Patient Forms

SOUND BODY INTEGRATIVE MEDICINE | 12640 W Cedar Dr Ste 400, Lakewood, CO 80228 | (303) 953-5200

PATIENT INFORMATION

Today's date:		Primary Care Physician:	
Patient's last name: First: Middle Initial:		Marital status: ☐ Single ☐ Married Widowed Divorced Significant Other	
Is this your legal name? ☐ **Yes** ☐ **No**	If not, what is your legal name?	Birth date:	Age: Sex: ☐ M ☐ F
Street Address:		Home phone #: ( )	
		Cell phone #: ( )	
P.O. Box: **City:** **State:** **Zip Code:**			
Occupation: Employer: Employer phone #: ( )			
Email:	Spouse's Name:		
Emergency Contact:	Spouse's Employer:		

I was referred to this clinic by (please check one box):

☐ Social Media Internet Patient Website ☐ Referral ☐ Insurance ☐ Other _____

If you selected referral, whom may we thank for referring you?

RESPONSIBLE PARTY (If Different from Patient)

Name:		Date of Birth:
Address:	Phone #	Relationship to Patient:
Employer:	Employer Address:	Employer Phone #:

INSURANCE

Name of Insured:	Relationship to patient:	Birth Date:	
Insurance Company:	Policy #:	Group #:	
Name of Employer:	Employer Address:	Employer Phone #:	

PAST MEDICAL HISTORY

Check all conditions that apply to you:

- ☐ Measles
- ☐ Mumps
- ☐ Chickenpox
- ☐ Whooping Cough
- ☐ Scarlett Fever
- ☐ Diphtheria
- ☐ Small Pox
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Arthritis
- ☐ STI
- ☐ Anemia
- ☐ Bladder Infection
- ☐ Epilepsy
- ☐ Migraine Headaches
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Cancer
- ☐ Polio
- ☐ Glaucoma
- ☐ Hernia
- ☐ Blood/Plasma Transfusion
- ☐ Back Trouble
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Hemorrhoids
- ☐ Asthma
- ☐ Hives/Eczema
- ☐ AIDS or HIV
- ☐ Infectious Mono
- ☐ Bronchitis
- ☐ Mitral Valve Prolapse
- ☐ Stroke
- ☐ Hepatitis
- ☐ Ulcer
- ☐ Kidney Disease Thyroid
- ☐ Disease Bleeding Disorder
- ☐ Other Disease

Date of Last Chest X-ray

Gynecologic History

Are you currently pregnant? Pregnancies# _____ Menstrual: Onset:_____ Duration: _____ Last menstrual period:_____

Your birth ☐ Natural ☐ C-Sec? Are they regular? Pain Associated?

Please list all medications you are currently taking. **If you need additional space, please use the back of this page.**

Name	Dosage	Name	Dosage	Name	Dosage

Activity Level

Select one of the following

- □ Inactive: no regular physical activity with a sit-down job
- □ Light Activity: no organized physical activity during leisure
- □ Moderate Activity: Occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.
- □ Heavy Activity: consistent lifting, stair climbing, heavy construction, etc. or regular participation in jogging, swimming, cycling or active sports at least three times per week.
- □ Vigorous Activity: Participation in extensive physical exercise for at least 60 minutes per session, 4 or more times per week.

Chief Complaint

What problem are you seeing the doctor for? (Specific Complaint, date of injury, place of injury):

Is it on the right or left side? RT ☐ LT ☐

How long have you had this problem?

What treatment have you tried in the past?

What activities have you given up due to the problem?

How severe is the problem? 1-10

Are you on any medications for the problem?

