Vail Integrative Medical Group

Vail: 1031 S. Frontage Rd. West Vail, CO 81657 Tel. (970) 479-6262 Fax (970) 479-7310
Edwards: 0105 Edwards Village Blvd. A203 Edwards, CO, Tel. (970) 926-4600 Fax (970) 926-4602
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vailhealth.com

CHART ID Number:	
DR. JD MP JS	Clinic: V ED EG
Dx1	Dx2
Dx3	Dx4

1

Confidential Patient Information

Patient's Full Name________________________ Date:____/____/____

Home Phone: ________________ Cell Phone: ________________

Mailing Address:________________________ City:__________ State:______ Zip:__________

E-Mail: ________________________ Male Female Age:__________

Date of Birth:____/____/____ Social Security # ______ - ______ - ______

Occupation:__________ Hours/Week____ Employer:__________ Business Phone__________

Spouse's Name:__________ Employer:__________ Business Phone__________

Emergency Contact:________ ________Relationship:__________ Phone: __________

Address:________________ City:__________ State:__________ Zip: __________

Concurrent Health Care

Are you currently receiving treatment for this problem? Yes / No

Family Physician: __________ City: __________ State:________ Phone__________

Have you had previous chiropractic care: Yes No If Yes, for what Problem: __________

Who referred you to us? __________How else did you hear about us?__________

2

Insurance Information:

Do you have health insurance? Yes No Company Name__________________

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, additional information is needed)

Person Responsible for Account: ________________ Phone: ________

Address:________________ City:__________ State:______ Zip: __________

3

AUTHORIZATION AND ASSIGNMENT: In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release **any information** you deem appropriate concerning my physical or emotional condition and/or health history to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the **direct payment to you** of any sum I now or hereafter owe you by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated make payment to me or you based in whole or in part upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me or to you for the charges made for your services **refuses to make such payment** upon demand by you , I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. However, it is understood that all reasonable efforts have been made to collect the sums due from the insurance company, or companies, contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance companies proceeds, whether it be all or part of what was due, I personally owe you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this state of Colorado
5. I further agree that this Authorization and Assignment is irrevocable until all moneys owed VIMG are paid in full.

Patient Signature________________________ Date______________

Initials:__________

NAME OF PATIENT ______________________ Account # ______________________ Date ____________

Family History

	AGE	HEALTH	AGE AT DEATH	CAUSE
Father				
Mother				

Has any immediate family ever had: (please check answers)

		WHO			WHO
CANCER	❑ NO ❑ YES		STROKE	❑ NO ❑ YES	
TUBERCULOSIS	❑ NO ❑ YES		EPILEPSY	❑ NO ❑ YES	
DIABETES	❑ NO ❑ YES		INSANITY	❑ NO ❑ YES	
HEART TROUBLE	❑ NO ❑ YES		SUICIDE	❑ NO ❑ YES	

Personal History

ILLNESSES

HAVE YOU EVER HAD - (if yes, please check box)

- ❑ MEASLES
- ❑ WHOOPING COUGH
- ❑ NEURITIS OR NEURALGIA
- ❑ GONORRHEA OR SYPHILIS
- ❑ MIGRAINE HEADACHES
- ❑ DIABETES
- ❑ FOOD, CHEMICAL OR DRUG POISONING
- ❑ EVEN BEEN KNOCKED UNCONSCIOUS
- ❑ CONVULSIONS
- ❑ ENLARGED THYROID OR GOITER
- ❑ SPITTING UP BLOOD
- ❑ EXTREME TIREDNESS OR WEAKNESS
- ❑ STOMACH TROUBLE OR ULCER
- ❑ GERMAN MEASELS
- ❑ PNEUMONIA
- ❑ BURSITIS, SCIATICA OR LUMBAGO
- ❑ ANEMIA
- ❑ TUBERCULOSIS
- ❑ CANCER
- ❑ HAY FEVER OR ASTHMA
- ❑ ANY EYE DISEASE, IMPAIRED SIGHT
- ❑ PARALYSIS
- ❑ SKIN DISEASE
- ❑ SHORTNESS OF BREATH
- ❑ KIDNEY DISEASE OR STONES
- ❑ APPENDICITIS
- ❑ MUMPS
- ❑ RHEUMATIC FEVER OR HEART DISEASE
- ❑ POLIO OR MENINGITIS
- ❑ JAUNDICE
- ❑ CONSTIPATION OR DIARRHEA
- ❑ HIGH OR LOW BLOOD PRESSURE
- ❑ HIVES OR ECZEMA
- ❑ ANY EAR DISEASE, IMPAIRED HEARING
- ❑ FREQUENT OR SEVERE HEADACHES
- ❑ CHRONIC OR FREQUENT COUGH
- ❑ SWELLING OF HANDS, FEET OR ANKLES
- ❑ ALBUMIN, SUGAR, PUS, ETC. IN URINE
- ❑ LIVER OR GALL BLADDER DISEASE
- ❑ CHICKEN POX
- ❑ ARTHRITIS OR RHEUMATISM
- ❑ BRIGHTS DISEASE
- ❑ EPILEPSY
- ❑ COLITIS OR OTHER BOWEL DISEASE
- ❑ NERVOUS BREAKDOWN
- ❑ BROKEN OR CRACKED BONES
- ❑ FAINTING SPELLS
- ❑ DEPRESSION OR ANXIETY
- ❑ CHEST PAIN OR ANGINA PECTORIS
- ❑ VARICOSE VEINS
- ❑ ABNORMAL THIRST

