West Root Care

Full Name:	Sex M / F
Date of Birth: Marital Status: S M D W	Height__ft__in Weight____lbs
Home Address: Apt_____	
City: State: Zip:	Please initial below. I understand that I am responsible for all fees associated with text messaging
Home Phone: Cell Phone	I allow Text messages ____
Email Address	I allow messages via email ____

How Did you hear about us? Website Insurance Company Friend/Family Newsletter Event_____ Media Social

Patient Employer	
Employer: Hrs/Week_____	Phone:
Address Ste	N/A Lt Labor Mod Labor
City: State: Zip:	Heavy Labor Office/Clerical
Guarantor	
Guarantor Name:	
Relationship to Guarantor: Spouse Parent Sibling Child Aunt/Uncle	Legal Guardian Other
Address:	Phone:
City: State: Zip:	Cell:
Spouse Name and Emergency Contact	
Spouse Name:	Cell Phone:
Spouse Place of Work:	Home Phone:
Emergency Contact: Relation	Phone
Insurance Information Do	you have Medicare Yes / No
Primary Insurance:	Phone:
ID #:	Group #:
Insured Name:	Relationship: Spouse Parent
Insured DOB:	Insured SSN#:
Secondary Insurance:	Phone:
ID #:	Group #:
Insured Name:	Relationship: Spouse Parent
Insured DOB:	Insured SSN#:

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Name:_____ Birth date: ____/____/_____ Age:_____

Marital Status:_____ Level Of Education:_____

Current Occupation:_____ Is Your Occupation enjoyable? Y / N

Is it stressful? Y / N Is it fulfilling Y / N Hazardous Material Exposure? Y / N

If retired, what was your main occupation?_____

YOUR GOALS:

_____

_____

PRESCRIPTION & OVER THE COUNTER MEDICATIONS YOU ARE CURRENTLY TAKING:

_____

_____

_____

_____

_____

PLEASE LIST ACTIVE MEDICAL PROBLEMS:

1._____

2._____

3._____

4._____

5._____

ALLERGIES – DRUGS:

_____

_____

_____

FOODS:

_____

_____

_____

NUTRIENTS/SUPPLIMENTS you are taking:

_____

_____

_____

CONDITIONS: Check any other conditions you have ever had in the past & indicate what year

___AIDS/HIV+	___Allergies/Asthma	___Anemia	___Alcohol/Drug Problem
___Anorexia/Bulemia	___Arthritis	___Atrial Fibrillation	___Anxiety/Panic Disorder
___Back Pain	___Bleeding Disorder	___Candida/Yeast	___Cancer-Specify_____
___Chronic Fatigue	___Crohn's Disease	___Colitis	___Diabetes – Type I II
___Depression	___Emphysema	___Epilepsy/Seizures	___Fibromyalgia
___Glaucoma	___Goiter	___Gout	___Hiatal Hernia/Reflux
___Heart Disease	___High Chloesterol	___Irritable Bowel	___Hypertension/ High BP
___Jaundice	___Kidney Disorder	___Kidney Stones	___Liver Disease
___Hepatitis	___Migraines	___Multiple Sclerosis	___Osteoporosis
___Pancreatitis	___Polio	___Prostate Problem	___Rheumatic Fever
___Pneumonia	___Sinusitis	___Stroke/TIA	___ Suicide Attempt
___Root Canal	___TMJ	___Tooth Abscess	___Tuberculosis
___Thyroid Problem	___Urinary Infection	__OTHER:_____	
___Ulcers		_____	

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CURRENT OR RECENT SYMPTOMS: Check any symptoms that you have noticed recently.

___Chest pain	___Blood in sputnum	___Fainting/Collapse	___Leg pain w/walking	___Kidney pain
___Nose bleeds	___Shortness of breath	___Swollen Ankles	___Snoring excessively	___Blood in urine
___Abdominal pain	___Acid reflux	___Black terry stool	___Bright blood in stool	___Frequency of urination
___Difficulty swallowing	___Loss of appetite	___Persistent nausea	___Mood swings	___Urgency of urination
___Change in headaches	___Double vision	___Dizzy/Spinning	___Eye pain	___Bone pain
___Unusual bruising	___Prolonged bleeding	___Bloated	___Excessive thirst	___Rapid heart beat
___Recent Changes in bowel habit		___Weight loss-unexpected	___Other symptoms: _____	
			_____	

HOSPITALIZATIONS: Please include surgeries, illness, severe accidents, births, miscarriages:

Year:	Procedure:	Reason:	Outcome:

FAMILY HISTORY: Please complete health information about your family:

