Dr. Akers Natural Health Clinic
17601 S. Golden Rd., Suite # 2, Golden, CO 80401
303-969-0884

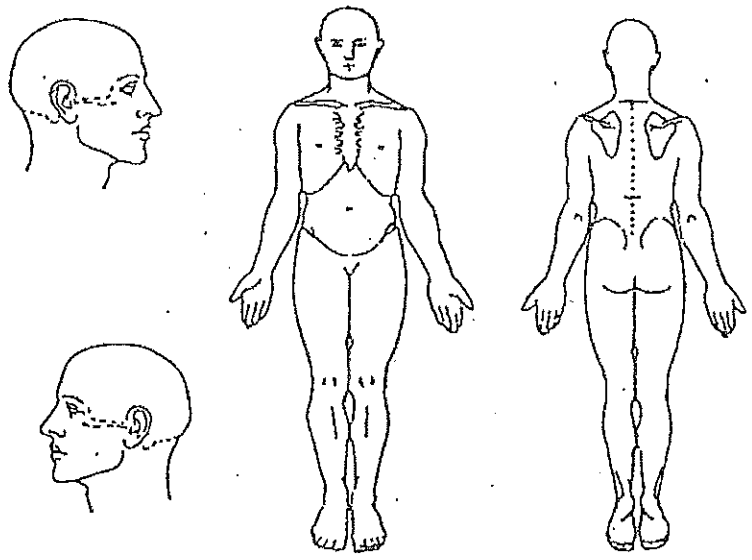
Full Name:_____ Date:_____
Date of Birth:_____ Age:_____ Social Security #:_____
Home Phone:_____ Cell phone:_____ E-mail:_____
Male ☐ Female ☐ Marital Status: M ☐ S ☐ W ☐ D ☐ Nickname:_____
Do you have children? Y/N If yes, how many and what ages?_____
Mailing Address:_____
City:_____ State:_____ Zip:_____
Occupation:_____ Employer:_____ Phone:_____
Employer Adress:_____
City:_____ State:_____ Zip:_____
Name of Spouse:_____ Spouse's phone:_____
Emergency Contact Name Other Than Spouse/relation:_____
Emergency Number:_____ Emergency Address:_____
City:_____ State:_____ Zip:_____
Referred By:_____

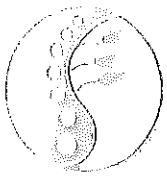
Please state your major health concerns:

		Constant	Comes & Goes	Getting Worse	Getting Better
1. _____	Date appeared:_____	☐	☐	☐	☐
2. _____	Date appeared:_____	☐	☐	☐	☐
3. _____	Date appeared:_____	☐	☐	☐	☐

Are your present concerns due to an injury? Y/N
If yes, what kind of accident: on the job ☐ auto accident ☐ personal injury ☐ other ☐ _____
Have you made a report of your accident? Y/N
If yes, to whom: employer ☐ insurance company ☐ other ☐ _____
Have you retained an attorney? Y/N
These health concerns are interfering with:
work ☐ sleep ☐ daily routine ☐ other ☐
What have you tried that makes you feel better:
_____
What have you found that makes it worse:
_____
List any diagnosis/treatment you have received for your present condition:_____
_____
Are you currently under the care of another Health Care Practitioner for this condition? Y/N
If yes, who?_____
Is there anything else you would like/need to address?_____
_____
_____
_____

PLEASE MARK YOUR AREAS OF CONCERN





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Health History

Women only - Please circle any conditions you have:

Abnormal pap smear	extreme menstrual pain	bleeding between periods	nipple discharge
breast lump	hot flashes	painful intercourse	other _____

Date of last menstrual cycle: _____ Date of last pap smear: _____ Date of last mammogram: _____
Are you pregnant? Y/N Number of children: _____ Have you miscarried? Y/N

Men only - Please circle any conditions you have:
Breast lump erection difficulties lump in testicles penis discharge sores on penis other _____

Please circle any health concerns **(past or current)**:

Back problems	skin disorder/sensitivity	abdominal pain	neurological problems
neck problems	seizures	high/low blood pressure	excessive hunger
high blood pressure	joint pain	muscular aches/pain	poor appetite

other _____

Please circle any conditions you have:

alcoholism	anemia	arthritis	eczema	thyroid disease	malaria
diabetes	diphtheria	herpes	emphysema	epilepsy	goiter
heart disease	influenza	arteriosclerosis	hepatitis	HIV	pneumonia
mononucleosis	cancer	multiple sclerosis	mumps	pleurisy	polio
rheumatic fever	scarlet fever	typhoid fever	ulcers	hemorrhoids	whooping cough
varicose veins	stroke	tuberculosis	cold sores	gout	bleeding gums
venereal disease	measles	auto immune disease	other _____		

