Total Wellness Center
4024 S. Parker Road
Aurora, CO 80014

Last Name: _____ First Name: _____ Middle Initial: _____

What do you prefer to be called: _____ Spouse's Name: _____

Home phone#:_____ Cell Phone#: _____

Address:_____ Email Address:_____

City:_____ State:_____ Zip:_____

Sex: Male/ Female Birthdate: _____/_____/_____ Age: _____ SS#_____-_____-_____

Status (Circle one): Minor Single Married Divorced Separated Widowed

# of Children: _____ How did you hear about our office?_____

Occupation: _____ How long: _____ Employer's Name: _____

Employer's Address: _____

Spouse's Employer: _____ Spouse's Birthdate: _____/_____/_____

Have you been a patient in our office before: Yes / No

Family Doctor's Name: _____

In case of emergency, please call (include phone#):_____

Do you have health insurance you would like us to file for you? Yes / No

Method of Payment (circle one): Cash Check Visa Mastercard

I hereby authorize Dr. Geersen, DC to examine me, including x-rays if indicated by my exam, and to release records to anyone I designate. I further authorize treatments deemed by the findings, and wish all my chiropractic records to be held in strict secret confidence and not to be given to anyone without my written consent. I authorize payment directly to the doctor from my insurance company and I clearly understand that I am totally responsible for payment should my insurance company deny payment, or make payment directly to me.

By signing your name below, you certify the accuracy of your medical and/or accident history and further certify that you present to Total Wellness Center for evaluation and treatment if a health related condition and for no other purpose.

Patient's Signature:_____ Date: _____

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Name:_____ Date:____/____/____ File#_____

Reason for today's visit (circle one): New Injury Old Injury Chronic Pain Wellness Care

Did your injury occur during (circle one): Work Auto Accident Sports/Play Daily Activities

Please list your main complaint(s):_____

_____

When did this condition begin:_____. How did this condition begin:_____

_____

Are you in pain now? Yes / No

Rate your pain on the following scale: (mild discomfort) 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (intense pain)

Do you have numbness? Yes / No If yes, where: _____

Is there pain when you cough or sneeze? Yes / No If yes, where: _____

Do you get frequent headaches? Yes / No

How has your condition changed (circle one): Gotten Worse Stayed the same Improving

How often do you experience symptoms (circle one): Constantly, Frequently, Occasionally, Intermittent.

What activities make your condition feel worse:_____

What activities make your condition feel better:_____

Have you had this condition in the past? Yes / No If yes, when? _____

Have you been treated for this condition before? Yes / No If yes, explain: _____

_____

Is your condition interfering with (circle one): Work, Sleep, Breathing, Bowel Movement, Daily Routine

Medications you currently take: _____

List any surgeries you have had: _____

Have you been treated by another chiropractor in the past? Yes / No

Have you been involved in an auto accident? Yes / No If yes, when? _____

What do you hope to achieve from your visit/treatment with us (circle all that apply):