Relation	Age	State of Health	Age at Death	Cause of Death	✔	Check if your blood relatives had any of the following:	Relation to you:
Father						Arthritis/Gout	
Mother						Asthma/Hay Fever	
Brothers						Cancer:Where:	
						Drugs/Alcohol	
						Diabetes	
						Heart Disease	
Sisters						High Blood Pressur	
						Osteoporosis	
						Stroke	
						Tuberculosis	

RECENT TESTS: If you have had any of these tests please complete:

TEST:	Date:	Reason:	Result:
Chest X-Ray			
EKG			
EGD(Stomach)			
Colonoscopy			
Ultrasound			
CAT Scan			
MRI Scan			
Bone Density			

HEALTH HABITS: Which substances do you consume:

Substance:	How Much?
Caffeine	Cups/Cans
Cigarettes	Packs/Day

Are you interested in quitting? Y / N

Alcohol	Type	Amount
Drugs Y / N	What	Amount
Chew Tobacco Y / N	Amount	Years
Nutrasweet	Servings per day:	
Sacchain	Servings per day:	

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Skin/Integumentary:

___Dry skin
___Thin lips
___Graying hair
___Skin blemishes
___Thin brittle nails
___Tendency to bruising
___Thinned skin-hands, face, arms
___Thinning hair-scalp, armpits, legs
___Wrinkling skin-face, neck, hands, arms
___Sagging skin-under eyes, arms, face, breasts

Neuro-cognitive:

___Loss of esteem
___Feeling hopeless
___Feeling defeated
___Loss of confidence
___Vision deteriorating
___Hearing deteriorating
___Memory deteriorating
___Sense of powerlessness
___Decreased sense of wellbeing

Gastrointestinal:

___Feel full faster
___Slower digestion
___Fullness after meals
___Eat less/Smaller meals
___Indigestion
___Burping/belching after meals
___Decreased sense of taste/smell

Muscle/Joints:

___Osteoporosis
___Aches and Pains
___Loss of strength
___Body & joints stiff
___Balance deteriorating
___Coordination deteriorating
___Thinning muscles
buttocks, arms, legs

Diet: Are you on any specific diet? (Please specify:_____. Successful? Y / N

List which diets have been successful in the past:_____

Stress:

Rate your current stress level: (Please circle) Extreme High Medium Low

How long has it been like this?_____

You expect this to last a (Please circle) Short Medium Long period of time.

Exercize: Please circle which you do.

Aerobic Weights Walking Other:_____

How long are your workout sessions?_____ How many days/week?_____

Sleep: Please check the symptoms that you notice.

___Trouble getting to sleep – racing mind
___Sleep not as restful/Wake up not rested
___Wake up through the night feeling like you are choking or having a smothered sensation
___Your partner has noticed very heavy snoring during sleep
___Your partner has noticed that you stop breathing through the night with heavy snoring
___Daytime drowsiness or sleepiness especially with periods of inactivity
___Toss and turn through night/wake frequently through the night

Take a moment to reflect on your response to the following question:

On a scale of 0-5(5 being the strongest response), circle your response:

How important and committed are you to improving your current health? 0 1 2 3 4 5

Patient Signature:_____ Date:_____/_____/_____

CONTROLLED SUBSTANCE CONTRACT

The patient has been prescribed a controlled substance at this time. The patient shows no signs of addiction or abuse and is using the medication appropriately, as prescribed. The patient has not requested early refills. There are no side effects related to this medication at this current time. The patient denies having received and opioid medications from any other physicians, while being treated with opioid medications through my clinic.

The patient was reminded that any controlled release medications should not be crushed, chewed or broken prior to ingestion. The patient understands the risks, benefits and alternatives to taking opioid medications and realizes that these medications are potentially addictive. The patient agrees to receive these medications from my office only. The patient was cautioned against driving while taking the opioid medications. The patient was informed that the product insert should be carefully reviewed personally, prior to starting any new medications.

The patient understands that chronic use of pain medications can result in renal or hepatic dysfunction.

The patient will follow up in our office in 4 (four) weeks for reevaluation. If the patient has any problems or questions they will contact our office.

_____ _____/_____/_____

Signature of Patient/Parent/Legal Guardian Date

_____ _____/_____/_____

Printed name of Patient Patient Date of Birth

_____

Witness Job Title

West Root Care

INJECTION WAIVER

DATE: _____/_____/_____

I understand that my physician will not bill my health insurance for the medication used in the injections or immunizations I am to receive. I agree to pay for these services on the date of service.

I understand that I have the option of taking a written prescription to the pharmacy, picking up the medication and returning to the office to have the shot administered. The office will charge for the administration of the injection/immunizations.

I have been advised to wait 20 minutes in the office once the injection/immunization has been administered.

