



112 Village Square West Suite #110
(North East corner of Stoplight in Ridgway)
#970-626-7137

NEW PATIENT WELCOME LETTER

24-HOURS CANCELLATION NOTICE IS REQUIRED

Please read your Welcome Letter very carefully and sign at the bottom.

Thank you for taking this first step towards improving your health naturally. Enclosed is important paperwork that will start you on your way to wellness.

- Please fill it out the following forms as completely as you can.
- Leave questions blank if you are uncertain of your answers.
- Bring completed forms to your appointment.
- *If you do not complete this paperwork for any reason prior to your first appointment, please arrive at least 30 minutes earlier than your scheduled appointment time.*

What to Expect

During your initial visit you will meet with our friendly front-office staff as well as get to know Dr. Bojar. Dr. Bojar will be interested in getting to know you and your health concerns. Your health related goals as well as your health history will be discussed in detail. An examination will be performed and any necessary laboratory tests will be recommended and/or ordered at that time.

Appointment Length and Cost

Your initial complete consultation and examination will take one to two hours and costs \$75 to \$175 depending on complexity of concerns as well as appointment time needed. Your second visit (report of findings) will take 30-45 minutes, fees are \$30 per 15 minutes. NOTE: It is during the follow-up visit that most or all test results are reviewed and the bulk of recommendations are provided. Our office requires payment in full at the time services are rendered.

About Laboratory Testing

Laboratory testing is frequently recommended, especially for more complex medical problems. Tests may include regular blood work if you have not had blood work within the last 4 months. Additional specialized tests may be recommended based upon your personal and family history and health goals. All testing requires your prior approval before completion and sample medium may include blood, urine, stool, saliva, breath or hair. You may decide not to have lab work performed. Depending upon your health concerns and goals this may be permissible. We will make our best-educated efforts to improve your health in this instance.

Payment Requests

Our office requires that payment be received for services rendered at the time of your visit. Please come prepared to pay your visit fees with a check, cash, or credit card. Our office cannot maintain a balance-due for services rendered. If paying by check, please bring more than one check since certain laboratory testing fees require separate payment directly to the laboratory. Some or all of your visit fees may be reimbursable to you by your insurance company. (Our front office staff will provide you with a receipt you can submit to your insurance company.)

First Visit Instructions

1. Bring in all completed paperwork (we prefer it be mailed, faxed, or emailed back to us prior to your first appointment) and outside doctor notes, recent lab work (last 2 years), etc.
2. Please arrive to your appointment at least 30 minutes early if you have not completed your intake forms.
3. Please do not wear perfume or cologne.
4. Continue taking any prescription medication(s).

You are taking an important step toward attaining true, lasting health. It is our mission to provide you with the most personalized health care possible at an affordable price. We look forward to working with you!

Patient's/Guardian Acknowledgement Signature Required

Today's Date:

HEALTH HISTORY

NAME: _____ DATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: HOME: _____ WORK: _____ CELL: _____

EMAIL: _____

DATE OF BIRTH: _____ AGE: _____ WEIGHT: _____ HEIGHT: _____

Please list your Health Concern:

1. _____

2. _____

3. _____

4. _____

Please explain your health-related goals:

Do you smoke? _____ How Much/For How Long? _____ Quit? When? _____

Do you Drink alcohol? _____ How much/How Often? _____

Do you drink caffeine? _____ How much/ How often? _____

Do you ever overeat? _____ If so, which foods and how often? _____

Do you have food allergies, restrictions, or sensitivities? _____

Describe your daily energy levels:

Do you get noticeably irritable, light-headed, or weak if you haven't eaten in a while?

Do you crave certain foods? _____ If so, which foods and when? _____

Do you crave any of the following?

Sugar Meat Fat Chocolate Fish Alcohol

Desserts Milk Bread Fried foods Other _____

Do you take any nutritional supplements or vitamins? _____ If so, which ones?

3 DAY DIET RECALL

Record everything that you eat and drink. Be as specific as possible as to size/amount of portion. Indicate how hungry you were and what you were doing while eating (i.e.: watching TV, driving, standing, talking, etc...)

DAY 1
BREAKFAST

MID-MORNING SNACK

LUNCH

AFTERNOON SNACK

DINNER

AFTER DINNER SNACK

DAY 2
BREAKFAST

MID-MORNING SNACK

LUNCH

AFTERNOON SNACK

DINNER

AFTER DINNER SNACK

DAY 3
BREAKFAST

MID-MORNING SNACK

LUNCH

AFTERNOON SNACK

DINNER

AFTER DINNER SNACK

Which prescription and over-the-counter medications do you take regularly? How long?

Which oils do you use/consume?