Family History

Previous Hospitalizations or Surgeries:

Allergies/Medication Allergies:

Do you have a Sulfa Allergy? ☐ Yes ☐ No

Family Medical History

Mother Age: Disease: _____ If Deceased, Cause of Death: _____

Father Age: Disease: _____ If Deceased, Cause of Death: _____

Siblings Age: Disease: _____ If Deceased, Cause of Death: _____

Siblings Age: Disease: _____ If Deceased, Cause of Death: _____

Children Age: Disease: _____ If Deceased, Cause of Death: _____

Use of:

Alcohol: Never: ☐ Rare: ☐ Moderate: ☐ Daily: ☐

Tobacco: Never: ☐ Rare: ☐ Moderate: ☐ Daily: ☐

Drugs: Never: ☐ Rare: ☐ Moderate: ☐ Daily: ☐

Exposure to: Fumes ☐ Dust ☐ Solvents ☐ Noise ☐

Hobbies and Activities:

Do you experience any of the following Symptoms (rate on a scale of 1-5 *Enter # which is most appropriate*)

1=Never, 2=Rare, 3=Occasionally, 4=Frequently, 5=All the Time

	1	2	3	4	5
I feel tired all the time:	○	○	○	○	○
I get dizzy when I stand:	○	○	○	○	○
I have muscle weakness:	○	○	○	○	○
I've been unable to sleep:	○	○	○	○	○
I wake up at night:	○	○	○	○	○

	1	2	3	4	5
Concentrating is hard:	○	○	○	○	○
I get muscle spasms/cramps:	○	○	○	○	○
I have trouble with my memory:	○	○	○	○	○
I've been more irritable lately:	○	○	○	○	○
I get headaches/migraines	○	○	○	○	○

	1	2	3	4	5
I'm frequently sick:	○	○	○	○	○
I take longer to heal:	○	○	○	○	○
My bones feel achy:	○	○	○	○	○
My skin is dry or cracking:	○	○	○	○	○
My hair is falling out:	○	○	○	○	○

	1	2	3	4	5
I feel pins and needles in my hands and feet:	○	○	○	○	○
I feel numbness or tingling in my fingers:	○	○	○	○	○
My nails easily break and are brittle:	○	○	○	○	○

MEDICAL HISTORY

1. Are you diabetic? If Yes Type 1 ☐ Type 2 ☐ Diagnosis Date: _____
2. Last HA1C: _____ Date: _____ Last Fasting Blood Sugar Level: _____ Date: _____
3. Do you have any implantable devices? Yes/ No If yes, please list: _____
4. Do you have a history of seizures? Yes/ No If Yes, list your last episode date: ___/___/___
5. History of cellulitis? Yes ☐ No ☐
6. Any current wounds, rashes, or skin infection? Yes/ No If yes, please list: _____

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SYMPTOM SURVEY	
(Check the box if applicable and if L or R):	**Description (Please select the term(s) that relates to your symptom)**
□ **Foot** Pain (Right☐ Left☐) When did this pain start?	Constant ○ On-and-Off ○ Dull Ache ○ Burning ○ Pressure ○ Sharp ○ Stabbing ○ Tight ○ Cramping ○ Tingling ○ Numb ○ Radiating ○ Deep ○ Sore ○ Throbbing ○
□ **Hand** Pain (Right☐ Left☐) When did this pain start?	Constant ○ On-and-Off ○ Dull Ache ○ Burning ○ Pressure ○ Sharp ○ Stabbing ○ Tight ○ Cramping ○ Tingling ○ Numb ○ Radiating ○ Deep ○ Sore ○ Throbbing ○
□ **Knee** Pain (Right☐ Left☐) When did this pain start?	Constant ○ On-and-Off ○ Dull Ache ○ Burning ○ Pressure ○ Sharp ○ Stabbing ○ Tight ○ Cramping ○ Tingling ○ Numb ○ Radiating ○ Deep ○ Sore ○ Throbbing ○
□ **Hip** Pain(Right☐ Left☐) When did this pain start?	Constant ○ On-and-Off ○ Dull Ache ○ Burning ○ Pressure ○ Sharp ○ Stabbing ○ Tight ○ Cramping ○ Tingling ○ Numb ○ Radiating ○ Deep ○ Sore ○ Throbbing ○
□ **Shoulder** Pain (Right☐ Left☐) When did this pain start?	Constant ○ On-and-Off ○ Dull Ache ○ Burning ○ Pressure ○ Sharp ○ Stabbing ○ Tight ○ Cramping ○ Tingling ○ Numb ○ Radiating ○ Deep ○ Sore ○ Throbbing ○
□ **Elbow** Pain (Right☐ Left☐) When did this pain start?	Constant ○ On-and-Off ○ Dull Ache ○ Burning ○ Pressure ○ Sharp ○ Stabbing ○ Tight ○ Cramping ○ Tingling ○ Numb ○ Radiating ○ Deep ○ Sore ○ Throbbing ○
□ **Wrist** Pain (Right☐ Left☐) When did this pain start?	Constant ○ On-and-Off ○ Dull Ache ○ Burning ○ Pressure ○ Sharp ○ Stabbing ○ Tight ○ Cramping ○ Tingling ○ Numb ○ Radiating ○ Deep ○ Sore ○ Throbbing ○
□ **Neck** Pain When did this pain start?	Constant ○ On-and-Off ○ Dull Ache ○ Burning ○ Pressure ○ Sharp ○ Stabbing ○ Tight ○ Cramping ○ Tingling ○ Numb ○ Radiating ○ Deep ○ Sore ○ Throbbing ○
□ **Low Back** Pain When did this pain start?	Constant ○ On-and-Off ○ Dull Ache ○ Burning ○ Pressure ○ Sharp ○ Stabbing ○ Tight ○ Cramping ○ Tingling ○ Numb ○ Radiating ○ Deep ○ Sore ○ Throbbing ○

