ASPEN INTEGRATIVE MEDICINE

Date: _____

Name: _____ Date of Birth: _____ How you heard about us:_____

Mailing Address: _____City:_____State:_____Zip_____

Home Phone: _____ Cell Phone: _____ Email: _____

SSN: _____ Referred by: _____ Primary Physician: _____

(Doctor's Area Only) Chief Complaint/HPI:

_____

_____

_____

_____

_____

_____

Past Medical/Surgical History: _____

_____

Family Medical History: _____

Medications/Supplements: _____

Allergies: _____

Alcohol / Tobacco / Drugs (if so, how much?): _____

Diet (typical breakfast, lunch, dinner, snacks):_____

Social (occupation and with whom do you live?):_____

Exercise (how much and what type?): _____

Chemical exposures (if so, what substance?):_____

Spiritual (How do you care for your spiritual essence?):_____

Review of Systems:

Head: Any old head injuries, current headaches or migraines?_____

Ears: Ringing or discharge?_____

Eyes: Blurred vision, floaters, trouble seeing at night? _____

Neck: Trouble swallowing, masses, or difficulty moving? _____

Mouth: Any root canals or amalgams? Any broken or painful teeth? Regular dentist?_____

Chest: Any chest pain, palpitations, murmurs, or difficulty breathing?_____

GI: Any stomach pain, burning with or without meals? Bowel movements? _____

GU: Urinary urgency, incontinence, painful urination, or discharge?_____

MS: Any pain or decreased range of motion with movement of head, neck, torso arms, hips, legs, or feet? Please also mark in graph below:_____

Skin/Hair/Nails: Hair loss? Skin rash? Cracked nails?_____

Neuro: Any sensation changes in arms and hands? Any trouble gripping objects or prickly feelings while touching objects with hands or feet? Trouble sleeping?_____

Psyche: Do you have frequent mood changes? Do you have a case manager?_____

Health Maintenance: Have you been exposed to vaccinations? _____

Other:_____

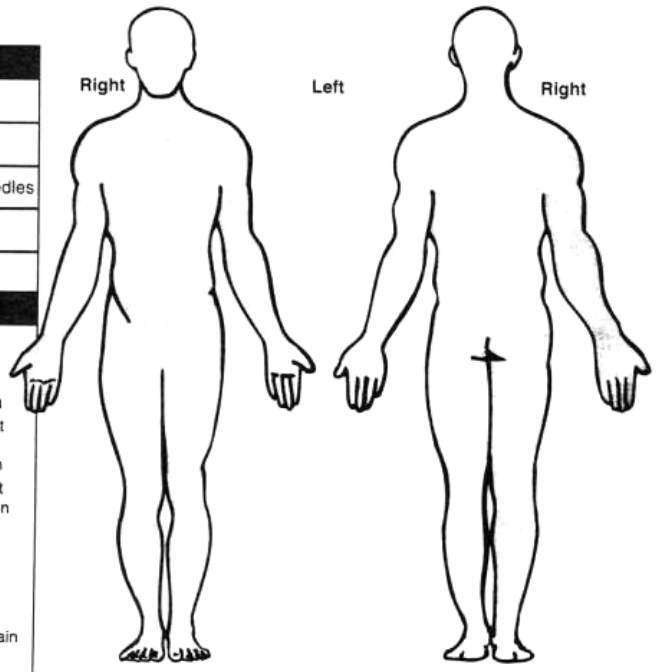
_____

Instructions: Mark these drawings according to where you hurt (if the right side of your neck hurts, mark the drawing on the right side of the neck, etc.). Please indicate which sensations you feel by referring to the key below.

☐ RIGHT HANDED
☐ LEFT HANDED

KEY	
//////	Stabbing
XXXX	Burning
0000	Pins & Needles
====	Numbness
++++	Aching

PAIN LEVEL	
0	No pain
1	Mild pain; you are aware of it but it doesn't bother you
2	Moderate pain that you can tolerate without medication
3	Moderate pain that requires medication to tolerate
4-5	More severe pain; you begin to feel antisocial
6	Severe pain
7-9	Intensely severe pain
10	Most severe pain; it may make you contemplate suicide



