

Integrated Wellness Center

No Scent Policy

Due to SEVERE chemical allergies of patients and employees, we kindly ask that you do not enter our office if you are wearing anything scented. This includes patients, sales reps, and visitors.

We thank you for your cooperation.

I _____ acknowledge that Integrated Wellness Center reserves the right to reschedule my appointment if I arrive and am wearing anything that is noticeably scented including but not limited to clothing or hair.

Patient Name

Date

Patient Info

Last Name _____ First Name _____ MI _____ Preferred _____
 Address _____ City _____ State _____ Zip _____
 DOB _____ Sex _____ SSN _____ Marital Status _____ Religion _____
 Primary # _____ Home # _____ Cell # _____ Work # _____
 Primary Language _____ Ethnicity _____ Primary Care Physician _____
 Emergency Contact _____ Phone _____ Relationship _____
 Responsible Party (if pt is a minor) Last Name _____ First Name _____ MI _____
 Address _____ City _____ State _____ Zip _____
 DOB _____ Sex _____ SSN _____ Email _____
 Primary # _____ Home # _____ Cell # _____ Work # _____
 Primary Pharmacy Name/Phone _____ Cross Streets _____
 Secondary Pharmacy Name/Phone _____ Cross Streets _____

Primary Insurance

Insurance Company _____ ID # _____ Group # _____
 Name of Subscriber _____ DOB _____ SSN _____
 Address of Subscriber _____ Relationship _____
 Primary # _____ Home # _____ Cell # _____ Work # _____
 Employer _____

Secondary Insurance

Insurance Company _____ ID # _____ Group # _____
 Name of Subscriber _____ DOB _____ SSN _____

Contact Information

Please list the preferred phone/mail type of contact you would like Integrated Wellness Center to reach you to leave messages/or send information.

Preferred Phone # _____ Alternate Phone # _____

Mail to Address Above **OR** E-Mail Address _____

I give my authorization to Integrated Wellness Center to invite me to use the Patient Portal using the email above.

I give permission to Integrated Wellness Center to speak with and/or leave messages regarding my appointments and/or medical care to _____ Phone _____ Relationship _____

By signing below, I attest that the information provided above is true and accurate.

Signature of Patient or Guardian (if minor) _____ Date _____

YOUR INSURANCE CARD AND PHOTO ID ARE REQUIRED AT EACH VISIT

Integrated Wellness Center

CONSENT FOR TREATMENT/FINANCIAL POLICY

I authorize the staff at Integrated Wellness Center to provide medical evaluations, testing and/or treatment as necessary and advisable for my diagnosis and treatment.

As a courtesy, Integrated Wellness Center (IWC) will submit claims to primary and secondary insurance carriers for billable services only. I understand that there is no guarantee of reimbursement or payment from my insurance company. I authorize IWC to release any medical information necessary to process claims for insurance benefits and permit payment directly to IWC for services rendered. I have provided current insurance information and will continue to inform the office when I have an insurance or address change. I understand that IWC has a policy that you see a physician for the first time to establish care and this visit will NOT be coded as preventive and I am responsible for whatever my insurance does not cover; i.e. copay, coinsurance, deductible.

I understand that all copays and past due balances are due at the time of my visit. I understand there will be a \$25 fee assessed for any co-payments not made at the time of service. If I choose not to pay my balance or contact the office to make payment arrangements within 30 days, I understand a \$25 late payment fee will be applied to my account and my account will be turned over to an outside collection agency withing 90 days of no contact. I understand that if my balance is not paid, I agree to pay all cost incurred in connection with the collection cost and any reasonable Attorney fees. I understand that when lab work or other testing is ordered, I will receive and be financially responsible for a separate bill from the lab or designated entity.

When labs, x-rays or other tests are ordered by IWC, I understand that it is my responsibility to check with my insurance for authorized locations. IWC will not be responsible for any bill for tests done at the wrong location.

