

# CONFIDENTIAL PATIENT CASE HISTORY

Please complete this questionnaire. This confidential history will be part of your permanent records.

Today's Date  Signature of Patient \_\_\_\_\_  
Signature of Parent/Guardian \_\_\_\_\_

Patient Title: (check one)  Mr.  Mrs.  Ms.  Miss  Dr.  Prof.  Rev.

First Name \_\_\_\_\_ Nick Name \_\_\_\_\_

Last Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Suffix \_\_\_\_\_

Address 1 \_\_\_\_\_

Address 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Primary Phone \_\_\_\_\_ Secondary Phone \_\_\_\_\_

Mobile Phone \_\_\_\_\_

Home Email \_\_\_\_\_ Work Email \_\_\_\_\_

Which email address would you like us to use to communicate with you? (Check one)

Home  Work

Contact Method (Check one)

Primary Phone  Secondary Phone  Mobile Phone  Home Email  Work Email

Date of Birth  Age \_\_\_\_\_ Gender (Check one)  Male  Female  Unspecified

Marital Status (Check one)  Single  Married  Other SSN \_\_\_\_\_

Employment Status (Check one)

Employed  FT Student  PT Student  Other  Retired  Self Employed

Race (Check one)

- |                                   |   |                                      |  |
|-----------------------------------|---|--------------------------------------|--|
| <input type="checkbox"/> White    | <input type="checkbox"/> Black/African American | <input type="checkbox"/> Hispanic    | <input type="checkbox"/> American Indian/Alaskan Native          |
| <input type="checkbox"/> Asian    | <input type="checkbox"/> Asian Indian           | <input type="checkbox"/> Chinese     | <input type="checkbox"/> Filipino                                |
| <input type="checkbox"/> Japanese | <input type="checkbox"/> Korean                 | <input type="checkbox"/> Vietnamese  | <input type="checkbox"/> Native Hawaiian or other Pacific Island |
| <input type="checkbox"/> Samoan   | <input type="checkbox"/> Guamanian or Chamorro  | <input type="checkbox"/> Other _____ | <input type="checkbox"/> I choose not to specify                 |

Multi-Racial (Check one)  Yes  No  Unknown

Ethnicity (Check one)  Hispanic or Latino  Not Hispanic or Latino  I choose not to specify

Preferred Language (Check one)

- |                                  |                                     |   |  |  |                                 |
|----------------------------------|-------------------------------------|---|--|--|---------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> Spanish    | <input type="checkbox"/> American Sign Language | <input type="checkbox"/> Chinese       | <input type="checkbox"/> French                  | <input type="checkbox"/> German |
| <input type="checkbox"/> Tagalog | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Italian                | <input type="checkbox"/> Korean        | <input type="checkbox"/> Russian                 | <input type="checkbox"/> Polish |
| <input type="checkbox"/> Arabic  | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Japanese               | <input type="checkbox"/> French Creole | <input type="checkbox"/> Greek                   | <input type="checkbox"/> Hindi  |
| <input type="checkbox"/> Persian | <input type="checkbox"/> Urdu       | <input type="checkbox"/> Gujarati               | <input type="checkbox"/> Armenian      | <input type="checkbox"/> I choose not to specify |                                 |



Other doctors or therapists who have treated THIS condition \_\_\_\_\_

What do you think caused this condition? \_\_\_\_\_

List surgical operations and years: \_\_\_\_\_

Do you have a family physician? Name: \_\_\_\_\_

Briefly list your main health problems: \_\_\_\_\_

Has any doctor diagnosed you with Hypertension presently?  Yes  No If yes, describe: \_\_\_\_\_

Has any doctor diagnosed you with Diabetes presently?  Yes  No If yes, what kind?  Type I  Type II

*If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%?*  Yes  No  Not Sure

*If yes, other comments regarding Diabetes:* \_\_\_\_\_

Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days?  Yes  No

**To be performed by clinic staff:**

Height: \_\_\_\_\_ inches    Weight: \_\_\_\_\_ pounds    BP: \_\_\_\_\_ / \_\_\_\_\_

