



Chris Bantock, DC
303-500-3038
drbantock@revhc.net
www.revolutionhealthcenter.net

Dear New Patient,

Welcome to our office! We look forward to becoming your partner in assessing and improving your health.

In your first visit, Dr. Bantock will obtain a complete medical history. The key to functional medicine is treating each person as an individual and getting to the root cause of health problems. That generally entails a detailed conversation about your current state of health, health history, family history, diet, lifestyle habits, etc. At that point, Dr. Bantock will discuss with you potential approaches and recommended laboratory workups. This visit will last approximately 90 minutes and is primarily an information gathering and sharing session. Dr. Bantock may make some simple recommendations at this time, but most advice will be deferred until after lab and physical exam results are in and there has been time to thoughtfully consider your case.

The second visit is generally scheduled a week or two later or when all lab results have come back. Any physical exam that is indicated will be performed during your second visit. It is at that time that Dr. Bantock will discuss the review of findings. This includes what may be causing your health problems and what supplementation (vitamin, minerals, herbs), diet, and lifestyle changes may be needed, as well as any or other medications that may be appropriate for your care. Follow-up visits are usually scheduled in approximately 4–8 weeks from this visit to evaluate progress and make any adjustments in your program.

How often you see Dr. Bantock after that will depend on why you are being treated. Some healthy people see Dr. Bantock only once a year for physical exams and screening lab tests. Many people who have multiple complaints are seen more often based on the severity of their condition.

If you have any further questions after reading the enclosed information, please call our office. I will be happy to assist you. Please be sure to complete all forms sent online, bring in recent lab work, and supplements. I look forward to working with you.

In health,

Chris Bantock, DC

4500 Cherry Creek Dr. S. #103 - Glendale, CO 80246

7465 E. 1st. Ave Ste. C, Denver, CO 80230



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FUNCTIONAL MEDICINE/CHIROPRACTIC INFORMED CONSENT

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. I hereby request and consent to the following:

Vitals and/or anthropometry	Hands On Soft Tissue Treatment	Examination
Bioimpedence measurements	Therapeutic nutritional protocols	Spinal Manipulation
Nutritional Counseling	Stress management counseling	Physiotherapy Modalities
Health Assessment	Instrument Soft Tissue Treatment	Acupuncture
Laboratory Testing	Lifestyle-associated health history	

The purpose of functional medicine laboratory testing in our office is to evaluate nutritional, biochemical, or physiological imbalance and to determine any need for medical referral. These lab tests in our office are not intended to diagnose disease. This office utilizes conventional lab tests as well as functional medicine assessment.

Functional medicine assessment is designed to assist our doctors and other healthcare providers in finding the underlying causes of your condition. Functional medicine has evolved through the efforts of scientists and clinicians from the fields of clinical nutrition, molecular biology, biochemistry, physiology, conventional medicine, and a wide array of scientific disciplines. Functional medicine evaluates the body as a whole, with special attention to the relationship of one body system to another and the nutrient imbalances and toxic overload that may adversely affect these relationships.

I understand and am informed that, as in the practice of medicine, in the practice of hands on chiropractic there are some risks to treatment, though extremely rare, including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains, and infections. Also, I do not expect the practitioner to be able to anticipate and explain all risks and complications, and wish to rely on the practitioner to exercise judgment during the course of the procedure, which the practitioner feels at the time, based upon facts then known, is in my best interests. No guarantee or warranty to the treatment. All patients respond differently to the treatment procedures. Each case must be evaluated separately.

Your medical physician may or may not agree with the necessity for—or our interpretation of—these tests. If you have any questions or concerns, please discuss them with our doctors.

I have had the opportunity to ask question about this content, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature _____ Date: _____

Parent/Guardian _____ Date: _____

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Option To Receive A Copy of “Notice of Privacy Practices”

By signing this acknowledgement of receipt of Notice of Privacy Practices, I acknowledge and agree that I have been provided access or offered a copy of the full Notice of Privacy Practices for review and to keep for my records on the date identified below.

I understand that Dr. Bantock may use and disclose necessary personal health information (for example my name, address, subscriber information number, exam information and/or type of service provided) to another part to permit Dr. Bantock to perform his administrative duties, provide me with services and products, process any claims and communicate with me regarding services provided (for example: mailing and emailing exam results, information about services or products provided by Dr. Bantock).

I can be assured that Dr. Bantock does not sell my personal health information of any kind to a third party of such party’s own use. I authorize Dr. Bantock to submit my claims to my plan sponsor or health plan to receive reimbursement directly for the services and products that I have received from Dr. Bantock and his associates.

I do not want a copy of the “Notice of Privacy Practices”

I would like a copy of the “Notice of Privacy Practices”

Name _____

Signature _____ Date _____

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