Integrated Wellness Center is a non-participating Medicare provider which means we have Opted out of Medicare and patients cannot submit their receipts to Medicare for reimbursement nor will IWC submit claims to Medicare. IWC does not accept Medicare, Medicare replacement plans, Tricare, Medicaid, Rocky Mountain Health Plans, and most HMO's. This list is not exhaustive of the insurance companies that we are not contracted with. If I have one of these plans, I understand that I am considered self-pay and payment is due at the time of service. IWC will not bill insurance if they are not in network. It is the patients' responsibility to verify eligibility and that we are in network with their plan.

Self-pay patients' payments are due at the time of service.

Payment for non-covered services is due at the time of service.

I understand that I will be charged a \$25 fee if I do not give 24 hours' notice to cancel my appointment.

There will be a \$30 fee for returned checked due to insufficient funds.

I consent to be contacted by telephone, regular mail or email regarding any matter related to my account.

I have read, understood and agree to the Consent for Treatment and Financial Policy listed above.

I understand that Integrated Wellness Center may use or disclose any Protected Health Information (PHI) necessary to carry out treatment, payment or healthcare operations as described in the Notice of Privacy Practices (HIPAA).

I acknowledge that I have been offered the Integrated Wellness Center's Notice of Privacy Practices (HIPAA) to review.

Signature _____ Date _____

Printed Name _____



I understand it is my responsibility to check for in-network laboratories with my insurance company. I am authorizing Integrated Wellness Center to send my labs to one of their designated labs unless I take my lab order to my in-network lab.

Printed Patient Name

Signed Patient/Guardian Name

Date

***Due to many of our staff and patients who have severe allergies, please avoid wearing anything scented the day of your visit.**

MALE - PATIENT IDENTIFICATION (Please Print)

Today's Date: _____

Marital Status: S M D Sep W If married, when? _____ If divorced, when? _____

Your Name: _____

Date of Birth: _____ Age: _____ Race: _____

Address: _____

Home Phone: _____ Work/Cell Phone: _____

Religion: _____ Practicing: YES NO Church/Synagogue: _____

Education: _____ years

Occupation: _____

Employer: _____

Referred By: _____

Primary Physician: _____

REASON FOR SEEKING CARE AT INTEGRATED WELLNESS CENTER:

ALLERGIES TO MEDICATIONS: _____

CURRENT MEDICATIONS (Please bring list of vitamins and supplements to your visit):

DRUG NAME	DOSAGE	REASON FOR TAKING
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

MEDICAL HISTORY (Check the appropriate column)

NO KNOWN MEDICAL PROBLEMS _____ ADOPTED _____

	You	Who in Your Family	Notes
ALLERGIES and/or Sensitivities 1. Environment: Mold/Pet 2. Food: Dairy/Fruit/Nuts/Wheat/Yeast 3. Testing done: _____ Date: _____			
Abuse: Domestic, Emotional, Sexual			
AIDS/HIV			
Alzheimer's Disease			
Alcoholism			
Blood Disorder			
Asthma: Adult, Childhood, Exercise			
Autoimmune Disease (Lupus)			
Birth Defects or Inherited Diseases			
Blood Clots in Lungs or Legs			
Blood Transfusion			
Breast Problems			
Cancer			
Celiac Disease/Sprue/Gluten Intolerance			
Depression/Anxiety			
Diabetes			
Heart Disease			
Hepatitis (type _____)			
High Blood Pressure			
High Cholesterol			
Kidney Problems			
Liver Disease			
Osteoporosis			
Seizures/Convulsions/Epilepsy			
Stomach/Bowel/Gallbladder Problems			
Stroke			
Thyroid Problems			
Tuberculosis			
Other Medical Problems			

HOSPITALIZATIONS/SURGERIES: Anything that required anesthesia

Month/Year	Illness or Operation and Reason	Complications

SOCIAL HISTORY

QUESTIONS	RESPONSE
Where did you grow up?	
How long have you been in Colorado?	
Where did you live before Colorado?	
What does your spouse do?	
Your occupation? Hours per week working?	
Rate your stress at work or home	HIGH MED LOW
Have you ever smoked? If yes, for how long? When did you quit?	
If you smoke now, how many packs per day?	
Do you drink alcohol?	
If you drink alcohol, what kind do you consume?	Beer Wine Whiskey
How much do you consume in a week?	
How much caffeine do you consume in a typical day?	1-2 cups 3-4 cups 5-6 cups
Do you take any street drugs?	
What type do you use?	
How much do you use in a day?	
Have you ever received individual or family counseling?	