-Correct the problem -Reduce symptoms -Preventative Care

-Resume/increase activity -Learn how to prevent this from occurring again

-Strengthen injured area -Explanation of condition/treatment

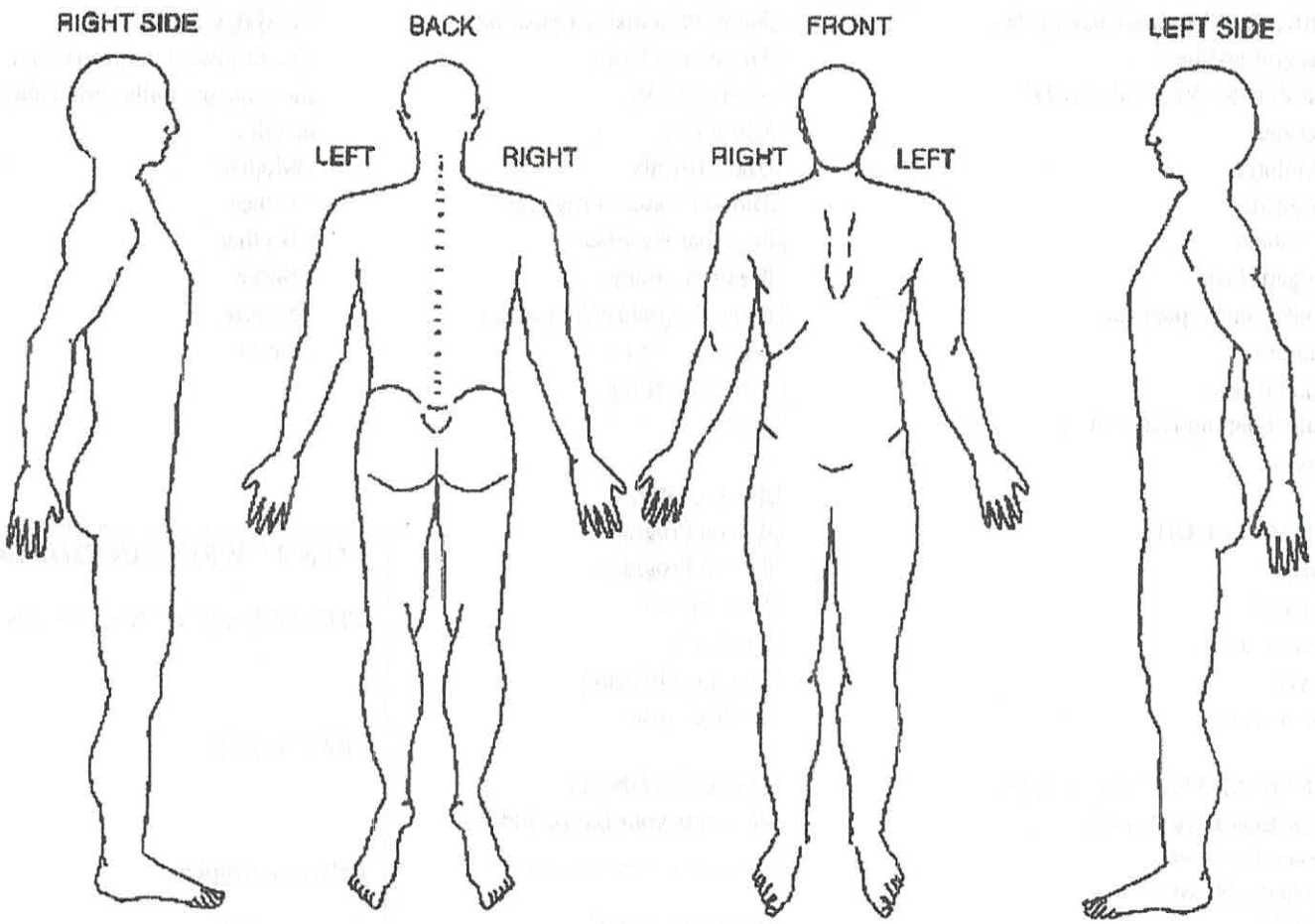
Patient Signature:_____ Date: _____

Total Wellness Center
Dr. Holly Geersen, DC
4024 S. Parker Road
Aurora, CO 80014

USE THE LETTERS BELLOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS RIGHT NOW

(Please remember to complete both sides of this form)

KEY: **A**=ACHE **B**=BURNING **N**=NUMBNESS
P=PINS/NEEDLES **S**=STABBING **O**=OTHER



OVER PLEASE

Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

☐Pneumonia ☐Mumps ☐Influenza
☐Rheumatic Fever ☐Smallpox ☐Pleurisy
☐Polio ☐Chicken Pox ☐Arthritis
☐Tuberculosis ☐Diabetes ☐Epilepsy
☐Whooping Cough ☐Cancer ☐Mental Disorders
☐Anemia ☐Heart Disease ☐Lumbago
☐Measles ☐Thyroid ☐Eczema

INTAKE:
☐Coffee
☐Tea
☐Alcohol
☐Cigarettes
☐White Sugar

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD IN THE PAST SIX MONTHS:

MUSCULO-SKELETAL CODE
☐Low Back Pain
☐Pain between the Shoulders
☐Neck Pain
☐Arm Pain
☐Joint Pain/Stiffness
☐Walking Problems
☐Difficulty Chewing/Clicking Jaw
☐General Stiffness

NERVOUS SYSTEM CODE
☐Nervous
☐Numbness
☐Paralysis
☐Dizziness
☐Forgetfulness
☐Confusion/Depression
☐Fainting
☐Convulsions
☐Cold/Tingling Extremities
☐Stress

GENERAL CODE
☐Fatigue
☐Allergies
☐Loss of sleep
☐Fever
☐Headaches

GASTROINTESTINAL CODE
☐Poor/Excessive Appetite
☐Excessive Thirst
☐Frequent Nausea
☐Vomiting
☐Diarrhea
☐Constipation
☐Hemorrhoids
☐Liver Problems
☐Gallbladder Problems
☐Weight Trouble
☐Abdominal Cramps
☐Gas/Bloating after meals
☐Heartburn
☐Black/Bloody Stool
☐Colitis

GENITO-URINARY CODE
☐Bladder Trouble
☐Painful/Excessive Urination
☐Discolored Urine

C-V-R CODE
☐Chest Pain
☐Short Breath
☐Blood Pressure Programs
☐Irregular Heartbeat
☐Heart Programs
☐Lung Programs/Congestion
☐Varicose Veins
☐Ankle Swelling
☐Stroke

EENT CODE
☐Vision Programs
☐Dental Programs
☐Sore Throat
☐Earaches
☐Hearing Difficulty
☐Stuffed Nose

FEMALES ONLY:
When was your last period?

