Payment Policy:
Who Pays for Your Care?

Dear Patient:

We know auto accidents are stressful and painful. The doctors in our office have 35+ years of successfully treating auto injuries. Dealing with auto insurance companies is confusing and frustrating. We hope this answers questions regarding payment of services received that you might have.

Who pays for my care if the accident **is** my fault?

Under Colorado law, medical payment coverage (med pay), under your auto insurance policy, is the **primary billing party and will be billed first**. If you have waived your rights to medical payment coverage on your auto insurance policy or choose to forgo medical payment coverage usage, you are now considered the primary source of payment and you **must provide payment at the time services are rendered.** If **medical payment coverage is exhausted you are now responsible for payment**. Most, not all **health insurance companies will deny coverage** for auto-accidents much like they will not pay for an accident that occurs at work.

Who pays for my care if the accident **is not** my fault?

Under Colorado law, the presumed, at-fault driver's insurance company is **never obligated to pay for medical treatment for you at any time**, much less as and when it is obtained, or for any other expenses until and unless it chooses to or its insured has been legally determined to be at fault. Even then, its **duty is only to its insured, never you**. The treatment bills will be taken into consideration if a settlement is being negotiated but, again, the other drivers insurance company never has to pay for the care you have received. So, when making decisions about whether to continue care, please make sure to **consider your own sources of payment**. If you have **medical payment coverage (med pay)** under your auto policy, that insurance is primary and will be billed first. It is **illegal in the state of Colorado to raise auto policy rates based on medical payment coverage usage**. If you are **legally deemed not at-fault** a third party lien for secondary payment will be considered for continuation of care, only after your medical payment coverage is exhausted, and **payment must be rendered upon settlement**. However, should payment not be received within 6 months after termination of care, or should you terminate care before being dismissed by the physician**, you will be charged the amount outstanding on your account to a designated credit card.**

By signing this you are stating that you have fully read and understood Belleview Spine and Wellness's payment policy and agree to abide by the aforementioned policy.

_____
Printed Name

_____ Date_____
Signature

CONFIDENTIAL AUTO ACCIDENT INFORMATION

(Please print clearly)

Last name First name MI Sex: ( )M ( )F Date

Address City State Zip Code

Home phone Work phone Cell phone

Social Security Date of Birth Email Address

Emergency Contact Relation Home phone Work phone

Date of Auto Accident:_____Time_____AM/PM

List all those in the vehicle with you:

	Name	Relationship	Age	Injured
1.				Yes( ) No( )
2.				Yes( ) No( )
3.				Yes( ) No( )
4.				Yes( ) No( )

Location of the accident:_____

What were the road and weather conditions like?_____

Total number of vehicles involved in accident: ( )1 ( )2 ( )3

The impact to your vehicle occurred from the: ( )Front ( ) Rear ( )Left Side ( ) Right Side

( )Other_____

Total number of impacts to your vehicle: ( )1 ( )2 ( )3 ( )4 ( )Other_____

Estimated speed of your vehicle at the time of impact: _____mph ( ) Stopped

Estimated speed of other vehicle at the time of impact: _____mph ( ) Stopped

Did you anticipate the impact? ( )Yes ( )No

What was the position of your head just before the impact?_____

Were you wearing a: ( ) Lap belt ( ) Lap and shoulder belt ( ) Neither

Was there a headrest? ( ) Yes ( ) No Did any windows break in your vehicle? ( ) Yes ( ) No

If yes describe: _____

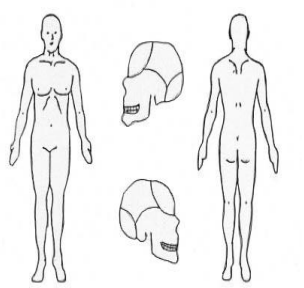
Make and model of your vehicle: _____ Year_____

Please describe, in detail, how the accident happened: _____
_____
_____
_____

Please diagram the accident below:

As best as you can recall, did you strike anything inside the vehicle? ( ) Yes ( ) No
If yes, please indicate the probable item struck on the list below and then draw a line to the region of the body struck using the diagram on the right.

