GATEWAY NATURAL MEDICINE
& Diagnostic Center

Dr. Brett Wisniewski, MS, DC, DACBN, DABCI - Dr. William Kleber, DC, DABCI
Dr. Katie Takacs, DC, DABCI - Dr. Shaun Adams, DC, DABCI
1211 Lake Ave, Berthoud, CO 80513 - P: 970-532-2755 F:970-532-9838

The following information provided is confidential and is for medical purposes only. It is important you fill it out to the best of your ability. Even if the question seems not to apply to your current condition please fill this form out completely as many things can be connected and will help us better serve you.

Name:_____ **Today's Date:**_____(mm/dd/yr)

DOB:_____ (mm/dd/yr) **Current age**:____ **Height**:____ **Weight**:_____ **Gender**: □ **male** □ **female**

Address:_____ **City:**_____ **State:**____ **Zip Code:**_____

Home Phone:_____ Permission to leave a 'medical' message? □ **Yes** □ **No**

Cell Phone:_____ Permission to leave a 'medical' message? □ **Yes** □ **No**

Email for medical/healthcare correspondence:_____

Occupation:_____ **Employer:**_____

Emergency Contact Name:_____ **Phone #:**_____

Please Describe your current problem/complaint that brought you to our office: List them in order of importance. For example #1 is most important, and #5 is least important. *(if your complaint is of pain please also use the diagram on the following page)*

1._____

2._____

3._____

4._____

5._____

How long have you had the above condition/s? _____ Is it getting worse? □ yes, □ no

Does it effect your (check appropriate box): □ work, □ sleep, □ other:_____

Initial cause of complaint: _____

Major goals for your first visit: Let us know what you would like to accomplish on your first visit.

1._____

2._____

3._____

4._____

Have you been treated for this condition in the past/present? □ yes, □ no; If YES, by whom?_____

Have you been diagnosed for this condition? □ yes, □ no; Diagnosis:_____

Is there anything else the Doctor should know about *you* or your *condition*?_____

PAST HISTORY

Have you… **Yes No** **If yes, explain briefly WITH approximate date/year**

... ever been hospitalized? □ □

_____

... had any surgeries? □ □

_____

... had any mental disorders? □ □

_____

... ever had a dental infection, root canal, fillings, etc? □ **yes,** □ **no** _____

… ever been bitten by a *tick or spider* that you know of? □ **yes,** □ **no** If yes, did you have a reaction such as a rash, fever, joint pain, etc. □ **yes,** □ **no**

_____

… ever have mono or Epstein-barr virus? □ **yes,** □ **no**

… ever had any chronic infections? □ **yes,** □ **no**

…ever been diagnosed with MRSA? □ **yes,** □ **no**

…ever been diagnosed with *C. diff*? □ **yes,** □ **no**

…ever been diagnosed with Lyme disease? □ **yes,** □ **no**

…had any other infections? □ **yes,** □ **no** : _____

Do you have any allergies to foods, medications or environment _____

_____

When was the last time that you felt well?_____

What seems to trigger your symptoms?_____

What seems to worsen your symptoms?_____

What seems to make you feel better?_____

How much time have you lost from work or school in the past year due to these conditions?_____

FAMILY HISTORY

If any blood relative has had any of the following conditions, please check and indicate which relative(s)

□ Cancer_____

□ High blood pressure _____

□ Anemia _____

□ Diabetes _____

□ High cholesterol _____

□ Arteriosclerosis _____

□ Emphysema _____

□ Multiple sclerosis _____

□ Epilepsy _____

□ Osteoporosis _____

□ Stroke _____

□ Bleed easily _____

□ Heart disease _____

□ Thyroid disease _____

□ Dementia/Alzheimer's/Parkinson's _____

□ OTHER: _____

_____

_____

HABITS and LIFESTYLE

Please *circle* any of the following you consume:

Alcohol Coffee Tobacco Drugs Soft Drinks OTC meds Pain Killers

Do you exercise regularly? If YES-what do you do? If NO what keeps you from exercise?

_____

DIET- Do you follow any particular diet regimen or restrictions?