**REVIEW OF SYSTEMS** Check only the ones you now have or have had in the past.

<u>GENERAL</u>	NOW	PAST	<u>THROAT</u>	NOW	PAST	<u>GASTROINTESTINAL</u>	NOW	PAST
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Bad Tonsils	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Bloated	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	Belching	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Trouble Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Infections	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>SKIN</u></b>			<b><u>NECK</u></b>			Irregular Bowel Habits	<input type="checkbox"/>	<input type="checkbox"/>
Color Changes	<input type="checkbox"/>	<input type="checkbox"/>	Neck Enlargement	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Nail Changes	<input type="checkbox"/>	<input type="checkbox"/>	Stiff Neck	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Hair Changes	<input type="checkbox"/>	<input type="checkbox"/>	Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Gas	<input type="checkbox"/>	<input type="checkbox"/>
Moles	<input type="checkbox"/>	<input type="checkbox"/>	Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Rashes	<input type="checkbox"/>	<input type="checkbox"/>	Masses	<input type="checkbox"/>	<input type="checkbox"/>	Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>
Sores	<input type="checkbox"/>	<input type="checkbox"/>	<b><u>BREASTS</u></b>			Food Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Bloody Stools	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>HEAD</u></b>			Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Black Stools	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	<b><u>GENITOURINARY</u></b>		
Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Urgency	<input type="checkbox"/>	<input type="checkbox"/>
Bumps	<input type="checkbox"/>	<input type="checkbox"/>	Nipple Changes	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Last Eye Exam			Skin Changes	<input type="checkbox"/>	<input type="checkbox"/>	Straining	<input type="checkbox"/>	<input type="checkbox"/>
Glasses	<input type="checkbox"/>	<input type="checkbox"/>	Bloated	<input type="checkbox"/>	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Contacts	<input type="checkbox"/>	<input type="checkbox"/>	<b><u>LUNGS</u></b>			Frequent Voiding	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>	Stones	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>EARS</u></b>			Phlegm	<input type="checkbox"/>	<input type="checkbox"/>	Burning	<input type="checkbox"/>	<input type="checkbox"/>
Hard of Hearing	<input type="checkbox"/>	<input type="checkbox"/>	Blood	<input type="checkbox"/>	<input type="checkbox"/>	Bed Wetting	<input type="checkbox"/>	<input type="checkbox"/>
Deafness	<input type="checkbox"/>	<input type="checkbox"/>	Short of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Small Stream	<input type="checkbox"/>	<input type="checkbox"/>
Ringing	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	Impotence	<input type="checkbox"/>	<input type="checkbox"/>
Earache	<input type="checkbox"/>	<input type="checkbox"/>	Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Dribbling	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Inhalant Exposure	<input type="checkbox"/>	<input type="checkbox"/>	Cloudy Urine	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<b><u>HEART</u></b>			Urine Color		
Room Spins	<input type="checkbox"/>	<input type="checkbox"/>	Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Spotting Between Periods	<input type="checkbox"/>	<input type="checkbox"/>
<b><u>NOSE</u></b>			Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Cramps	<input type="checkbox"/>	<input type="checkbox"/>
Decreased Smell	<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	Cold Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Painful Intercourse	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain/Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Periods	<input type="checkbox"/>	<input type="checkbox"/>
Obstruction	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>
Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Contraception Type	_____	
Deviated Septum	<input type="checkbox"/>	<input type="checkbox"/>	Blue Extremities	<input type="checkbox"/>	<input type="checkbox"/>	Age at First Period	_____	
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<b><u>BLOOD</u></b>			Duration of Cycle	_____	
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Duration of Flow	_____	
<b><u>MOUTH</u></b>			Low Blood Iron	<input type="checkbox"/>	<input type="checkbox"/>	No. of Pregnancies	_____	
Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>	No. of Births	_____	
Sores	<input type="checkbox"/>	<input type="checkbox"/>	Easy Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	No. of Miscarriages	_____	
Dental Problems	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Nodes	<input type="checkbox"/>	<input type="checkbox"/>	No. of Abortions	_____	
Bad Breath	<input type="checkbox"/>	<input type="checkbox"/>	Painful Nodes	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Flow	<input type="checkbox"/>	Heavy <input type="checkbox"/>
Loss of Taste	<input type="checkbox"/>	<input type="checkbox"/>	Sugar in Blood	<input type="checkbox"/>	<input type="checkbox"/>	Mod <input type="checkbox"/>	Light <input type="checkbox"/>	
Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Red Spots	<input type="checkbox"/>	<input type="checkbox"/>	Last Period	_____	
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>				Last Pap Smear	_____	
Blisters	<input type="checkbox"/>	<input type="checkbox"/>				Last Vaginal Exam	_____	
						Last Mammogram	_____	
						Last Prostate Exam	_____	

