Vail Integrative Medical Group

Vail Village: Vail Athletic Club, Tel. (970) 479-6262
Edwards: 0105 Edwards Village Blvd A203 Tel. (970) 926-4600 Fax (970) 926-4602
Additional Fax (970) 766-4600
Eagle: 717A Sylvan Lake Rd., Tel. (970) 328-1200 Fax (970) 328-1600
vailmed.com

1 Confidential Patient Information

Patient's Name: _____ Today's Date: _____/_____/_____
Last First (Legal) Middle Initial

Home Phone: _____ Cell Phone: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

E-Mail: _____ ☐ Male ☐ Female

Date of Birth: _____/_____/_____ Age: _____

Occupation: _____ Hours/Week: _____ Employer: _____ Business Phone: _____

Spouse's Name:_____ Employer: _____ Business Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Concurrent Health Care

Family Physician: _____ City: _____ State: _____ Phone: _____

How were you referred to us? _____

2 Insurance Information:

Is Today's Visit Due To a: Work Related Injury: ☐Yes ☐No **Auto Accident:** ☐Yes ☐No **Date Of Injury:_____**

(If yes to either questions above, please check with receptionist as additional information is required.)

Do you have health insurance? ☐ Yes ☐ No

Name of Primary Account Holder: _____

Date of Birth of Primary Account Holder: _____

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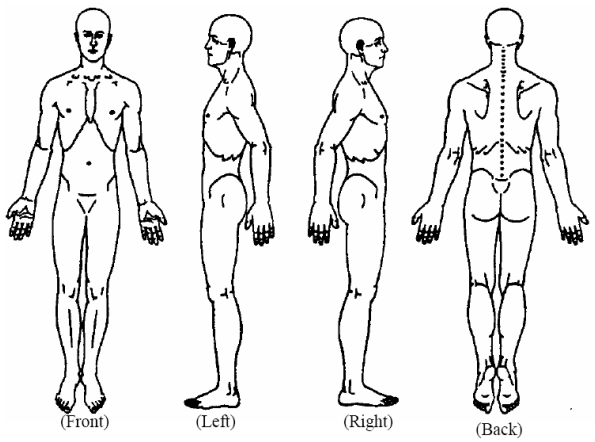
3 Please complete this brief health questionnaire.

Date of Onset: _____ Was the Onset: ☐ Gradual ☐ Sudden Since onset, has it gotten: ☐ Worse ☐ Better

Chief complaint: _____

Secondary or related complaint (if any): _____

PLEASE MARK WHERE YOUR PAIN IS LOCATED:



SEVERITY OF PAIN:

Circle the number which represents the intensity of your pain.

Current Pain Level 0 1 2 3 4 5 6 7 8 9 10
no pain unbearable

Best Pain Level 0 1 2 3 4 5 6 7 8 9 10
no pain unbearable

Worst Pain Level 0 1 2 3 4 5 6 7 8 9 10
no pain unbearable

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Describe what caused the pain: _____

Describe the quality of the complaint/pain: □ sharp □ dull/ache □ throbbing □ tingling/numbness □ other: _____

Does any of the following make the pain worse: □ lifting □ bending □ pushing □ pulling □ cough □ sneeze □ bowel movement
□ driving □ riding □ sitting □ walking □ running □ standing
□ other: _____

Describe if pain is in a single spot or does it spread out: □ radiating dull □ deep ache □ pin point □ burning □ sharp □ stabbing
□ tingling □ numb □ other: _____

Does any of the following make it better: □ rest □ laying down □ sitting □ walking □ exercise □ other: _____

How often are you aware of the pain: □ intermittent (less than 25% of time when awake) □ occasional (25-50% of time when awake)
□ frequent (50-75% of time when awake) □ constant (75-100% of time when awake)

Does it interfere with your daily activities: □ minimal (annoyance, no impairment) □ slight (tolerated, some impairment)
□ moderate (marked impairment) □ marked (precludes any activity)

Have you detected any possible relationship of your current complaint with any of the following?
□ Muscle Weakness □ Bowel/Bladder problems □ Digestion □ Cardiac/Respiratory □ Other: _____

Have you tried any self-treatment or taken any medication (over the counter or prescription): □ Yes □ No
If yes, explain; _____ Results: _____