	Yes	No
1. Have you had any previous testing, workup, or imaging for the above selected conditions?	☐	☐
2. Loss of Function or Paralysis?	☐	☐
3. Bowel/Bladder incontinence?	☐	☐
4. Sleep issues?	☐	☐
5. Motor Weakening?	☐	☐
6.Do you have to hold on to walls/furniture?	☐	☐
7.Do you Stumble?	☐	☐
8.Have you tried TENS therapy?	☐	☐

Failed treatments: _____

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PATIENT CONSENT FOR COMMUNICATION:

We have the ability to call or text you, reminding you of your appointments. If you would like to receive this feature in the future, please read the consent below and sign. Patients in our practice may be contacted via phone/text message to be reminded of an appointment, to obtain feedback on an experience within our office, and to provide general health reminders/information.

1.I consent to receiving appointment reminders and other healthcare communications via telephone from Sound Body Integrative Medicine.

2.I consent to receive text messages from Sound Body Integrative Medicine to my cell phone and any number forwarded or transferred to that number. The cell phone number that I authorize to receive messages for appointment reminders,feedback and general reminders/ information is:

3.I consent to receive emails regarding appointment reminders,feedback and general reminders/information. My email address is:

I understand that this request to receive communications by email and/or text message will apply to all future appointment reminders/ feedback/general reminders and information.

Signature:_____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received Notice of Privacy Practices for protected health information.

Date: Name of Patient Date of Birth

Signature of Patient/ Personal Representative:_____

Documentation of Good Faith Effort to Obtain Written Acknowledgment:

I made a good faith effort to obtain the patient's written acknowledgment of our Notice of Privacy Practices for protected health information by (check all that apply):

- o Showing the patient the Notice of Privacy Practices posted in our office.
- o Giving the patient a copy of our Notice of Privacy Practices to read prior to receiving any treatment or service.
- o Giving the patient all necessary information to obtain our Notice of Privacy Practices on our website.
- o Asking the patient to sign this Acknowledgment form.
- o Other (explain in detail)_____

I was unable to obtain the patient's written Acknowledgment because (check all that apply):

- o The patient refused to sign this form.
- o The patient would not sign the form because the patient said he/she did not understand the Notice.
- o Other
  (explain in detail)_____

Date:_____ Name of Office Personal: _____

ASSIGNMENT OF BENEFITS

Assignment of Benefits & Payment Responsibility to Peter S Halvorson, DC and These Hands Wellness, LLC dba Sound Body Integrative Medicine (referred to as "Providers")

