## Office Financial Policy

Our office utilizes electronic medical records and electronic insurance claims submission. As a courtesy to patients with insurance coverage, our office will bill most insurance carriers directly via electronic claims submission. We believe, however, that health care is a matter best kept between the patient and the doctor.

Therefore, we request that payment be made at the time of service. We participate with insurance carriers as an out of network provider. We DO accept Medicare as a non-participating provider. In most cases of personal injury and auto accidents, we will accept payment directly from the insurance carrier. We accept cash, checks, and VISA and MasterCard, Discover, and PIN authorized Debit cards.

### Cancellation Policy

We value our patients as well as Dr. Coleman's time, so we ask for 24 hours notice when cancelling an appointment. Otherwise, we reserve the right to charge you for appointment no-show or cancellations with less than 24 hours notice ($50 fee for 15-30 minute appointments; $100 fee for 45 and 60 minute appointments). You may also be asked to provide a credit card to book your next appointment.

Kindly telephone in advance to reschedule an appointment to avoid this unnecessary fee.

*By my signature below, I understand that all charges incurred in this office are my responsibility. I understand that all personal balances are to remain on a current basis. An 18% (1.5% per month) interest charge may be applied to accounts with balances over 30 days. Should my account become delinquent, I understand that I am responsible for any interest, collection fees, attorney's fees and court costs incurred in collecting any outstanding balance. In the occurrence of a returned check or non-sufficient funds, a $25.00 charge will be applied.*

**Print Name:**_____

**Signed:**_____**Date:**_____

The Wellness Center For Sport & Spine
181 W. Boardwalk Drive • Suite 204 • Fort Collins, CO 80525
(970) 493-3100 (970) 237-4802

Dr. Gil Z. Coleman *Sports & Family Chiropractor*
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www.PremierFortCollinsChiropractor.com

## *PEDIATRIC QUESTIONAIRRE*

Patient Name _____

Parent(s) Name _____ Parents' E-mail Address _____

Address _____

City/State/Zip _____

Phone # Work_____ Home # _____

Patient Social Security # _____ Patient Date of Birth _____

Who is responsible for your child's bill? ❑ you ❑ spouse ❑ auto insurance ❑ health insurance

During pregnancy, was the mother on medication? ❑ Yes ❑ No

Did the mother smoke or consume any alcoholic beverages? ❑ Yes ❑ No

Was there back pain?

_____

Approximately how long was labor?

_____

Was mother physically ill? (Colds, flu, German measles, or other similar conditions) Please list.

_____

**Labor**

1. Was labor chemically induced? ..... ❑ Yes ❑ No
2. Doctor assisted? ..... ❑ Yes ❑ No
3. Was C-Section performed? ..... ❑ Yes ❑ No
4. Were forceps used? ..... ❑ Yes ❑ No
5. Did the doctor have his/her hands on the infant's head or neck? ..... ❑ Yes ❑ No
6. Were you lying on your back, in a birthing chair, or other? ..... ❑ Yes ❑ No
7. Was a family member present? If yes, Who? _____
8. Was the baby premature? ..... ❑ Yes ❑ No

If so, what was his/her age and weight?

**Does your child suffer from any health problems:**

| | | | |
|---|---|---|---|
| Headaches | ❑ Yes ❑ No | Allergies | ❑ Yes ❑ No |
| Ear Problems | ❑ Yes ❑ No | Sleeping Disorders | ❑ Yes ❑ No |
| Breathing Problems | ❑ Yes ❑ No | Fatigue | ❑ Yes ❑ No |
| Irritability | ❑ Yes ❑ No | Hyperactivity | ❑ Yes ❑ No |
| Frequent Colds | ❑ Yes ❑ No | Flu | ❑ Yes ❑ No |

| | |
|---|---|
| 9. Is your child accident-prone? ..... | ❑ Yes ❑ No |
| 10. Has your child had any falls down steps? ..... | ❑ Yes ❑ No |
| 11. Has your child ever fallen from heights over 2 feet? ..... | ❑ Yes ❑ No |
| 12. Has your child ever been involved in a motor vehicle accident? ..... | ❑ Yes ❑ No |
| 13. Has your child ever been hospitalized or had surgery? ..... | ❑ Yes ❑ No |
| **Does your child suffer from:** | |
| 14. Asthma ..... | ❑ Yes ❑ No |
| 15. Has your child ever had any broken bones or sprain injuries? | ❑ Yes ❑ No |
| 16. Is your child on any medications? ..... | ❑ Yes ❑ No |
| 17. Has your child had a scoliosis examination by an M.D. or Chiropractor? . | ❑ Yes ❑ No |
| 18. Have learning disorders? ..... | ❑ Yes ❑ No |
| 19. Poor posture? ..... | ❑ Yes ❑ No |
| 20. Does your child have any problem associating with friends? ..... | ❑ Yes ❑ No |
| 21. Is your child nervous, or has anyone suggested that your child was nervous? ..... | ❑ Yes ❑ No |
| 22. Does your child show any signs of nervousness, twitching, or excessive talking to themselves? ..... | ❑ Yes ❑ No |
| 23. If you could improve ONE aspect of your child's health or behavior, what would it be? ..... | |

