center for vital health, inc.

NEW PATIENT FORMS

Thank you for making an appointment with Center for Vital Health, Inc.! We appreciate your confidence in our ability to help address your health concerns.

NEW PATIENT FORMS

For your convenience, new patient forms have been provided online to give you the ability to print and fill them out in advance of your appointment, in the comfort of your own home. Please bring your completed forms with you at the time of your visit. These forms are also available in our office. Should you choose to wait to complete them there, please allow an extra 15-20 minutes prior to your scheduled appointment to do so.

BRING YOUR INSURANCE CARD, PHOTO ID & CO-PAY

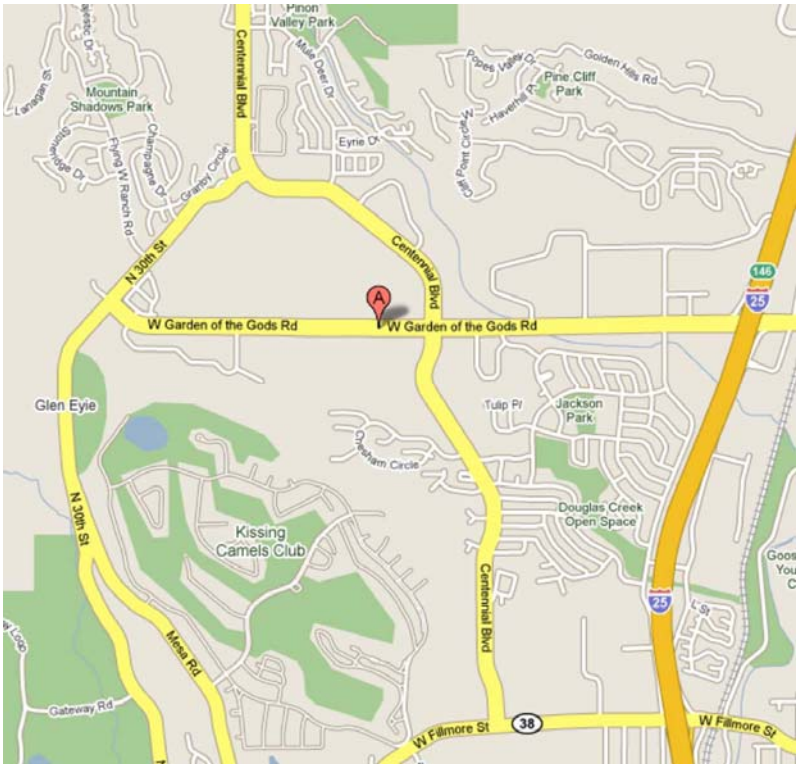
At the time of your appointment we will need to make a copy of both your insurance card and a Driver's License or Photo ID. Any deductible/co-payment will be due at the time of services. *If we are not contracted with your insurance company, we recommend you contact the insurance company regarding "out-of-network" benefits and we will provide you with all documents necessary to attempt reimbursement from your insurance carrier.*

DIRECTIONS TO OUR OFFICE

Dr. Mary Harrow, President
CENTER FOR VITAL HEALTH, INC.
1485 Garden of the Gods Road
Suite 172
Colorado Springs, CO 80907
719.531.6778

From I-25: Exit West on Garden of the Gods Road, make a U-turn at the second left after Centennial (you will then be heading East). Turn right right into our parking lot. Our office is located on the West side of the brown stucco building with black glass. You will see Farmer's Insurance Company in the front of the building.

You may access our building via Intel's parking lot if you turn before entering our parking lot.



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PATIENT INFORMATION

Patient's Name _____ Spouse's or Parent's Name _____
First Last (MI)

Patient's Mailing Address _____
Street/PO Box City State Zip

Patient's Home Phone ( ) _____ Work Phone ( ) _____ Ext. _____

Patient's SSN _____ Patient's Birth Date _____

Patient's Sex: Male Female Patient's Marital Status: S M D W Separated

Patient's Employer _____ Location _____

Emergency Contact _____ Phone # _____

How did you hear about us? _____

INSURANCE INFORMATION

Please have your insurance card and driver's license available for us to photocopy

Primary Insurance Company _____

Policy/Group # _____ ID# _____

Insured's Name _____
First Last (MI)

