

JENNIFER J. McPEEK, D.O.

Specializing in Cranial Osteopathy
<http://www.fluidbody.net>

Lakewood, CO
(303) 980-5553

Steamboat Springs, CO
(970) 367-6129

INSURANCE AND FINANCIAL POLICIES

Thank you for choosing Dr. McPeek for your health care. If you have medical insurance that covers Dr. McPeek's services, we are happy to assist you in submitting your insurance claims. If you do not, payment is expected at the time of services. Co-pay, co-insurance or deductibles are your responsibility and are due at the time of service.

Insurance:

You are responsible for checking with your insurance plan regarding any co-payment, deductible or co-insurance that might be owed at the time of service. If you have questions about your coverage, speak to your employer or contact your insurer directly. Please bring your health insurance card or policy information with you at the time of service.

In many cases we will be able to verify coverage before your visit. If we are not able to verify insurance coverage, payment in full is expected at your visit. If your insurance company remits payment, you will be reimbursed.

BY SIGNING THIS AGREEMENT YOU AGREE TO PAY YOUR CO-PAY, CO-INSURANCE, DEDUCTIBLE AND ANY FEES THAT YOUR INSURANCE COMPANY DOES NOT COVER, AT THE TIME OF SERVICE.

Cancellation/Missed Appointments:

As a courtesy to other patients requiring services, we request that you provide notice of cancellation 24 hours in advance of your appointment. Patients who do not give 24 hour notice will be charged the full appointment fee.

Method of Payment:

We accept cash, checks, Visa and MasterCard.

Authorizations:

I have read the above information and agree regardless of my insurance to be responsible for the balance of my account. I agree to pay for all services rendered not covered by my insurance and to notify this office should there be any change to my insurance coverage. **I also agree to pay my balance in full within 60 days. If my balance is not paid within 60 days, I authorize the balance to be paid on my credit card as follows:**

Card Type: _____ Card Number: _____ Exp Date: _____

Card Holders Name: _____ Signature: _____

Patient or Authorized Person's Signature: _____ Date: _____

Printed Name: _____

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HEALTH HISTORY QUESTIONNAIRE

Name _____ Date _____

1. Primary Complaint: _____

2. History of Primary Complaint (in detail): _____

3. Past Medical History. Please Circle All That Apply:

Illnesses:

Measles, Rubella (German Measles), Chicken Pox, Mumps, Whooping Cough, Scarlet Fever, Rheumatic Fever, Tonsillitis, Strep Throat, Ear Infections, Sinusitis, Pneumonia, Bronchitis, Croup, Infectious Mononucleosis, Meningitis, Urinary Tract Infection, Staph Infection, Yeast Infection

Other Health Conditions: (Please check if you have had any of these and give age of onset and frequency)

- Anemia _____
- Diabetes _____
- Hypoglycemia _____
- High Blood Pressure _____
- Low Blood Pressure _____
- Heart Problems _____
- Thyroid Problems _____
- Gall Bladder Problems _____
- Kidney Problems _____
- Asthma _____
- Other Respiratory Problems _____
- Cancer _____
- Obesity/Overweight _____
- Underweight _____
- Back Problems _____
- Neck Problems _____
- Scoliosis _____
- Ulcer/Stomach Problems _____
- Constipation/Diarrhea _____

---Irritable Bowel _____
 ---Hiatus Hernia _____
 ---Other Digestive Problems _____
 ---Bladder Problems _____
 ---Rheumatoid Arthritis _____
 ---Foot Problems _____
 ---Hepatitis _____
 Other: _____

4. Surgeries: Please list all with approximate date or your age. _____

5. Allergies: _____ Meds: _____ Other: _____

6. Medications: Medications taking now – including vitamins, herbs, aspirin, Tylenol, Advil, etc. Reason for each and name of doctor who prescribed or recommended it. _____

7. Neurological History: Please check if you have had any of these and give age at onset, frequency of incident and details.

_____ Fainting Spells	_____
_____ Dizziness	_____
_____ Equilibrium/Balance	_____
_____ Motion Sickness	_____
_____ Tinnitus (ears ringing)	_____
_____ Hearing Loss	_____
_____ Vision Problems	_____
_____ Memory Problems	_____
_____ Attention/Concentration Problems	_____
_____ Weakness in Extremities	_____
_____ Burning in Extremities	_____
_____ Numbness in Extremities	_____
_____ Cramps in Extremities	_____
_____ Difference Between Sides of Body	_____
_____ Other	_____

Have you had any diagnostic tests done (e.g. X-ray, EMG, CAT scan, MRI)? If yes, please give doctor's name, where test was done, approximate date, results. _____

8. Gynecological History: Please circle any that apply.

PMS, Menstrual Cramps, Heavy Bleeding, Infertility, Miscarriages, Hot Flashes, Other Problems

Pregnancies How Many? _____ Complications? _____

9. Infants and Children

Please describe your pregnancy: _____

Please describe your child's birth detailing any complications: _____

apgar scores _____

What immunizations has your child received? _____

Is/was your child breast fed? _____

Has your child had any of the following: Please circle any that apply.

Ear Infections, Colic or Frequent Spitting Up, Injuries, Developmental Delays, Difficulty Breathing, Diarrhea, Constipation

Please describe your child's temperament: _____

10. Habits

Sleep Habits (Please describe): _____

Do you smoke? _____ No _____ Yes How much? _____

For how long? _____ Quit? _____ How long ago? _____

Consume alcohol? _____ No _____ Yes How much? _____

11. Diet: Please describe your diet, i.e. milk free, low fat, vegetarian, etc. _____

What exercising do you do? How often? How long at a time? Include competitive sports. _____

Have you ever had any fractures/broken bones? Please list all and any after effects. _____

Head Injuries: Please list all with cause, treatment, after effects, approximate age. _____

List all other major injuries: _____

List all Doctors, Therapists, etc, which you are seeing currently: _____

Family History:

Mother: Healthy Yes No _____

 Deceased: cause _____

Father: Healthy Yes No _____

 Deceased: cause _____

Siblings: (x_____) Healthy Yes No

Deceased: cause _____

Is there any history of the following in your family other than yourself? If yes, list family members for which condition.

Cancer _____

Diabetes _____

High Blood Pressure _____

Heart Problems _____

Asthma _____

Respiratory Problems _____

Allergies _____

Kidney _____

Gall Bladder _____

Weight Problems _____

Headaches _____