Are you wearing: ☐ heel lift ☐ arch supports ☐ other orthotic supports
Are you currently taking: ☐ pain killers ☐ muscle relaxers ☐ blood pressure meds. ☐ antidepressants
☐ birth control ☐ tums
List any current medications: _____
Are you currently taking: ☐ multi vitamins ☐ individual vitamins ☐ individual minerals ☐ herbs
☐ homeopathics ☐ other _____
List any surgeries and the year: _____
Do you have any surgical implants: ☐ spinal fusions ☐ joint replacement ☐ pacemaker ☐ other (explain)
_____
Have you ever been in an auto accident or other serious injury? Y/N Were you knocked unconscious? Y/N
If yes, please explain: _____
Have you been hospitalized other than surgery? Y/N If yes, please explain: _____
_____
Do you have allergies to: ☐ drugs ☐ food ☐ environment
Habits: ☐ smoking packs/day____ ☐ alcohol drinks/day____ ☐ coffee cups/day____ ☐ other _____
Exercise: ☐ none ☐ moderate ☐ daily Type: _____

Family History:	Diabetes	Heart	Kidney	Cancer	Back
Mother	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Brother No.___	☐	☐	☐	☐	☐
Sister No.___	☐	☐	☐	☐	☐

Have you previosly been seen by a chiropractor? Y/N If yes, please explain: _____
Have you previosly been seen by a acupuncurist? Y/N If yes, please explain: _____

Signature _____ Date: _____

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Name:_____ Date:_____

Please rate each of the following symptoms based upon your experience over the past 30 days.

Point scale: 0 = Never or almost never have this symptom
1 = Occasionally have symptom, effect is **NOT** severe
2 = Occasionally have symptom effect **IS** severe
3 = Frequently have symptom, effect **NOT** severe
4 = Frequently have symptom, effect **IS** severe

Head
_____ headaches
_____ faintness
_____ dizziness
_____ insomnia
_____ TOTAL

Eyes
_____ watery or itchy eyes
_____ swollen/reddened/sticky eyelids
_____ bags or dark circles under eyes
_____ blurred or tunnel vision
_____ TOTAL

Ears
_____ itchy ears
_____ earaches/infection
_____ drainage from ear
_____ ringing in ears/hearing loss
_____ TOTAL

Nose
_____ stuffy nose
_____ sinus problems
_____ hay fever
_____ sneezing attacks
_____ excessive mucus formation
_____ TOTAL

Throat
_____ chronic coughing
_____ gagging/frequent need to clear throat
_____ sore throat/hoarseness/loss of voice
_____ swollen/discolored tongue/gums/lips
_____ TOTAL

Skin
_____ acne
_____ hives/rashes/dry skin
_____ hair loss
_____ flushing/hot flashes
_____ excessive sweating
_____ TOTAL

Heart
_____ irregular/skipped heartbeat
_____ rapid/pounding heartbeat
_____ chest pain
_____ shortness of breath
_____ swollen ankles
_____ left arm pain
_____ TOTAL

Lungs
_____ chest congestion
_____ asthma/bronchitis
_____ shortness of breath
_____ difficulty breathing
_____ TOTAL

Energy
_____ fatigue/sluggishness
_____ apathy/lethargy
_____ hyperactivity
_____ restlessness
_____ TOTAL

Emotion
_____ mood swings
_____ anxiety/fear/nervousness
_____ anger/irritability/aggressive
_____ depression
_____ TOTAL

Joints
_____ pain/aches in joints
_____ arthritis
_____ stiffness/limited movement
_____ pain/aches in muscle
_____ feeling of weakness/tiredness
_____ TOTAL

Weight
_____ binge eating/drinking
_____ craving certain foods
_____ excessive weight gain/loss
_____ water retention
_____ TOTAL

Digestive
_____ nausea vomiting
_____ diarrhea/constipation
_____ bloating feeling
_____ belching/passing gas
_____ heartburn
_____ TOTAL

Mind
_____ poor memory
_____ poor concentration
_____ difficulty making decisions
_____ slurred speech
_____ learning disabilities
_____ confusion
_____ TOTAL

Grand Total _____

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Thank you for choosing our clinic, as we are committed to the success of your treatment and care. Please understand that payment of your bill is part of this treatment and care. We strive to keep our policies as simple and fair as possible. **All patients must complete the entire intake package and sign in the appropriate area.** We believe that a good relationship is based on understanding and open communications. For your convenience, we have answered a variety of commonly asked financial policy questions below. If you need further information about any of these policies, please ask to speak with our Office Manager.

