Last Name, First Name________________________________ DATE OF BIRTH: ____________

New Patient Intake Form

Date:_________

Welcome to Vitality Healthcare PC! This is your New Patient information packet. Please take the time to read, fill out, and sign the appropriate sections. Please plan to arrive 15 minutes prior to your scheduled appointment time as this allows us to better take care of your needs. If you wish to cancel or reschedule your appointment, please contact our office **24 hours or more in advance**. It is our goal to provide each of our patients the best care possible. If you feel you have been treated otherwise, please let us know.

What are your most important health concerns and how long have you had each concern?

Condition	How long?
1.	
2.	
3.	
4.	

Pain Assessment

Please rate your level of ***pain 1-10*** = Highest _______ To what do you attribute your pain? ______________

Please indicate the ***type of pain*** you are having:

___ Sharp ___ Dull ___ Throbbing ___Numbness ___Aching ___Shooting

___ Burning ___ Tingling ___Cramps ___Stiffness ___ Swelling ___ Other ______________

Is your pain the result of an auto or work injury? _________ If so, when? ________________

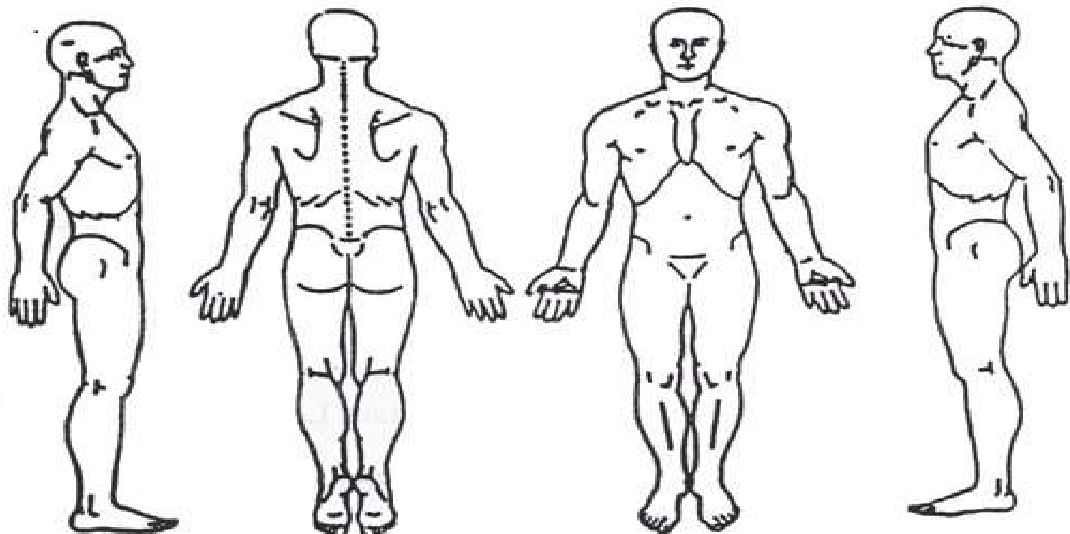
Do any movements/positions/activities make the pain ***better or worse***?

____

Please describe, if applicable, any ways in which your pain ***interferes with your daily activities***.

____

Please place an "X" on the area or areas that best show the location(s) of your pain.



Last Name, First Name___________________________________ DATE OF BIRTH: ______________

Please mark each of the following symptoms with "1" if you have the problem *now/currently*; mark "2" for anything you've had *__problems with in the past__*.

General

___ Weight gain
___ Weight loss (without cause)
___ Headaches
___ Fatigue
___ Fever
___ Difficulty sleeping
___ Anxiety
___ Depressed moods
___ Dizziness

Muscles/Joints

___ Low back pain
___ Neck pain/stiffness
___ Knee pain
___ Shoulder pain
___ Hip pain
___ Foot trouble/pain
___ Muscle weakness
___ Numbness/pain
___ Arm/leg/hand pain

Gastro-Intestinal

___ Frequent heartburn
___ Chronic use of PPIs
___ Stomach pains
___ Belching or gas
___ Nausea
___ Vomiting with meals
___ Diarrhea
___ Constipation
___ Hemorrhoids
___ Blood in stool

Cardio-Vascular

___ Heart palpitations
___ Chest pains
___ Ankle/leg swelling
___ Poor circulation
___ Varicose veins
___ Cold hands/feet
___ Easy bruising