_____

_____

MOST RECENT VISIT TO A DOCTOR: *When was the last time you consulted a doctor, and for what reason?*

_____

Date of last complete physical exam: _____

Date of most recent lab/blood tests: _____

WOMEN ONLY—date of last PAP smear:_____ results:_____

Currently pregnant? YES NO UNSURE

Do you still have your monthly period? YES NO UNSURE

Do you have any children? YES NO **How many?**_____ **Healthy?**_____

Name/s of your children:_____

Is there anything else the Doctor should know or you would like to elaborate on?:

_____

_____

_____

Current prescription medications (e.g., Prozac, lipitor, etc), **non-prescription medications** (e.g., aspirin, Tylenol, ibuprofen) and/or **health supplements** (e.g., vitamins, minerals, herbs): *Please list the medications and/or supplements that you are currently taking. If you need more room please attached a sheet to this form.*

******Please also list any drug/supplement allergies******

NAME *of medication or supplement—drugs, vitamins, herbs, minerals*	**DOSE** *in milligrams or grams (or number of capsules, tablets)*	**FREQUENCY***:* **Times per day/ week/ month**	**DURATION***: Been* **taking for how long?**	**REASON:** Why are you taking this?

REVIEW of SYSTEMS: Simply circle the most appropriate number for each attribute so we can better understand and discuss your current condition. Although this list is extensive it is important to fill out completely and as accurately as possible. If you mark "YES" to a question please provide additional info to the right or on the bottom of the page.

GENERAL HEALTH	Never- Very rare	Occasional- Mild	Intermittent- Moderate	Frequent- Severe
Fatigue, lack of energy, lack of stamina	□ 0	□ 1	□ 2	□ 3
Tired even after "good" sleep	□ 0	□ 1	□ 2	□ 3
Lack of desire to get out of bed	□ 0	□ 1	□ 2	□ 3
Undesired weight gain, difficulty losing weight	□ 0	□ 1	□ 2	□ 3
Undesired weight loss	□ 0	□ 1	□ 2	□ 3
Hard time falling asleep	□ 0	□ 1	□ 2	□ 3
Hard time staying asleep	□ 0	□ 1	□ 2	□ 3
Faint/dizzy/nauseous if a meal is skipped	□ 0	□ 1	□ 2	□ 3
Decreased appetite	□ 0	□ 1	□ 2	□ 3
Food or environmental allergies	□ 0	□ 1	□ 2	□ 3
Sensitive to perfumes, chemical smells, exhaust, etc.	□ 0	□ 1	□ 2	□ 3
Cold sores and blisters	□ 0	□ 1	□ 2	□ 3
Morning stiffness/muscle cramps	□ 0	□ 1	□ 2	□ 3
Pain at night/Night sweats	□ 0	□ 1	□ 2	□ 3
Past or present diagnosis of serious conditions such as: cancer, systemic infection, kidneys disease, heart disease or other	□ **NO**	□ **YES —>**		

HAIR, SKIN, and NAILS	Never- Very rare	Occasional- Mild	Intermittent- Moderate	Frequent- Severe
Oily or dry skin (please circle)	☐ 0	☐ 1	☐ 2	☐ 3
Eczema	☐ 0	☐ 1	☐ 2	☐ 3
Psoriasis	☐ 0	☐ 1	☐ 2	☐ 3
White spots on finger nails	☐ 0	☐ 1	☐ 2	☐ 3
Small bumps on the back of the arms	☐ 0	☐ 1	☐ 2	☐ 3
Skin rash or fungal infection	☐ 0	☐ 1	☐ 2	☐ 3
Increased body or facial hair	☐ 0	☐ 1	☐ 2	☐ 3
Decrease in body or facial hair	☐ 0	☐ 1	☐ 2	☐ 3
Acne	☐ 0	☐ 1	☐ 2	☐ 3
Discoloration or depigmentation of skin	☐ 0	☐ 1	☐ 2	☐ 3
Other problems or concerns in this area	☐ **NO**	☐ **YES —>**		

