Patient Registration Date_____

Full Legal Name_____

Birthdate_____Gender_____

Phone(cell)_____(home)_____

Email_____

Mailing Address_____

City_____State_____Zip_____

Last 4 of SSN_____

May we leave a message on your voicemail? Yes No

Preferred contact number_____

Emergency Contact_____phone_____

Are you financially responsible for your account? Yes No

If "No," who is responsible for your account? Name_____

Phone_____Email_____

INSURANCE INFO:

Primary Insured_____Birthdate_____

Company_____ID_____

Group_____

Mailing Address_____City_____State_____Zip_____

Phone_____

Do you have a Primary Care Provider? Yes No

Name and Office_____

How did you learn about our office?_____

CONTINUED ON BACK

Healing Gardens Health Center requests your payment for services at the time of your visit. We accept cash, checks, and credit cards. If you need to make plan for a short-term payment plan, please speak with our office manager. We will file claims with insurance with which we are contracted. If you would like a superbill to submit to your out of network insurance, please ask upon check out.

Please read carefully and sign below.

I hereby authorize Healing Gardens Health Center to furnish information to my insurance carrier concerning my medical care and treatment. A photocopy of this authorization shall be considered as valid as the original. I authorize payment of medical benefits from my insurance provider to Healing Gardens Health Center for services rendered. I understand and agree that I am responsible for all charges, including those not covered by insurance.

Signature_____Date_____

The Healing Gardens

Patient Policies:

Office Hours: Monday- Friday 8:30 am- 4 pm.

Insurance: Please note when you have an appointment all copays and fees are due at time of service. If you have a deductible that has not been met, we require half of the visit to be paid at time of service.

Phone Calls and Messages: Phone hours are 8:30-4:00pm Monday through Friday. We will make every effort to return your phone call in a timely manner. Due to high call volume, please do not leave numerous messages. Please remember that we are caring for those patients who are in the office and are only able to return call as time allows. This may mean it may be several hours or the next day until we are able to return all calls. Questions for the provider can be left with a staff member who will obtain an answer and return your call. Providers will not call patients back; it will be the nurse. Questions can also be emailed to healinggardenshealthcenter@hotmail.com.

If you wish to have a phone consultation with a provider, we can schedule that for you. However, there is a charge for phone consultations that is not billable to insurance.

Labs: Please beware there will always be a draw fee for labs whether it goes to a local lab or is a kit draw. If our providers are ordering labs, it is office policy that you as a patient follow up with the providers. Medically/ legally they are to review those labs with you at a follow up visit unless otherwise specified by the provider. You will receive copies of your labs at the time of the follow up visit, no sooner unless approved by a provider.

Medication Refills:
Please allow at least forty-eight hours for all refills. For refills from a pharmacy, call the pharmacy and they will fax a request order to 970-472-6799. Please be aware for medical/ legal reasons, you must be seen at least once a year to have medications refilled. Medications will not be refilled if you have not been seen.

CONTINUED ON REVERSE SIDE

315 Canyon Avenue Suite 1
Fort Collins, CO 80521
healinggardenshealthcenter@hotmail.com
www.thehealinggardens.org
Office 970 472 6789
Store 970 472 6802
Fax 970 472 6799

Missed Appointments:
A minimum of twenty-four (24) hour notice is required to cancel or reschedule an appointment. There will a be a charge of $75 to $125 for all missed or late cancelled appointments. This charge is not billable to insurance.

Cash Pay Services:
There are services we provide at Healing Gardens Health Center that are not billable to insurance and must be paid at the time of service. Some of these include, Myers infusions, phone consults, letters, neurofeedback, alpha stim, e stim, copies and postage.

Urgent Care Services:
We allow time in the schedule to accommodate urgent care needs of our patients. Please call as early in the day as possible if you have an urgent need. If we are unable to see you, we may refer you to an urgent care center or the emergency room depending upon the symptoms you are having.