**NEUROLOGIC    NOW   PAST**

- Seizures
- Vertigo
- Dizziness
- Hand Trembling
- Loss of Sensation
- Incoordination
- Loss of Facial
- Weak Grip
- Paralysis
- Difficulty Speech
- Tingling
- Loss of Memory
- Numbness

**ENDOCRINE**

- Weight Loss
- Weight Gain
- Extremely Thin
- Heat Intolerance
- Cold Intolerance
- Hair Changes
- Breast Changes

**IMMUNIZATION/VACCINATION**

- DPT
- Mumps
- Smallpox
- Typhoid
- Tetanus
- Measles
- Pneumococcal
- Influenza
- Polio
- MMR

**BLOOD TYPE**

- A +       A -
- B +       B -
- AB +    AB -
- O +       O -
- Other \_\_\_\_\_

**BLOOD TRANSFUSIONS**

- Date \_\_\_\_\_
- Date \_\_\_\_\_
- Date \_\_\_\_\_
- Date \_\_\_\_\_

**PSYCHIATRIC    NOW   PAST**

- Hyperventilation
- Insecurity
- Depression
- Troubled Sleep
- Irritable
- Undecidedness
- Timid
- Hallucinations
- Loss of Memory
- Alcoholism
- Drug Addiction
- Drug Dependent
- Suicidal Thoughts
- Extreme Worry
- Sexual Problems

**MUSCULOSKELETAL    NOW   PAST**

- Muscle Pain
- Muscle Weakness
- Muscle Cramps
- Muscle Twitching
- Joint Stiffness
- Joint Pain

**PAST MEDICAL HISTORY. Check only the ones you have had in the past.**

- |  |  |
|--|--|
| Hay Fever <input type="checkbox"/>       | Parasites <input type="checkbox"/>         |
| Mumps <input type="checkbox"/>           | Epilepsy <input type="checkbox"/>          |
| Rheumatic Fever <input type="checkbox"/> | Paralysis <input type="checkbox"/>         |
| Allergies <input type="checkbox"/>       | Polio <input type="checkbox"/>             |
| Angina <input type="checkbox"/>          | Mental Illness <input type="checkbox"/>    |
| Cancer <input type="checkbox"/>          | Alcoholism <input type="checkbox"/>        |
| Tumor <input type="checkbox"/>           | Depression <input type="checkbox"/>        |
| Blood Disease <input type="checkbox"/>   | Nervous Breakdown <input type="checkbox"/> |
| Leukemia <input type="checkbox"/>        | Migraine <input type="checkbox"/>          |
| Heart Trouble <input type="checkbox"/>   | Gout <input type="checkbox"/>              |
| Varicose Veins <input type="checkbox"/>  | Hemorrhoids <input type="checkbox"/>       |
| Phlebitis <input type="checkbox"/>       | Prostate Problems <input type="checkbox"/> |
| Hypertension <input type="checkbox"/>    | Sexual Problems <input type="checkbox"/>   |
| Stroke <input type="checkbox"/>          | Gonorrhea <input type="checkbox"/>         |
| Ulcers <input type="checkbox"/>          | Syphilis <input type="checkbox"/>          |
| Jaundice <input type="checkbox"/>        | Diabetes <input type="checkbox"/>          |
| Skin Trouble <input type="checkbox"/>    | Bladder Trouble <input type="checkbox"/>   |
| Gallstones <input type="checkbox"/>      | Kidney Stones <input type="checkbox"/>     |
| Liver Trouble <input type="checkbox"/>   | Kidney Infections <input type="checkbox"/> |
| Hepatitis <input type="checkbox"/>       | Dysentery <input type="checkbox"/>         |