Patient's Relationship to the Insured _____Insured's Employer _____

Insured's Mailing Address _____
Street/PO Box City State Zip

Insured's Home Phone ( ) _____ Work Phone ( ) _____ Ext. _____

Insured's SSN _____ Insured's Birth Date _____

Amount of Yearly Deductible _____ Have you met your deductible this year? Yes No

Do you have a Co-Pay? Yes No Amount _____ Person responsible for your bill _____

Secondary Insurance Company _____

Policy/Group # _____ ID# _____

I certify that all information given by me is correct. I understand I am financially responsible for any balance unpaid by my insurance. I authorize Center for Vital Health, Inc. to release any medical or incidental information that may be necessary for either medical care or in processing application for financial benefit. I request that all payments for authorized benefits on my behalf are made directly to Center for Vital Health, Inc.

X_____ Date _____
Signature

X_____ Date _____
Witness

center for vital health, inc.

FINANCIAL POLICY AND PATIENT AGREEMENT

The following is the practice's financial policy, which we require that you read and sign prior to treatment:

Payment is due at the time of service. Acceptable forms of payment include Cash, Checks, MasterCard, Visa and Discover Card. Payment not made at the time of service is past due when the patient leaves the facility. There is a $40.00 returned check fee.

Regarding insurance, the patient must recognize that they are responsible to pay the amount for all services unless the practice has an agreement with the patient's insurance carrier for alternative payments. Complete insurance information, including referrals from other providers, for primary and secondary insurance coverage(s) must be made available to the practice, including all identification and benefit cards/documents for accurate filing of claims. The patient agrees that if the insurance company denies coverage for any reason, that the patient is responsible for immediate payment of the full amount of the bill. If the insurance company fails to remit payment within 90 days of filing, the bill will become the patient's responsibility.

Our policy on accepting insurance payments varies based on the type of insurance as follows:

INDEMNITY-TYPE INSURANCE

Insurance payments received by the practice will be applied to the patient's account and the patient agrees to pay the balance. We will estimate the patient-responsible portion of the bill at the time of service, and payment of that amount is expected at the time of service. **Co-Payments are due at the time of service and are collected before service is provided.**

HMOs and PPOs

If the practice has an agreement with the patient's insurance carrier; we will accept payment from the carrier for services covered by the patient's benefit plan. **Co-Payments are due at the time of service and are collected before service is provided.** Payment for prolotherapy is due at the time of service, as it is not covered by insurance companies/benefit plans, and there is no *procedure code* associated with the treatment. For all other services not covered by the patient's benefit plan, payment is due at the time of service.

By this agreement, I also authorize treatment and release of medical information relating to my care to my insurance company(ies), and authorize insurance payments to be made directly to the practice for the medical and/or surgical care provided under my insurance agreement and otherwise payable to me.

I understand that delinquent accounts are subject to finance and/or rebilling charges, and that I will be responsible for any Collection Fees and Legal Fees.

There will be a $50.00 fee, which is not covered by insurance, if I fail to call and cancel a scheduled office appointment 24 hours in advance (inclement weather will be excluded).

There will be a 70% fee, which is not covered by insurance, if I fail to call and cancel a scheduled injection appointment 24 hours in advance (inclement weather will be excluded).

_____ _____

Patient's Printed Name Patient's Signature (parent/guardian if under 18)

Patient's Social Security # _____ Date _____

HEALTH HISTORY

Name _____ Date of Birth _____ Today's Date _____

Occupation _____Age_____ Height _____ Gender _____ Number of Children _____

Marital Status: ❒ Single ❒ Partner ❒ Married ❒ Separated ❒ Divorced ❒ Widow(er)

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Reason for office visit Date began

_____ _____

_____ _____

Date of last physical exam _____ Practitioner name and phone number _____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis)

_____

Outcome _____

What types of therapy have you tried for this problem(s)?

❒ Diet modification ❒ Fasting ❒ Vitamin/mineral ❒ Herbs ❒ Homeopathy ❒ Chiropractic ❒ Acupuncture ❒ Conventional drugs

❒ Other _____

List current health problems for which you are being treated: _____

_____

Current medications (prescription or over-the-counter): _____

_____

Major hospitalizations, surgeries, injuries: Please list all procedures, complications (if any) and dates:

Year	Operations, illness, injury	Outcome
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): _____

Do you consider yourself: ❒ underweight ❒ overweight ❒ just right Your weight today _____

❒ Unintentional weight loss or gain of 10 pounds or more in the last three months

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, farmer, miner)? _____

❒ Corrective lenses ❒ Dentures ❒ Hearing Aid ❒ Medical devices/prosthetics/implants, describe: _____

Do you experience any of these general symptoms EVERYDAY?