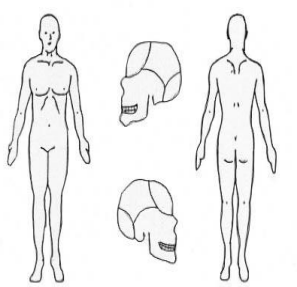
( ) Dashboard
( ) Steering wheel
( ) Inner door panel
( ) Windshield
( ) Shifter
( ) Ceiling
( ) Side window
( ) Headrest
( ) Armrest
( ) Other:_____



Did you receive: ( ) Cuts ( ) Bruises ( ) Abrasions

If yes, use the diagram below to detail where these visible injuries occurred:

Use "C" for cuts
Use "B" for bruises
Use "A" for abrasions



At the time of the accident, did you lose:

Consciousness	( ) Yes	( ) No
Bowel or Bladder control	( ) Yes	( ) No
Fluids from the ears	( ) Yes	( ) No

Did you have any other unusual experiences? ( ) Yes ( ) No

If yes, describe how you felt: _____

Describe any damage done to the vehicle you were driving: _____
_____
_____

Were you able to get yourself out of the vehicle? ( ) Yes ( ) No

If no, describe how you were removed from the vehicle: _____
_____

Who was called or came to the scene? ( ) Highway Patrol ( ) Local Police
( ) Sheriff ( ) Paramedics
( ) Ambulance ( ) Other _____

Was a report made? ( ) Yes ( ) No Do you have a copy of the report? ( ) Yes ( ) No

Were you on company business at the time of the accident? ( ) Yes ( ) No
If yes, did you report the accident to your employer? ( ) Yes ( ) No

Did you receive any first aid at the scene of the accident? ( ) Yes ( ) No

If yes, what was done and by whom?

_____

_____

Did you go to the emergency room? ( ) Yes ( ) No

Did you go to a Doctor's office? ( ) Yes ( ) No
If you answered "yes" to either of the 2 questions above, complete the following:

A. Who attended you there? _____

B. What was done for you there? ( ) Examination ( ) Medication ( ) Muscle Relaxants

( ) Anti-inflammatory ( ) X-Rays ( ) Supports/Braces ( ) Pain Medication ( ) Other _____

C. What diagnosis were you given? _____

D. Were you told to do anything by the attending Doctor? ( ) Yes ( ) No

If yes, please explain: _____

Were you hospitalized as a result of the injuries you sustained from the accident? ( ) Yes ( ) No
If yes, complete the following information:

Name of Hospital/Location: Entered/Discharged Treating Doctor

_____

_____

What was done for you at the hospital? _____

_____

_____

Describe how you felt:

A. Immediately after the accident: _____

B. Later that day: _____

C. The next day: _____

Did you see any other health care professional since the day of the auto accident? ( ) Yes ( ) No

If yes, please complete the information below. Begin with the person you saw first and proceed to the most recent.

Name	Title	Dates Seen	What was performed?

What medications, prescribed or not, are you currently taking to treat symptoms of your injury?

_____

_____

_____

What other medications, prescribed or not, are you currently taking for problems unrelated to your injury?

_____

_____

_____

Have you missed work *as a result of* the auto accident? ( ) Yes ( ) No

If yes, please provide details:

_____

_____

_____

_____

_____

_____

Health History

Have you had any significant injury or illness of any type "prior" to the injury? ( ) Yes ( ) No

If yes, what was the nature of the problem and when did it occur? If professional care was rendered, how long were you treated, by whom and what was performed?

_____

_____

_____

Have you ever had any surgeries? ( ) Yes ( ) No

If yes, what for and by whom and what was done:

_____

_____

_____

Check all that apply:

Present	Past		Present	Past		Present	Past	
		Headaches			High Blood Pressure			Diabetes
		Neck Pain			Heart Attack			Excessive Thirst
		Upper Back Pain			Chest Pains			Frequent Urination
		Mid Back Pain			Stroke			Smoking/Tobacco Use
		Low Back Pain			Angina			Drug/Alcohol Dependence
		Shoulder Pain			Kidney Stones			Allergies
		Elbow/Upper Arm Pain			Kidney Disorder			Depression
		Wrist Pain			Bladder Infection			Systemic Lupus
		Hand Pain			Painful Urination			Epilepsy
		Hip Pain			Loss of Bladder Control			Skin Disorder
		Upper Leg Pain			Prostate Problems			HIV/AIDS
		Knee Pain			Abnormal Weight Gain/Loss			Ankle/Foot Pain
		Appetite Loss			Jaw Pain			Abdominal Pain
		Joint Pain/Stiffness			Ulcer			Arthritis
		Hepatitis			Rheumatoid Arthritis			Liver/Gallbladder Disorder
		Cancer			General Fatigue	***Women Only***		
		Tumor			Muscular Disorder			Birth Control Pills
		Asthma			Visual Disturbances			Hormonal Replacement
		Chronic Sinusitis			Dizziness			Pregnancy
		Other:						
Please list any known **allergies:**								

