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. On the menu bar click on **New Patient Forms**
2. Under Instructions click on the 2nd link: **Adult Auto Accident New Patient Forms**
3. Print, fill out, and sign forms

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
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Windsor, CO 80528
970-493-3100 Office
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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

Name: _____ Age: _____ Birthday ____/____/____Today's Date ___/____/ _____

Address: _____ City_____ State _____ Zip _____

Home Telephone (____) ____-_____ Work Telephone (____) ____- _____ Cell Phone (____) ____-_____

Social Security #_____-____-_____ Driver's License # _____ E-mail _____

Occupation/Employers Name and address _____

❑Male ❑ Female ❑ Single ❑ Married ❑ Divorced ❑ Widowed #of children _____

Name of Spouse_____ Name(s) of Children _____

Reason for consulting our office? _____

Who may we "Thank" for referring you to our office? _____

****Please check if you are here for any of the following: ____Motor Vehicle Accident ____Work Injury _____ Other Injury __**

Your Health Profile

Your answers to the following questions will give us a general view of the stresses you have faced in your lifetime, thus allowing us to better assess your current status and more accurately determine your true health potential.

The Beginning Years: Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some even starting at birth. Please answer the following questions to the best of your ability.

Birth History: Please check those items that apply to you.

- ☐ Mother smoked/drank/drugs while pregnant
- ☐ C-Section
- ☐ Labor Induced
- ☐ Epidural/Meds in labor
- ☐ Forceps Delivery
- ☐ Complications
- ☐ Breech Vaginal Delivery
- ☐ Vacuum Extractor used
- ☐ Other _____

Childhood Years (Age 0-17 yrs): Please check those items that apply to you.

- ☐ Childhood Illness
- ☐ Very Inactive
- ☐ Alcohol/Drug Abuse
- ☐ Vaccinated
- ☐ Serious Falls
- ☐ Car Accident(s)
- ☐ Smoker
- ☐ Severe Emotional Trauma(s)
- ☐ Active in Sports
- ☐ Surgery/Stitches
- ☐ Antibiotics/Other Meds
- ☐ Broken Bones

Adult Years (Age 18 to present): Please check those items that apply to you.

- ☐ Present Smoker
- ☐ Alcohol Use
- ☐ Car Accidents
- ☐ High Personal Stress
- ☐ Poor Sleep
- ☐ No Exercise
- ☐ Hard Falls
- ☐ Former Smoker
- ☐ Surgery/Stitches
- ☐ Work Injury
- ☐ Drive a lot
- ☐ Not Enough Sleep
- ☐ Wear Orthotics/Lifts
- ☐ Severe Health Problems
- ☐ OTC/Prescription Meds
- ☐ Play Sports
- ☐ High Job Stress
- ☐ Sit a lot
- ☐ Poor/Inadequate Diet
- ☐ Flat Feet
- ☐ Broken Bones

Please check (✓) all symptoms you have ever had, even if they do not seem related to your current problem. **P=Past; C=Current**

P	C		P	C		P	C		P	C	
☐	☐	Headaches	☐	☐	Pins & Needles Legs	☐	☐	Fainting	☐	☐	Neck Pain
☐	☐	Pins & Needles Arms	☐	☐	Loss Of Smell	☐	☐	Back Pain	☐	☐	Loss Of Balance
☐	☐	Dizziness	☐	☐	Buzzing In Ears	☐	☐	Ringing In Ears	☐	☐	Nervousness
☐	☐	Numbness In Fingers	☐	☐	Numbness In Toes	☐	☐	Loss of Hearing	☐	☐	Upset Stomach
☐	☐	Fatigue	☐	☐	Depression	☐	☐	Irritability	☐	☐	Tension
☐	☐	Sleeping Problems	☐	☐	Stiff Neck	☐	☐	Cold Hands	☐	☐	Cold Feet
☐	☐	Diarrhea	☐	☐	Constipation	☐	☐	Fever	☐	☐	Hot Flashes
☐	☐	Cold Sweats	☐	☐	Sensitive Eyes	☐	☐	Problem Urinating	☐	☐	Heartburn
☐	☐	Mood Swings	☐	☐	Menstrual Pain	☐	☐	Menstrual Irregularity	☐	☐	Ulcers

List any medications you are taking: _____

_____

1. **Health problem**: _____

The pain is:
Intensity ❑ Mild……❑ Moderate …….. ❑ Moderately Severe…….. ❑ Severe …… ❑ Intolerable
Quality ❑ Sharp ……. ❑ Dull …….. ❑ Constant ……. ❑ Traveling… ❑ Radiating
Frequency ❑ 0-25% of time.... ❑ 25-50% of time.. ❑ 50-75% of time…… ❑ 70-100% of time
Since this problem began my symptoms are: ❑ About the same ❑ Getting better ❑ Getting worse ❑ Variable

What makes it better? _____

What makes it worse? _____

This problem interferes with… ❑ Work ❑ Sleep ❑ Walking ❑ Sitting ❑ Exercise ❑ Hobbies ❑ Leisure Activities
Other Doctors seen for this problem (please list) ☐ Chiropractor ☐ Medical Doctor ☐ Other

2. **Health problem**: _____

The pain is:
Intensity ❑ Mild……❑ Moderate …….. ❑ Moderately Severe…….. ❑ Severe …… ❑ Intolerable
Quality ❑ Sharp ……. ❑ Dull …….. ❑ Constant ……. ❑ Traveling… ❑ Radiating
Frequency ❑ 0-25% of time.... ❑ 25-50% of time.. ❑ 50-75% of time…… ❑ 70-100% of time
Since this problem began my symptoms are: ❑ About the same ❑ Getting better ❑ Getting worse ❑ Variable