List of Current Medication(s) and Dosage(s):

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Past Health and Social History:

1. Is this the first time you have experienced this problem? □ Yes □ No If no, When: _____

2. Was treatment provided? □ Yes □ No If yes, By whom:_____ Outcome:_____

3. Have you **ever** had any **major illnesses, injuries, broken bones, hospitalizations, or surgeries?** If Yes, please list below:

Date	Injury / Fracture / Illness	Treatment	Results

4. What is your approximate height? _____ What is your approximate weight?_____

5. Do you regularly exercise? □ Yes □ No If yes, how many hours a week and what activities: _____

6. Do you drink alcohol? □ None □ light □moderate □ heavy How many glasses per week? _____

7. Check any conditions you have had:

□ AIDS/HIV
□ Allergies
□ Anxiety/Depression
□ Arm/shoulder pain
□ Arthritis
□ Asthma
□ Bladder Problems
□ Cancer
□ Chronic Fatigue
□ Deafness
□ Diabetes
□ Digestion Problems
□ Earache
□ Ear ringing
□ Epilepsy
□ Headaches
□ Headache – Migraine
□ Heart Disease
□ Herniated Disc
□ High blood pressure
□ Insomnia
□ Irregular Cycle
□ Kidney Problems
□ Leg Pain
□ Low back pain
□ Neck Pain
□ Osteoporosis
□ Poor Circulation
□ Prostrate Problems
□ Rheumatoid Arthritis
□ Sciatica
□ Shingles
□ Sinus Infections
□ Stroke
□ Thyroid Problems
□ TMJ
□ Venereal disease
□ Vertigo/Dizziness
Other:
_____
_____
_____

Please initial below to indicate you have read the provided paperwork regarding the following office policies:

INFORMED CONSENT: _____
Patient initial

ASSIGNMENT OF BENEFITS: _____
Patient initial

CANCELLATION AND NO-SHOW POLICY: _____
Patient initial

STATEMENT OF FINANCIAL LIABILITY: _____
Patient initial

RECEIVING UNENCRYPTED EMAILS: _____
Patient initial

NOTICE OF LIABILITY FOR "NON-COVERED" SERVICES: _____
Patient initial

Patient's Printed Name:_____

Patient / Guardian Signature:_____ **Date:**_____

VIMG OFFICE FINANCIAL POLICY

Thank you for choosing Vail Integrative Medical Group (VIMG) for you healthcare needs. Please take a moment to read this page thoroughly to understand our financial policy. As advocates in your recovery, we are here to assist you with any questions or concerns you may have.

1. **If You Do Not Have Insurance (Self pay) OR Choose NOT To Use Your Insurance:** All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $100 at any time or care may be terminated unless under an authorized payment plan. Our payment plans make care an affordable part of your monthly budget. VIMG participates in a medical discount plan called ChiroHealthUSA which allows us to legally reduce our usual and customary fees to offer discounted services.

2. **If You Have Insurance:** Our financial policy allows the courtesy of assigning your insurance benefits to VIMG for payment. All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed $100 or care may be terminated unless under an authorized payment plan. Our payment plans make care an affordable part of your monthly budget.

   ****** You are considered a **cash patient** until you bring in your completed insurance forms, we verify and accept your insurance coverage. Once insurance coverage has been received, we will review this information with you.

   Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard and of care in this area. If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim.

   VIMG does NOT mail statements for patient balances. Our policy requires a credit card on file through a Payment Card Industry hosting provider (which meets The Payment Card Industry Data Security Standard). Once your insurance processes, adjudicates, and releases payment, the credit card on file will be charged for the outstanding balance on the date our Explanation of Benefits (EOB) is received by our office. An unencrypted email will be sent for receipt of payment to the email listed below.

   I authorize VIMG to process any payments up to $500 to my credit card listed below. If my account balance is greater than $500, VIMG will contact me prior to my credit card being charged.