Please write anything else you would like to express: _____

_____

_____

_____

_____

By signing my name below, I hereby certify that all statements and answers given on this form, and all future communications, written and verbal, are and will be accurate and truthful. I understand that any false statements made to the doctor could potentially result in the worsening of my child's condition for which the doctor is not responsible. I, (Parent or Legal Guardian) hereby give permission to Dr. Gil Z. Coleman to examine and treat the child listed above.

_____ _____

Signature (Signature) Date

## AUTHORIZATION TO TREAT A MINOR

I _____ (NAME of parent/legal guardian), by signing my name below, hereby represent that I am the legal guardian/parent of _____ (child's name) whose **date of birth** is _____.

I certify that all statements and answers given on new patient intake forms, and all future communications, written and verbal, are and will be accurate and truthful. I understand that any false statements made to the doctor could potentially result in the worsening of my child's condition for which the doctor is not responsible. I, (Parent or Legal Guardian) hereby give permission to Dr. Gil Z. Coleman to examine and treat the child listed above.

_____ _____

Print Full Name of Parent/Legal Guardian Date

_____

Signature

_____

Witness

**The Wellness Center For Sport & Spine, Inc.**
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181 W. Boardwalk Drive ◆ Suite 204
Fort Collins, CO 80525
Web: www.PremierFortCollinsChiropractor.com
***Making Great Athletes Better***
**(970) 493-3100**

# NOTICE OF PRIVACY PRACTICE SUMMARY

**The Health Insurance Portability and Accountability Act of 1996 (HIPAA) affords individuals certain rights to privacy regarding protected health information. While we've always protected your privacy concerning your personal health information, this summary discloses how your health information may be used. An expanded notice of your privacy rights is available for review upon request. Be aware that the terms of this notice may change from time to time and that you may contact us at anytime to obtain the most current copy of this notice.**

**The Wellness Center For Sport & Spine Inc. (TWCFSS) uses your health information for your treatment (including direct or indirect treatment by other healthcare providers), to obtain payment for treatment from third party payors (for example, an insurance company), to evaluate the quality of care that you receive, and for administrative purposes.**

**TWCFSS may use your health information in the day-to-day operations of our practice. This may include, but not be limited to daily sign in sheets, sending appointment reminders, phone messages, birthday cards, newsletters, holiday greetings and information about treatment alternatives or other health related issues.**

**TWCFSS may disclose your health information for public health activities, research, health and safety, governmental function in order to comply with worker's compensation laws and other pertinent legislative rules and regulations. TWCFSS will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so. You have a right to request restrictions on how your health information may be used and disclosed to carry out treatment, reimbursement, and healthcare operations. TWCFSS may not be required to agree with these requested restrictions, however if we do agree with these requests then we are bound to comply with them. Further, you have a right to request and retain a copy of your health record, request communication of your information by alternative means at alternative locations when appropriate, revoke your authorization and request an accounting of your healthcare records. However, any use or disclosure that occurred prior to the date of revocation is not affected.**

**You may talk to the Privacy Officer of TWCFSS and/or to the Department of Health and Human Services if you believe your privacy rights have been violated. In the event that a complaint is filed, you will not experience any retaliation.**

**TWCFSS must maintain the privacy of protected health information as provided by this Privacy Practice Summary. We are obligated to obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under current law.**

**This office is a semi-private facility. If you wish to discuss clinical or financial information privately, please notify a staff member and we will provide a private setting for that discussion.**

**In the interest of protecting the privacy of your personal health information, there may be instances when you are asked additional questions to verify your identification. Further, you will not be allowed access into areas designated as "authorized personnel only".**

**By my signature below, I acknowledge that I have reviewed this information and understand its contents.**

_____ _____

**Patient Signature** **Date**

_____

**Patient Name (Printed)**