❒ Debilitating fatigue	❒ Shortness of breath	❒ Insomnia	❒ Constipation	❒ Chronic pain/inflammation
❒ Depression	❒ Panic attacks	❒ Nausea	❒ Fecal incontinence	❒ Bleeding
❒ Disinterest in sex	❒ Headaches	❒ Vomiting	❒ Urinary incontinence	❒ Discharge
❒ Disinterest in eating	❒ Dizziness	❒ Diarrhea	❒ Low grade fever	❒ Itching/rash

Medical History

- ☐ Arthritis
- ☐ Allergies/hay fever
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Autoimmune disease
- ☐ Blood pressure problems
- ☐ Bronchitis
- ☐ Cancer _____
- ☐ Chronic fatigue syndrome
- ☐ Carpal tunnel syndrome
- ☐ Cholesterol, elevated
- ☐ Circulatory problems
- ☐ Colitis
- ☐ Dental problems
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticular disease
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Eyes, ears, nose, throat problems
- ☐ Environmental sensitivities
- ☐ Fibromyalgia
- ☐ Food intolerance
- ☐ Gastroesophogeal reflux disease
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart disease
- ☐ Infection, chronic
- ☐ Inflammatory bowel disease
- ☐ Irritable bowel syndrome
- ☐ Kidney or bladder disease
- ☐ Learning disabilities
- ☐ Liver or gallbladder disease (stones)
- ☐ Mental illness
- ☐ Mental retardation
- ☐ Migraine headaches
- ☐ Neurological problems (Parkinson's, paralysis)
- ☐ Sinus problems
- ☐ Stroke
- ☐ Thyroid trouble
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Sexually transmitted disease
- ☐ Seasonal affective disorder
- ☐ Skin problems
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Urinary tract infection
- ☐ Varicose veins

Other _____
_____

Medical (Men)

- ☐ BPH
- ☐ Prostate cancer
- ☐ Decreased sex drive
- ☐ Infertility
- ☐ STD

Other _____
_____

Medical (Women)

- ☐ Menstrual irregularities
- ☐ Endometriosis
- ☐ Infertility
- ☐ Fibrocystic breasts
- ☐ Fibroids/ovarian cysts
- ☐ PMS
- ☐ Breast cancer
- ☐ Pelvic inflammatory disease
- ☐ Vaginal infections
- ☐ Decreased sex drive
- ☐ STD

Other _____
Age of first period _____
Date of last gynecological exam __
Mammogram ❒+ ❒ -
PAP ❒+ ❒ -
Form of birth control _____
Number of children _____
Number of pregnancies _____

- ☐ C-section _____
- ☐ Surgical menopause
- ☐ Menopause

Date of last menstrual cycle _____
Length of cycle _____ days
Interval of time between cycles ___ days
Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty)? _____

Family Health History (parents and siblings)

- ☐ Arthritis, rheumatoid
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Cancer _____
- ☐ Depression
- ☐ Diabetes
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Heart disease
- ☐ Infertility
- ☐ Learning disabilities
- ☐ Mental illness
- ☐ Mental retardation
- ☐ Migraine headaches
- ☐ Neurological disorders (Parkinson's, paralysis)
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Suicide

Other _____

Health Habits

- ☐ Tobacco:

Cigarettes: #/day _____
Cigars: #/day _____

- ☐ Alcohol:

Wine: # glasses/d or wk _____
Liquor: #ounces/d or wk _____
Beer: #glasses/d or wk _____

- ☐ Caffeine:

Coffee: #6 oz cups/d_____
Tea: #6 oz cups/d _____
Soda w/caffeine: #cans/d _____
Other sources _____

- ☐ Water: #glasses/d _____

Exercise

- ☐ 5-7 days per week
- ☐ 3-4 days per week
- ☐ 1-2 days per week
- ☐ 45 minutes or more duration per workout
- ☐ 30-45 minutes duration per workout
- ☐ Less than 30 minutes
- ☐ Walk
- ☐ Run, jog, bike, jump rope
- ☐ Weight lift
- ☐ Swim
- ☐ Box
- ☐ Yoga