NUTRITION/EXERCISE

GOAL WEIGHT _____

SPECIAL DIET _____

Do you consume food supplements?	
How many meals do you eat in a day?	1 2 3 4 5 6
In a year, how often do you diet?	Never 1-2 times 3-4 times 5+ times
Have you gained or lost weight recently?	___ Gained ___ Amount ___ Lost ___ Amount
Have you ever had an eating disorder? Is it resolved?	___ Anorexia ___ Bulimia ___ Pica ___ Yes ___ No
Number of times per week you exercise	1 time 2 times 3 + times
What type of exercise do you do?	___ Aerobics ___ Running ___ Walking ___ Bicycling ___ Other

Patient Name: _____ Date of Birth: ____/____/____

Male Review of Current Symptoms Within Last 30 Days (Check all that apply)

Constitutional	<input type="checkbox"/> Appetite change	<input type="checkbox"/> Binge eating	<input type="checkbox"/> Fatigue
	<input type="checkbox"/> Fever	<input type="checkbox"/> Hypoglycemic episodes	<input type="checkbox"/> Insomnia
	<input type="checkbox"/> Night sweats	<input type="checkbox"/> Sugar cravings	<input type="checkbox"/> Weight gain
Eyes	<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Dark circles under eyes	<input type="checkbox"/> Dry eyes
	<input type="checkbox"/> Eye irritation	<input type="checkbox"/> Eye pain	<input type="checkbox"/> Spots in vision
	<input type="checkbox"/> Sticky eyelids	<input type="checkbox"/> Swollen eyelids	<input type="checkbox"/> Watery eyelids
ENT	<input type="checkbox"/> Nasal obstruction	<input type="checkbox"/> Postnasal drainage	<input type="checkbox"/> Hearing loss
	<input type="checkbox"/> Sneezing attacks	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Ringing in ears
	<input type="checkbox"/> Bad breath	<input type="checkbox"/> Swollen tongue	<input type="checkbox"/> Itchy ears
	<input type="checkbox"/> Mouth lesions	<input type="checkbox"/> Ear drainage	<input type="checkbox"/> Vertigo
	<input type="checkbox"/> Dry mouth	<input type="checkbox"/> Ear pain	<input type="checkbox"/> Sore throat
Respiratory	<input type="checkbox"/> Asthma	<input type="checkbox"/> Cough	<input type="checkbox"/> Sputum production
	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Sleep apnea	
	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Difficulty breathing	
Cardiovascular	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Irregular or skipped heartbeat	
	<input type="checkbox"/> Leg ulcers	<input type="checkbox"/> Rapid or pounding heartbeat	
Gastrointestinal	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Belching or passing gas (x5 or greater)	<input type="checkbox"/> Vomiting
	<input type="checkbox"/> Bloating	<input type="checkbox"/> Bloody stools	<input type="checkbox"/> Black stools
	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Food intolerance	<input type="checkbox"/> Constipation
	<input type="checkbox"/> Reflux/Heartburn	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Nausea
Musculoskeletal	<input type="checkbox"/> Back pain	<input type="checkbox"/> Joint pain	<input type="checkbox"/> Joint swelling
	<input type="checkbox"/> Leg pain at night	<input type="checkbox"/> Muscle aches	<input type="checkbox"/> Muscle cramps
	<input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Neck pain	<input type="checkbox"/> Numbness or tingling
	<input type="checkbox"/> Limited range of motion	<input type="checkbox"/> Stiffness	

