WELCOME TO WHOLE HEALTH CENTER
DR. HOLDEN CHIROPRACTIC, LLC
CONTACT INFORMATION

First Name: _____ Last Name: _____

Address: _____

City, State, ZIP: _____

Patient Sex: □ Male □ Female **Date of Birth:** _____

Telephone: Home _____ Cell _____ Work _____

Do we have your permission to send appointment reminders, and clinic updates to your email address?
Yes _____ No _____ We will not sell or give your email to any other agency.

Email Address: _____

Emergency Contact: Name _____

Telephone _____ Relationship_____

How did you hear about us?

□ Friend or Family(name)_____ □ Whole Foods Massage Therapist_____

□ Website □ Internet □ Other: _____

Current Complaints:

Nature of injury: Automobile * □ Work □ Other □

Please describe: _____

_____

Date of injury: _____ Date symptoms appeared: _____

Have you ever had the same condition? □ No □ Yes If Yes, when? _____

List other practitioners seen for this injury/condition _____

Have you ever been under chiropractic care? □ No □ Yes

If yes, please describe: _____

If an auto accident, please provide the following information:

Insurance company name: _____ Contact Person: _____

Contact Phone #: _____ Contact Fax #: _____

Policy #: _____ Claim #: _____

DISCLAIMER

Merely an office location through which independent practitioners conduct their business, Whole Health Center does not render any services or provide any care or treatment. The individual practitioner that performs the services is independent from Whole Health Center and responsible for the services rendered. Additionally, not all of the practitioners at Whole Health Center are licensed medical doctors; some services available at Whole Health Center are complementary to and not a substitution for treatment by a licensed medical doctor. As such, by signing below, you indicate that you understand this disclaimer and agree to hold Whole Health Center harmless from any and all claims related to services obtained at Whole Health Center.

Signature: _____ Date: _____

Whole Health Center Financial Policy for Patient Care Services

Whole Health Center wants to provide the most efficient and affordable health care services, so it is necessary for us to have a financial policy stating our requirements for timely payment of services and products provided by our office. We welcome the opportunity to discuss any aspect of our financial policy. To help us help you, please:

1.) Provide us with accurate and updated information on yourself.
2.) Pay at the time of service for your entire balance.
3.) Discuss your account balance only with the front office staff. It is important for practitioners to be allowed to provide patient care. If the front office staff cannot help you, do not hesitate to contact the office manager.

Whole Health Center and its providers accept worker's compensation and auto accident insurance. We require that a lien signed by the patient and any attorneys is on file when applicable. WHC and its providers are willing to extend the expectation of payment within 60 days for worker's compensation and auto accident insurance when Med-Pay is not available.

If you prefer that we do not file insurance claims for you, you may pay the "Cash at Time of Service" discounted rate and send the claim to your insurance carrier. If you choose to submit your own claims, we will provide you with a superbill, but cannot assist you in filing your claims.

Cancellation Policy:
In order to provide you with the best care, please arrive 10 minutes prior to your appointment – late arrival may result in cancellation. We require 24 hours' notice of cancellation or you may be charged a fee. Please remember that failure to appear for your appointment prevents others from receiving care.

Finance Charges:
Failure to pay for services and products provided by our office will result in a finance charge. If we need to forward your account to a collection agency for further legal action, you will be responsible for the entire balance on your account plus any collection fees.

NSF Charges:
We charge a NSF charge if any payment is returned due to insufficient funds. If payment is returned then we are authorized to charge your credit card on file for the balance owed plus the NSF Charge.

Permission to Charge Credit Card on File for Past due balances:
We will always attempt to contact you regarding past due invoices. However, after repeated attempts to collect, we will charge your credit card on file. Your signature on the line below indicates that you understand you are agreeing to allow Whole Health Center to charge your credit card for a past due balance if your invoice balance lapses past the due date. If we do not have a credit card on file, we will forward your account to collections for the entire balance on your account plus any collection fees.

_____ _____

Responsible Party or Authorized Person Signature Date

HIPAA Agreement

Whole Health Center will receive health information that is protected as defined by the regulations promulgated under HIPAA (the "HIPAA privacy rule") in order to provide chiropractic care on behalf of the patient. Therefore, the parties agree as follows:

1. Whole Health Center will not use and/or disclose, and will require his agents and subcontractors to whom he provides personal health information (PHI) as permitted to agree not to use and/or disclose PHI except (1) as necessary to provide the services described in the Certification and Assignment; (2) as otherwise permitted or required by these HIPAA Privacy Provisions; (3) as required or permitted by law; (4) for the proper management and administration of his business.

2. Whole Health Center will use appropriate safeguards to prevent the use or disclosure of PHI other than as provided for by this Agreement.

3. Whole Health Center will report to patient any use or disclosure of PHI not provided for by this Agreement of which he becomes aware.

4. Whole Health Center will ensure that any agent of his, including subcontractors to whom he provides PHI received from or created by Whole Health Center on behalf of patient, agrees to the same restrictions and commitments that apply to Whole Health Center with respect to such information.

5. Whole Health Center will make available PHI to the extent required under 45 C.F.R. and 164.524, which describes the requirements applicable to an individual's request for access by the PHI relating to the individual.

6. Upon patient's request, Whole Health Center will make available PHI relating to a patient available to patient for amendment and incorporate any amendments or corrections to PHI when notified to do so in writing by patient in accordance with the provisions of 45 C.F.R. and 164.526 as finalized.