HEAD and MIND	Never- Very rare	Occasional- Mild	Intermittent- Moderate	Frequent- Severe
Lack of desire to get out of bed	☐ 0	☐ 1	☐ 2	☐ 3
Headaches or Migraines (please circle)	☐ 0	☐ 1	☐ 2	☐ 3
Loss of consciousness or feeling faint, dizzy	☐ 0	☐ 1	☐ 2	☐ 3
Hard time remembering (long or short term)	☐ 0	☐ 1	☐ 2	☐ 3
Difficulty speaking or "finding" words	☐ 0	☐ 1	☐ 2	☐ 3
Difficulty concentrating	☐ 0	☐ 1	☐ 2	☐ 3
Dyslexia or word confusion	☐ 0	☐ 1	☐ 2	☐ 3
Other problems or concerns in this area	☐ **NO**	☐ **YES —>**		
Feelings of sadness or depression	☐ 0	☐ 1	☐ 2	☐ 3
Anxiety and stress	☐ 0	☐ 1	☐ 2	☐ 3
Inability to cope with stressful situations	☐ 0	☐ 1	☐ 2	☐ 3
Lack of interest or concern	☐ 0	☐ 1	☐ 2	☐ 3
Mental sluggishness	☐ 0	☐ 1	☐ 2	☐ 3
Use of alcohol, drugs, vitamins/minerals/herbals to deal with stress	☐ 0	☐ 1	☐ 2	☐ 3
Recent or current thoughts of suicide	☐ 0	☐ 1	☐ 2	☐ 3
Difficulty speaking or "finding" words	☐ 0	☐ 1	☐ 2	☐ 3
Other problems or concerns in this area	☐ **NO**	☐ **YES —>**		
Diagnoses of any mental disorder- depression, bipolar, schizophrenia or other	☐ **NO**	☐ **YES —>**		

CARDIOVASCULAR and PULMONARY	Never- Very rare	Occasional- Mild	Intermittent- Moderate	Frequent- Severe
Pain in the chest, left arm, and/or left side of neck	☐ 0	☐ 1	☐ 2	☐ 3
Shortness of breath upon relaxation or exertion	☐ 0	☐ 1	☐ 2	☐ 3
Swelling in upper or lower extremities	☐ 0	☐ 1	☐ 2	☐ 3
Irregular heart beat	☐ 0	☐ 1	☐ 2	☐ 3
Pounding heart beat heard when resting your head on a pillow	☐ 0	☐ 1	☐ 2	☐ 3
Rapid heart beat	☐ 0	☐ 1	☐ 2	☐ 3
Irregular breathing or discomfort	☐ 0	☐ 1	☐ 2	☐ 3
“Blushed” or red faced	☐ 0	☐ 1	☐ 2	☐ 3
Tightness of the chest	☐ 0	☐ 1	☐ 2	☐ 3
Other problems or concerns in this area	☐ **NO**	☐ **YES —>**		

EYES, EARS, NOSE, THROAT	Never- Very rare	Occasional- Mild	Intermittent- Moderate	Frequent- Severe
Watery, red, or itchy eyes	☐ 0	☐ 1	☐ 2	☐ 3
Dark circles under eyes	☐ 0	☐ 1	☐ 2	☐ 3
Loss of vision/Blurry vision	☐ 0	☐ 1	☐ 2	☐ 3
Hard to see at night	☐ 0	☐ 1	☐ 2	☐ 3
Pain in, near, or behind the eye	☐ 0	☐ 1	☐ 2	☐ 3
Earache or pain in the ears	☐ 0	☐ 1	☐ 2	☐ 3
Tinnitus/ Ringing in the ears	☐ 0	☐ 1	☐ 2	☐ 3
Reoccurring ear infections	☐ 0	☐ 1	☐ 2	☐ 3
Decrease or loss of hearing	☐ 0	☐ 1	☐ 2	☐ 3
Enlarged lymph nodes under the chin/jaw/on the neck	☐ 0	☐ 1	☐ 2	☐ 3
Bleeding/ sore gums	☐ 0	☐ 1	☐ 2	☐ 3
Tongue has a white coating	☐ 0	☐ 1	☐ 2	☐ 3
Dry mouth, eyes, and/or nose	☐ 0	☐ 1	☐ 2	☐ 3
Halitosis/ bad breath	☐ 0	☐ 1	☐ 2	☐ 3
Sore throat	☐ 0	☐ 1	☐ 2	☐ 3
Excessive mucus formation	☐ 0	☐ 1	☐ 2	☐ 3
Other problems or concerns in this area	☐ **NO**	☐ **YES —>**		