Psychiatric	<input type="checkbox"/> Anger or aggressive	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression
	<input type="checkbox"/> Irritability	<input type="checkbox"/> Mood swings	<input type="checkbox"/> Panic attacks
	<input type="checkbox"/> Tearfulness	<input type="checkbox"/> Tension	
Integumentary	<input type="checkbox"/> Acne	<input type="checkbox"/> Dry skin	<input type="checkbox"/> Hair loss
	<input type="checkbox"/> Hives	<input type="checkbox"/> Rash	<input type="checkbox"/> Toenail fungus
	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Eczema	
Neurologic	<input type="checkbox"/> Confusion	<input type="checkbox"/> Decreased concentration	<input type="checkbox"/> Difficulty making decisions
	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Fainting spells	<input type="checkbox"/> Headaches
	<input type="checkbox"/> Learning disabilities	<input type="checkbox"/> Memory problems	<input type="checkbox"/> Numbness
	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Poor balance	<input type="checkbox"/> Poor coordination
	<input type="checkbox"/> Slurred speech	<input type="checkbox"/> Tremors	
Endocrine	<input type="checkbox"/> Cold intolerance	<input type="checkbox"/> Decreased sex drive	
	<input type="checkbox"/> Heat intolerance	<input type="checkbox"/> Frequent thirst	
Heme-Lymph	<input type="checkbox"/> Bleeding tendencies	<input type="checkbox"/> Frequent illness	<input type="checkbox"/> Swollen lymph nodes
Allergic- Immunologic	<input type="checkbox"/> Eczema	<input type="checkbox"/> Hives	<input type="checkbox"/> Seasonal allergies
Genitourinary	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Urinary urgency	<input type="checkbox"/> Sexual dysfunction
	<input type="checkbox"/> Painful urination	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Genital itch
	<input type="checkbox"/> Urinary frequency	<input type="checkbox"/> Penile discharge	<input type="checkbox"/> Painful sex

NAME _____ DATE _____

MALE YEAST QUESTIONS: Please circle, check, or write in as detailed as possible

1. Is there a family history of alcoholism (parents, uncles, aunts, siblings, etc.)? YES NO
If so, who? _____
2. Have you ever had personal history of alcohol problems? YES NO
If so, when and how long? _____
3. When was the most recent time that you were on antibiotics for whatever the reason?
This year, last year... ? _____ Reason: _____
4. Were you born prematurely? YES NO
If so, how much earlier? _____
5. Did you have frequent strep throats or ear infections that required antibiotics in childhood?
YES NO
If so, until what age? _____ About how many times? _____
6. Have you ever been diagnosed with infectious Mono or Epstein Barr Virus? YES NO
If so, when? _____
7. Have you ever taken daily antibiotics for acne? YES NO
If so, when? _____ For how long? _____
8. Have you ever had antibiotics for bladder infections (cystitis, UTI's) in your life? YES NO
If so, how many times? 0-5 _____, 6-10 _____, 11-15 _____ too numerous to count _____
9. Have you ever taken antibiotics for sinus infections? YES NO
If so, how many times? 0-5 _____, 6-10 _____, 11-15 _____ too numerous to count _____
10. Have you ever taken antibiotics for bronchitis or pneumonia? YES NO
If so, how many times? 0-5 _____, 6-10 _____, 11-15 _____ too numerous to count _____
11. Have you ever taken antibiotics for dental work? YES NO
If so, how many times? 0-5 _____, 6-10 _____, 11-15 _____ too numerous to count _____
12. Have you ever received IV antibiotics? YES NO
If so, when? _____ Reason: _____
13. Have you ever taken any steroids in your life? YES NO
If so, how many times each? Oral: _____ Injections (shots): _____
14. Have you ever had finger or toenail fungus? YES NO
If so, when? _____ Treated with: _____
15. Have you ever had jock itch? YES NO
If so, when? _____ Treated with: _____
16. Do you have sugar cravings? YES NO
17. Have you ever been treated for yeast overgrowth or candidiasis? YES NO
If so, when? _____ By whom? _____
18. Have you ever lived or worked in a moldy environment? YES NO
If so, for how long? _____ When? _____