7. Whole Health Center will make available PHI to the extent required to provide an accounting of disclosures in accordance with 45 C.F.R. and 164.528, which describes the requirements applicable to an individual's request for an accounting of disclosures of PHI relating to the individual.

8. Whole Health Center agrees to make his internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by Whole Health Center on behalf of patient available to the Secretary of the Department of Health and Human Services for the purpose of determining patient compliance with the use and disclosure of PHI.

9. These Terms and Conditions cannot be amended except by the mutual written agreement of Whole Health Center and patient.

In the event any provision of these HIPAA Privacy Provisions is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions in this Agreement will remain in full force and effect. In addition, in the event a patient believes in good faith that any of these provisions fails to comply with the then-current requirements of the HIPAA Privacy Rule, such party so shall notify the other party in writing. For a period of up to 30 days, the parties shall address in good faith such concern and shall amend the terms of this Agreement, if necessary to bring it into compliance.

Signature: _____ Date: _____

(Signature of patient or legal guardian)

Patient's Name: _____

(Print Name)

Informed Consent to an "Unproven" Procedure

This consent form identifies those services or procedures performed in this office that are designated "unproven" by the Colorado State Board of Chiropractic Examiners and their effectiveness has not been demonstrated. "Unproven" means that the service or procedure is one that is not generally recognized or does not have scientific validity whose research was not sponsored and investigative findings have not been printed in scientific journals.

By signing this form, the patient grants permission for the practice to proceed with the rendering of these services on an as needed basis.

Services rendered in this practice that are designated as "unproven" by the State Board of Chiropractic Examiners includes:

- Soft or Cold Laser Therapy for use not approved by the Food and Drug Administration
- Reflexology
- Detox Ionic Foot Baths

By signing this consent, I _____ understand that the procedure(s) referenced have been designated as "unproven" by the Colorado State Board of Chiropractic Examiners and the effectiveness has not been demonstrated. I also understand that by signing this waiver, I consent to the use of or rendering of these services by this practice on an as needed or as recommended basis and I grant my doctor permission to proceed with these services. I also understand that at any time I can elect to discontinue the receipt of these services by informing my doctor or staff member of my decision.

_____ _____

Print Name Date

_____

Signature

_____

(Guardian or Authorized Representative Printed Name)

_____

(Guardian or Authorized Representative Signature)

Medical History

Have you been treated for any conditions in the last year? ☐ No ☐ Yes

If yes, please describe _____

Date of last physical exam _____ Is there a chance that you are pregnant? ☐ No ☐ Yes

Have you had X-rays taken? ☐ No ☐ Yes If yes, where? _____

What medications are you taking and for what conditions (Please list dosage and amounts, etc). _____

_____

_____

What vitamins, minerals, or herbs do you currently take? (Please list for what condition, dosage, and frequency).

_____

_____

Have you ever:	No	Yes	Briefly Explain
Broken bones?	☐	☐	_____
Been hospitalized?	☐	☐	_____
Been in an auto accident?	☐	☐	_____
Had Sprains/Strains?	☐	☐	_____
Been struck unconscious?	☐	☐	_____
Had surgery?	☐	☐	_____

Family History

Family Member	Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Habits:	None	Light	Moderate	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐
Water	☐	☐	☐	☐
Salty Foods	☐	☐	☐	☐
Sugary Foods	☐	☐	☐	☐
Artificial Sweeteners	☐	☐	☐	☐

	Yes	No
Do you experience pain every day?	☐	☐
Do your symptoms interfere with daily life?	☐	☐
Does pain wake you up at night?	☐	☐
Are your symptoms worse during certain times of the day?	☐	☐
Do changes in weather affect your symptoms?	☐	☐
Do you wear orthotics?	☐	☐
Do you take vitamin supplements?	☐	☐

What activities aggravate your symptoms?

_____

_____

_____

Have you ever suffered from:

- Alcoholism ☐
- Allergies ☐
- Anemia ☐
- Arteriosclerosis ☐
- Arthritis ☐
- Asthma ☐
- Back Pain ☐
- Breast lump ☐
- Bronchitis ☐
- Bruise Easily ☐
- Cancer ☐
- Chest Pain/Conditions ☐
- Cold extremities ☐
- Constipation ☐
- Cramps ☐
- Depression ☐
- Diabetes ☐
- Digestion Problems ☐
- Dizziness ☐
- Ears Ring ☐
- Excessive Menstruation ☐
- Eye Pain/Difficulties ☐
- Fatigue ☐
- Frequent Urination ☐
- Headache ☐
- Hemorrhoids ☐
- High Blood Pressure ☐
- Hot Flashes ☐
- Irregular Heart Beat ☐
- Irregular Cycle ☐
- Kidney Infection ☐
- Kidney Stones ☐
- Loss of memory ☐
- Loss of balance ☐
- Loss of smell ☐
- Loss of taste ☐
- Lumps In Breast ☐
- Neck Pain or Stiffness ☐
- Nervousness ☐
- Nosebleeds ☐
- Pacemaker ☐
- Polio ☐
- Poor Posture ☐
- Prostate Trouble ☐
- Sciatica ☐
- Shortness of breath ☐
- Sinus Infection ☐
- Sleep problems/insomnia ☐
- Spinal Curvatures ☐
- Stroke ☐
- Swelling of ankles ☐
- Swollen Joints ☐
- Thyroid Condition ☐
- Tuberculosis ☐
- Ulcers ☐
- Varicose Veins ☐
- Venereal Disease ☐
- Other: ☐

Current Complaints (Continued)

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache
B=Burning
N=Numbness
O=Other
P=Pins & Needles
S=Stabbing