HOW MAY I PAY?

We accept payment by cash, check, VISA, MasterCard and Discover. You are expected to make payment in full upon services rendered unless auto injury case.

DO YOU ACCEPT GROUP INSURANCE?

We are **OUT-OF-NETWORK** with all insurances. We require full payment on any visits and we do not accept assignment. We will provide a superbill you can use to submit a claim for reimbursement from your insurance company. We advise that you verify your out-of-network benefits with your insurance company.

DO YOU ACCEPT FLEX PLANS AND HEALTH SAVINGS ACCOUNTS?

Most of those plans cover Chiropractic, Acupuncture and Massage. Some even cover prescribed supplements and vitamins. Please check with your particular plan on what services/products are fully covered. We are happy to provide you with copies of your prescriptions and visits to satisfy plan inquiries.

DO YOU BILL MEDICARE?

We do not accept assignment on Medicare so you must pay our discounted fee at the time of service. We will send the claim to Medicare and your secondary insurance (if you have it) so that you may be reimbursed at their allowed amount. Typically Medicare covers around $20.00 per chiropractic adjustment and the secondary pays around $5.00 (the 20% Medicare does not pay) after you satisfy a $130 deductible per year. Medicare **ONLY** pays for the spinal manipulation part of your visit, they do not cover any other services in our office. You must sign the Medicare section of the intake and may be asked to sign an ABN form. An ABN form lets you know that you may have to pay for services, like maintenance care, that are not covered by Medicare.

DO YOU ACCEPT MEDICAID?

No we are not providers of Medicaid

WHAT KIND OF CASH DISCOUNTS DO YOU OFFER?

We offer prepaid treatment plans for a 10% discount, Gold Member Cards allow discounts that are good for most services (ask for details) and other promotional discounts. Please see our website, Facebook page or ask the front desk for more information.

DOES YOUR OFFICE DO X-RAYS or MRIs?

We do not take X-rays or MRIs in our office. You may bring in your X-rays/MRIs or we will refer you to our network of imaging providers, if they are required for your care. We work with a Radiologist office that offers a cash discount.
If your insurance covers imaging and they have a preferred provider, we can write your prescription for that location. Then that facility will bill your insurance. Interpretations of X-Rays or MRIs, at this office, are subject to a fee for the doctor's time.

DO YOU ACCEPT AUTO INJURY CASES?

We only accept Auto injury cases if you have **Medpay** and have an active claim number on your personal insurance. You can call your agent to find out if you have Medpay coverage. **You must have all of your New Patient Auto Intake information filled out before your first visit or your appointment will be rescheduled.** You are responsible for notifying your agent that you were injured so that a claim can be made. In the event that the injury is severe enough to use all the Medpay and you were NOT the at-fault party we may bill the rest of the case as a TORT (this means the at-fault party's insurance will settle with you at the end of treatment). If the case goes TORT then you are responsible for the remaining balance. We require a Lien to be signed so that the insurance company or Lawyer's office may pay us directly. **If you receive the check instead of us it must be paid within 10 days of you receiving a check. You must adhere to the treatment plan schedule, missed appointments can be grounds for insurance companies to stop paying a claim. Contact our office before you accept any settlement, to insure you receive the correct amount to cover all bills.** When the case is closed, we allow **90 days** to process the claim. **After the 90 days we charge 8% interest on all unpaid balances.**

WHAT IF I MISS AN APPOINTMENT?

We require 24 hours notice by phone prior to the appointment time. We reserve the right to charge you $80 for a missed appoint-ment and (3) not cancelled, missed appointments are grounds for patient discharge. Our scheduling system sends out appoint-ment reminders via email. We are not responsible if your reminders go to your junk/spam folder. Please make sure that you mark them as safe in your email.

_____ **Initial Here**

WHAT ABOUT RUNNING LATE?

If you are running late please be mindful and call ahead. At this time, you will be advised on if the schedule will be able to accommodate the change or if you will need to reschedule. We understand there are times that tardiness is out of your control and a call will help us arrange appointments accordingly.

When you arrive promptly for you appointed time we will do our best to see you in a timely fashion. Due to the nature of our practice, there may be times that Dr. Akers and his staff may need to spend more than allotted for some patients. We are understanding that your time is valuable and this may be an inconvenience, please be patient and keep in mind the same care will be given to you.