- | | | | | | |
|--------------------------------------|--------------------------------------|-------------------------------------|--------------------------------------|--|--|
| <input type="checkbox"/> Butter | <input type="checkbox"/> Peanut Oil | <input type="checkbox"/> Canola | <input type="checkbox"/> Margarine | <input type="checkbox"/> Corn Oil | <input type="checkbox"/> Sun/Safflower |
| <input type="checkbox"/> Olive Oil | <input type="checkbox"/> Crisco | <input type="checkbox"/> Mayonnaise | <input type="checkbox"/> Coconut Oil | <input type="checkbox"/> Vegetable Oil | <input type="checkbox"/> Flaxseed Oil |
| <input type="checkbox"/> Soybean Oil | <input type="checkbox"/> Other _____ | | | | |

How is your dental health? _____

Have you ever had a filling removed or replaced? _____ If so, How Many _____ When? _____

How many bowel movements do you have a day?

Rank your skin without lotion: Very Dry Dry Normal Oily Combination

Please check off any of the following that pertain to you now or in the past.
 (Please mark Present conditions with a P next to it):

- | | | |
|--|--|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Difficulty losing weight | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Addiction (alcohol, drugs) | <input type="checkbox"/> Difficulty gaining weight | <input type="checkbox"/> Liver problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emotional problems (instability or sensitivity) | <input type="checkbox"/> Loose stools |
| <input type="checkbox"/> Anorexia/Bulimia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Memory loss or confusion |
| <input type="checkbox"/> Anxiety or nervousness | <input type="checkbox"/> Fainting | <input type="checkbox"/> Nails, poor growth |
| <input type="checkbox"/> Arthritis (Rheumatoid or Osteo) | <input type="checkbox"/> Gall bladder problems | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Parasites |
| <input type="checkbox"/> Bladder infections (Cystitis) | <input type="checkbox"/> Hair loss or poor hair growth | <input type="checkbox"/> PCOS |
| <input type="checkbox"/> Bloating, gas or indigestion | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pregnant or nursing mother |
| <input type="checkbox"/> Blood Sugar problems | <input type="checkbox"/> Heart disease or problems | <input type="checkbox"/> Respiratory problems |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Colds or flu (frequent) | <input type="checkbox"/> Herpes simplex or type II | <input type="checkbox"/> Severe mood swings |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Skin conditions |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> HIV | <input type="checkbox"/> Suicidal tendencies |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Thyroid condition |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Diabetes I (insulin dependent) | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Yeast infections |
| <input type="checkbox"/> Diabetes II (adult onset) | <input type="checkbox"/> Intestinal problems | |

Women: Please check all that pertain:

- PMS
- Irregular periods
- Painful periods
- Loss of periods
- Hormone Replacement Therapy
- Birth control pills
- Menopause
- Painful intercourse
- Children
- Hysterectomy
- Miscarriages

Men: Please check all that pertain:

- Frequent urination
- Difficulty urinating
- Difficulty with erection
- Loss of libido
- Prostate enlargement

Please list any disease, illness, or ailments in your immediate family (i.e. mother-breast cancer, father-type II diabetic, grandfather-heart disease).

Do you exercise? _____ If so, what kind? _____
 How often: Since when? _____

Please rate the following:

- | | | | | |
|------------------------------|------------------------------------|-------------------------------|-----------------------------------|-------------------------------|
| Daily energy level: | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Energy level after exercise: | <input type="checkbox"/> Excellent | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| Daily stress level: | <input type="checkbox"/> Very High | <input type="checkbox"/> High | <input type="checkbox"/> Moderate | <input type="checkbox"/> Low |

Do you have a support system of family and friends? _____
 General enjoyment of life: Excellent Good Fair Poor

How many hours do you sleep? _____ Do you sleep throughout the night? _____
Do you wake up without an alarm? _____ Do you wake up feeling rested? _____
Do you fall asleep within 15 minutes? _____ How many nights a week do you sleep through the night? _____

For those interested in Weight-Loss, Please answer the following questions:

Personal weight loss history: How many diets have you been on? _____

Which ones? _____

What were your results? _____

Have you ever taken weight loss supplements or "diet pills"? _____

What do you feel triggered your initial weight gain? (Circle One)

HEREDITY EATING HABITS STRESS HORMONES
BOREDOM SMOKING CESSATION OTHER _____

Was your weight gain: (Circle One)

SUDDEN GRADUAL PROBLEM SINCE CHILDHOOD

Please describe any other health concerns you think are important:

By signing below, you acknowledge that any dietary or supplemental suggestions made by this office are entirely nutritional in nature, and are not intended as the diagnosis, cure or treatment for any disease or ailment. You also acknowledge that your physician is your primary health care provider, and is responsible for supervising all changes in diet and nutrient intake that you make.

