Thank you for choosing The Wellness Center For Sport & Spine and Dr. Gil Coleman. We look forward to meeting you and promise to provide a great experience and do our best work for you.

*****PLEASE EMAIL OUR OFFICE AND LET US KNOW YOU RECEIVED THIS EMAIL*** THANK YOU!!**

The Wellness Center For Sport & Spine offers our new patient forms online so they can be completed it in the comfort of your home or office.

These forms require Adobe Reader http://get.adobe.com/reader/ to install the Adobe Reader application.

What to bring:

1. Printed filled out new patient intake forms
2. Copies of imaging DVD media, x-rays, MRI/CT scans, radiology reports, and or surgical reports
3. Typed chronological detail (in outline form) of your personal health history
4. If you have orthotics, please *bring them with you*

In chronological order past to present, please type an outline of your personal health history that includes details of your medical history, injuries, accidents, broken bones, surgery, treatment, imaging studies, and other health information.

It would be most helpful if you would please email me the timeline of your past health history in the form of an outline in date order. Again, EMAIL please so I can copy and paste your information into your electronic health record. In other words, tell me more about what's lead up to why you want my help and what's occurred in your past that may contribute to what is going on.

How to download your new patient forms
Please download, print, and complete the new patient forms prior to your office visit by following the steps below:
NOTE: DO NOT EMAIL SENSITIVE HEALTH INFORMATION.

Go to www.PremierFortCollinsChiropractor.com.

1. Click on **New Patients**
2. Click on the first link: **Adult New Patient Forms (ONLY)**
3. Print, fill out, and sign forms

In the meantime, if you have any questions, please feel free to call our office at 970-493-3100. We are dedicated to providing you a great experience. If for any reason you are unable to keep your scheduled new patient appointment, we require 24 hours advanced notice, and reserve the right to charge $45 for missed appointments. We understand that some delays are unavoidable. If you are late, please call our office and be aware that you may have to wait or be rescheduled.

Thank you for choosing The Wellness Center For Sport and Spine. We look forward to meeting with you!
Congratulations! You're one step closer to a happier and healthier life!

Dr. Gil Z. Coleman - Sports & Family Chiropractor
The Wellness Center For Sport & Spine
5468 Tiller Court
Fort Collins, CO 80528
970-493-3100 Office
970-237-4802 Fax
www.PremierFortCollinsChiropractor.com
gilcoleman@gmail.com
"Doing Whatever It Takes"

Directions to My Office

WHEN USING GPS USE WINDSOR INSTEAD OF FORT COLLINS WITH ZIP CODE 80528

Directions from Fort Collins

My home-office is located in the **Highland Meadows Subdivision** 1-mile East of I-25 off the Windsor Exit (Exit 262)

Take Carpenter Road (HWY 392) 1-mile East of I-25
Turn RIGHT onto HIGHLAND MEADOWS PARKWAY FOR ¼ mile
Turn LEFT on TILLER COURT
Our home office is located at the end of the street on the LEFT to the left of the light pole.

Directions from Denver
Merge onto I-25 N/US-87 N toward FT COLLINS
Take the WINDSOR exit, EXIT 262.
Turn RIGHT onto HIGHWAY 392 (CARPENTER ROAD) FOR 1 MILE
Turn RIGHT onto HIGHLAND MEADOWS PARKWAY FOR ¼ mile
Turn LEFT on TILLER COURT
Our home office is located at the end of the street on the LEFT to the left of the light pole.

Directions From Cheyenne, Wyoming
Merge onto I-25 S/US-87 S toward FORT COLLINS
Take WINDSOR EXIT 262.
Turn LEFT HIGHWAY 392 (CARPENTER ROAD) FOR 1 MILE
Turn RIGHT onto HIGHLAND MEADOWS PARKWAY FOR ¼ mile
Turn LEFT on TILLER COURT
Our home office is located at the end of the street on the LEFT to the left of the light pole.

If you get lost, please call 970-493-3100.

Please drive safely.

Dr. Gil Z. Coleman - Sports & Family Chiropractor
The Wellness Center For Sport & Spine
5468 Tiller Court
Windsor, CO 80528
970-493-3100 Office
970-237-4802 Fax
www.PremierFortCollinsChiropractor.com
gilcoleman@gmail.com
“Doing Whatever It Takes”

Office 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 that health care is a matter best kept between the patient and the doctor. Therefore, payment is expected at the time of service. We participate with insurance carriers as an out of network provider. It is your responsibility to verify any potential insurance coverage with your insurance carrier. Our fees are the same whether you have insurance benefits or not, and are not dependent on any potential insurance benefits or coverage. We DO NOT participate with Medicare. In some 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. Dr Coleman's fee for your initial 1-hour office visit that includes the consultation and examination is $365. This fee does not include treatment. If treatment is required after your examination, fees will be discussed in advance for your peace of mind.

You understand by your signature below that your condition, your health, and any treatment we may recommend to help you, is **not a promise of cure or remedy**. Dr. Coleman will provide honest and straight forward advice and counsel to best serve your needs.

You Don't Pay if You're Not Satisfied

On any visit if you are not satisfied with my care you will not pay for the specific services(s) you are unsatisfied with. To be clear, this satisfaction does NOT mean that you will leave feeling "like new" and or "not in pain". It means that I will listen and respond uniquely to you and your needs, and care for you in a way you have long expected and deserve. My recommendations will be made specific to you personally. If in the unlikely event I come up short, hold onto your wallet. Expect miracles but know healing takes time.

A few comments about Patient Satisfaction

In the unlikely event you are unsatisfied, you are responsible to say something **at the time of your visit** not 1 day or 3 months later! Please tell Dr. Gil what made you feel this way. You will not be asked to defend yourself! We simply want to understand what you feel. This has not happened often. However, if it does for you, we will not make you financially responsible for whatever service you are dissatisfied.

It's not acceptable to be unsatisfied because of our fee schedule because Dr. Coleman ALWAYS reviews ALL fees and costs and gets patient agreement (or not) BEFORE any services are provided. There is NEVER any pressure to do anything.

Cancellation Policy

Dr. Coleman's policy is that he does not double or triple book appointments like many offices and doctors. The time you schedule for your health on his calendar is reserved by him for you and no one else. Patients who cancel appointments due to non-emergency circumstances and less than 24-hours notice, are financially responsible for time reserved at $400 per hour at $100 for each 15-minute increment you reserve and schedule. Car accidents and emergency room visits are examples of emergencies. Spur of the moment work meetings, oversleeping, and last-minute practices scheduled by your coach are not considered emergencies. Sorry, no exceptions.

If an appointment you scheduled needs to be changed, we will do our best to help you avoid any late cancellation fee by attempting to reschedule you for an appointment the same day if our schedule permits, at a mutually convenient time.

Kindly telephone at least 24-hours 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 $35.00 charge will be applied.

Print Name:_____**Signed:**_____**Date:**_____

The Wellness Center For Sport & Spine
5468 Tiller Court ◆ Fort Collins, CO 80528
(970) 493-3100 (970) 237-4802

Dr. Gil Z. Coleman, Sports & Family Chiropractor
gilcoleman@gmail.com
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

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as a cervical arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

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)