_____

Are you pregnant?
☐Yes ☐No

MALE/FEMALE CODE
☐Menstrual Irregularity
☐Menstrual Cramps
☐Vaginal Pain/Infection
☐Breast Pain/Lumps
☐Prostate Sexual Dysfunction
☐Other Problems
☐_____
☐_____
☐_____

FAMILY HISTORY
The following members have the same or similar problem(s) as I do:
☐Mother
☐Father
☐Brother
☐Sister
☐Spouse
☐Child

DO NOT WRITE IN THIS BOX

CHIROPRACTIC ANALYSIS:

DIAGNOSIS:

Patient Accepted:

☐ Yes ☐No

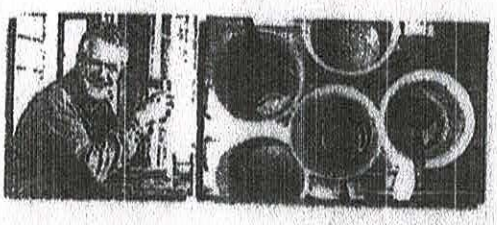
_____

Doctor's Signature

PRE-SCAN Checklist for: _____ Date _____

Your nervous system controls and regulates every cell of your body. We use an instrument that reveals how well your nervous system is working.

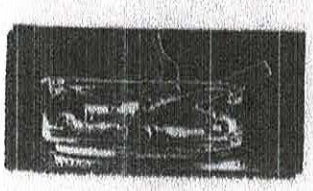
Please let us know if we need to be mindful of the following:



Drinking coffee or tea can excite the nervous system.
Have you had any of these caffeinated beverages today?

❑ **No** ❑ **Yes**
About ___ cups.

Cola drinks contain caffeine and chemicals that can affect the nervous system.
How many sodas have you had today: _____.

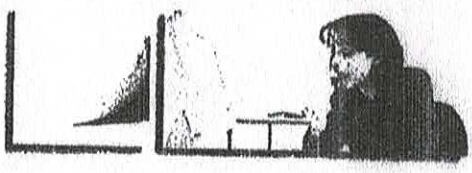


Nicotine is a nervous system stimulant.
Have you used any tobacco today?

❑ **No** ❑ **Yes** How much: _____

Common, over-the-counter drugs can impact the nervous system.
Have you taken any of these types of drugs today?

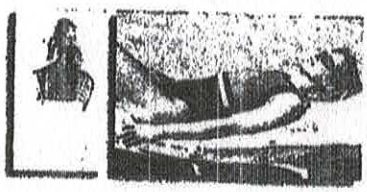
❑ **No** ❑ **Yes:** _____



Many prescription drugs and muscle relaxers affect the nervous system.
Have you taken any type of prescription medication today?

❑ **No** ❑ **Yes:** _____

Excessive exposure to the sun affects the accuracy of your scan.
Have you had a sunburn in the last five days? ❑ **No** ❑ **Yes**



Bath salts, oils or sunscreen on your skin can influence instrument sensitivity.
Have you used any of these products today? ❑ **No** ❑ **Yes**

Vigorous physical activity can exaggerate your scan results.
Have you had a workout today? ❑ **No** ❑ **Yes**

Stress, depression, anxiety or emotional upsets can affect nervous system tension.
Compared to a typical day, are you currently experiencing any type of emotional turmoil? ❑ **No** ❑ **Yes**

NOTICE OF PRIVACY PRACTICES

(MEDICAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW CAREFULLY!

The health Insurance Portability Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other individually identifiable health information used of disclosed by us in any form, whether electronically, on papers, or orally, are kept confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for the covered entities that misuse personal health information.

As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

Treatment Payment and Health Care Operations.

- Treatment means providing, coordinating, or managing health care and related services by one of more health care providers. An example of this would include a physical examination.
- Payments means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company.
- Health Care Operations includes the business aspects of running our practice. Such as, conducting quality assessment and improvement activities, auditing functions, cost management analysis and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references of individually identifiable information.

We may contact you to provide appointment reminders of information about treatment alternative or other health-related benefits and services that may be of interest to you.

Any other uses and disclosers will be made only with your written authorization. You may revoke such authorizations in writing, to which we are required to honor and abide by, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respects to your protected health information, which you can exercise by presenting a written request to the Privacy Officer

- The right to request restrictions on certain uses and disclosers of protected health information, including those related to disclosers to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to requested restrictions. If we do agree to restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable request to receive confidential communications of protected health information from us by alternative means of at alternative locations.
- The right to inspect and copy your personal health information.
- The right to amend your personal health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protect health information.