Respiratory

___ Chronic cough
___ Bloody sputum
___ Chronic phlegm
___ Wheezing
___ Difficulty breathing

Genito-Urinary

___ Frequent urination
___ Painful urination
___ Blood in urine
___ Kidney stones
___ Bed wetting
___ Incontinence
___ Erectile dysfunction
___ Prostate trouble

Skin/Allergies

___ Acne
___ Rash
___ Dryness
___ Frequent boils
___ Irregular mole

Eye/Ear/Nose/Throat

___ Changes in vision
___ Pain in eyes
___ Hearing loss
___ Earache
___ Ringing in ears
___ Frequent colds
___ Frequent sore throat
___ Frequent sinusitis
___ Seasonal allergies
___ Enlarged thyroid

Women Only

___ Painful periods
___ Heavy menses
___ Irregular cycles
___ Hot flashes
___ Cramps
___ Vaginal discharge
___ PMS

Last menstrual cycle:
___/___/_____

Date of last PAP:
___/___/_____

Date of last Mammo:
___/___/_____

Please mark exposure history:

___ Mononucleosis
___ Polio
___ Rheumatic fever
___ Measles
___ Influenza
___ Root canal
___ Mercury fillings
___ Mold exposure
___ Chemical exposure
___ Tuberculosis
___ Vaccinations
___ Mumps
___ Whooping cough
___ Chicken pox/Shingles

Reviewer Notes:

Last Name, First Name___________________________________ DATE OF BIRTH: _____________

Habits/ Lifestyle

Do you use tobacco? Current Everyday Some Days Former smoker Never

Use alcoholic beverages? None Occasionally Frequently Daily History of Alcoholism

Do you eat Healthy meals Y N

Are you following any special Diet? Gluten free / Paleo / Dairy free / Vegetarian / Vegan / Other ___________

Have you dieted recently and if so, how much weight did you lose? _____________________________________

Tell us everything you've eaten in the last 24 hours (breakfast, lunch, dinner, snacks)

____

____

Do you exercise regularly? Y N If yes, what kind/how often_________________________

Do you drink coffee Daily? Y N Do you drink soda/pop regularly? Y N

Occupation? ________________________ Do you enjoy your work? Y N

Please rate your energy level on average (10 is best). 1 2 3 4 5 6 7 8 9 10

Please rate your stress from 1-10 (10 highest). 1 2 3 4 5 6 7 8 9 10

Hours of sleep each night? __________ Sleep well? Y N Awake rested? Y N

Have a supportive relationship? Y N Have a religious/spiritual practice Y N

Past Medical History

Condition/Disease	Year Began	Condition/Disease	Year Began
___ Cataracts		___ Nephrolithiasis (kidney stone)	
___ Wear glasses/contacts		___ Arthritis	
___ Hearing Aids		___ Gout	
___ Allergic Rhinitis/ seasonal allergy		___ Dermatitis/ Chronic Rash	
___ DVT (blood clot)		___ Psoriasis	
___ Hypertension		___ Epilepsy	
___ Murmur of Heart		___ Severe Headaches/ Migraines	
___ MI (heart attack)		___ Stroke	
___ Asthma		___ Bipolar	
___ COPD or Emphysema		___ Depression	
___ Cirrhosis		___ Hyperlipidemia/ Cholesterol	
___ GERD/ Heart Burn		___ Thyroid disease	
___ Stomach Ulcers		___ Hashimotos	
___ Hemorrhoids		___ Diabetes __ Type 1 __ Type 2	
___ Incontinence		___ Cancer	

Last Name, First Name___________________________________ DATE OF BIRTH: _____________

Allergies

Any drug allergies? ______ If yes, please explain medication and reactions:

____

Any food allergies? ______If yes, explain food and reactions:

____

Any chemicals or environmental allergies/sensitivities? Y N If yes, explain item and reactions:

____

Have you ever had allergy testing completed? Y N

Current Medications/Supplements

Prescription Medications:

Medication	**Length of time**	**Dose**	**Frequency**
Ex. Atenolol	1 yr	20 mg.	1x per day PRN
1.			
2.			
3.			
4.			
5.			
6.			

Vitamins/Supplements:

____

____

____

____

____

Over the Counter Medications (i.e Motrin, Benadryl, etc.)

