The Wellness Center 303.357.9355 Medical History Summary

Last Name: _____ **First Name**:_____ **Today's date:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: Home# _____ **Work#**_____ **Cell #** _____

E-Mail Address: _____ ***RECEIVE SPECIAL DISCOUNTS*** via our email newsletter!**

DOB: _____ **Occupation:** _____ **Spouse's Name:** _____

How did you hear about us?

○ Friend: (name) _____

○ Whole Foods ○ Driving by ○ Chair massage downstairs ○ A List

○ Website ○ Yelp.com ○ YellowPages.com ○ Other _____

Emergency Contact: _____

Name **Phone#** **Relationship to you**

Personal physician: _____ **Phone:** _____

Please list your Top 5 major health concerns:

1._____

2._____

3._____

4._____

5._____

Medical History:

Have you ever been hospitalized with an illness? If yes, please describe: _____

Please check if you have a history of the following:

Have you had any of the following disorders?

- O Heart Disease
- O Hypertension (high blood pressure)
- O Elevated Cholesterol or other blood fats
- O Hypoglycemia
- O Thyroid problem: if yes, Specify_____
- O Diabetes
- O Cancer
- O Other: _____

Have you had any of the following surgeries?

- O Abdominal
- O Thyroid
- O Surgery to correct obesity
- O Other: _____

Please list any medications you currently take and for what conditions:

_____

_____

Please list any natural supplements you currently take and for what conditions:

_____

_____

I have read all the information on this sheet, have completed the above answers, and certify this information is true and correct to the best of my knowledge. I will notify this office of any change in health status or information of the above named patient.

_____ **Date**_____

Patient Signature (guardian signature if patient is a minor)

Consent for Care and Notice of Privacy Practices

This summary discloses how health information about you may be used. A full notice of your privacy rights can also be provided to you upon your request. Also, the full notice is posted in the front office.

I understand that the nature of the recommended medical treatments for my care will be explained to me. I understand that I will have the opportunity to ask questions of those involved in my care. I am not being forced by anyone to accept medical treatment. I consent to the use or disclosure of my protected health information by The Wellness Center for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of The Wellness Center. I understand that a record will be kept confidential and will not be released to others unless they are involved in my care plan. I understand that I may look at my medical record at any time and can request a copy of it (as dictated by the Health Information Portability and Accountability Act of 1996).

The Wellness Center may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues. The Wellness Center must maintain the privacy of protected health information, abide by the terms of this notice, accommodate reasonable requests you may make to communicate health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information.

You may contact our Director and/or Assistant Director and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

I hereby grant permission to The Wellness Center and its clinicians to perform such examinations and therapeutic treatments as are considered necessary or advised for my diagnosis and treatment plan. Clinicians who treat me include, but are not limited to: medical doctors, naturopathic doctors, acupuncturists, massage therapists, herbalists, nutritionists, physical therapists, and/or chiropractors. My signature on this document indicates my consent for treatment.

Authorization to Release Information (for insurance clients only)

I authorize The Wellness Center to release any information required to process this claim to any insurance company or attorney in this case. I also authorize any insurance company or medical provider to release my medical records to The Wellness Center. This information is to be used for the purpose of processing my claim for benefits due. I hereby agree that a photocopy of this document is as valid and effective as the original copy.

Payment Agreement

I assume full responsibility for and agree to pay all costs, charges and expenses of every kind and description for services furnished by The Wellness Center. I must pay charges and services not covered by any insurance or other third-party pay or and/or not paid to The Wellness Center for any reason within a time period The Wellness Center deems reasonable. The amount of the bill shall be due and payable upon presentation to the patient, his/her agent, guardian, conservator or third party responsible for payment of the charges.

The Wellness Center maintains a **strict 4 hour notice of cancellation policy**. Although a courtesy call, email or text is usually made, it is my responsibility to remember and show up for my appointments. Late cancellations and no show appointments will be charged for the full amount of the service.

How do you prefer to be reminded of appointments?

○ Phone ○ Email ○ Text

Liability Agreement

I have read and completed the above information to the best of my knowledge. I will not hold The Wellness Center, Inc. responsible for any condition, of which they were not informed, which may worsen over time through treatment.

_____ _____

Date Signature of Patient or Legal Guardian