Is there anything else you feel we should know?

_____

_____

_____

CURRENT MEDICAL COMPLAINTS

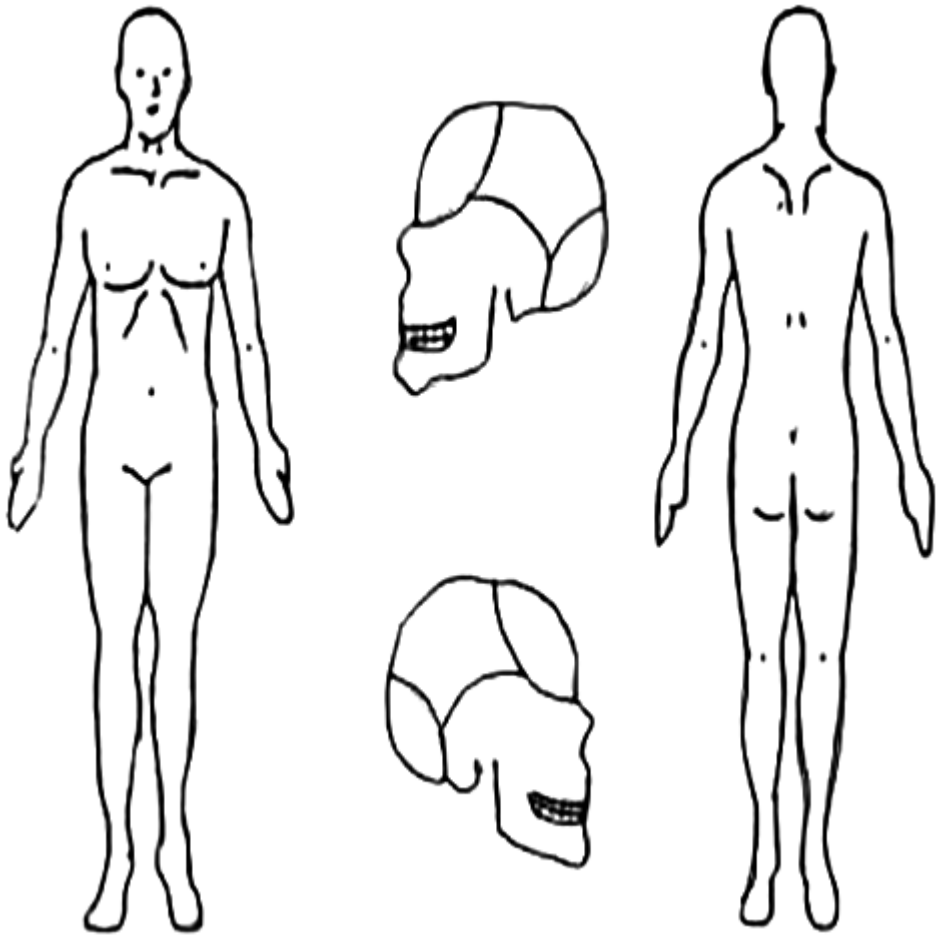
Please use the space provided below to describe any medical complaints you are currently experiencing, or any additional comments you may wish to make regarding your condition.

_____
_____
_____
_____

Mark the areas on the body where you feel the described sensations. Use the appropriate symbol. Include all affected areas.

Numbness = = **Pins and Needles oo** **Burning xx**

Stabbing/Sharp Pain // **Aching/Dull Pain ((**



INSTRUCTIONS: Please print your response and circle the most appropriate choice(s):

Primary complaint?	**Secondary complaint?**	**Tertiary complaint?**
_____	_____	_____

When did the problem begin?