Legal Assignment of Insurance Benefits: In exchange for and in connection with any and all of the service(s) provided to me ("Services") by Providers, I hereby Irrevocably assign to Providers all of my rights, benefits, privileges, protections, claims, and any interests of any kind whatsoever, without limitation, including, but without limitation, direct payment to Providers for the Services, appealing rights, rights to fiduciary duties, rights to sue, rights to payment, rights to penalties or interest, rights to plan documents, and rights to Information, notices, and disclosures from any source, (collectively "Rights") that I had, have or may have In the future pursuant to or in connection with any Insurance plan, health benefit plan; trust, fund, or any other source of payment, insurance, indemnity or health or medical coverage of any kind (collectively "Health Coverage"), such that I am hereby transferring all and retaining none of these Rights under any Health Coverage to which I am now, previously, or may be entitled to in the future. Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, I Instruct my applicable Insurance plan, health benefit plan, trust, fund, or any other source of payment, insurance, Indemnity, or health or medical coverage of any kind to please advise and disclose to Providers In writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment Is waived on any pending claims for benefits under the respective policies. I agree that, should the amount received be insufficient to cover the entire claim I will be responsible for payment of any coinsurance and/or deductible that remains unpaid by my health Insurance company, workman's compensation plan, and/or auto accident insurance; I will be responsible to Providers for payment of the entire invoice. 2. Denial of Claim: I understand that Providers will make every effort to obtain payment of all health care services or products provided by providers from my Insurance company. I agree that I will be jointly and severally financially responsible for any portion of the Providers invoice that Is not paid; I understand that I am responsible for any health insurance deductibles and co-payments; I hereby irrevocably assign the benefits payable for any services rendered by Providers to me and authorize Providers to submit a claim to any medical Insurance company that I may have for payment to Providers. 3. One Time Claim Submission: I understand that Providers will make every effort to obtain payment for all services and or products provided by workman's compensation plan and/or auto accident Insurance, Providers will look to me for payment of any Providers services and/or products supplied to me. I agree that I will be jointly and severally financially responsible for any portion of the claim, in whole and in part, that is not paid. 4. I certify that the Information given by Patient to Providers In applying for payment to my workman's compensation plan and/or auto accident Insurance or any other medical Insurance that I may have, is correct. I agree that if assigned insurance benefits owed to Providers by me are paid to me, I shall Immediately notify Providers of such, and immediately endorse benefits check to Providers. 5.Appointment as Authorized Representative And Right to Sue: I hereby designate Provider's as my duly authorized representative In connection with all matters arising from or relating to Services, Rights and Health Coverage, such that Providers completely and without reservation stands in my shoes and takes my place for all purposes, and is granted absolute power and legal authority to do, seek, claim, appeal or obtain anything that I would have been entitled to do, seek, claim, appeal, or obtain In my own capacity pursuant to or in connection with the Services, Rights or Health Coverage, In any appeal, review, grievance, or any other process, procedure or entitlement under any Health Coverage. 6. Agreement to Cooperate: In addition, I hereby agree to personally cooperate with, and take all steps necessary, required or reasonably requested by, and Health Coverage, to effectuate, perfect, confirm or validate my assignment and/or authorization of Providers as my authorized representative, and I promise to assist and cooperate with Providers as a needed or reasonably requested by Providers In connection with any action In any forum, whether legal, formal or informal, without limitation, commenced or maintained by Providers in connection with the Services or relating to any Rights provided under Health Coverage. I understand that, In the event I don't fulfill any of the above obligations, I will remain personally liable for payment of the Services to the extent of the law.

By signing below, I acknowledge my authorization of treatment and receipt of all documentation in accordance with my treatment.

_____

Signature of Patient or Responsible Party

_____ _____

Printed Name of Patient or Responsible Party Date

Informed Consent to Treat

I hereby request and consent to the performance of chiropractic treatments (also known as chiropractic adjustments or chiropractic manipulative treatments) and any other associated procedures: physical examination, tests, physiotherapy, physical medicine, etc. on me by the doctor of chiropractic and/or other assistants and/or licensed practitioners.