CIRCLE YOUR CURRENT PAIN LEVEL

0 1 2 3 4 5 6 7 8 9 10

PATIENT RESPONSIBILITY AND HIPAA AGREEMENT

- I acknowledge that there is a 24-hour Cancellation Policy or 48 hours' notice for Monday appointments. I understand that if I do not cancel 24 hours before my scheduled appointment, or do not show for my appointment, I accept the responsibility of being charged $75.00.
- If medical insurance is to be applied, I request that payment of benefits be made on my behalf to Aspen Integrative Medicine for any services rendered. I understand and acknowledge that submission of claims is not a guarantee of payment. If for any reason my carrier does not cover any and/or all of my office visits or lab work after 3 months, I agree that I am responsible for the amount.
- **I understand that it is my responsibility to make sure that my bills are paid in a reasonable time (no longer than 1 month from the date of treatment). Services that go unpaid for more than 1 month will be billed to my credit card on file, unless a payment plan has been agreed upon.**
- I understand and agree that if my carrier makes any payments directly to me for services rendered I will remit the same payment to Aspen Integrative Medicine.
- I understand it is my responsibility to notify Aspen Integrative Medicine of any changes in my insurance carrier or coverage as soon as possible. Any failure to report such changes will result in the patient being financially responsible for any lapse in coverage or authorization.
- I understand that should I not pay for services rendered, I may be responsible for all collection, court, attorney, and legal fees.
- I understand that my email address will be added to the monthly newsletter unless I note otherwise.

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke his Consent in writing at any time and all future disclosures will then cease.

SIGNATURE:_____ DATE:_____

PATIENT INJECTION CONSENT

I give my permission for Dr. Hughes to give me injections as he determines if they are medically necessary. I acknowledge that I will have been given the opportunity to discuss the nature and purpose of the treatment; alternate methods of treatment; and the risks, complications and consequences associated with the administration of injections. These risks include but are not limited to: bruising, temporary increase in pain, inflammation, infection, allergic reaction, numbness, weakness or paralysis, spinal headache, lung puncture, or death. I further acknowledge that any questions I have regarding the procedure have been answered to my satisfaction and that I have been further told that any additional questions I may have will be answered.

I have read (or have had read to me) the above consent. I fully understand that there is no guarantee of successful treatment has been implied. I understand that I am entitled to a copy of this consent form upon request. Any and all medical malpractice claims are to be disputed and resolved via arbitration per Fairway Physicians Insurance Company. You signature authorizes arbitration as a solution for any malpractice claims and waives all court involvement.

SIGNATURE:_____ DATE:_____

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any claim of medical malpractice, including any claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered or omitted, will be determined by submission to binding arbitration in accordance with the provisions of part 2 of article 22 of this title, and not by a lawsuit or resort to court process except as Colorado law provides for judicial review of arbitration proceedings. The patient has the right to seek legal counsel concerning this agreement, and has the right to rescind this agreement by written notice to the physician within ninety days after the agreement has been signed and executed by both parties unless said agreement was signed in contemplation of the patient being hospitalized, in which case the agreement may be rescinded by written notice to the physician within ninety days after release or discharge from the hospital or other health care institution. Both parties to this agreement, by entering into it, have agreed to the use of binding arbitration in lieu of having any such dispute decided in a court of law before a jury.

Article 2: **All Claims Must Be Arbitrated**: It is the intention of the parties that this agreement shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Colorado revised Statute 13-64-403 and the Federal Arbitration Act (9 U.S.C. §§ 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: **Severability Provision**: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with Colorado law.

I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

NOTE: BY SIGNING THIS AGREEMENT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL BINDING ARBITRATION RATHER THAN BY A JURY OR COURT TRIAL.

YOU HAVE THE RIGHT TO SEEK LEGAL COUNSEL AND YOU HAVE THE RIGHT TO RESCIND THIS AGREEMENT WITHIN NINETY DAYS FROM THE DATE OF SIGNATURE BY BOTH PARTIES UNLESS THE AGREEMENT WAS SIGNED IN CONTEMPLATION OF HOSPITALIZATION IN WHICH CASE YOU HAVE NINETY DAYS AFTER DISCHARGE OR RELEASE FROM THE HOSPITAL TO RESCIND THE AGREEMENT.

NO HEATHCARE PROVIDER SHALL WITHHOLD THE PROVISION OF EMERGENCY MEDICAL SERVICES TO ANY PERSON BECAUSE OF THAT PERSON'S FAILURE OR REFUSAL TO SIGN AN AGREEMENT CONTAINING A PROVISION FOR BINDING ARBITRATION OF ANY DISPUTE ARISING AS TO PROFESSIONAL NEGLIGENCE OF THE PROVIDER.

NO HEALTHCARE PROVIDER SHALL REFUSE TO PROVIDE MEDICAL CARE SERVICES TO ANY PATIENT SOLELY BECAUSE SUCH PATIENT REFUSED TO SIGN AN AGREEMENT OR EXERCISED THE NINETY-DAY RIGHT OF RESCISSION.

By: J. C. Hughes, D.O.
Physician's or Duly Authorized Representative Signature (Date)

By
Print or Stamp Name of Physician, Medical Group or Association Name

By:
Signature of Translator (if applicable) (Date)

Print Name of Translator

By:
Patient's Signature (Date)

Print Patient's Name

By:
Patient's Representative's Signature (if applicable) (Date)

Print Name and Relationship to Patient