Thank you for providing the following information below so that we can provide you the highest quality care and service possible.

Consent: I authorize Cherry Creek Wellness Center to render physical, occupational, and massage therapy as deemed medically necessary.

Records Release: I have reviewed CCWC's HIPAA policy. I authorize the release of any private health information necessary to process this claim or provide continuation of medical care. I authorize the release of records to myself and to any additional parties listed below for one year from the signature date.

Permission to release protected health information to additional parties:

NAME:________________________________ RELATIONSHIP:_______________________ (CIRCLE) MEDICAL BILLING

NAME:________________________________ RELATIONSHIP:_______________________ (CIRCLE) MEDICAL BILLING

How did you hear about Cherry Creek Wellness Center? (CIRCLE)

GOOGLE YELP PRINT AD SOCIAL NETWORK FRIEND/COLLEAGUE EVENT OTHER____________________

Cancellation Policy: $50 fee for appointment no-shows or cancellations with less than 24 hours' notice.

Email Policy: CCWC will NEVER give or sell your email address. You can unsubscribe from CCWC occasional messages at any time. EMAIL ADDRESS:____

Appointment Reminders: I would like to receive reminders: (CIRCLE)

TEXT MESSAGE (cell number and carrier name)____________________________________ (or) EMAIL: (address above)

IS YOUR INJURY: (PLEASE CIRCLE) **WORK RELATED** **AUTO RELATED** **N/A** WORK DAYS MISSED:__________

INJURY DATE ___________ **ADJUSTER**:___________________________ **ATTORNEY**:_______________________________

PRIMARY INSURANCE:____ ID#:________________________________

POLICY HOLDER NAME:_____________________ RELATIONSHIP:________________ INSURED DOB:________________

COPAY:_____ CO-INSURANCE:_____ OOP MAX:_____________ DEDUCTIBLE:______________ VISIT LIMIT:_____________

EMPLOYER:________________________________ TITLE:___________________________ HOURS/WEEK:______________

SECONDARY INSURANCE:____

COMMENTS:____

REFERRING MD:_______________________________ PHONE:__________________

SOME CONTRACTS SUBMIT THROUGH OVERSEEING PHYSICIAN **DR. BENNETT MACHANIC**. THIS INFORMATION MAY APPEAR ON YOUR BILLING STATEMENT.

CHERRY CREEK WELLNESS CENTER CAN NOT GUARANTEE YOUR INSURANCE BENEFITS

I understand I am responsible for any charges not covered by my insurance. Benefits are checked and claims are submitted to insurance as a courtesy. It is always recommended that patients confirm their insurance coverage because plans vary greatly and it is patient responsibility to see that the balance is paid in full. Processing insurance claims often takes time, and this may cause a delay in billing.

Billing Inquiries: Flatirons Practice Management: 303-546-9158

PRINT NAME:____ DATE:______________________________

SIGNATURE:____

Continued on back.

Please circle all that apply

High blood pressure	Heart problems	Shortness of breath
Changes in hair or nails	Diabetes	Low blood sugar
Thyroid problems	Difficulty sleeping while lying flat	Lung problems
Asthma	Ulcers	Cancer
Night sweats	Nausea/vomiting	Bleeding/bruising
Tumors/lumps/bumps	Unexpected weight gain/loss	Long term steroid use
Osteoporosis	Head trauma/Stroke/TIA	Fainting/Blackouts
Change in vision	Dizziness	Balance problems
Ringing in ears	Major dental work	Difficulty eating/swallowing
Change in ability to taste food	Abuse	Vocal changes
Ear pain	Headaches	Mental illness
Numbness/Tingling	Arthritis	Muscle cramps
Broken bones in last year	Surgery	Varicose veins
Hot or cold intolerance	Productive coughing	Contagious disease
Rash	Fever	Bowel or bladder changes
Pelvic inflammatory disease	Difficulty urinating	Blood in urine
Bladder or kidney infection	Abnormal or painful menstruation	Incontinence
Currently pregnant	Current smoker	Alcohol use (how often)

Additional comments/conditions: ____

Why are you here? ____

Prior physical therapy for this condition? ____

What makes this condition **worse**?____

What makes this condition **better**? ____

Current medications: ____

Pain rating Please mark on scale: (NO PAIN)◆···························◆(WORST PAIN EVER)

Pain map (please indicate location and type)

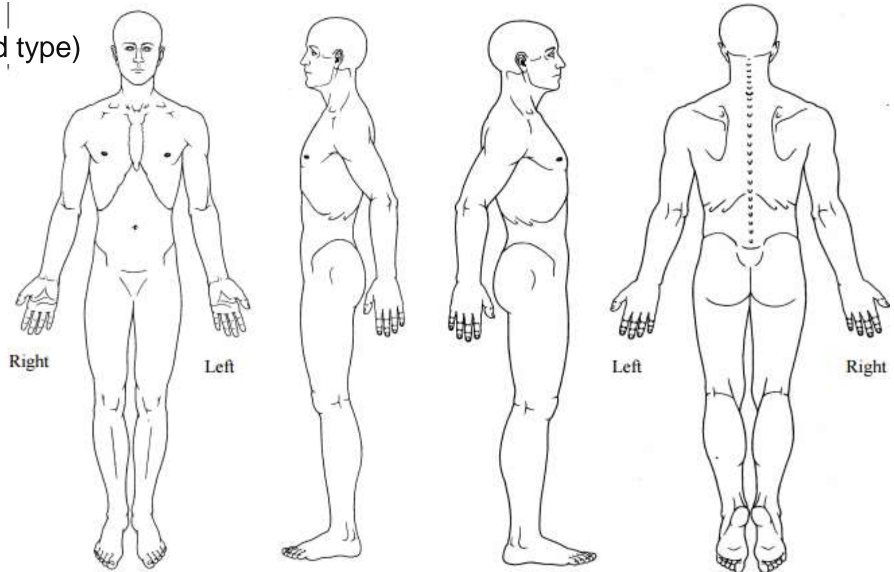
NUMBNESS
****

PINS & NEEDLES
0000

BURNING
XXXX

STABBING
////

ACHING
^^^^



I have stated all my known medical conditions, answered all questions honestly, and agree to keep the therapist updated with changes. There will be no liability on the therapist shall I fail to do so.

SIGN:______________________________ DATE:______________________________