____

____

____

____

** Please list additional medication or supplements on a separate sheet of paper**

Family History

	Father	Mother	Siblings	Maternal Grandparents	Paternal Grandparents
Age if living:					
Age when Died:					
Reason for Death:					

No Health Concerns					
Arthritis					
Asthma					
COPD					
Diabetes					
Heart disease					
Hypertension					
Mental illness					
Other:					
Cancer, type:					

Doctor, Hospitalization, Surgery, Imaging

Primary Care Physician (name and phone #) ____

SURGICAL HISTORY

Surgery/Procedure	AGE AT TIME OF SURGERY	Reason Performed/Result

Have you had any recent Bloodwork completed? Y N Location of results ___________________________________

Have you had any recent Imaging completed? Xrays MRI CT Ultrasound Other __________________

(If blood work or imaging has been performed within the last year, please bring a paper copy with you to your first medical appointment. We cannot accept labs via phone screenshots.)

The following questions will help us understand your expectations.

1. Why did you choose to come to Vitality Healthcare?

___

___

2. What aspect of a holistic / nutritional approach appeals to you?

___

___

3. As the process of assessment, planning, intervention, and follow-up progresses, how will you know you are getting better? What will you be able to do that you can't do now?

___

___

4. What is your present level of commitment to address any underlying causes of your health concerns that relate to your lifestyle? (Rate 1-10 = 100% committed)

   1 2 3 4 5 6 7 8 9 10

5. What lifestyle habits do you currently engage in that you believe support your health?

___

___

6. What lifestyle habits do you currently engage in that you believe harm your health?

___

___

7. What beliefs/obstacles do you foresee that could undermine your progress?

___

___

8. What else is important to you that we (the Vitality Healthcare doctors and staff) should be aware of as we begin working together?

___

___

___

Demographic Information

Full Legal Name: ____

Address: ____

City: _______________________________ State: _______ Zip Code: _________ Gender: M❑ F ❑

Telephone # (Home):___________________(Work):____________________(Cell): ____________________

Email Address: ____ Date of Birth: ______________________

Age: _______ If under 18, Guarantor: ____

Marital Status: Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Single ❑ # Children ______

Occupation: ________________________ Hours per week: ______________________ Retired: ❑

Employer: ________________________ Work Address: _______________________________________

How did you hear about Vitality Healthcare PC and/or who can we thank for referring you?

____

Have you attended Dr. Osterhout's "Health Solutions Seminar"? _____ Date Attended: __________________

Emergency Contact: ____ Relationship: _______________

Emergency Contact Address: ____ Phone: ____________________

Do you have health insurance?: ❑Yes ❑No Name of Carrier: _____________________________________

Policy Holder Name: ________________________________ Policy Holder Date of Birth: ___________________

Policy Holder's Employer: ____

Policy Holder's relationship to patient (if other than self): _________________ Phone: _____________________

Policy Holder's address: ____

Insurance Contract ID #: __________________________________ Group #:______________________________

Your relationship to policyholder: ____Self ____Spouse ____Child ____Other

Do you have secondary insurance?: ❑Yes ❑No Name of Carrier: __________________________________

Policy Holder Name: ________________________________ Policy Holder Date of Birth: ___________________

Policy Holder's Employer: ____

Policy Holder's relationship to patient (if other than self): _________________ Phone: _____________________

Policy Holder's address: ____

Insurance Contract ID #: __________________________________ Group #:______________________________

Your relationship to policyholder: ____Self ____Spouse ____Child ____Other

** Please provide the front desk with copies of all insurance cards

Last Name, First Name___________________________________ DATE OF BIRTH: _____________

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN
APPOINTMENT AND/OR DESIGNATION AS AN ERISA/PPACA REPRESENTATIVE AND A BENEFICIARY

I understand and agree that, regardless of whatever health insurance or medical benefits I have, I am ultimately responsible to pay Vitality Healthcare as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, and/or medications that *have been* or *will be* rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA plan, PPACA plan, or insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our representative, ERISA representative, or PPACA representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment and/or designation will remain in effect unless revoked in writing. A photocopy or scan of this document is to be considered as valid and as enforceable as the original.

Signed this ______ day of _________________ 20 ______.

X____
(Patient Signature)

____
(Please Print Patient Name)

X____
(Signature of Guardian, if applicable)

Last Name, First Name___________________________________ DATE OF BIRTH: _____________

Please read our **Financial Policy** carefully and discuss with us any questions or concerns that you may have.

- You are financially responsible to pay for any services your insurance company does not pay.
- Services denied as not covered by your insurance company are your responsibility.
- Please direct any coverage, benefit or participation questions directly to your insurance company.

