



INTEGRATIVE HEALTH, INC. WELLNESS CENTER

EXPERTS PROVIDING NATURAL HEALTHCARE

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Phone: 303-577-9977 Fax: 303-694-4341

www.integrativehealthinc.com

Patient Intake Information

Please fill out the following information prior to your appointment.

Patient Information

Name: _____ SSN: _____ Today's Date: _____
(if using medical insurance with payment)

Phone: (____) _____ Email Address: _____

Address: _____
Street City Zip

Emergency Contact Name: _____ Contact's Phone: (____) _____

Your Date for Birth: _____ Gender: Male | Female
Month Day Year (please circle)

Are you currently under medical care? Yes | No
(please circle)

Place of Occupation: _____

Insurance Information

Medical Insurance: If you are using medical insurance today, please clip your card to the clipboard so we may make a photocopy for our records.

Auto Insurance: if you plan on billing under auto insurance due to a motor vehicle accident or Workman's Comp, please bring this to the receptionist's attention.

Consent for Purpose of Treatment and Healthcare Operations

In this document, "I" and "my" refer to the patient/client

I consent to the use or disclosure of my protected health information by Integrative Health for the purpose of analyzing, diagnosing and providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that analysis, diagnosis or treatment of me by Integrative Health may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice, Integrative Health is not required to agree to the restrictions that I may request. However, if Integrative Health agrees to a restriction that I request, the restriction is binding on Integrative Health. I have the right to revoke this consent, in writing at any time, except to the extent that Integrative Health has taken action in reliance on the consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, health plan, my employer or a health care clearing house. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I may obtain a copy of the Notice of Privacy Practices of Integrative Health and understand that I have the right to read that Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Integrative Health, as well as my rights and duties of Integrative Health with respect to my protected health information. The Notice of Privacy Practices for Integrative Health is located in our waiting room.

Printed Name of Patient

Signature of Patient or Personal Representative

Date

Description of Personal Representatives Authority

Survey

Your feedback directly impacts the quality of service we provide. Please take a moment after your treatment to fill out this survey.

Name (optional): _____ Phone: _____

1. Overall, how was your visit? (please circle) Extremely Enjoyable Average Unacceptable

2. What type of treatment did you receive on this visit? (massage, acupuncture, etc.)

3. Did you enjoy the treatment? (please circle) Extremely Enjoyable Average Unacceptable

4. Was this your first visit? (please circle) Yes | No

If no, roughly how many times have you been here? 2-5 | 10-20 | other: _____

If no, what treatments do you usually get? _____

5. How did you hear about us or the treatment you came in for today?

- | | |
|--|---|
| <input type="checkbox"/> Website/Search Engine | <input type="checkbox"/> Referral by Friend: _____ |
| <input type="checkbox"/> Newspaper | <input type="checkbox"/> Referral by Medical Dr.: _____ |
| <input type="checkbox"/> Mailing | <input type="checkbox"/> Referral by Other: _____ |
| <input type="checkbox"/> Signage in the Reception Area | <input type="checkbox"/> Was Given a Gift Certificate |
| <input type="checkbox"/> Service performed at your workplace | Service: _____ Workplace: _____ |
| <input type="checkbox"/> Other: _____ | |

6. We offer seminars on weekends and some week nights featuring mental health, nutrition, exercise, etc. Are there any seminars (listed above or not) that you would be interested in attending? Yes | No

If yes, please note: _____

7. We occasionally send out emails that include discounts, seminar information, and upcoming events. In the future, we plan to send email reminders for appointments. If you are interested in receiving such emails, please provide your email address below. By providing your email address, you are giving us permission to send you email as described above. *Your email is safe with us. We will NOT give your email address to any third parties.*

Email: _____