



## 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

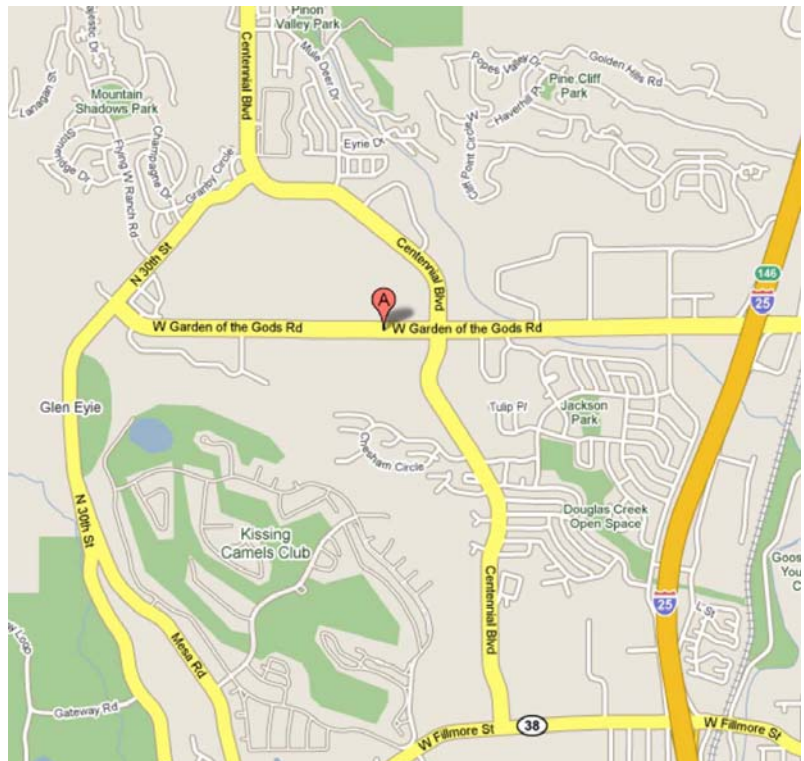
At the time of your appointment we will need to make a copy of both your insurance card and a Driver's License or Photo ID. Any deductible/co-payment will be due at the time of services. *If we are not contracted with your insurance company, we recommend you contact the insurance company regarding "out-of-network"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



# center for vital health, inc.



## 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? \_\_\_\_\_

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## 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# \_\_\_\_\_

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*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



## 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?**

<input type="checkbox"/> Debilitating fatigue	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Constipation	<input type="checkbox"/> Chronic pain/inflammation
<input type="checkbox"/> Depression	<input type="checkbox"/> Panic attacks	<input type="checkbox"/> Nausea	<input type="checkbox"/> Fecal incontinence	<input type="checkbox"/> Bleeding
<input type="checkbox"/> Disinterest in sex	<input type="checkbox"/> Headaches	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Urinary incontinence	<input type="checkbox"/> Discharge
<input type="checkbox"/> Disinterest in eating	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Low grade fever	<input type="checkbox"/> 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
- Gastroesophageal 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.)



**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