



Lifetime Health & Wellness

A Member of the WellnessOne Alliance

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Your Name: _____ Today's Date: _____

Address: _____ City: _____ Zip Code: _____

Social Security #: ____ -- ____ Home Phone: () _____ Work Phone: () _____

Marital Status: S M D W Male Female Cell Phone: () _____

Date of Birth: ____ / ____ / ____ Age: _____ E-mail Address: _____

Your Insurance Company: _____ Spouse Name: _____

Policy/Group #: _____ Who Referred You To Our Office?: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Please indicate Your Doctor of Preference: Any Dr. Snyder Dr. Pillon Dr. Bates

Your Employer: _____ City: _____

Your Occupation: _____ Job Type: Office-oriented Manual Travel

Job Requirements: Lifting Bending Stooping Typewriting/Data Entry Telephone Cradling
Lifting Children Prolonged Sitting Prolonged Standing

Your Primary Care Physician: Name: _____ Phone: _____

Which of the following statements best describes your attitude towards health and health care (check the statement that best describes you):

- I seek medical attention only when absolutely necessary.
- My primary health goal is to be symptom free. I take care of symptoms when they are relatively minor.
- I am inclined to prevent future health problems via lifestyle choices such as exercise, nutrition, and other "health habits".

Tell Us What Is Bothering You

In order to give the doctor a clear understanding of your case, we would like to answer a few simple questions. Please be as specific as possible on both the body diagrams and questions. If you are unsure about any part of this form, please feel free to ask the staff, or especially, the doctor.

What health problem brings you to our office? _____

Is it due to a recent accident or injury? Yes No Unknown

If "Yes", was it Work Auto Other (describe): _____

Date of Accident: _____ Time: _____ a.m. p.m.

Have your injuries been reported? Yes No If "yes", to whom?: _____

Have you seen other doctors and been treated as a result of this condition/accident? Yes No

If "yes", please list names and specialties: _____

What did the other doctor(s)/specialist(s) do? Examination Injections X-rays Traction
 Physiotherapy (how long?): _____ Other

What is your main area of chief complaint? (i.e., neck pain, headaches, low back pain, arm/leg pain): _____

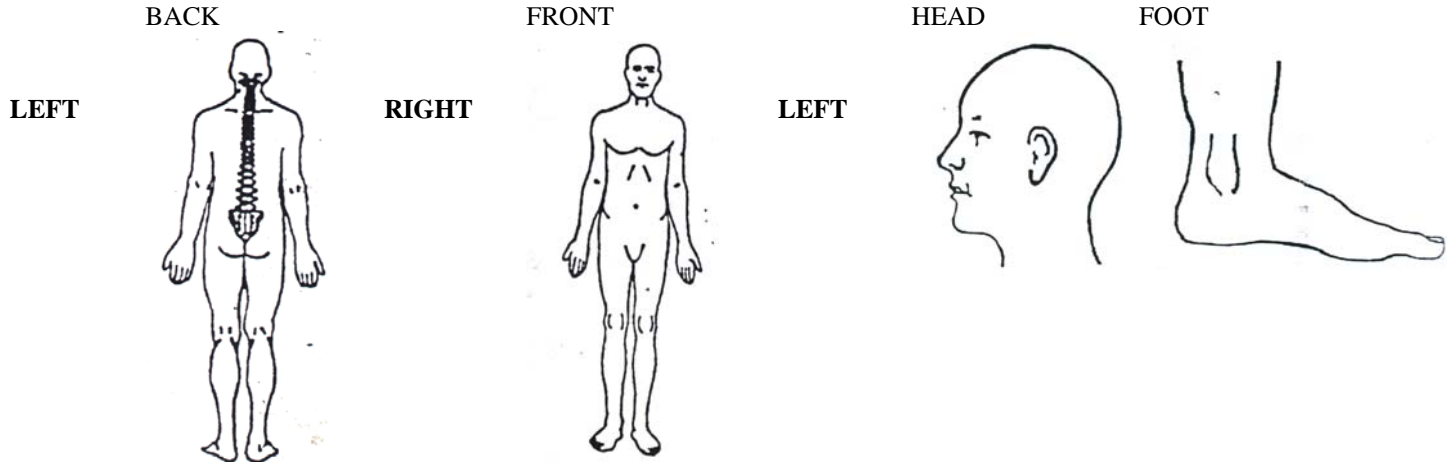
Exact date problem began (if you have had this problem a long time, give date you finally felt you needed to get care): _____

How long has it been since you really felt good? _____

How long have you been under the care of a physician? _____

Are you still under a doctor's care? Yes No

Please mark the appropriate area of your chief complaint on the following diagrams. If you are experiencing radiating pain, please mark the areas the pain is going to.