Medicinal Store: Phone Number- 970-472-6802
For your convenience we have a store on site where you can purchase vitamins, nutritional supplements and homeopathic remedies. All our products are approved by our providers to assure the best possible quality for you. We also offer mail service for store products if needed.

Thanks,

Healing Gardens Health Center Team

Signature: _____ Date: _____

PATIENT'S PERSONAL HISTORY FORM

NOTE: This is a confidential record and will be kept in this facility or your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

NAME _____ Age _____ Date _____

Occupation _____ Birth Place _____ Birth Date _____

Dr. _____ Date of last Physical Examination _____

List all States and Countries in which you have lived _____

Chief Complaints: (Please list all symptoms.)

1. _____ 3. _____

2. _____ 4. _____

Please answer each of the following questions by placing an (✓) in the "yes" box if your answer to the question is yes, or by placing an (✓) in the "no" box if your answer to the question is no. Fill in "who" and "when" information when necessary.

FAMILY HISTORY

Has Any Blood Relative Ever Had:

Cancer, Including Leukemia	☐ NO	☐ YES	WHO _____
Tuberculosis	☐ NO	☐ YES	WHO _____
Diabetes	☐ NO	☐ YES	WHO _____
Heart Trouble	☐ NO	☐ YES	WHO _____
Heart Attack	☐ NO	☐ YES	WHO _____
High Blood Pressure	☐ NO	☐ YES	WHO _____
Stroke	☐ NO	☐ YES	WHO _____
Epilepsy	☐ NO	☐ YES	WHO _____
Bleeding Disorder	☐ NO	☐ YES	WHO _____
Asthma	☐ NO	☐ YES	WHO _____
Allergies	☐ NO	☐ YES	WHO _____
Liver Disease	☐ NO	☐ YES	WHO _____
Migraine Headaches	☐ NO	☐ YES	WHO _____
Alcoholism	☐ NO	☐ YES	WHO _____
Emphysema	☐ NO	☐ YES	WHO _____
Stomach or Duodenal Ulcer	☐ NO	☐ YES	WHO _____
Kidney Disease	☐ NO	☐ YES	WHO _____
Glaucoma	☐ NO	☐ YES	WHO _____
Sickle Cell Anemia	☐ NO	☐ YES	WHO _____

Family History (continued)

Other Anemia	☐ NO	☐ YES	WHO _____
Mental Illness	☐ NO	☐ YES	WHO _____
Suicide	☐ NO	☐ YES	WHO _____
Birth Defects	☐ NO	☐ YES	WHO _____
Other Serious Disease	☐ NO	☐ YES	WHO _____

PERSONAL HISTORY

Do You Smoke? ☐ NO ☐ YES

If Yes, What _____

How Much _____

Do You Drink?

Beer ☐ NO ☐ YES

Wine ☐ NO ☐ YES

Other Alcoholic Beverages ☐ NO ☐ YES

How Much of Each? _____

Are You on a Special Diet? ☐ NO ☐ YES

What Diet? _____

	Living	Dead	Age at Death	Cause of Death
Father				
Mother				
Brother or Sister				
Husband or Wife				
Son or Daughter				

SYSTEM REVIEW

Do You Have Any of the Following Complaints:

General

Fever	☐ NO	☐ YES
Chills	☐ NO	☐ YES
Aches or Pains	☐ NO	☐ YES
General Weakness	☐ NO	☐ YES
Memory Loss	☐ NO	☐ YES
Swollen Glands	☐ NO	☐ YES
Easy Bruising	☐ NO	☐ YES