   *If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable **in full** by you, regardless of any claim submitted. The only exception will be those under an active payment plan.*

Patient's Printed Name: _____

Patient's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Email Address for Correspondences: _____

Phone #:

- ***Primary Credit Card***

Card #: _____ Expiration Date: _____ CVV: _____

Name as appears on card:

Billing address: _____ City: _____ State: _____ Zip Code: _____

- ***HRA/HSA Card***

Card #: _____ Expiration Date: _____ CVV: _____

Name as appears on card:

Billing address: _____ City: _____ State: _____ Zip Code: _____

Please read below forms before examination and treatment.

INFORMED CONSENT:

Medical Doctors, Doctors of Chiropractic and Physical Therapists that perform procedures are required by law to obtain your informed consent before beginning treatment.

I do hereby give my consent to the performance of conservative, noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used. Although spinal and extremity manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures. Some risks and complications associated with therapy are as follows:

Soreness/Bruising: I am aware that, like exercise, it is common to experience muscle soreness and occasionally bruising in the first few treatments.
Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.
Fractures/Joint Injury: I further understand in isolated cases, underlying physical defects, deformities or pathologies (like weak bones from osteoporosis) may render the patient susceptible to injury. When conditions such as osteoporosis, degenerative disc disease or other abnormities are detected, this office will proceed with extra caution.
Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in a million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of Aspirin or Tylenol causing death.
Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase in pain and possible blistering. This should be reported to the doctor. Tests have been or will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.
Trigger Point Dry Needling (TDN): This valuable treatment is for musculoskeletal pain. Like any treatment, there are possible complications. While these complications are rare in occurrence, they are real and must be considered prior to giving consent to treatment. The most serious risk associated with TDN is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely only require a chest x-ray and no further treatment. The symptoms of shortness of breath may last for several days to weeks. A more severe lung puncture can require hospitalization and re-inflation of the lung. This is a rare complication and in skilled hands should not be a concern. Other risks may include excessive bleeding (causing a bruise), infection or nerve injury. Bruising is a common occurrence and should not be a concern unless you are taking a blood thinner. As the needles are very small and do not have a cutting edge, the likelihood of any significant tissue trauma from TND is unlikely. As required by the Colorado Department of Regulatory Agencies, Joel Dekanich FNP, DC, BSN, MS, DACBSP, Ryan Azeltine DC, Joshua Nichols DC, Jaclyn Garvey MPT, DPT and Daniel Young DPT are qualified to perform trigger point dry needling.

TREATMENT RESULTS
I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, including chiropractic and physical therapy, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures. I agree to the performance of these procedures by my doctor and such other person of the doctor's choosing.

ALTERNATIVE TREATMENTS AVAILABLE
Reasonable alternatives to these procedures have been explained to me including: rest, home applications of therapy, prescription or over-the counter medications, exercises and possible surgery.
Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.
Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.
Surgery: Surgery may be necessary for joint instability or serious disc rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.
Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or had read to me the above explanation of treatment. Any questions I have had regarding these procedures have been answered to my satisfaction prior to signing this consent form. I have made my decision voluntarily and freely.

ASSIGNMENT OF BENEFITS:

Your signature is necessary for us to process any insurance claims and to ensure payment of services rendered. I authorize release of all medical information necessary to process my insurance, workman's compensation or personal injury claims or that is pertinent to my medical care. I assign all medical benefits to which I am entitled to the above named physician or clinic. This agreement will remain in effect until all money owed to the above named physician or clinic is paid in full. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this state of Colorado.

CANCELLATION AND NO-SHOW POLICY:

We take this subject very seriously as this can make a difference between responding to treatment or not. **We require a 24 hour notice in the event of a cancellation**. **THERE IS A $25 CHARGE FOR A LATE CANCELLATION (WITHIN 24 HOURS OF SCHEDULED APPOINTMENT) AND A $50 NO-SHOW CHARGE WITHOUT PROPER NOTICE**. For worker's compensation and personal injury cases, documentation of any missed appointment is forwarded to your case manager and/or primary physician. This charge will not be covered by your insurance, worker's compensation or personal injury cases, and **IS YOUR RESPONSIBILITY.**

STATEMENT OF FINANCIAL LIABILITY:

I understand that I am fully responsible for the payment of this account, and hereby assume and guarantee prompt payment of all expenses incurred. I understand that I am responsible for payment of office charges. I understand that unless otherwise indicated below, I hereby request and authorize VIMG to bill my insurance policy/policies for all services provided to me. I authorize payment to VIMG for all such services. I acknowledge that the fees charged by VIMG are considered to fall within the "usual, customary and reasonable" range by most insurance companies. Since your policy is an agreement between you and your insurer, VIMG will not enter into any dispute between you and your insurance company. When you begin treatment with VIMG, our billing department will call your insurance company to verify that you do have valid insurance coverage. However, that verification is only a confirmation of a valid policy and **NOT** a guarantee of coverage. VIMG recommends that each patient call and verify their own insurance coverage and benefits by calling member services with their insurance.