Date of Last Chest X-Ray \_\_\_\_\_  Normal    Abnormal

Last TB Skin Test \_\_\_\_\_  Normal    Abnormal

Allergies: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**FAMILY HISTORY** List any of the diseases listed above which run in your family.

Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____	_____
Maternal Grandfather	_____	_____	_____	_____	_____
Maternal Grandmother	_____	_____	_____	_____	_____
Paternal Grandfather	_____	_____	_____	_____	_____
Paternal Grandmother	_____	_____	_____	_____	_____

**SOCIAL HISTORY** Check the boxes and fill in.

Current Weight \_\_\_\_\_ Have you recently lost or gained weight? \_\_\_\_\_

Mental Work     Heavy     Moderate     Light    Hours per day \_\_\_\_\_

Physical Work     Heavy     Moderate     Light    Hours per day \_\_\_\_\_

Exercise     Heavy     Moderate     Light    Hours per week \_\_\_\_\_ Type \_\_\_\_\_

Alcohol    Beer/Week \_\_\_\_\_    Liquor/Week \_\_\_\_\_    Wine/Week \_\_\_\_\_    No. of Years \_\_\_\_\_

Caffeine    Cups/Day \_\_\_\_\_    No. of Years \_\_\_\_\_  
 (Coffee, Tea, Cola)

Aspirin    No./Day \_\_\_\_\_    No. of Years \_\_\_\_\_    Others \_\_\_\_\_

**SYMPTOMS** Mark the areas of your symptoms on the figure to the right.

Use the following symbols:

Aches ^^^^^    Numbness oooo    Pins/Needles ....    Stabbing ////

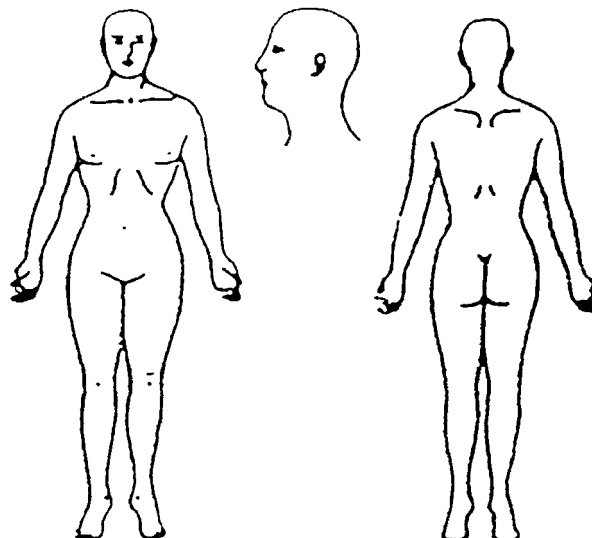
Mark an "X" on the following two lines:

How bad are your symptoms now?

\_\_\_\_\_ None Most Severe

How bad have they been in the past?

\_\_\_\_\_ None Most Severe





Center for Integrated Health and Wellness, LLC

## Confidential Patient Information

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Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Primary Insurance Carrier: \_\_\_\_\_ Secondary Insurance Carrier: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Who is financially responsible for this bill? \_\_\_\_\_ By: Cash \_\_\_\_\_ Check \_\_\_\_\_ Credit Card \_\_\_\_\_

Whom may we contact in case of an emergency? \_\_\_\_\_ Phone: \_\_\_\_\_

Nearest Relative not living with you: \_\_\_\_\_ Phone: \_\_\_\_\_

Nearest Friend not living with you: \_\_\_\_\_ Phone: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_ Phone: \_\_\_\_\_