GENITO-URINARY	Never- Very rare	Occasional- Mild	Intermittent- Moderate	Frequent- Severe
Pain in the mid to lower back	☐ 0	☐ 1	☐ 2	☐ 3
Kidney stones	☐ 0	☐ 1	☐ 2	☐ 3
Cloudy, bloody, or dark urine	☐ 0	☐ 1	☐ 2	☐ 3
Urinary tract infections	☐ 0	☐ 1	☐ 2	☐ 3
Frequent urination	☐ 0	☐ 1	☐ 2	☐ 3
Painful urination	☐ 0	☐ 1	☐ 2	☐ 3
Difficulty controlling urination, incontinence	☐ 0	☐ 1	☐ 2	☐ 3
Low sex drive/ libido	☐ 0	☐ 1	☐ 2	☐ 3
HIV test	☐ NOT TESTED	☐ YES —>	☐ Positive	☐ Negative
Sexually transmitted disease	☐ **NO**	☐ **YES —>**		
Other problems or concerns in this area	☐ **NO**	☐ **YES —>**		

GASTROINTESTINAL	Never- Very rare	Occasional- Mild	Intermittent- Moderate	Frequent- Severe
Constipation / Diarrhea (please circle)	☐ 0	☐ 1	☐ 2	☐ 3
Gas or bloating	☐ 0	☐ 1	☐ 2	☐ 3
Nausea / Vomiting (please circle)	☐ 0	☐ 1	☐ 2	☐ 3
Pains in the stomach or lower abdomen	☐ 0	☐ 1	☐ 2	☐ 3
Heartburn or “GERD”	☐ 0	☐ 1	☐ 2	☐ 3
Sense of fullness after meals	☐ 0	☐ 1	☐ 2	☐ 3
Tired after meals or feel better if you skip meals	☐ 0	☐ 1	☐ 2	☐ 3
Undigested food in stool	☐ 0	☐ 1	☐ 2	☐ 3
Food allergies	☐ 0	☐ 1	☐ 2	☐ 3
Mucous build up/ sinus congestion after meals	☐ 0	☐ 1	☐ 2	☐ 3
Greasy or fatty foods upset your stomach	☐ 0	☐ 1	☐ 2	☐ 3
Anal itching	☐ 0	☐ 1	☐ 2	☐ 3
Coated white tongue	☐ 0	☐ 1	☐ 2	☐ 3
Fungal or yeast infections	☐ 0	☐ 1	☐ 2	☐ 3
Symptoms get worse after eating sugar	☐ 0	☐ 1	☐ 2	☐ 3
Dark circles under the eyes	☐ 0	☐ 1	☐ 2	☐ 3
Hemorrhoids	☐ 0	☐ 1	☐ 2	☐ 3
Blood or mucous in the stool (please circle)	☐ 0	☐ 1	☐ 2	☐ 3
Crohn’s disease or Celiac disease (please circle)	☐ **NO**	☐ **YES —>**		
History of alcohol abuse	☐ **NO**	☐ **YES —>**		
History of hepatitis	☐ **NO**	☐ **YES —>**		
Long term use of prescription/recreational drugs	☐ **NO**	☐ **YES —>**		
Loss of bowel control, incontinence	☐ **NO**	☐ **YES —>**		
Other problems or concerns in this area	☐ **NO**	☐ **YES —>**		

MALE ONLY	Never- Very rare	Occasional- Mild	Intermittent- Moderate	Frequent- Severe
Difficulty or painful erections	☐ 0	☐ 1	☐ 2	☐ 3
Cloudy, bloody, or dark urine	☐ 0	☐ 1	☐ 2	☐ 3
Painful or difficulty with ejaculation	☐ 0	☐ 1	☐ 2	☐ 3
Waking to urinate at night	☐ 0	☐ 1	☐ 2	☐ 3
Decreased sexual function	☐ 0	☐ 1	☐ 2	☐ 3
Difficulty controlling urination, incontinence	☐ 0	☐ 1	☐ 2	☐ 3
Family history of prostate cancer	☐ **NO**	☐ **YES —>**		
Painful/tender testis	☐ **NO**	☐ **YES —>**		
Undescended testis, testis in abdomen or pelvis	☐ **NO**	☐ **YES —>**		
Other problems or concerns in this area	☐ **NO**	☐ **YES —>**		

Female Health Information

Date of Last Period:_____ Date prior period began:_____

Do you have a history of the following:	**Yes**	**No**		**Yes**	**No**
Pelvic Inflammatory Disease			Fibroids		
Chronic Yeast or vaginal discharge			Urinary tract infections		
Loss of bladder control			Breast cancer or benign tumors		
Blood in Urine			Painful urination		
Chronic vaginal itching or burning			History or current STD if yes, which ones?		

