only if it is going to cause you harm or someone else harm. If your doctor is allowed to deny your access to your records, but only if it is going to cause you harm or someone else harm. If your doctor denies you access to your records the denial has to be referred to a health care review professional, which would be the privacy officer who was designated. Your doctor is allowed to charge a copy fee which should not exceed State law allowances.

You have the right to request that the use and disclosure of your PHI be restricted.

This means you have the right to request the restrictions on how your doctor will use of disclosure your PHI about treatment, payment, and healthcare operations. Your doctor is not required to agree to your request for restriction, but would be bound by any restrictions to which you and your doctor agree on.

You have the right to request to receive confidential communication from your doctor by alternative means or an alternative location Your doctor must accommodate your request provided it is reasonable, and you clearly state that not doing so could endanger you.

You have the right to request amendments (changes)to your records. If changes are made to your records it does not mean that your doctor will destroy his or her records or your doctor will rewrite theri records, it means that your doctor will add an addendum to your current records to reflect your changes. Your doctor has the right to deny or reject your request to change your records, but you have the right to submit a statement in the medical records that you disagree with. Your doctor also has the right to add to the record a rebuttal statement.

You have the right to receive your doctors' Notice of Privacy Practices. The law requires that your doctor provided you in writing their policy on how they are protecting and using your PHI.

You have the right to revoke an authorization. The revocation can be done at any time provided it is in writing. There is an exception to revocation that is if your doctor has taken any action in reliance on the use or disclosure indicated in the doctor's Authorization Notice.

Patient's Right to File a Complaint: If you believe that any of your Privacy Rights have been violated by us you can file a written complaint with our Privacy Officer (please see our front desk to obtain a complaint form). Your complaint must be filed within 180 days of when you knew or should have known that act had occurred. In addition, you can also file a written complaint either on paper or electronically with the Office of Civil Rights)OCR). Please note that the Privacy law prohibits our office from taking any retaliatory actions against you.

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Patients Written acknowledgement of the Doctor's Notice of Privacy Practices:

I _____ acknowledge that I have read and was given a copy of Health Restoration Inc's (upon request) Notice of Privacy Practices and fully understand this, and have had all of my questions answered to my satisfaction.

_____ _____

Patient's Signature *date*

CANCELLATION POLICY

FOR HEALTH RESTORATION, HR PAIN AND STEM CELL COLORADO

Your doctor will review your prescription for care and treatment timeline for your health and well-being. Please discuss, in person, with your provider if you foresee any issues with being able to complete your prescription for care, and they will make arrangements with you. We understand that scheduling conflicts do occur, and we encourage you to put your health first and keep all scheduled appointments. This is the most direct way to move along your treatment timeline, retain all of your improvements and maintain recovery momentum.

We require all patients to cancel or reschedule their appointment 24 hours prior to the scheduled appointment. There are costs incurred by the clinic in preparation for your arrival and treatment. If you are unable to make your appointment, we ask that you please call us 24 hours prior to your appointment or you will be assessed a $30.00 “no-show”/”late cancellation” fee to offset the costs to the clinic on your behalf.

I _____(patient name) understand this policy, and I agree that I will attend all of my scheduled appointments or I will be assessed a $30.00 “no-show/late cancellation” fee for all missed appointments not cancelled or rescheduled 24 hours prior to my scheduled appointment. Thank you for trusting us with your care.

Patient Name: _____

Patient Signature: _____ Date: _____

Provider: _____ Date: _____

Patient Authorization

Health Restoration Inc.

Patient Name: _____

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I authorize **Health Restoration Inc.** to obtain medical records and/or professional information from my physician or other medical professional, attorney and insurance company as it relates to my treatment and claim.

I have read and understand the above release.

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