Head

Blurred Vision Not Corrected by Glasses	☐ NO	☐ YES
Double Vision	☐ NO	☐ YES
Light Flashes	☐ NO	☐ YES
Halos Around Lights	☐ NO	☐ YES
Pain in Your Eyes	☐ NO	☐ YES
Ear Pain	☐ NO	☐ YES
Drainage from Ear	☐ NO	☐ YES
Hearing Difficulty or Deafness	☐ NO	☐ YES
Buzzing or Ringing in Ears	☐ NO	☐ YES
Nosebleeds Not Due to Injuries	☐ NO	☐ YES
Sinus Trouble	☐ NO	☐ YES
Difficulty Swallowing	☐ NO	☐ YES
Mouth, Tooth or Tongue Problem	☐ NO	☐ YES
Persistent Hoarseness	☐ NO	☐ YES
Severe Headaches	☐ NO	☐ YES
Other_____	☐ NO	☐ YES

Skin

Changing Mole	☐ NO	☐ YES
Rash	☐ NO	☐ YES
Yellow Skin	☐ NO	☐ YES
Other Skin Problem _____	☐ NO	☐ YES

Neck

Swelling	☐ NO	☐ YES
Lumps	☐ NO	☐ YES
Stiffness	☐ NO	☐ YES
Other _____	☐ NO	☐ YES

Chest, Heart, Lungs

Shortness of Breath	☐ NO	☐ YES
Poor Exercise Tolerance	☐ NO	☐ YES
Fluttering of Heart	☐ NO	☐ YES
Unusual Heartbeat	☐ NO	☐ YES
Chest Pain or Pressure Attacks	☐ NO	☐ YES
Frequent Cough	☐ NO	☐ YES
Coughing Up Blood	☐ NO	☐ YES
Wheezing	☐ NO	☐ YES
Night Sweats	☐ NO	☐ YES
Swollen Ankles	☐ NO	☐ YES
Leg Cramps	☐ NO	☐ YES
Other_____	☐ NO	☐ YES

Gastrointestinal

Poor Appetite	☐ NO	☐ YES
Indigestion or Heartburn	☐ NO	☐ YES
Difficulty Swallowing	☐ NO	☐ YES
Nausea or Vomiting	☐ NO	☐ YES
Vomiting Blood	☐ NO	☐ YES
Abdominal Pain or Cramps	☐ NO	☐ YES
Abdominal Swelling	☐ NO	☐ YES
Diarrhea	☐ NO	☐ YES
Constipation	☐ NO	☐ YES
Change in Bowel Habits	☐ NO	☐ YES
Pass Blood from Rectum	☐ NO	☐ YES
Black, Tar-like Bowel Movements	☐ NO	☐ YES
Other_____	☐ NO	☐ YES

Kidney

Blood in Urine	☐ NO	☐ YES
Pain or Burning While Urinating	☐ NO	☐ YES
Difficulty Passing Urine	☐ NO	☐ YES
Difficulty Controlling Urine	☐ NO	☐ YES
Getting Up at Night to Urinate	☐ NO	☐ YES
Other_____	☐ NO	☐ YES

Genitalia

Women

Breast Lump	☐ NO	☐ YES
Discharge from Nipple	☐ NO	☐ YES
Other Breast Problem	☐ NO	☐ YES
Vaginal Discharge	☐ NO	☐ YES
Vaginal Bleeding or Spotting (not with periods)	☐ NO	☐ YES
Hot Flashes	☐ NO	☐ YES
Pain with Intercourse	☐ NO	☐ YES
Possibly Pregnant	☐ NO	☐ YES
Change in Periods	☐ NO	☐ YES
Pain Not Associated with Periods	☐ NO	☐ YES
Other _____	☐ NO	☐ YES

Men

Breast Lump	☐ NO	☐ YES
Discharge from Penis	☐ NO	☐ YES
Sore on Penis	☐ NO	☐ YES
Lump in Testicles	☐ NO	☐ YES
Difficulty Having Erections	☐ NO	☐ YES
Other _____	☐ NO	☐ YES

Neuromuscular

Weakness in Arm or Leg	☐ NO	☐ YES
Difficulty with Balance	☐ NO	☐ YES
Dizzy Spells	☐ NO	☐ YES
Fainting Spells	☐ NO	☐ YES
Speech Difficulty	☐ NO	☐ YES
Other _____	☐ NO	☐ YES