*I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered. I realize that I am responsible to make sure that my insurance carrier, policy number and policy information is current. I agree that if the insurance carrier is delinquent in timely paying the office, I will personally call the carrier and thus assume full responsibility for the charges. I also agree that I will notify the office of any changes in my status or of the above information. I certify that the above information is true and correct to the best of my knowledge.*

*I hereby authorize the doctor(s) and his representatives to release all information necessary to secure and satisfy the payment of benefits from the insurance carrier. By signing below, I authorize the use of this signature on all insurance submissions on my behalf and hereby authorize the insurance carrier to pay Center for Integrated Health and Wellness, LLC directly on my behalf.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_ Office Initials



## **CENTER FOR INTEGRATED HEALTH & WELLNESS, LLC. FINANCIAL POLICY**

Thank you for choosing Center for Integrated Health & Wellness, LLC as your healthcare provider. We are committed to your treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of your Financial Policy which will require you to read carefully and sign prior to any treatment.

To patients not using insurance:

- Full payment is expected at time of service

To patients using health insurance:

- We bill your insurance company as a courtesy
- You must provide us with a copy of your current insurance card, drivers' license, and properly filled out forms for proper billing
- It is your responsibility to know your insurance coverage
- All co-pays and deductibles are due at time services are rendered

To all patients:

- You assume full responsibility for care given, whether or not an insurance company is involved.
- You are responsible for any additional charges our office incurs to help you in getting your claim paid. (ie. Certified letters, etc.)
- We accept CASH, CHECKS, or MASTERCARD/VISA/DISCOVER
- We will carry no balances over \$150.00
- Parents or Guardians are responsible for a minor's payment
- All Personal Injury patients will adhere to this as well as the Personal Injury Financial Policy
- I, the patient, regardless of any insurance, am ultimately responsible for my charges and bill

We will charge \$25 for missed appointments, unless cancelled in at least 24 hours in advance. This fee is not billed to your insurance company and must be taken care of prior to your next appointment.

I have read, understand, and agree to the Financial Policy.

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Signature of Patient or Responsible Party

Date



## Informed Consent for Examination and Treatment

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I (we) hereby consent to the performance of examination and treatment on me or on \_\_\_\_\_, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists who may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand that neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which includes rarely, but not limited to fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.  
Date of last menstrual period\_\_\_\_\_.

\_\_\_\_\_  
Patient's Name (Print)

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship of Authority if not  
Signed by patient

\_\_\_\_\_  
Witness

Parent/Guardian D.O.B.\_\_\_\_\_  
SS#\_\_\_\_\_



CENTER FOR INTEGRATED HEALTH & WELLNESS, LLC

Dear Patients;

Due to numerous insurance companies and their different policies, we cannot be responsible to know the conditions of your individual policy and insurance company even if we are a provider. It is a legal contract between you, your employer and the insurance carrier.

It is the patient's responsibility to know if the insurance company requires prior authorization of office visits, x-rays, and the amount of your co-payment. It is also your responsibility to know how many office visits your insurance company allows per year and to keep track of these visits. We will verify your coverage and offer you our best estimate but the ultimate responsibility lies with you, the patient.

It was explained to me that my co-pay is an estimated amount assigned by my insurance company. At times, your doctor may feel it is necessary to perform additional services depending upon my condition and this may or may not increase my co-pay amount.

My medical benefits given to me by the staff at Center for Integrated Health & Wellness is only a quote of benefits from my insurance company and is not a guarantee of payment. I am ultimately responsible for my bill. I fully understand that I, not Center for Integrated Health & Wellness, am fully responsible for any balance unpaid by my insurance company.

It is also necessary for you to know which MRI/laboratory facility you may use for any necessary procedures. All of the aforementioned information is often contained in your insurance booklet provided by your company or can be obtained by calling your insurance company.

By signing below, you acknowledge that you have read, and understand the above.

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Signature

Date