Patient Name:_____

Signature:_____

West Root Care

Financial Policy

Patient Name:_____ DOB:____/____/_____ Date:____/____/_____

Thank you for choosing us as your healthcare provider. The following is our Financial Policy. If you have any questions or concern about our payment policies, please do not hesitate to ask our billing department **702-912-4077**

1. Your insurance policy is a contract between you, your employer, and the insurance company. Our relationship is with you, not your insurance company. All services are provided to you with the understanding that you are responsible for their cost regardless of your insurance coverage. If you would like to know the cost of a service, please inquire with the staff prior to treatment. Please be aware that not all services are a covered benefit in all insurance policies. You are responsible for knowing, per your insurance plan on what services are or are not covered. **Fees for these services, along with any unpaid deductible and co-payment are due prior to the time of treatment.** You are responsible for these amounts.
2. You are responsible for knowing your insurance benefits. Does your insurance require a referral? What facilities participate in your plan? If we can be of assistance, please let us know. We are sure that we can answer most questions regarding your insurance.
3. We will send you a statement monthly to keep you informed on the status of your account until the account is paid in full or placed in collection.
4. We will bill the insurance information you provided to us **as a courtesy**, but you are still ultimately responsible for payment of any services you receive. We will also follow up on your claim. We will be checking with your carrier once verbally and once in writing. If, however, your insurance does not respond to us within 60 days of claim submission, the amount will become your responsibility and you will have to follow up with your carrier for payment of the claim.
5. If your medical claim has not been paid by your insurance company, and you have contacted them with no results, there is recourse for you. The Nevada Department of Business and Industry has established an insurance division to receive questions, complaints, and comments from the consumers in Nevada concerning healthcare plans. Their address is 555 E. Washington Ave., Las Vegas, NV 89101 and phone number is (702)486-4000.
6. If you are a Medicare beneficiary by Federal Law we are required to collect 20% of the "Medicare Assignment" portion which the Federal Government does not pay. Medicare will only pay 80% of the assigned amount after your deductible has been paid. Again, if you have financial problems or questions, please ask for our Office Manager or Billing Department.
7. Failure to cancel or reschedule an appointment without 24 hour notice will result in a $25 fee. No Exceptions.

By signing this agreement I acknowledge that I have personally guaranteed the debts and obligations incurred by me, and agree that I am personally obligated to perform all of the terms of, and make payments to Weingrow Wellness required by, the agreement of which this application is a part. I authorize this office to release any necessary information to third parties when requested and if I become delinquent and my account is assigned over to a collection agency associate that they are hereby given the right to report same accurately to all the Credit Bureaus. I agree to pay all collection expenses **West Root Care** may incur in the collection of any delinquent balance plus, attorney's fees, court costs, filing fees including charges or commissions that may be assessed by any collection agency retained to pursue this matter. Collection fees will be 40% for regular collections and 50% for legal collections or forwards, which may be as much as twice the original balance owing. Patient further agrees to pay interest rate of 2% per month, 24 % per year from the first date the account becomes delinquent.

I understand all of the above and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to **West Root Care** will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the convenience of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. Please be aware that we do understand any temporary problems one may have at the time of the visit. We encourage you to make us aware of this prior to the treatment, so we can assist you in any way regarding your balance. OUR MAIN CONCERN IS OUR PATIENTS WELL BEING.

_____ _____/_____/_____

Signature of Patient or Guardian Date

West Root Care

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the following physician/facility to release my protected health information:

Previous Physician/Facility:_____

Address: _____

_____

Phone:_____ Fax:_____

Information to be disclosed (Check all that apply):

☐ Complete Health Records ☐ Hospital Records ☐ Progress Notes Only

☐ Radiology Reports & Laboratory Tests ☐ Other (Please Specify):_____

_____

I UNDERSTAND THAT THESE WILL INCLUDE INFORMATION RELATING TO:

- Human Immunodeficiency Virus (HIV) Infection
- Behavioral Health Services/Psychiatric Care
- Treatment for Alcohol/Drug Abuse

West Root Care

Please release the above noted medical records to: **Provider Name:** _____

4527 West Sahara Ave,
Las Vegas NV 89102

Phone: **702-912-4077** Fax: **702-912-4078**

I certify that I have read and upon request will receive a copy of this Authorization.

I agree to this release of health information as described herein.

_____	_____	_____
Patient Name	Signature	Date
_____	_____	_____
(Legal Representative) Print	(Legal Representative) Sign	Date

DOB: _____ SS#:_____ Contact #:_____

Failure to provide us with the above information will prevent this transfer from being processed.

West Root Care

PREFERRED PHARMACY:

Pharmacy Name:_____

Address: _____

_____

Phone Number :_____

Fax Number: _____