It is important that you appear for all scheduled appointments. By way of courtesy, we usually (but need not) text or email you to confirm your appointment a day or two before the scheduled appointment. Your failure to cancel an appointment in a timely manner at least 24 hours prior to the visit deprives other patients of an opportunity to visit our office. You will be responsible for paying a missed appointment fee of **$25** if you fail to appear for a scheduled visit and/or **$50** if you fail to appear for a scheduled **massage** visit and have not provided at least 24 hours advance notice of cancellation. If you miss a total of three (3) scheduled appointments, we reserve the right to discharge you from our practice.

We have implemented a required policy which enables you to maintain your credit card information securely on file with us. If you are not able to keep your card on file with us, we require payment, in full, at time of service. We will submit your claim for you, and refund you if payer makes additional payment on your account.
Note: Your credit card information is not kept on file in this office. It is kept securely offsite and this office does not have access to the full credit card number once it is entered into the system for the first time.

You are giving *Vitality Healthcare, PC* permission to automatically charge your credit card on file for any balances due after your insurance company processes your claims, or for ***claims that remain unprocessed/unpaid by your insurance company for 90 days***. By signing this you authorize this agreement will remain in effect until the expiration of the credit card account or that you revoke this agreement, at any time, by submitting a written request.

Outstanding Balance: If your insurance provider has paid their portion of your bill and there is an outstanding balance owed, *Vitality Healthcar*e, PC your credit card on file will be automatically charged. This, in no way, compromises your ability to dispute a charge or question your insurance company's determination of payment.

I authorize *Vitality Healthcare, PC* to charge co-pays and outstanding balances on my account to the card on file.

Please send email notifications to:

If your card on file is declined and the patient account balance is still outstanding after 90 days, the account will be automatically submitted to our collection agency.

- The patient will be responsible for any reasonable collection cost, including attorney fees if incurred. Accounts that are placed with our collection agency will be charged $125 in addition to the outstanding balance due.

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process this claim. I understand that I am financially responsible for all services that I receive from provider.

____ ________________________________

Signature Date

Insured's or Authorized Person's Signature: I authorize payment of medical benefits to the undersigned provider for services that I receive by the provider.

____ ________________________________

Signature Date

I have read and agree to the above financial policy. I agree to be financially responsible for services provided to me today, and in the future.

____ ________________________________

Signature Date

Last Name, First Name__________________________________ DATE OF BIRTH: _____________

Informed Consent to Care

A patient coming to the doctor gives his/her permission and authority to care for them in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities; which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, claims or disputes will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I have read and understand the above consent form.

Sign here: X_________________________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of Vitality Healthcare.
(Please initial one of the following options and sign below.)

__________ I wish to receive a paper copy of the Privacy Notice.

__________ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and that the Privacy Notice is posted in the office. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

This serves as a notice that as part of our effort to deliver the most consistent healthcare we can to every patient. We use an electronic healthcare system that enables us to retrieve up to 13 months of prescription history through your insurance carrier.

I acknowledge that it is the policy of this office to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

X____ ___________________________________
Signature of Patient/Guardian Date

X____ ___________________________________
Witness (Office Staff) Date

Last Name, First Name___________________________________ DATE OF BIRTH: _____________

GOOD FAITH ESTIMATE & DISCLOSURE FORM

If you do not have health insurance or choose not to bill your health insurance; or, your health benefit plan may or may not provide coverage for all the health care services you are scheduled to receive; or, our practice does not participate with your insurance:

- Your health benefit plan may or may not reimburse a provider for all services provided if the provider is not in your health benefit plan network.
- A nonparticipating provider must provide good faith estimates of the cost of health care services to be provided. A good-faith estimate does not take into account unforeseen circumstances, which may affect the cost of the health care services provided.
- You also have a right to request that the health care services be performed by a provider who participates with your health benefit plan network. You may also contact your carrier to arrange for those services to be provided at what may be a lower cost and to receive information on in-network providers who can perform the health care services that you need.

Estimated Services and Items for Initial Visit:

Day 1: Neurological Exam: $40

New Patient Functional Exam: Complimentary

New Patient Chiropractic Exam:
CPT Code: 99203 – Patient Responsibility Dependent on Insurance
Self-Pay at Time of Service: $120

Day 2: New Patient Medical Exam
CPT Code: 99203 – Patient Responsibility Dependent on Insurance
Self-Pay at Time of Service: $120

Day 3: Report of Findings & Financial Consultation: Complimentary

Chiropractic Adjustment (Spinal Manipulation):
CPT Code 98940-98942 – Patient Responsibility Dependent on Insurance
Self-Pay at Time of Service: $50

Patient Signature Date