This notice is effective as of _____ 20____and we are required to abide by terms of NOTICE OF PRIVACY PRACTICES currently in effect. We reserve the right to by the terms of our NOTICE OF PRIVACY PRACTICES and to make new notice provisions effective to all protected health information that we maintain. We will pose changes and you may request a written copy of a revised NOTICE OF PRIVACY PRACTICES from this office. We will not retaliate against you for filing a complaint.

For more information about HIPPA, or to file a complaint:

The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Ave S.W.
Washington, D.C. 20201
Or Call (202) 619-0257
Toll Free: 1-877-696-6775

_____
Signature

The Back Expert P.C.
d/b/a Total Wellness Center

Patient Policy Procedures

1) A treatment schedule is provided to assist the patient in attaining the best results in the quickest time possible.
2) Treatment schedules are revised every 30-90 days based on the progress of the patient.
3) If the patient fails to call and cancel their appointment, a cancellation fee may be added to patients account.
4) A missed appointment will be made up within seven(7) days to keep the patient on optimal treatment protocol.

Patient/responsible party signature:_____

Date:_____

Financial Policy and Authorization to Provide Medical Services and Treatment

1) Patient hereby authorizes The Back Expert, P.C. to treat specific illnesses or injuries related to spinal misalignments, nutrition, and to perform other such health related services.
2) The Back Expert, P.C. will submit all necessary paperwork to patient's insurance company as a courtesy. Patient acknowledges that some, if not all, of the services provided by the Back Expert, P.C. may not be paid by patient's insurance company or may be paid at a reduced rate.
3) Patient acknowledges that patient (or the patients legal guardian or parents) are ultimately responsible for fees incurred by the Back expert P.C. as a result of service rendered and performed.
4) Patient acknowledges any account balance(s) that are not paid within 150 days from the date of service may be forwarded to collections agency. Account balances not paid within 150 days will bear interest at the rate of 1.5% per month(18%perannum). Should litigations become necessary to collect an amount owed, the patient or responsible party agrees to pay at all costs of collections including, but not limited to, collection fees, attorneys fees, interest and court costs.
5) Patient acknowledges that should The Back Expert, Inc. file a lawsuit for collections of any past due balances, venue of the lawsuit will be in the County of Arapahoe.

Patient/responsible part signature:_____

Date:_____

Total Wellness Center
Dr. Holly Geersen D.C.
4024 S. Parker Road
Aurora, CO 80014
303-627-7995

AUTHORIZATION OF ASSIGNMENT

I hereby authorize and direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/or other legal entities, which many elect or be obligated to pay, provide, or distribute benefits to me for any medical conditions, accidents, injuries, or illnesses, past, present, or future("conditions") to pay directly and excessively in the name of The Back Expert P.C, dbc Total Wellness Center("office")such sums be owing to Total Wellness Center for charges incurred by me at the office relating to my condition, with such payments to be made exclusively I the name of the Total Wellness. I further grant a lien to Total Wellness Center with respect to my charges. This lien shall apply to all payers and to the full extent permitted by law. For the purpose of this document (herein, "Assignment and Lien"), benefits shall include, but not limited to, proceeds from any settlement, judgment or verdict, as well as any proceeds relating to commercial health or group insurance, attorney retainer agreements, medical payments benefits, personal injury protection, no-fault coverage, uninsured and underinsured motorist coverage, third party liability distribution, disability benefits, worker's compensations benefits, and any other benefits or proceeds payable to me for the purposes stated herein.

In the event that I retain one or more attorneys to represent me in this matter who are not located in Colorado, I will direct each attorney to issue a letter of protection to this office regarding my charges. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of this office.

I authorize this office to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Assignment and Lien. I further authorize and direct all payers to release to Total Wellness Center any information regarding ay coverage or benefits which I may have including, but not limited to, the amount of coverage and the amount paid thus far, and the amount of any outstanding claims. I hereby direct this office to file a copy of this Assignment of Lien, together with any applicable charges, with any and all payers, regardless of whether a claim has been established with said payers. I hereby authorize Total Wellness Center to endorse/sign my name on my and all checks listed to me as a payee which are presented to this office for payment of an account related to me, my spouse or any of my dependents. I further authorize Total Wellness Center to apply any credit balances on charges incurred by me, any other outstanding charges still owed by me, my spouse, or my dependents, regardless of these other charges are related to my condition.

I understand that in the event of any of the above defined payers were to pay me directly, and not make payments directly to Total Wellness Center, I will be held personally responsible for the total amounts due Total Wellness Center for their services.

This Assignment and Lien shall not be modified or revoked without the mutual written consent of Total Wellness Center and myself, I hereby revoke any previous signed authorizations, whether executed at this office or any office to the extent that the terms of those authorizations conflict with the terms of this Assignment of Lien.

Patient Name(Please Print)_____

Patient Signature_____Date:____/____/_____

Name of Custodial Parent or Legal Guardian(Please Print):_____

Parent/Guardian Signature:_____Date:____/____/_____