Office Policies & Services

We believe that health care is a matter best kept between the patient and the doctor. Therefore we do not accept insurance or third party payment, and request that payment be made at the time of service. We provide each patient with a detailed statement or superbill that can be submitted to most insurance companies for direct reimbursement. We accept cash, checks, and VISA and MasterCard, Discover, and PIN authorized Debit cards.

The Wellness Center For Sport & Spine offers a menu of services and products designed to support people with active lifestyles. From amateur to professional, competitive athletes and people who treasure physical fitness and peak performance in sport, appreciate our treatment being personalized and the results they receive. Our services support the mental, emotional, and spiritual, as well as the physical. They are designed especially to complement the services found through conventional health care.

Services to Optimize Your Health:

- In-depth chiropractic structural and functional evaluations and treatment for acute and chronic conditions for spine, extremity, nerve, muscle and joint disorders.
- Health and wellness consultations
- Health Coaching & Consulting for individual athletes, TEAMS and corporate clients
- Second opinions offered for alternative methods for diagnosed conditions
- Lifestyle and health skills training and education
- Customized nutritional and supplement programs
- Individualized health optimizing strategies
- Healthcare Teamwork - collaboration with coaches, trainers, and other healthcare providers designed to enhance individual results

Diagnostic Evaluations:

- In-depth biomechanical testing including spine, extremity and muscle function
- Computerized foot evaluations
- Sports injury evaluations
- Second and third opinions
- Offering alternatives to frequently prescribed surgical procedures in spine and extremity conditions
- Nutritional screening
- X-ray diagnostics for structural and functional evaluations
- Analysis of gastrointestinal function and health

Treatment and Therapy:

- Chiropractic spine and extremity treatment using hands on and instrument methods
- Spinal decompression
- Treatment for extremity disorders including shoulders, knees, hips, feet, elbow and wrist
- Muscle/soft tissue rehabilitation
- Electrical muscle stimulation
- Cold laser therapy
- Intersegmental traction
- Myofascial release therapy
- PNF (Proprioceptive Neuromuscular Facilitation)
- Health and personal growth coaching
- Nutritional correction and nutriceutical supplementation
- Detoxification strategies using approaches customized to your situation

Educational Programs:

The Wellness Center and Dr. Coleman offer a wide variety of informative, entertaining, and thought-provoking programs which can be adapted to any setting and group size. Please contact our office at 970-493-3100 to see how we can help meet your needs in this area.

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 and under $500.00. An 18% (1.5% per month) interest charge may be applied to accounts with balances over 60 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 $25.00 charge will be applied

Print Name:_____________________________________

Signed:____**Date:**________________________

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

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)

Directions to Our Office

Directions from Fort Collins

1. Take I-25 South
2. EXIT I-25 at Exit #262 (Hwy 392 - and turn LEFT/East off Exit Ramp toward WINDSOR.
3. Take CO-HWY. 392 East 1 mile. (Pond with fountain on right)
4. Turn RIGHT onto HIGHLAND MEADOWS PKWY. For 0.2 miles
5. Turn LEFT onto TILLER CT. <0.1 miles
6. End at 5468 Tiller Ct Fort Collins, CO 80528

House is the last house on the left in the cul-de-sac #5468

If you get lost, please call 970-690-6665.

Dr. Coleman's office is located in the Highland Meadows Subdivision

Directions from Denver

1. Take I-25 North
2. EXIT I-25 at Exit #262 (Hwy 392 [CR32])- and turn RIGHT/East off Exit Ramp toward WINDSOR.
3. Take CO-HWY. 392 East 1 mile. (Pond with fountain on right)
4. Turn RIGHT onto HIGHLAND MEADOWS PKWY. For 0.2 miles
5. Turn LEFT onto TILLER CT. <0.1 miles
6. End at 5468 Tiller Fort Collins, CO 80528

House is the last house on the left in the cul-de-sac #5468

If you get lost, please call 970-690-6665.

Dr. Coleman's office is located in the Highland Meadows Subdivision

Please drive safely.