Menstrual History	**Yes**	**No**		**Yes**	**No**
Are your periods regular?			Age at first period:		
Date of last PAP:			*Date of last breast exam:*		
Were the results normal?			Date of last mammogram:		
History of abnormal paps?			Abnormal findings?		
Any unusual pelvic pain, pressure or fullness?			If yes, when?		
Did you have a normal puberty?			If no, why?		

Menstruating Women: Please mark any of the following symptoms you experience before (B), during (D), or after (A) your menstrual cycle. If you do not have a cycle, please mark symptoms you are currently experiencing with an (X).

B D A	Symptoms	B D A	Symptoms	B D A	Symptoms	B D A	Symptoms
	Cramping or pain		Headache		Bloating		Weight Gain
	Constipation		Breast tenderness		Increased Appetite		Sweet Cravings
	Depression		Nervous Tension		Irritability		Mood Changes
	Forgetfulness		Anxiety		Confusion		Crying
	Heart pounding		Insomnia		Fatigue		Insomnia

When not on BC pills:
Number of days between periods: _____ Length of flow (days): _____

Days of heavy bleeding: _____ Light bleeding: _____ Spotting bleeding: _____

How many of each of the following do you use during your menstrual period?

Tampons: _____ Pads: _____

Menopausal Women: If you are currently perimenopausal or postmenopausal, do you experience any of the following symptoms? Please indicate (Y), no (N) or past (P).

Y N P	Symptoms	Y N P	Symptoms	Y N P	Symptoms	Y N P	Symptoms
	Hot flashes		Insomnia		Vaginal dryness		Memory loss
	Fatigue		Decreased libido		Weight gain		Mood changes

Your age at menopause: _____ Mother: _____ Sister(s): _____ Mother's age if she has not yet begun: _____

Obstetric History:	**Yes**	**No**		
Are you currently pregnant?			If yes, # of weeks	
Are you trying to conceive?				
Have you had problems with infertility?			If yes, please explain:	
Any pregnancy complications?			If yes, please explain:	
Are you currently breastfeeding?			If yes, how often:	
# of pregnancies: # of births: # of Miscarriages: # of abortions:				

Sexual History:	**Yes**	**No**	
Are you currently sexually active?			If yes, current contraception?
Have you ever used birth control pills			If yes, how long?
Have you ever used an IUD?			If yes, how long and what kind?
Do you have any lack of libido?			If yes, for how long?
Any vaginal dryness or painful intercourse?			If yes, how often:

Informed Consent and Mutual Understanding

TO THE PATIENT: Once this document has been reviewed with you verbally, please read it in its entirety prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

It is not necessary or encouraged to discontinue treatments with other physicians or healthcare providers. If you are on any current medication or nutritional supplementation- it is your responsibility to inform changes in your condition, symptoms, contact information, or treatments between visits.

You are encouraged to contact Dr. William Kleber, D.C., DABCI, Dr. Brett Wisniewski, M.S., D.C., DACBN, DABCI, Dr. Katie Takacs D.C., DABCI and/or Dr. Shaun Adams D.C., DABCI at anytime with health related questions as this is a team effort and every effort will be made to keep you focused on your ultimate goal of optimal health.

Dr. William Kleber, D.C., DABCI, Dr. Brett Wisniewski, M.S., D.C., DACBN, DABCI, Dr. Katie Takacs D.C., DABCI and/or Dr. Shaun Adams D.C., DABCI hold a Doctor of Chiropractic Degree and are currently licensed in the state of Colorado. Each procedure/lifestyle modification/treatment holds both risks and benefits. Your case will be thoroughly evaluated to avoid some of these negative reactions and customized to your unique health status; but no guarantees can be assured regarding the outcomes of treatment(s) or procedure(s) nor are they implied.