Bones–Joints

Painful Joints	☐ NO	☐ YES
Swollen Joints	☐ NO	☐ YES
Loss of Muscle Strength	☐ NO	☐ YES
Lump or Swelling in Muscle	☐ NO	☐ YES
Lump on Bone	☐ NO	☐ YES
Back Pain	☐ NO	☐ YES
Other_____	☐ NO	☐ YES

Endocrine

Thirsty All the Time	☐ NO	☐ YES
Cold Most of the Time	☐ NO	☐ YES
Too Warm Most of the Time	☐ NO	☐ YES
Unusually Tired or Sluggish	☐ NO	☐ YES
Unusually Jumpy or Nervous	☐ NO	☐ YES

Psychologic

Do You Find Your Life:

Generally Unsatisfactory	☐ NO	☐ YES
Too Demanding	☐ NO	☐ YES
Boring	☐ NO	☐ YES
Satisfactory	☐ NO	☐ YES

Do You Worry About:

Money	☐ NO	☐ YES
Job	☐ NO	☐ YES
Marriage	☐ NO	☐ YES
Home Life	☐ NO	☐ YES
Children	☐ NO	☐ YES

Do You:

Cry Easily	☐ NO	☐ YES
Feel Inferior to Others	☐ NO	☐ YES
Feel Shy	☐ NO	☐ YES
Feel Things Often Go Wrong	☐ NO	☐ YES
Often Feel Depressed	☐ NO	☐ YES
Have Irrational Fears	☐ NO	☐ YES
Feel Anxious or Upset	☐ NO	☐ YES

Have You:

Seriously Considered Suicide	☐ NO	☐ YES
Attempted Suicide	☐ NO	☐ YES

NOTICE OF PRIVACY PRACTICES

This summary describes how we use and share information about you.
This summary describes how you may see and get copies of this information.

WE MIGHT USE OR SHARE INFORMATION ABOUT YOU FOR...

Treatment: Such as when our providers, nurses and medical assistants discuss your care or provide copies of your medical record to another healthcare provider for continuation of care.
Payment: Such as when we bill your insurance company for services provided to you.
Other ways: Such as when we send disease reports to county and state health offices as required by law.
When we provide information to funeral directors, organ donation groups and researchers.
When we share information to protect the health and safety of others or you.

HOW YOU MAY SEE AND GET COPIES OF THIS INFORMATION

You have the right to:

- Ask for restrictions on the ways we use and give out your information. However, we are not required to do as you ask.
- Get and inspect a copy of your medical record.
- Add information to your medical record.
- Ask that your health information be sent to a different address or that we call you at a different phone number.
- Change your mind if you told us we could use or share your information for reasons other than those listed above.
- Get a list of the times we gave out your information. It will be a list of the times that the law requires us to keep a record of giving out your information.

OUR COMMITMENT TO RESPECT PRIVACY

We are required to:

- Keep your information confidential.
- Let you know is we cannot do what you have asked us to do with your information.
- Try to reach you at another location or phone number if you ask us to do so.
- Use and/or give out your information as listed above and as the law permits, unless we have your permission to do more.

As we serve our patients we may change what we do with your information to comply with the federal regulations. If we make a change we will inform you the next time you visit us for care. You may call or write us to check if we have made any changes.

If at any time you feel that your privacy rights have been violated you may file a complaint with us. You will not be mistreated for filing a complaint.

Healing Gardens Health Center
315 Canyon Avenue, Suite 1
Fort Collins, CO 80521

_____ _____
Name of Patient (please print) Date of Birth

I hereby acknowledge that I received Healing Gardens Health Center's Notice of Privacy Practices.

_____ _____
Signature of patient or patient representative Date

☐ Patient refused to sign.

☐ Patient was unable to sign or initial because:
_____
_____

☐ The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.

☐ Other reason (describe below):
_____
_____

_____ _____
Signature of Employee Completing Form Date