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Our Commitment: To be the best at delivering wellness care by measuring where a persons current level of health is and designing specific programs to help them gain the level of health they desire.

Patient Information

Date____

Patient Name _________________________________
Last Name

____
First Name Middle Name

Address ______________________________________

City _______________________ State _____________

Zip___________ Email _________________________

Sex □ M □ F Date of Birth __________________

□ Married □ Widowed □ Single □ Minor □ Divorced

Phone Numbers

Home # (____)__________ Cell # (____)___________

Cell Carrier ___________________ (for text messages)

Best time/Way to reach you ______________________

Insurance Information

Who is responsible for account?________________________

Relationship to Patient_________________________________

Insurance Co.______________________________________

ID #___________________________ Group #_____________

Subscriber Name_____________________________________

Date of Birth__________________ SS#__________________

In Case of Emergency Contact

Name____

Relationship ____________________________________

Home # (____)__________Work # (____)___________

Employment/School Information

Occupation_____________________________________

Patient Employer/School__________________________

Employer/School Address_________________________

Employer/School Phone___________________________

Parent Information

Name(s)____

Date of Birth(s)__________________________________

Employer(s)______________________________________

Employer Phone___________________________________

Accident Information

Is condition due to an accident? □ Yes □ No Date _____

Type of Accident □ Auto □ Work □ Home □ Other

To whom have you reported your accident?
□ Auto Insurance □ Employer □ Work Comp □ Other

Attorney Name (if applicable) ______________________

Attorney Address
____

Assignment and Release
I certify that I, and/or my dependent(s), have insurance coverage with ___________________________ and assign directly to Optima Health & Vitality Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named clinic may use my health care information and may disclose such information to the above-named insurance company and _________________________ their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

____
Signature of Patient, Parent or Guardian

____
Print Name of Patient, Parent or Guardian

____
Date Signed

____
Relationship to Patient

OFFICE POLICY

We believe that REGAINING AND MAINTAINING YOUR HEALTH is our main priority and a clear definition of our office policies will allow both you the patient, and us the doctor, to concentrate on that

APPOINTMENT POLICY

If you are currently on a care plan, it is important to reschedule your missed appointment as close to your original date as possible.

Once an appointment is made, that time is reserved specifically for you. If you are unable to keep an appointment for any reason, please call immediately to notify the office.

This office reserves the right to charge for missed appointments and those appointments cancelled without a 24 hour notification.

E-MAIL POLICY

Unsecure email communication containing sensitive health information can be sent between Optima and you. If this form is sign by you, **and** at a future date you request information to be emailed to you, then unsecure email communication about your medical care and treatment may be used to transmit information

X-RAY POLICY

The x-rays that are taken are the property of Optima Health & Vitality Center. Release for purposes of review can be arranged at your request.

WORKMEN'S COMP POLICY

Our office does accept workmen comp cases. However, it is not considered work comp until we have all insurance information, a claim number on file and liability is accepted. Until that time, all charges are the patient's responsibility and are collected in full at time of service.

PERSONAL INJURY POLICY

Our office does accept personal injury cases. Optima Health will be happy to submit all services to your insurance company. However all charges are the patients responsibility and are collected in full at time of service unless other arrangements are made with the business office.

FINANCIAL AGREEMENT-NO INSURANCE

In consideration for the services rendered to me by Optima Health & Vitality Center, I agree to pay for all charges incurred on my behalf and my dependents behalf at time services are received.

FINANCIAL AGREEMENT-INSURANCE

For patients submitting services to insurance, Optima Health & Vitality Center will call to verify benefits, and will submit billable charges to your insurance company.

Verification of benefits is not a guarantee of payment. All deductibles, co-pays and co-insurances are due at the time services are rendered.

I understand it is my obligation to pay any and all balances regardless of any agreements between myself and my insurance companies. Non-payment by my insurance company after 45 days will result in a patient balance and will be due upon receipt of statement.

LAB WORK/BLOOD WORK POLICY

All lab and blood charges will be collected in full at time of service. There will be an additional $30 draw fee collected at All Lab Tests Fast. We will be happy to submit to insurance for you and will refund you any amount paid by your insurance company.

NSF CHECKS / PAST DUE ACCOUNTS

There is a $30 NSF fee charged on all returned checks. Accounts over 90 days past due may be turned over to collections.

FOR YOUR CONVENIENCE WE OFFER MANY OPTIONS FOR PAYMENT, INCLUDING:

Cash / Personal Check / Visa / MasterCard / Discover / American Express / Care Credit

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By signing below I acknowledge that I have read, understand and agree to the terms of the office and financial policies of Optima Health & Vitality Center. I hereby authorize the Doctor to treat my condition as he/she deems appropriate through treatment methods used. I also agree that I am responsible for all bills incurred in this office. I authorize release of all records, correspondence and all imaging studies to Optima Health & Vitality Center for my continued medical care.