For distance consultations: *Due to the nature of this consult, a primary care provider is necessary and should have performed a physical exam on your current major complaint that you are seeking advice from Dr. William Kleber, D.C., DABCI, Dr. Brett Wisniewski, M.S., D.C., DACBN, DABCI, Dr. Katie Takacs D.C., DABCI and/or Dr. Shaun Adams D.C., DABCI for.* Because of the nature of phone visits and internet consultations there is the inability to perform physical examination during these visits thus you need to have a complete physical exam by a local primary care physician or other healthcare provider and you need to try to provide very complete information and an accurate description of any physical ailments. For skin rashes and other visible problems, digital photos sent by email are helpful and will aid in the assessment. You must also appreciate that a full evaluation may not be possible but that in most instances we can share sufficient information to proceed with safety and effectiveness.

INTIAL_____

Nutrition Informed Consent:

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean:

> "Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease."

A Vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy. Although a Vitamin, a Mineral, Trace Element, Amino Acid, Herb or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented or be classified as a drug by anyone. However, these substances can have significant effects on physiology and must be used rationally. In this office, we provide nutritional counseling and make individualized recommendations regarding use of these substances in order to upgrade the quality of foods in a patient's diet and to supply nutrition to support the physiological and biomechanical processes of the human body. Although these products may also be suggested with a specific therapeutic purpose in mind, their use is chiefly designed to support overall health and well-being. Use of nutritional supplements may be safely recommended for patients already using pharmaceutical medications (drugs), but some potentially harmful interactions may occur. For this reason, it is important to keep all of your healthcare providers fully informed about all medications and nutritional supplements, herbs, or hormones you may be taking. Adverse reactions are rare, and may include, but are not limited to: bloating, nausea, vomiting, rash, fatigue, diarrhea, constipation, headaches and dizziness. If any of these or other symptoms appear, please discontinue immediately and talk to Dr. Kleber or Dr. Wisniewski, or in case of emergency, go to your local urgent care facility/Hospital. May times adjustments in dosages and or timing is all that is needed to alleviate these symptoms. Keep in

mind also; there is often an initial “Herxhiemer” reaction. This was first described by a German physician of the same name. He observed that as patients started to fulfill a need nutritionally, or emotionally, often a “detox” would start to happen as the body adjusts to metabolic pathways becoming functional again. This is usually temporary and may last a few days to several weeks.

Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom.
Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient’s diet in order to supply good nutrition supporting the physiological and biomechanical processes of the human body.
Nutritional advice and nutritional intake may also enhance the stabilization of chiropractic adjustments and treatment.

INTIAL_____

Distance Consultations
Due to the nature, distance consultations carry their own unique risks. It is **required** you consult with a local physician in conjunction with any care recommended which includes but is not limited to exercises, supplementation and dietary/lifestyle changes. A physical exam is strongly recommended to be performed prior to any consultation. Should any emergency arise, call 911 immediately.

INTIAL_____

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
I have read the above explanation of the chiropractic adjustment and related treatment. Dr. William Kleber, D.C., DABCI, Dr. Brett Wisniewski, M.S., D.C., DACBN, DABCI, Dr. Katie Takacs D.C., DABCI and/or Dr. Shaun Adams D.C., DABCI has discussed this document with me as it pertains to my specific case and has answered all my questions to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient Name (print) _____

Patient/Guardian Signature_____ Date _____

Gateway Natural Medicine and Diagnostic Center Financial Agreement and Cancellation Policy

Dr. William Kleber, D.C., DABCI, Dr. Brett Wisniewski, M.S., D.C., DACBN, DABCI, Dr. Katie Takacs D.C., DABCI and/or Dr. Shaun Adams D.C., DABCI strive to see patients in a timely manner. We respect your time and ask you to respect our time and other patients' needs by keeping your appointment. Each appointment time slot is important and cannot be recovered if a patient chooses not to keep their appointment. We collect fees to ensure that Dr. William Kleber, D.C., DABCI, Dr. Brett Wisniewski, M.S., D.C., DACBN, DABCI, Dr. Katie Takacs D.C., DABCI and/or Dr. Shaun Adams D.C., DABCI can continue to see patients. Please keep in mind that each skipped or missed appointment is not just time lost, but also time when other patients cannot be seen.
Please refer to the guidelines below to learn more about our missed Appointment/Cancellation policy:

• It is your responsibility to provide us with a working telephone number to allow us to communicate important information, such as laboratory results, and provide telephone reminders of scheduled appointments. Having a valid telephone number is truly important; please help us to maintain your records.

