

INTEGRATIVE HEALTH & WELLNESS

Kurt A. Bailey DC, ND, NP-C
(208) 799-3333

First Name -	Middle Name -	Last Name -
What would you preferred to be called? -	Social Security # -	Work Phone -
Cell Phone -	Home Phone -	Contact Email -
Street Address -	City -	State/Province -
Zip Code -	Birthday (MM/DD/YYYY) -	Age -
Gender -	Marital Status -	# of Children -
Occupation / Title -	Employer -	
Spouse Name -	Spouse Cell Phone -	Spouse Occupation / Employer -
Emergency Contact -	Emergency Contact Phone Number -	
How did you hear about our clinic? -	Have you ever filed for Bankruptcy or Medical Malpractice? -	When? -
Insurance Company -	Insured ID # -	

I understand and agree that insurance policies are an arrangement between the insurance company and the patient. Although Integrative Health will help me bill, I acknowledge that ultimate payment is my responsibility. **Payment is expected at the time of service.** I authorize the release of any medical or other information necessary to process claims. All sales are final, no refunds or transfer of credit balances is available.

Signature

Date Signed

Printed Name

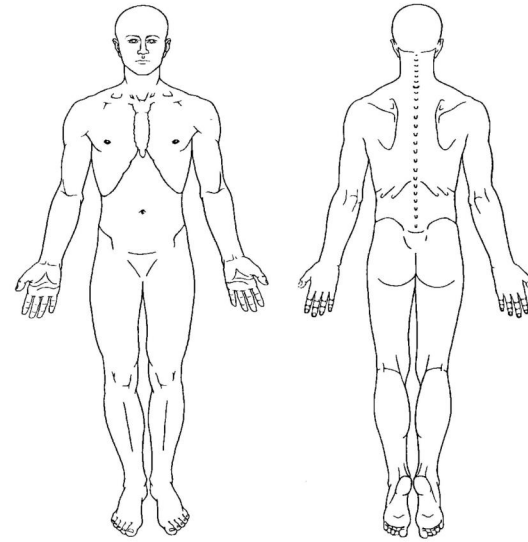
Email

Complaint

What are you seeking care for?

Describe – in detail – your concerns, symptoms and when your started having issues

Mark your Pain Point



Check all that describe your symptoms

How often are the complaints present

Are your complaints affecting your ability to work or otherwise be active

What makes your problem worse

What else increases your pain?

What makes your problem better?

What else makes your pain better?

What treatment have you received for this present condition

What other treatments have you received?

Were you previously treated for a different occurrence of this same condition? If so, by who?

-

How would you grade your general stress level?

-

What is your overall physical activity

-

Patient History

Tobacco use?

-

Packs per day

-

Number of years

-

Alcohol Use:

-

How much per week?

-

Number of years

-

Recreational Drugs:

-

Other drugs:

-

Number of years

-

Caffeine

-

How much per day?

-

Number of years

-

Family History

Father

-

Age

-

Medical Problems

-

Mother

-

Age

-

Medical Problems

-

Siblings

-

Age

-

Medical Problems

-

Spouse

-

Age

-

Medical Problems

-

**Mark if you are currently experiencing these symptoms
or if you have had them in the past**

MUSCLES / SKELETAL

-

NEUROLOGICAL / MIGRAINES

-

HEART / CARDIOVASCULAR

-

STOMACH / INTESTINES

-

EMOTIONAL

-

BREATHING / RESPIRATORY

-

NOSE / THROAT

–

URINARY

–

EARS / HEARING

–

EYES / VISION

–

MALE

–

FEMALE

–

Medications / Allergies / Supplements

Current Family Physician

–

Current pharmacy/ pharmacist

–

Please list any medications, vitamins or supplements you are currently taking:

1. (Medication, Dosage, Frequency)

–

2. (Medication, Dosage, Frequency)

–

3. (Medication, Dosage, Frequency)

–

4. (Medication, Dosage, Frequency)

–

5. (Medication, Dosage, Frequency)

–

6. (Medication, Dosage, Frequency)

–

Please list any known allergies and your reaction to them:

1. (Allergy, Reaction, Onset Date)

–

2. (Allergy, Reaction, Onset Date)

–

3. (Allergy, Reaction, Onset Date)

–

4. (Allergy, Reaction, Onset Date)

–

Please list supplements and naturals you are currently taking:

1. (Supplement, Dosage, Frequency)

–

2. (Supplement, Dosage, Frequency)

–

3. (Supplement, Dosage, Frequency)

–

4. (Supplement, Dosage, Frequency)

–

Integrative Care

I am aware that Kurt A. Bailey is trained as a Doctor of Chiropractic and Naturopathic Medical Doctor and as a Family Nurse Practitioner. I can see him for any of these specialties, individually or collectively.

Patient Signature

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I understand I can ask for treatment from one of these professions and it is possible my care/ treatment may cross between chiropractic, naturopathic and medicine, and I may be asked to return for an additional appointment in order to complete further examination, lab work, x-rays, injections, etc.

I understand the cost of care will be based upon treatment rendered at the time of service.

HIPAA Privacy Practice

In general, the HIPAA policy gives individuals the right to request a restriction on uses and disclosures of Protected Health Information (PHI). Our Policy is to take reasonable steps to limit the use or disclosures of PHI to the minimum necessary to accomplish the intended purpose. Your personal photo will be taken and used for identification and clarification purposes only. We also do not release PHI without your informed consent.

Patient Signature

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I acknowledge that a copy of the clinic's Notice of Privacy Practices is available to me. I further acknowledge and understand that if I have any questions about Integrative Health's privacy practices or my rights with regard to my personal health information, I may contact the clinic office for further information.

Notice of Release of Records

I agree that the clinic may disclose certain portions of my health information to a family member, friend or other caregiver because such person is involved with my health care or payment relating to my health care. In that case, Dr. Bailey's office will disclose only information that is directly relevant to the person's involvement in my health care or payment relating to my care.

Patient Initials

-

Disclosure of Fee's / Payment Policy

I understand that I am responsible for payment of all services rendered. If I have insurance, the clinic may bill as a courtesy only and in the event my insurance fails to pay I am responsible for any remaining balance. I understand that if any balance remains unpaid for any extended period of time that I promise to pay any and all collection, court and attorney fees in association with the collection of my account.
All sales are final. No refunds or transfer of credit balances are available.

Patient Signature

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Cell Phone Usage Agreement

I give authorization to Integrative Health & Wellness, Aesthetics & Med Spa to call, text or send voice mail transmissions using an automated system to the cell phone number I have provided.

I understand I am not required to provide sign authorization as a condition or purchasing any product, property, goods or services. On promotion, events, education webinars and special offers we will limit such text messages. You can opt-out at any time you choose.

Please check with your carrier as message and data rates may apply. we respect your privacy and no other vendors will ever be provided access to your information. Please confirm by signing the correct box.

I agree to received appointment reminders, appointment confirmations, special offers, promotions, events via text messages from Integrative Health & Wellness, Aesthetics & Med Spa.

Patient Signature

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Cancellation Policy

In order to ensure our patients enjoy the most timely and reliable access to our providers, this office has established a firm policy for “no shows” and late cancellations. Should you fail to keep a scheduled appointment or fail to cancel an appointment less than 48 business hours in advance, the result is a charge of \$50.

Patient Signature

-

Signature	Date Signed
-	-
Printed Name	Email
-	-