



## APPLICATION FOR CARE AT INFINITY WELLNESS CENTER

### PATIENT INFORMATION

Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_  
\_\_\_\_\_ o Male o Female

Address: \_\_\_\_\_ City: \_\_\_\_\_  
\_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
\_\_\_\_\_ Fax: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
\_\_\_\_\_

Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_  
Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_  
\_\_\_\_\_ Occupation: \_\_\_\_\_

Names and Ages of your children:  
\_\_\_\_\_

Who referred you to our clinic? \_\_\_\_\_

### HISTORY OF COMPLAINT

Please identify if you came to this office, not as a result of a complaint, but for wellness care by completing the following:

#### Your Goals of Wellness Care:

\_\_\_\_\_

Please identify, if any complaints, injury or illnesses that brought you to this office:  
\_\_\_\_\_

When did these problem(s) begin? \_\_\_\_\_

Is your problem(s) the result of ANY type of accident. o Yes o No

If yes identify type: Auto Work Home Other (*please explain*):  
\_\_\_\_\_

Date of Accident: \_\_\_\_\_

Have you suffered with any of this or a similar problem(s) in the past?  No  Yes If yes when?  
\_\_\_\_\_

Please state what type of treatment you have tried for this problem(s)  
\_\_\_\_\_

Who provided it:  
\_\_\_\_\_

When:  
\_\_\_\_\_

What were the results?  Favorable  Unfavorable → Please explain:

**\*PLEASE MARK** the areas on the Diagram with the following letters to describe your symptoms:

**CONFIDENTIAL PATIENT HEALTH RECORD** Date: \_\_\_\_\_

**PERSONAL HISTORY**

Name: _____	Birth Date: _____	Age: _____
Address: _____	Sex: Male / Female	
City: _____ State: _____ Zip: _____	Home Phone: _____	
Social Security #: _____	Cell Phone: _____	
Driver's License #: _____	E-mail Address: _____	
Business Employer: _____	Fax #: _____	
Occupation: _____	Business Phone: _____	
Name of Spouse: _____	Spouse's Employer: _____	
Type of Work: _____	Names & Ages of Children: _____	
Referred To This Office By: _____	Relationship: _____	
Name & Number of Emergency Contact: _____	Who is Responsible for your list, you and: <input type="checkbox"/> Spouse <input type="checkbox"/> Worker's Comp <input type="checkbox"/> Auto Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid	
Personal Health Insurance Carrier: _____	Health Card ID #: _____	
Insured Person's Name: _____	Group #: _____	
Insured Person's Date of Birth: _____	Have You Had Previous Chiropractic Care? _____	
Insured Person's Social Security #: _____	Name of Previous Chiropractor: _____	
	Amount of Time Under Care of a Chiropractor? _____	

**CURRENT HEALTH CONDITION**

Chief Complaint (only you're here today): \_\_\_\_\_

**PLEASE OUTLINE ON THE DIAGRAM THE AREA OF DISCOMFORT:**

When did this condition begin? \_\_\_\_\_

Has it ever occurred before?  Yes  No

Is condition:  Auto Related  Work Related  Other  No Injury

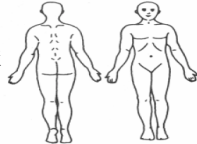
Explain: \_\_\_\_\_

Date of Accident: \_\_\_\_\_

Complaint/Pain Onset Date: \_\_\_\_\_

If Work: Have you filed an injury report with your employer?  Yes  No

Claim #: \_\_\_\_\_



**R = Radiating B = Burning D = Dull A = Aching N =**

**Numbness**

**S = Sharp/ Stabbing T= Tingling**



What percentage of the day do you experience your symptoms: \_\_\_\_\_%

What relieves your symptom(s)? \_\_\_\_\_

What makes them feel worse? \_\_\_\_\_

Have you had previous chiropractic care?  Yes  No

Name of Previous Chiropractor: \_\_\_\_\_

How long were you under care: \_\_\_\_\_

What were the results? \_\_\_\_\_

On a scale of 1 to 10 with 10 being the worst pain and 0 being no pain, rate how you feel today (**Circle the number**):

0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

**PAST HISTORY**

If you have ever been diagnosed with any of the following conditions please indicate with a **P** for in the **Past**, **C** for **Currently** have and **N** for **Never** have had a: [ ] Disability [ ] Broken Bone [ ] Fracture [ ] Dislocations [ ] Tumors [ ] Rheumatoid Arthritis [ ] Osteo Arthritis [ ] Cerebral Vascular [ ] Heart Attack [ ] Diabetes [ ] Other Serious Conditions: \_\_\_\_\_

**PLEASE, identify ALL PAST and any CURRENT conditions you feel may be contributing your present problem:**

**SOCIAL HISTORY**

**1. Smoking:**  cigars  pipe  cigarettes → How often?  Daily  Weekends  Occasionally  Never

**2. Alcoholic Beverage:** consumption occurs →  Daily  Weekends  Occasionally  Never

**3. Recreational Drug use:**  Daily  Weekends  Occasionally  Never

**FAMILY HISTORY:**

1. Does anyone in your family suffer with the same condition(s) you currently have?  No  Yes **If yes whom:**

grandmother  grandfather  mother  father  sister(s)  brother(s)  son(s)  daughter(s)

Have they ever been treated for their condition?  No  Yes  don't know

2. Any other hereditary conditions the doctor should be aware of.  No  Yes:

\_\_\_\_\_

I hereby authorize payment to be made directly to Infinity Wellness Center, for all benefits which may be due and payable under insurance coverage for the above named patient. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I will remain financially responsible to Infinity Wellness Center.

\_\_\_\_\_

\_\_\_\_\_

**Patient or Authorized Person's Signature Date File # (clinic use)**

## **NOTICE OF HIPAA PRIVACY PRACTICE**

Infinity Wellness Center is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **Personal Health Information**. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which by law, or as dictated by - our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled 'HIPAA' on tables in the reception. Once you have read this notice, please sign at the bottom of the page, and return it to our front desk receptionist.

### **PERMITTED DISCLOSURES:**

1. Treatment purposes- discussion with other health care providers involved in your care.
2. Inadvertent disclosures- open treating area means open discussion. If you need to speak privately to the doctor please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any available collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation.
5. Emergency- in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent to or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -we may call your home and leave messages regarding a missed appointment or apprise you of changes in practice hours or upcoming events.
11. Spouses, household partners and other close family members.
12. Change of ownership- in the event this practice is sold the new owners would have access to your PHI.

### **YOUR RIGHTS:**

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice.
3. To request mailings to an address different than residence.

4. To request Restrictions on certain uses and disclosures and with whom we release information to.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance.
6. To request amendments to information, however like restrictions we are not required to agree to them.

**COMPLAINTS:**

If you wish to make a formal complaints about how we handle your health information please call Dr. Tim Cummins at 720-747-5333. If they are unavailable, you may make an appointment with our receptionist to see them within 2 working days.

**Note:** This office reserves the right to amend this notice of privacy practice at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I have received a copy of Infinity Wellness Centers Patient Privacy Notice and understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding to the doctor. I understand that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

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**Patient signature Date**

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**Witness Date**