What makes it better? _____

What makes it worse? _____

This problem interferes with… ❑ Work ❑ Sleep ❑ Walking ❑ Sitting ❑ Exercise ❑ Hobbies ❑ Leisure Activities
Other Doctors seen for this problem (please list) ☐ Chiropractor ☐ Medical Doctor ☐ Other

3. **Health problem**: _____

The pain is:
Intensity ❑ Mild……❑ Moderate …….. ❑ Moderately Severe…….. ❑ Severe …… ❑ Intolerable
Quality ❑ Sharp ……. ❑ Dull …….. ❑ Constant ……. ❑ Traveling… ❑ Radiating
Frequency ❑ 0-25% of time.... ❑ 25-50% of time.. ❑ 50-75% of time…… ❑ 70-100% of time
Since this problem began my symptoms are: ❑ About the same ❑ Getting better ❑ Getting worse ❑ Variable

What makes it better? _____

What makes it worse? _____

This problem interferes with… ❑ Work ❑ Sleep ❑ Walking ❑ Sitting ❑ Exercise ❑ Hobbies ❑ Leisure Activities
Other Doctors seen for this problem (please list) ☐ Chiropractor ☐ Medical Doctor ☐ Other

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 condition for which the doctor is not responsible. If this information is for a minor, I state I am the legal guardian for the child and give permission to Dr. Gil Z. Coleman to render a chiropractic examination and treatment.

_____ _____
Signature Date

The Wellness Center For Sport & Spine • Dr. Gil Z. Coleman, D.C.
5468 Tiller Court • Fort Collins, CO 80528 • 970-493-3100
www.PremierFortCollinsChiropractor.com

Name: _____ Date: _____

AUTO ACCIDENT INFORMATION:

What was your position in the vehicle?
☐ driver ☐ front passenger ☐ rear passenger ☐ rear passenger

What type of vehicle were you driving
☐ compact car ☐ mid size car ☐ full size car
☐ compact truck ☐ full size truck
☐ mini van ☐ full size van
☐ compact SUV ☐ full size SUV
☐ motorcycle ☐ motorhome ☐ bicycle

What speed were you traveling at the time of the accident
☐ stopped at a stop light
☐ slowing down for an intersection
☐ at a complete stop
☐ moving slowly
☐ merging into traffic
☐ traveling at approximately _____ mph

Who hit you
☐ compact car ☐ mid size car ☐ full size car ☐ compact truck ☐ full size truck
☐ mini van ☐ full size van
☐ compact sport utility vehicle ☐ full size sport utility vehicle ☐ motorcycle ☐ motorhome ☐ bicycle

What was your vehicles point of impact
☐ front ☐ right front ☐ left front ☐ middle front
☐ rear ☐ right rear ☐ left rear ☐ middle rear
☐ right side ☐ front right side ☐ rear right side ☐ middle right side
☐ left side ☐ front left side ☐ rear left side ☐ middle left side

What speed was the other vehicle traveling

_____ mph

What was the other vehicles point of impact
☐ front ☐ right front ☐ left front ☐ middle front
☐ rear ☐ right rear ☐ left rear ☐ middle rear
☐ right side ☐ front right side ☐ rear right side ☐ middle right side
☐ left side ☐ front left side ☐ rear left side ☐ middle left side

Were you wearing seat restraints
☐ was wearing a full lap and shoulder restraint
☐ was wearing a lap restraint
☐ was wearing a shoulder restraint
☐ was not wearing any seat restraints

What position were your vehicles head rests in
☐ did have a head rest which was adjusted in the highest position
☐ did have a head rest which was adjusted in the middle position
☐ did have a head rest which was adjusted in the lowest position
☐ was not equipped with a head rest

Patient Signature: _____ Date: _____

Did your vehicles airbag deploy
☐ Air bags were deployed ☐ Air bags did not deploy

Were you prepared for the impact
☐ was completely surprised by the accident
☐ saw the collision coming
☐ saw the collision coming and braced appropriately

What position was your body in just prior to the impact
☐ a straight position
☐ a tilted forward position
☐ a position rotated to the left
☐ a position rotated to the right
☐ a position that cannot be remembered

What happened to your body at the moment of the impact
☐ body was tensed for impact
☐ body whipped violently forward and backward
☐ body violently torqued and twisted
☐ body was thrown over the seat
☐ body was thrown from the vehicle
☐ body was pinned in the vehicle
☐ body was thrown violently from side to side
☐ body was badly cut and bruised

What was your mental/emotional state immediately following the accident
☐ was not rendered unconscious by the impact of the accident
☐ was not rendered unconscious but was shaken and disoriented
☐ was not rendered unconscious but was shaken up
☐ was not rendered unconscious but was disoriented
☐ was rendered unconscious by the impact of the accident

Did you receive medical attention at the scene of the accident
☐ did not receive medical attention
☐ did receive medical attention

Were did you go immediately following the accident
☐ was taken to the hospital
☐ was taken home
☐ was taken to a personal physician
☐ was taken to this office
☐ resumed activities

List all body parts that struck the following areas within your vehicle:
☐ Dashboard ☐ Winshield ☐ Steering wheel ☐ Right door ☐ Left door ☐ Seat frame ☐ Unknown object

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)