Nutrition & Diet

- ☐ Mixed food diet (animal and vegetable sources)
- ☐ Vegetarian
- ☐ Vegan
- ☐ Salt restriction
- ☐ Fat restriction
- ☐ Starch/carbohydrate restriction
- ☐ The Zone Diet
- ☐ Total calorie restriction
- ☐ Specific food restrictions:

❒dairy ❒wheat ❒eggs
❒soy ❒corn ❒all gluten
Other _____

Food Frequency

Servings per day:
Fruits (citrus, melons, etc.) _____
Dark green or deep yellow/orange vegetables _____
Grains (unprocessed) _____
Beans, peas, legumes _____
Dairy, eggs _____
Meat, poultry, fish _____

Eating Habits

- ☐ Skip breakfast
- ☐ Two meals/day
- ☐ One meal/day
- ☐ Graze (small frequent meals)
- ☐ Food rotation
- ☐ Eat constantly - hungry or not
- ☐ Generally eat on the run
- ☐ Add salt to food

Current Supplements

- ☐ Multivitamin/mineral
- ☐ Vitamin C
- ☐ Vitamin E
- ☐ EPA/DHA
- ☐ Evening Primrose/GLA
- ☐ Calcium, source_____
- ☐ Magnesium
- ☐ Zinc
- ☐ Minerals, describe _____
- ☐ Friendly flora (acidophilus)
- ☐ Digestive enzymes
- ☐ Amino acids
- ☐ CoQ10
- ☐ Antioxidants (e.g. lutein, resveritrol, etc.)
- ☐ Herbs – teas
- ☐ Herbs – extracts
- ☐ Chinese herbs
- ☐ Ayurvedic herbs
- ☐ Homeopathy
- ☐ Bach flowers
- ☐ Protein shakes
- ☐ Superfoods (e.g., bee pollen, phytonutrient blends)
- ☐ Liquid meals (e.g., Ensure)

Other_____

Would you like to:

- ☐ Have more energy
- ☐ Be stronger
- ☐ Have more endurance
- ☐ Increase your sex drive
- ☐ Be thinner
- ☐ Be more muscular
- ☐ Improve your complexion
- ☐ Have stronger nails
- ☐ Have healthier hair
- ☐ Be less moody
- ☐ Be less depressed
- ☐ Be less indecisive
- ☐ Feel more motivated
- ☐ Be more organized
- ☐ Think more clearly and be more focused
- ☐ Improve memory
- ☐ Do better on tests in school
- ☐ Not be dependent on over-the-counter medications like aspirin, Tylenol, Benadryl, sleeping aids, etc.
- ☐ Stop using laxatives or stool softeners
- ☐ Be free of pain
- ☐ Sleep better
- ☐ Have agreeable breath
- ☐ Have agreeable body odor
- ☐ Have stronger teeth
- ☐ Get less colds and flus
- ☐ Get rid of your allergies
- ☐ Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)

center for vital health, inc.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Effective Date of this Notice: 04/14/2003

With my consent, Center for Vital Health, Inc. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Center for Vital Health, Inc.'s *Notice of Privacy Practices* for a more complete description of such uses and disclosures.

I have the right to review the *Notice of Privacy Practices* prior to signing this consent. Center for Vital Health, Inc. reserves the right to revise the *Notice of Privacy Practices* anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Center for Vital Health, Inc. at Center for Vital Health, Inc., 1485 Garden of the Gods Road, Suite 172, Colorado Springs, CO 80907.

With my consent, Center for Vital Health, Inc. may mail to my home, or other designated location, any item that assists the practice in carrying out TPO, such as appointment reminder cards and patient statements; as long as they are marked 'Personal and Confidential.'

I have the right to request that Center for Vital Health, Inc. restrict how the practice uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Center for Vital Health, Inc.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing, except to the extent that the practice had already made disclosures in reliance upon my prior consent. If I do not sign this consent, Center for Vital Health, Inc. may decline to provide treatment to me.

_____ _____

Date Patient's Signature (parent/legal guardian if under 18)

_____

Patient's Printed Name

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score