ALLERGIES

(check all that apply)

❑ PENICILLIN ❑ ADHESIVE TAPE ❑ PROCAINE NOVOCAINE ❑ SULFA

❑ OTHER DRUGS ______________________

CONVULSIONS

Have you ever had convulsions? ❑ Yes ❑ No If so, please answer the following:

Age first appearance ______________ How frequent ______________

Did (do) you lose consciousness? ❑ Always ❑ Occasionally o Never

Anticonvulsant Drugs - List names of drugs and how often taken ______________

MEDICATION

Please list the medications you care currently taking ______________

MISCELLANEOUS

Do you smoke? ☐ Yes ☐ No Packs per day: ______

Ever been treated for alcoholism? ☐ Yes ☐ No

Even been treated for drug habits? ☐ Yes ☐ No

Even taken insulin / tablets for diabetes? ☐ Yes ☐ No

Even had any operation or been hospitalized for any illness? ☐ Yes ☐ No

Give details and dates (use reverse side if necessary) ______

To Our Patients:

Thank you for choosing Vail Integrative Medical Group (VIMG). In order to familiarize yourself with our standard practices, we urge you to read the following material in detail. Understanding our policies and procedures before you begin treatment should remove much of the uncertainty of beginning chiropractic care. It should also help avoid any unexpected surprises concerning financial arrangements and payment obligations. We believe that as a result of that understanding you will be more relaxed, more receptive to treatment, and a more active participant in your own rehabilitation.

Most health insurance policies do provide some level of coverage for chiropractic treatment. However, you are personally responsible for you deductible, for any co-pays, for any percentage of your charges not covered by your insurance, and for items for which your insurance will not pay. (I.E. orthopedic supports, pillows, etc.)

As a courtesy for our patients, VIMG submits claims to all primary insurance companies on a daily basis, corresponding with the services provided. When you begin treatment, our Billing Agent or Office Manager will telephone 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 full coverage.* Our fees are considered to fall within the usual and customary range by most companies, but not all services are a covered benefit in all contracts. Since your policy is an agreement between you and your insurance company. We will be happy to provide either you or your insurance company any information that might be required, <u>but problem resolution is your responsibility.</u>

When you accept services from VIMG you also accept full responsibility for paying for those services. In all cases, please understand the ultimate financial responsibility is yours, not your insurance company's nor your employer's. Unless other arrangements have been made with our Office Manager or Billing Agent, <u>payment is due at the time service is rendered</u>. We accept cash, check, Visa, American Express or Master Card. Our facility is also a Care Credit client and offer interest-free loans. Past due accounts will be assigned to collection.

Our clinic personnel will e happy to answer any questions that might arise so please feel free to ask. Thank you again for choosing Vail Integrative Medical Group as you health care provider. We appreciate your trust and confidence.

Respectfully,
VIMG Staff

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Signature of Patient   Date

To Our Patients Regarding Cancellations and No-Shows

The following are our policies regarding cancellations and no-shows. We take this subject seriously because it can make a difference between responding to treatment or not. Usually your referring doctor and/or therapist have prescribed a frequency of treatment. If you show up for treatment, it will enable you to get better. Other than that all you need to do is follow your doctor's instructions, and you should achieve your treatment goals.

We require 24 hours notice in the event of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get the full number of prescribed treatments that week whenever possible.

There is a $20 charge for a cancellation or no-show without proper notice. This charge will not be covered by your insurance, but will have to be paid by you personally.

For Workmen's Compensation and Personal Injury patients, documentation of any missed appointments is forwarded to your case manager and primary physician. This could jeopardize your claim.

You may occasionally need to see another physician other than the one who normally sees you if you do need to re-arrange your appointment. All of our physicians are experienced professionals and they will study your chart. You may return to your original physician at the next appointment.'

Please understand that your pain will probably increase and decrease as your course of treatment progresses and before it is finally eliminated. Either condition should not be a reason no to come in: 1) Your pain is gone or 2) Your pain is worse. If the pain is gone, now is the time to really begin rehabilitating the injured area to prevent recurrence. If your pain is worse, we can do something to help.

When you don't show as scheduled, three people are hurt. 1) You, because you didn't get the treatment you need as prescribed by your doctor; 2)The doctor who now has a hole in their schedule; 3) The person that couldn't get in when you had your appointment scheduled.

Thank you for cooperating with us on this matter. We are looking forward to working with you.

Patient Signature ______________________ Date ______________________

<u>HIPPA Acknowledgement Form</u>

I acknowledge that I have received a copy of the *"Notice of Privacy Practices for Vail Integrative Medical Group Regarding Privacy of Personal Health Information"*.

____
Patients Signature

____
Printed Signature

____
Date