- **New patient appointments will be subject to fees below. When a patient does not show up or does not cancel within 24 business hours the follow fees will be added to the patient's account:**
  $225 fee for New Patient Internal
  $125 fee for New Patient Chiropractic
  A credit card will be required to schedule all future appointments and will be charged full cost if the appointment is not cancelled/rescheduled within the 24hrs notice policy.

Established patients
We understand that circumstances occur that do not allow you to keep your scheduled appointment. If this is the case, please call and discuss this with the office staff as soon as possible.
$10 fee for Internal Medicine
$10 fee for Chiropractic
A credit card will be required to schedule all future appointments and will be charged full cost if appointments are not cancelled / rescheduled within the 24 hour notice.

•Any cancellation not made at least 24 hours before the scheduled appointment is considered a missed appointment and subject to the terms above.
By signing below I agree to have my credit card automatically charged for the above mentioned fees. We realize that there are times that you may arrive for a scheduled appointment time and are not able to be seen promptly at your appointed time. Please know that we go out of our way to make certain that this does not happen, however there are times when Dr. William, Dr. Brett, Dr. Shaun and Dr. Katie need to spend extra time with a patient that was not foreseen, as they may have done with you in the past or need to, with you, in the future.

Patient Name (print): _____

Patient: _____

Guardian Signature: _____Date _____

Notice to Medicare/Medicaid Patients

The following is the office policy for treatments performed at Gateway Natural Medicine and Diagnostic Center regarding Medicare Benefits. **Please read carefully and sign only if you understand and agree to the terms.**

We will not bill Medicare insurance for you if you have coverage with Medicare or with a secondary insurance policy; **payment for the visit is due at time of service**.

For patients of Dr. William Kleber, D.C., DABCI, Dr. Brett Wisniewski, M.S., D.C., DACBN, DABCI, Dr. Katie Takacs D.C., DABCI and/or Dr. Shaun Adams D.C., DABCI:

Medicare will not reimburse you if you submit a super bill for coverage since Drs. William Kleber, Brett Wisniewski, Katie Takacs and Shaun Adams are non-providers. You CAN NOT submit codes and charges for coverage by Medicare/Medicaid if receiving services by Drs. William Kleber, Brett Wisniewski, Dr. Shaun Adams and/or Katie Takacs.

Notice of Exclusion from Medicare/Medicaid Benefit (NEMB)

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them directly.

Please see our fee schedule for a more complete list of services offered and associated prices.

Before you make a decision, you should read this entire notice carefully.

If you have any questions, please ask us so we can clarify. By signing below you are acknowledging that you have read, understand and agree to these terms.

Patient Name (print) _____

Patient/Guardian Signature_____ Date _____

Policy on Nutraceuticals

You have the option of picking up your nutraceuticals in office or having them shipped to you. We can hold orders for 48 hours. If they are not picked up by that time, they will be placed back into inventory.

Un-opened: May be returned within 30 days of purchase date. There will be a 10% restocking fee applied.

Opened: Pre-authorization is required from a doctor and/or office manager and may be subject to restocking fee.

If you have any questions, please ask us so we can clarify. By signing below you are acknowledging that you have read, understand and agree to these terms.

Patient Name (print) _____

Patient/Guardian Signature_____ Date _____

HIPAA NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law. Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage. Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment. We may use or disclose your protected health information in the following situations without your authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers’ Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization. Your Rights: Following is a statement of your rights with respect to your protected health information. You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. You have the right to request to receive confidential communications from us

by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically. You may have the right to have our organization amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any questions concerning or objections to this form, please ask to speak with our owner in person or by phone at 970-532-2755.

Associated companies with whom we may do business, such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided. We welcome your comments: Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.

Patient Name (print) _____

Patient: _____

Guardian Signature: _____Date _____

We understand that this was a lengthy intake and you were asked to provide a lot of details. We appreciate you and your time in filling this out completely. We really do utilize this entire form and it helps establish an accurate account of your history and current health status.

Thank you!