RECEIVING UNENCRYPTED EMAILS:

You agree to receive unencrypted emails from VIMG. VIMG does NOT mail statements for patient balances. Our policy requires a credit card on file through a Payment Card Industry hosting provider (which meets The Payment Card Industry Data Security Standard). Once your insurance processes, adjudicates, and releases payment, the credit card on file will be charged for the outstanding balance on the date our Explanation of Benefits (EOB) is received by our office. An unencrypted email will be sent for receipt of payment to the email provided.

NOTICE OF LIABILITY FOR "NON-COVERED" SERVICES:

You are being provided with this Notice and Waiver for certain Non-Covered and/or Excluded Services because we have determined that specific procedures, supplies and/or equipment we feel are necessary for the treatment of your condition, may be excluded or not covered by your health benefit plan.

Please be advised that carriers Anthem Blue Cross and Blue Shield (Anthem), UMR, United Health Care, Medicare, Rocky Mountain Health Plans and Golden Rule will only pay for services, supplies or equipment that it determines to be medically necessary and/or not experimental or investigational under their applicable policies. If they determine that a particular service is "not reasonable and necessary", "experimental," "investigational or "not medically necessary" under the applicable health benefit plan and/or policies, or other applicable standards, they will deny payment of that service. **This means that you will be personally responsible for paying the Provider for all or a portion of that service, supply or equipment.**

Please be assured that we will only order the treatments and procedures we feel are necessary for your treatment and care. In an effort to deliver our expected quality of care and maintain affordability, we have discounted these rates as outlined below. If you have any questions about whether or not a particular service is covered by your health benefits contract, someone in our office will be happy to assist you. Thank you for your understanding.

NON-COVERED PROCEDURES AND TREATMENTS (but not limited to the following)

- Active Release and Graston Technique Treatments $30 per unit
- Trigger Point Dry Needling $30 per unit
- Kinesio or Rock Taping $20 per body part
- Vax-Decompression Therapy $150
- Hyperbaric Oxygen Therapy $130

PATIENT AGREEMENT

I acknowledge that I have been told in advance by this office that my health insurance plan either does not cover the service or product listed above or pays less than the purchase price associated with the product we provided, and I agree to pay for this product at the time of service. I agree to be personally and fully responsible for any charges related to the services listed above regardless of the insurance company's determination of benefits.

I understand that my insurance carrier or Medicare may deny payment or consider some or all services performed by VIMG to be "non-covered." I am fully responsible for payment of all such "non-covered" services.

ALTERNATE BILLING / PAYMENT INSTRUCTIONS:

I hereby direct VIMG NOT TO bill my insurance company for services provided to me and instead I agree to pay all fees for services furnished to me. I further understand and agree that all payments are expected at the time of service or by an authorized payment plan. My personal balance may not exceed $100 at any time or care may be terminated unless under an authorized payment plan. VIMG's payment plans make care an affordable part of my monthly budget. VIMG participates in a medical discount plan called ChiroHealthUSA which allows them to legally reduce their usual and customary fees to offer discounted services.

PERMISSION TO RELEASE MEDICAL INFORMATION: (HIPAA ACKNOWLEDGEMENT)

I authorize VIMG to release information from my medical record or from the person for whom I am legally responsible, to my/their insurance company, other third party payers or their reviewing agencies, as reasonably necessary to expedite claim processing. This authorization is valid for every visit to VIMG until written notice revoking it is provided. I release VIMG of all responsibility or liability for loss of confidentiality through access and/or copies of records release, or other information disclosed in compliance with this authorization.

I have read all of the above and understand/agree to all provisions therein regarding responsibility for payments and release of information.