Chiropractic examination and therapeutic procedures are considered safe and effective methods of care. Occasionally, however, complications may arise. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to, soreness, inflammation, soft tissue injury, dizziness, headaches, and temporary transient worsening of symptoms. More serious complications are extremely rare, but do occur. Some types of manipulation of the neck have been associated with injuries to arteries in the neck leading to or contributing to complications including stroke.

I do not expect the doctor to be able to anticipate all risks and complications. However, I wish to rely upon the doctor to exercise the best judgment during the course of the procedure(s), which the doctor feels at the time, based upon the facts then known, that are in my best interest. I also understand that I will be given an explanation of the procedures to be rendered, any alternatives available to me, relative risks for specific procedures, and any questions I have will be welcomed, appreciated, and answered to the best of the physician's ability.

I will receive the majority of my care under the supervision of the attending physician licensed to provide chiropractic care. However, there may be times that it will be clinically warranted to have the therapy provided by the attending massage therapist, limited to the scope of their license to provide care. By my signature, I give permission for my attending physician and the licensed massage therapist to discuss my care as needed in order to provide complete clinical care.

I understand that I play an important role in my own health care. Just as a patient can choose to discontinue care at any time, the doctor reserves the right to terminate a doctor-patient relationship for non-compliance and/or other reasons that affect the doctor-patient relationship. I also understand that there is no guarantee or warranty for specific care results.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Patient Signature or Guardian Signature Date

Financial Policy Agreement

Thank you for choosing Dr. Peter Halvorson, DC, as your Chiropractic healthcare provider. We are committed to giving you the best care possible, and we want you to completely understand our financial policies. There are always ongoing changes in the healthcare industry, and these changes may affect you in the services that are covered by your insurance carrier, or in services that are determined to be due and payable directly by you. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

1.Payment is due at time of service unless arrangements have been made in advance. Your financial responsibility to us will be your cash fee (if you do not have insurance coverage), co-payments and the amount your insurance company deems your responsibility such as deductibles and coinsurance, and denials for services not covered under your policy. We accept cash, checks, and credit cards. Please note if paying by check, all dishonored or returned checks are subject to a $30 charge to your account.
2. Keep in mind that your insurance policy is basically a contract between you and your insurance company and as the patient, you are ultimately responsible for the payment for services rendered. As a service to you, we file your insurance claim and the insurance company usually pays us directly. Please bring your insurance card and personal identification to each appointment.
3. Due to the multiplicity of insurance plans, we are unable to know each carrier's reimbursements and what procedures apply to your deductible and what does not. It is your responsibility to contact your insurance carrier directly for your specific benefits.
4.Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered" you will be responsible for the complete charge. Payment is due upon the receipt from our office.
5.The billing department will file your Medicare Claims. Medicare supplemental insurance is billed as a courtesy to you. If no payment is received from your supplemental insurance within sixty days of filing, the balance becomes your responsibility, and we will bill you.
6. Only after exhausting our internal attempts for payment, we will send a delinquent account to our collection agency or small claims court. Should this happen, you will be responsible for all costs incurred in collecting the account. You will be required to pay your account in full before scheduling another appointment if your account is in collections.
7. In the instance of prepayment for service, should care be discontinued at any point, a prorated refund will be issued. If financial arrangements were made, and care is discontinued at any time, payment is still due for services rendered.

Cancellation / Missed Appointment Policy

In order to serve you better, please provide us with at least 24 hours notice if you will be unable to attend your appointment. This advance notice allows us to provide other patients awaiting an appointment the opportunity to receive care.

Our office runs on-time. If you miss an appointment without providing at least 4 hours notice for Chiropractic and Functional Medicine appointments, you will be responsible for the below charges. We will do our best to accommodate you, however, arriving more than 5 minutes late to an appointment may be considered a missed appointment depending on availability.

- $30 – Chiropractic appointment
- $30 – Functional medicine Follow Up appointment
- $45 – Report of Findings appointment

I have read and understand the above FINANCIAL POLICY AGREEMENT and CANCELLATION/MISSED APPOINTMENT POLICY, and I agree to be bound by its terms.

Printed Name of Patient	Signature of Patient or Legal Guardian	Date