Patient Signature ______________________________________ Date ______________________________

Parent/Guardian Signature _______________________________ Date ______________________________

Please choose how you would prefer your care approached here at Optima Health & Vitality Center:

_____ Treat my symptoms only

_____ Treat my symptoms and find the underlying cause

_____ Treat my symptoms, find the underlying cause, and improve my overall health

_____ Rate your desire to change your health from 1 (very little desire) to 10 (strongly desire)

What needs to change with your health in order to feel you have had a "win" with your care? Please list below.

____

Patient History

For Doctor's Use

What is your chief concern?

When did this concern begin? ______

Is it getting better or worse? ______

How often is this problem present? ______

When do you notice it most? ***AM*** ***PM*** ***Constantly***

What makes it better? ______

What makes it worse? ______

Is it constant or does it come and go? ______

What do you feel is causing this problem? ______

Does this problem interfere with any of the following?

Sleep ***Daily Routine*** ***Play***

What treatments have you used for this concern? ______

What other health care professionals have you consulted about this concern? ______

What are your health goals in dealing with this concern?

[ ] ***Fix this problem***

[ ] ***Fix this problem AND fix whatever caused this problem***

[ ] ***Fix this problem, fix whatever caused this problem, AND improve general health***

HEALTH QUESTIONNAIRE

Did your child suffer any health problems, such as:

Headaches	☐ yes ☐ no	**Meningitis**	☐ yes ☐ no
Allergies	☐ yes ☐ no	**Diarrhea**	☐ yes ☐ no
Ear Problems	☐ yes ☐ no	**Constipation**	☐ yes ☐ no
Sleeping Problems	☐ yes ☐ no	**Colic**	☐ yes ☐ no
Breathing Problems	☐ yes ☐ no	**Rashes**	☐ yes ☐ no
Fatigue	☐ yes ☐ no	**Lactose Intolerance**	☐ yes ☐ no
Irritability	☐ yes ☐ no	**Bed Wetting**	☐ yes ☐ no
Hyperactivity	☐ yes ☐ no	**Digestive Problems**	☐ yes ☐ no
Frequent Colds	☐ yes ☐ no	**Other:** ________________________	
Flu	☐ yes ☐ no	________________________________	
Bloody Noses	☐ yes ☐ no	________________________________	

Regarding your child today:

Is your child accident prone? ☐ yes ☐ no

Has your child had any falls down steps?
☐ yes ☐ no

Has your child ever fallen from heights over two feet? ☐ yes ☐ no

Has your child ever been involved in a motor vehicle accident? ☐ yes ☐ no

Has your child ever been hospitalized or had surgery? ☐ yes ☐ no

Does your child suffer from:

Allergies ☐ yes ☐ no
Asthma ☐ yes ☐ no
Headaches ☐ yes ☐ no

Has your child ever had any broken bones or sprain injuries? ☐ yes ☐ no

Is your child on any medications? ☐ yes ☐ no

Has your child had a scoliosis examination previously? ☐ yes ☐ no
If yes, where? ___________________

Is your child hyperactive? ☐ yes ☐no

Have learning disorders? ☐ yes ☐ no

Sleeping difficulty? ☐ yes ☐ no

Does your child have any problems associating with friends? ☐ yes ☐ no

Is your child nervous, or has anyone suggested that your child was nervous?
☐ yes ☐ no

Does your child show any signs of nervousness, twitching, or excessive talking to themselves? ☐ yes ☐ no

If you could improve one aspect of your child's health or behavior, what would it be? _____________________
____
____

During Pregnancy:

Were you on medication? ☐ yes ☐ no If yes, what? ______________________________

Did you smoke or consume any alcoholic beverages? ☐ yes ☐ no

Was there back pain? ____

Approximately how long was labor? ____

Were you physically ill? (colds, flu, allergies, German measles, etc.) _______________

____

____

Regarding Labor:

Was it chemically induced? ☐ yes ☐ no ______________________________

Doctor assisted? ☐ yes ☐ no ______________________________

Was a C-Section performed? ☐ yes ☐ no ______________________________

Were forceps used? ☐ yes ☐ no ______________________________

(95% of all infants were born with hands on or forceps)

Did doctor have hands on infant? ☐ yes ☐ no ______________________________

Were you lying down? ☐ yes ☐ no ______________________________

Was family member present? ☐ yes ☐ no ______________________________

If yes, who? ____

Was the baby premature? ☐ yes ☐ no

If so, what was his/her age and weight? ____