_____ **Initial Here**

I have read the financial policy and understand my responsibility.

_____ _____

Patient (parent/guardian) Signature Date

Authorization to release information

I hereby authorize the release of any medical information such as reports, exams, x-rays, treatment visits and billing to any authorized third party payer. I fully understand and agree that I am directly responsible to pay in full for any and all services provided to me by Dr. Akers Natural Health Clinic. I further understand and agree that such payment to this office is not *contingent upon any settlement, claim, judgment or verdict by which I may eventually recover said fee.*

_____ _____

Patient (parent/guardian) Signature Date

HIPPA Notice of Privacy Practices:

Signature below is acknowledgement that you have received a copy of the HIPPA Notice of Privacy.

_____ _____

Patient (parent/guardian) Signature Date

HIPAA Notice of Privacy Practices

Dr. Akers Natural Health Clinic
17601 South Golden Rd. Ste2
Golden, CO 80401
303-969-0884

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. **Uses and Disclosures of Protected Health Information**

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that se patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see vu: We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable 1Du Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on or before **April 14, 2003**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature:_____ Date: _____

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Medicare Benefits Determination

Are you eligible for Medicare? **Yes** **No** **(circle)** If no, Skip to bottom and sign

Part A helps pay for inpatient hospital care, skilled nursing, hospice and other services.

Part B (original medicare) helps pay for doctors' fees, outpatient hospital visits, and other medical services and supplies not covered by Part A.

Part C (Medicare Advantage) plans allow you to choose to opt out of Part B and receive all of your health care services through a provider organization such as Secure Horizons, AARP, Anthem, Kaiser or other 3rd party insurance companies.)

Are you enrolled in : **(circle one)**

- **Original Medicare Parts A and B**
- **Medicare Part C ((Medicare Advantage)** Our office will not submit claims for Part C plans as they do not cover our services.

Do you have Secondary or Supplemental Insurance in addition to your Medicare?**(circle one)**

- **No**
- **Yes** We will bill Medicare and your Secondary Company and you will be reimbursed at the level of benefit stated in your medical coverage. Payments and Benefit Statements will come directly to you.

Secondary/Supplemental Company Name _____

Policy Number_____

Policy Holder_____

These are my Medicare benefits to the best of my knowledge

_____ _____

Patient Signature **Date**

Revised 2-6-19

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Medicare Office Policy and Billing Procedures

Our office only bills Medicare part B and insurance plans having "out of network" benefits. We bill Medicare and they will reimburse you directly. Since we do not accept assignment on medicare **you are required to pay in full** when services are performed.

Medicare Part B pays 80 percent of the Medicare-approved amount for covered chiropractic care after a $185 per year deductible. On average Medicare reimbursed around $24.36 per Chiropractic Adjustment in our office.

Medicare Part B covers only limited chiropractic services. Medicare Part B covers chiropractic manipulation of the spine (no other parts of the body), and only to correct a spinal subluxation (bones of the spine not in proper position). All other services we provide in our office are not eligible for Medicare reimbursement. We do not submit those charges unless they are covered by a Secondary/Supplemental plan.

Medicare only pays for chiropractic adjustments for active treatment of injury or illness. Maintenance adjustments are not covered. The definition of maintenance care is: any chronic, permanent condition that is irreversable by chiropractic care and/or any condition that will require care just to maintain a level of health due to daily living or occupation; or any condition by which the initial correction phase has been completed and the patient is returning for maintenance and/or supportive care to maintain a level of stability we have achieved to this point.

I have read, understood and agree to the Medicare Office Policy and Billing Procedures above.

_____ _____

Patient Signature **Date**

Revised 2-6-19

Communication Consent

Dr. Akers Natural Health Clinic
17601 South Golden Rd. Ste2
Golden, CO 80401
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Patient Name:_____ **Date:**_____

Email

Our office sends out occasional health and office updates via email, and you can also receive appointment reminders and confirmations to your email. Please provide your email and signature below to authorize email updates and reminders.

Email:_____ Initials:_____

Phone

You will receive a text reminder for your appointment 24 hours in advance. You can text STOP at any time to opt out of text notifications. Please provide the phone number you want to receive text reminders at below as well as your signature.

Phone:_____ Initials:_____

Opt-out

By providing your initials, you affirm that you do not wish to receive either email or phone reminders. The option to opt-out is presented in each text reminder.

Initials:_____

Signature:_____ **Date:**_____