Check any of the following terms which describe your pain Sharp Stabbing Dull Ache Gnawing Other: _____
 Deep

Intensity of Pain / Frequency of Pain 0-10 (10 highest) _____ Frequency: (#times/wk) _____

Check the following symptoms which apply to your condition:

- | | | |
|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Tension | <input type="checkbox"/> Double vision |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Fainting | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Pain in joints |
| <input type="checkbox"/> Eye strain | <input type="checkbox"/> Pain behind eyes | <input type="checkbox"/> Feet cold |
| <input type="checkbox"/> Pallor | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Excessive sweat |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Leg problems | <input type="checkbox"/> Muscle jerking |
| <input type="checkbox"/> Nausea or vomiting | <input type="checkbox"/> Hands cold | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Extreme fatigue | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Extreme nervousness | <input type="checkbox"/> Digestive disorders | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Difficulty in prolonged sitting | <input type="checkbox"/> Head seems too heavy | |
| <input type="checkbox"/> Pain radiating into: | <input type="checkbox"/> Upper <input type="checkbox"/> Mid <input type="checkbox"/> Lower | |
| <input type="checkbox"/> Restriction of motion: | <input type="checkbox"/> Arms <input type="checkbox"/> Buttock <input type="checkbox"/> Legs <input type="checkbox"/> Feet | |
| <input type="checkbox"/> Numbness/Tingling in: | <input type="checkbox"/> Neck R/L <input type="checkbox"/> Shoulders R/L <input type="checkbox"/> Arms R/L | <input type="checkbox"/> Hips R/L <input type="checkbox"/> Fingers R/L <input type="checkbox"/> Legs R/L |
| <input type="checkbox"/> Pins & Needles in: | <input type="checkbox"/> Neck R/L <input type="checkbox"/> Shoulders R/L <input type="checkbox"/> Arms R/L | <input type="checkbox"/> Hips R/L <input type="checkbox"/> Fingers R/L <input type="checkbox"/> Legs R/L |
| | <input type="checkbox"/> Feet R/L | |

Any other condition not specified: _____

What factors aggravate your complaint (make it worse):

- | | | | |
|--|--|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Sitting for long periods of time | <input type="checkbox"/> Standing for long periods of time | <input type="checkbox"/> Walking | <input type="checkbox"/> Driving |
| <input type="checkbox"/> Lifting <input type="checkbox"/> Light | <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy | <input type="checkbox"/> Repeated | |
| <input type="checkbox"/> Twisting <input type="checkbox"/> Light | <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy | <input type="checkbox"/> Repeated | |
| <input type="checkbox"/> Standing <input type="checkbox"/> Light | <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy | <input type="checkbox"/> Repeated | |
| <input type="checkbox"/> Other activities (please list): | | | |

Check any of the following that have helped you get relief from your complaint:

- | | | | | |
|---|-------------------------------|---|-------------------------------|----------------------------------|
| <input type="checkbox"/> Ice | <input type="checkbox"/> Heat | <input type="checkbox"/> Stretches/Exercise | <input type="checkbox"/> Rest | <input type="checkbox"/> Massage |
| <input type="checkbox"/> Medication (list): | | | | |
| <input type="checkbox"/> Other (specify): | | | | |

Does your pain seem to be worse at any of the following times of day?

- Worse in morning Worse in afternoon Worse in evening
- Wakes me up at night Worse only with activity
- Constant, no relief Other (specify): _____

Are there any activities you cannot do because of your condition?

- Work (how long) Clean House Drive Lift things Play sport/activity
- Other (specify): _____

Does your pain seem to be getting:

- Better Worse Same

Have you ever had the same or similar condition?

- Yes No

Other health problems that concern you: _____

HISTORY:

Auto Accident: _____

Serious Fall: _____

Hospitalizations: _____

Surgeries: _____

Emotional Upsets: _____

Recent Dr. Visits: _____

Date of Last: Physical Exam Spinal X-Ray Spinal Exam
 Chest X-Ray Blood Test Dental X-Ray
 Urine Test

Do you take: Nerve pills Muscle relaxers Pain killers "Pep" pills
 Tranquilizers Insulin Birth control Other: _____

Do you now take vitamins and/or minerals?: Yes No If yes, list: _____

Habits (please give amount):

- Tobacco _____ (packs/day) Alcohol _____ (drinks/day)
- Caffeine (coffee/tea/cola) _____ (drinks/day) Non-job exercise _____ (hrs/wk)
- Sleep _____ (hrs/night) Do you sleep on your: Back Side Stomach
- Do you use a bedboard? Yes No Is your bed comfortable? Yes No

Do you wear: Heel lifts Sole lifts Inner soles Arch supports Back brace Prescribed orthotics

Mark the following diseases you have had:

- AIDS/HIV Heart Disease Rheumatoid Arthritis Anemia
- Hepatitis A B C Rheumatic fever Cancer/Tumors Malaria
- Small pox Chicken Pox Measles Tuberculosis
- Diabetes Multiple Sclerosis Typhoid Fever Diphtheria
- Mumps Whooping Cough Eczema Pneumonia
- Polio Epilepsy Other: _____

Are you aware of any diseases that run in your family? Yes No If yes, describe: _____

Do any family members have similar health problems? Yes No (If yes, please describe): _____

FOR WOMEN ONLY:

Date of your last normal period: _____ **Interval between periods:** _____ days

First period at age: _____ **Date of last visit to gynecologist:** _____

Is there any chance you may be pregnant? Yes No

Check all that apply:

- Irregular cycles Excessive flow Congested breasts, lumps in breasts
- Premenstrual tension Other menstrual symptoms
- Pain or bleeding during Vaginal discharge
- Cramps or backache Menopausal symptoms

ALL PATIENTS

The best doctor/patient relationship is when there is complete understanding of treatment and financial responsibilities between the doctor and the patient.