Signed: _____ Date: _____

Balance Natural Medicine LLC

**Jason Bojar D.C.
Jessica Balbo D.C.**

GENERAL INFORMED CONSENT

I have sought the chiropractic and health care services of Balance Natural Medicine LLC for my personal healthcare, or for my child or children, who are minors. I understand that this chiropractic office uses some diagnostic and treatment methods that are known as complementary, alternative or holistic and may not be covered by my insurance plan, or generally accepted by mainstream medicine. The terms complementary, alternative, and holistic refer to therapies that may include, but are not limited to, dietary and nutritional supplement advice and various diagnostic/testing procedures. Furthermore, the information gained from laboratory and evaluation tests may be interpreted differently from mainstream doctors. Approaches for improving general health and nutrition may be based upon the tests/evaluations and philosophies of complementary medicine and may or may not be consistent with mainstream medical tests/evaluations and philosophies.

In addition to recommending oral nutritional supplements, our office may recommend acupuncture, massage and/or exercise therapies. Some of these products/approaches are not FDA approved or evaluated for any disease or condition, and are not considered the standard practice in mainstream medicine.

Our chiropractic and nutrition practice is exclusively an office-based practice. We are not affiliated with a local hospital. As a result, **WE STRONGLY RECOMMEND THAT IN ADDITION TO OUR CARE YOU MAINTAIN A RELATIONSHIP WITH ONE OR MORE PHYSICIANS QUALIFIED TO CARE FOR HEALTH CONDITIONS.**

For example, in the case of children, we advise that you seek the advice of a pediatrician; if you have cardiovascular disease, consult with a cardiologist; and if you have cancer, consult with an oncologist, etc. Our office routinely refers patients to these and other health care professionals when it is deemed necessary. These physicians can provide you and your family with emergency care if hospitalization is needed, with ongoing follow-up care. We are happy to cooperate and communicate with your doctor(s) regarding your chiropractic condition(s), treatment options, or any other health related issues.

Our office and its employees make no representations, claims, or guarantees regarding the efficacy of our treatment recommendations. The treatments we recommend are based upon a combination of our clinical experience and knowledge of scientific and chiropractic literature. With this information individualized treatments may be offered and applied either as adjunctive (complementary) or primary treatments for various symptoms and disease states.

By signing this informed consent, you agree to hold harmless Balance Natural Medicine LLC including Jason Bojar DC, Jessica Balbo DC and its employees from all professional and personal liability. You agree to be responsible for all legal costs and fees that may result from action(s) on your part or on the part of your representative(s) against us. If a legal case is brought against us, you agree that we shall be judged by the standards and principles of complementary, alternative, and/or holistic medicine and not the standards and principles of consensus conventional medicine. You have the right to have this consent reviewed by your lawyer before accepting any chiropractic and/or nutritional services from this office.

Our office makes available nutritional supplements and other health products. You are in no way obligated to purchase these products from our office or any other specific location or company. You may freely choose to purchase such products from any source(s) as you wish. Balance Natural Medicine LLC and its employees may profit from the sale of supplements and other products that we make available to our patients.

Most insurance plans cover services that they consider medically necessary and/or reasonable and customary. Many of our services (such as nutritional consultations, acupuncture, and others) are often not considered by insurance companies to be necessary based upon their own internal criteria. By signing this form you accept full financial responsibility for all services, including consultations, lab tests and other procedures. In the event that an insurance company would like information from your file to be faxed and/or e-mailed to them by our office staff, a charge of \$30 per 15 minutes (time necessary to organize and send information) will be billed to you, the patient. Please tell the doctor if you do not want this information shared.

SIGNATURE ON FILE: I authorize any holder of medical/chiropractic information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.

Your signature verifies that you have not been told to discontinue treatments with any other medical specialists or other health care providers.

Your signature is being given prior to rendering any services, advice, and/or recommendations whatsoever from Balance Natural Medicine LLC.

It is the responsibility of the patient to follow-up with our office for results of all testing and lab procedures. It should not be assumed on the part of the patient that if they are not contacted by Balance Natural Medicine, or its employees, or if the patient does not schedule or keep a consultation, that test results are normal (or without abnormalities), and may not require further medical treatments or advice. Health/medical recommendations and/or possible referral and additional follow-up may be warranted based upon laboratory testing and evaluations.

The patient is further notified that some tests, or all, may not be covered by their insurance company. The patient assumes full responsibility for the costs of non-covered tests. Balance Natural Medicine LLC does not assume responsibility for costs incurred regarding non-covered and/or potentially covered services, including procedures, lab tests and consultations.

PAYMENT REQUIREMENTS

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By entering your signature below, you are acknowledging that you understand all terms, verbiage (language), and concepts herein.

I understand this consent agreement and have executed it freely and willingly.

Patient Name (printed)

Date

Patient signature

Guardian Name (printed)

Guardian signature