CHERRY CREEK
WELLNESS CENTER

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. **Initial**_____

HIPAA/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. **Initial**_____

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. **Initial**_____

Phone call/Email Policy: By signing below, you are authorizing us to call you at whatever phone numbers you provide, to include your home phone, work phone, and mobile phone, regarding outstanding balances and any other matters related to your treatment at our facility. CCWC will NEVER give or sell your email address. You can unsubscribe from CCWC occasional messages at any time. **Initial**_____

Appointment Reminder: Text ☐ Call ☐ Email ☐ _____

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:_____

SECONDARY INSURANCE:_____

COMMENTS:_____

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 **Initial**_____

PRINT NAME:_____ DATE:_____

SIGNATURE:_____

Please circle all that apply

Alzheimer's	History of Cancer	Bowel or bladder changes
Cardiovascular Disease	Huntington's	Change in vision
Cauda Equina Syndrome	Immunosuppression	Ringing in ears
Cerebral Vascular Accident	Lupus	Currently pregnant
Current Infection	Muscular Dystrophy	Dizziness
Type 1 Diabetes/ Type 2 Diabetes	Obesity	Incontinence or difficulty urinating
Traumatic Brain Injury	Osteoarthritis	Abuse
Fibromyalgia	Parkinson's	Headaches
Fracture or Suspected Fracture	Rheumatoid Arthritis	Abnormal or painful menstruation
High Blood Pressure	Major dental work	Contagious disease

Additional comments/conditions: _____

Why are you here? _____

Prior physical therapy for this condition? _____

What makes this condition **worse**?_____

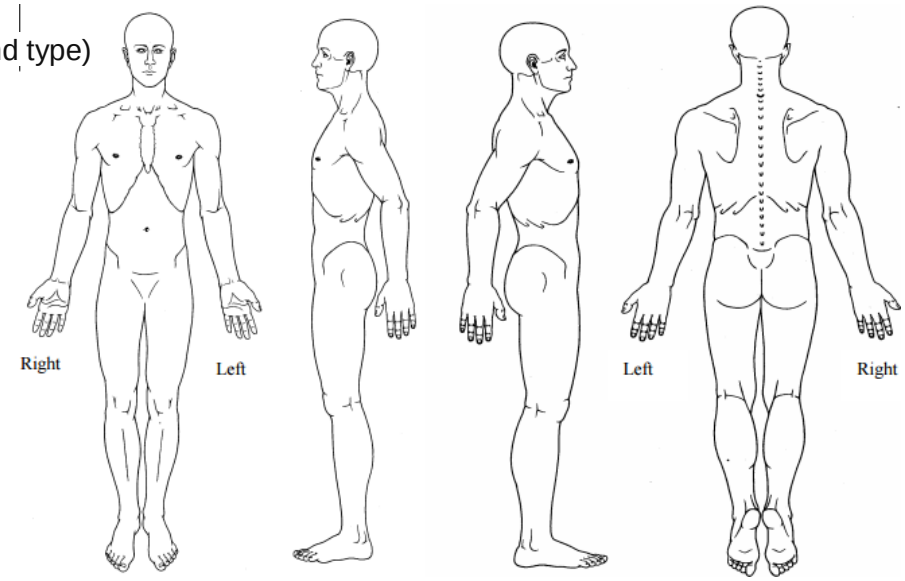
What makes this condition **better**? _____

Current medications: _____

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

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:_____