I understand and agree that all services rendered are charged directly to me, and that I am personally responsible for payment upon delivery of services unless prior arrangements are made. All patient co-pays or non-covered percentage fees are to be paid by the patient following each day's services. I understand that should my account fall delinquent, it may be turned over for legal collection and reported to the credit bureau. I understand that a 30% interest charge will be added to all delinquent account balances.

The statutes of the State of Colorado are specific with respect to Doctor/Patient relationships. In accordance with the statutes, no doctor shall engage in a personal relationship with any patient outside the parameters of the normal conduct of doctor-patient interaction. Doctors are precluded from dating patients, having intimate relations with patients, or having sexual contact with patients during the course of the doctor/patient relationship, and for six months thereafter. The policy of this office is to strictly adhere to said regulation.

Signature of Patient or Legal Guardian (*I acknowledge that I have read and understand the above policy*) Date

INSURANCE PATIENTS **AUTHORIZATION TO RELEASE INFORMATION**

Most health insurance policies have a deductible and a percentage for which the patient is responsible (co-insurance). Therefore, it is our standard office policy to have all of the initial office visit fees paid by you on the first visit.

If you, the patient, request the extension of credit for future treatment, you must complete our office insurance questionnaire at this time. Subsequently, our insurance department will contact your insurance company for verification of coverage. Your insurance carrier will tell us what your coverage handles and what percentage they will pay. However, they will also state that coverage does not guarantee payment. Sometimes coverage is actually more or less, depending on your contract.

Statements will be sent to your insurance carrier on a weekly basis. On receipt of benefits, you will be advised of the benefits received, on amounts not paid, or credit balance. You are responsible for any balance due at that time. Credit balance may be refunded or applied toward further care.

I hereby authorize CEO Westminster Inc., to release any information deemed appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered; and I hereby release CEO Westminster Inc., of any consequences thereof. I also authorize my insurance and/or attorney to pay by check made out and mailed directly to CEO Westminster Inc., any moneys due him, and otherwise payable to me, the same to be deducted from any settlement made on my behalf, for professional services rendered. Further, I agree to pay CEO Westminster Inc., the difference, if any, between the total amount of their charges and the amount paid by the insurance carrier and/or attorney. I hereby state and agree that a photocopy of this document will be deemed as valid and binding on all parties involved .

If any portion of this contract is deemed unenforceable, the remaining contents remain severable.

Signature of Patient or Legal Guardian (*I acknowledge that I have read and understand the above policy*) Date

THANK YOU



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BROKEN APPOINTMENT POLICY

At Lifetime Health & Wellness, it is our responsibility to provide our patients with excellent health care in a timely manner. As a service, we want to give care to as many patients as possible each day with minimal waiting time. We reserve your appointment time to achieve that goal. Because of this, we require a notice for missed appointments.

For appointments that are forgotten or willfully missed, it is our policy to charge for these appointments. We understand that people get sick, cars break down, etc. and will take that into account. No show appointments or appointments cancelled with less than 3 hours notice will be charged \$20.00 (You may leave a voice mail message if our office is closed.)

YOUR INSURANCE COMPANY IS NOT RESPONSIBLE FOR PAYING FOR MISSED APPOINTMENTS.

Thank you for your respect of our policy and other patients. By signing this, I agree to the cancellation terms of this office.

Date: _____

Name _____ Signature: _____
(Please Print)



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Consent for Purposes of Treatment, Payment & Healthcare Operations

I consent to the use or disclosure of my protected health information by C.E.O. Westminster for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that analysis, diagnosis or treatment of me by C.E.O. Westminster 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. C.E.O. Westminster is not required to agree to the restrictions that I may request. However, if C.E.O. Westminster agrees to a restriction that I request, the restriction is binding. I have the right to revoke this consent, in writing, at any time, except to the extent that C.E.O. Westminster has taken action in reliance on this 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, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of C.E.O. Westminster. I understand that I have a legal right to review C.E.O. Westminster's Notice of Privacy Practices before I sign this consent and we encourage you to read it in full. 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 at our clinic. The Notice of Privacy Practices for C.E.O. Westminster is also posted in the waiting room at 8155 W. 94th Avenue Broomfield, CO 80021.

C.E.O. Westminster's Notice of Privacy Practices is subject to change. I may obtain a revised notice of privacy practices by calling our clinic and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Printed Name of Patient

Date of Signing

Description of Personal Representative's Authority