_____	_____	_____

This problem began:

Gradually	Gradually	Gradually
Suddenly	Suddenly	Suddenly

This problem can best be described as:

Dull	Dull	Dull
Throbbing	Throbbing	Throbbing
Sharp	Sharp	Sharp
Stabbing	Stabbing	Stabbing
Burning	Burning	Burning
Tingling	Tingling	Tingling
Other:_____	Other: _____	Other:_____

This problem is:

Constant	Constant	Constant
Near Constant	Near Constant	Near Constant
Frequent	Frequent	Frequent
Rarely Present	Rarely Present	Rarely Present
Other:_____	Other:_____	Other:_____

This problem is worse with:

Coughing	Coughing	Coughing
Sneezing	Sneezing	Sneezing
Straining	Straining	Straining
Sleeping	Sleeping	Sleeping
Lifting	Lifting	Lifting
Rest	Rest	Rest
Activity	Activity	Activity
Weather Changes	Weather Changes	Weather Changes
Other:_____	Other: _____	Other:_____

This problem is better with:

Medication	Medication	Medication
Rest	Rest	Rest
Activity	Activity	Activity
Stretching	Stretching	Stretching
Treatment	Treatment	Treatment
Other:_____	Other:_____	Other:_____

What household, social, recreational, at work activities are now difficult or impossible to do because of your condition?

_____

_____

_____

_____

QUESTIONNAIRE FOR POST-CONCUSSION SYNDROME

Please place a check mark "☑" in the space provided next to any of the follow symptoms that you have noticed since your accident. If you are unsure, then please place a "?" in the space. If you should have any additional symptoms of an unusual nature, then please list them in the space provided at the bottom of the page. Thank you for your assistance.

_____ 1. Light headedness

_____ 2. Vertigo/dizziness

_____ 3. Neck pain an/or stiffness

_____ 4. Headache

_____ 5. Photophobia (eye sensitive to bright light)

_____ 6. Phonophobia (sensitivity to loud noises)

_____ 7. Tinnitus (ringing in the ears)

_____ 8. Impaired Memory

_____ 9. Difficulty Concentrating

_____ 10. Impaired comprehension or awareness

_____ 11. Forgetfulness

_____ 12. Impaired logical thinking

_____ 13. Difficulty with new or abstract concepts

_____ 14. Insomnia (difficulty sleeping)

_____ 15. Easy Fatigability

_____ 16. Apathy

_____ 17. Outbursts of anger

_____ 18. Mood swings

_____ 19. Depression

_____ 20. Loss of libido

_____ 21. Personality change

_____ 22. Intolerance to alcohol

Comments: _____

_____

_____

_____

Insurance Billing Information

Regardless of fault, in the State of Colorado, your MedPay (part of your auto insurance policy) will cover medical expenses. If you do not have MedPay and the accident was your fault, you are responsible for all treatment charges. If you do not have MedPay and the accident was not your fault, the party (3rd party) at fault will be responsible and all medical expenses will be paid at the conclusion of treatment.

Do you have MedPay? ____ Yes ____ No Amount of Coverage: _____

Your Auto Insurance Company: _____

Adjuster Name: _____

Adjuster Phone #: _____

Claim #: _____

If you auto insurance does not include MedPay:

3rd Party Insurance Company: _____

Adjuster Name: _____

Adjuster Phone #: _____

Claim #: _____

If you have an attorney:

Attorney Company Name: _____

Attorney Name: _____

Attorney Phone #: _____

CREDIT GUARANTEE
ACCIDENT INSURANCE ASSIGNMENT
PERSONAL BALANCES

INSURANCE ASSIGNMENT:

Our Accident Insurance Liability Program is designed to render you immediate care and keep your out-of-pocket expenses to a minimum. As a courtesy to you, we will bill your insurance carrier on your behalf and wait up to 6 months for payment. As a prerequisite, we ask that you provide a credit card to guarantee payment of your bill and that you provide us with the your complete accident insurance information.

FILING PROCEDURE:

We will submit claims on your behalf to your insurance carrier.

Balances not paid within 6 months after conclusion of your care will be charged to your designated credit card below. You will be sent a payment voucher. Should settlement be reached prior to the 6 month grace period or should care be terminated for any reason prior to your physician dismissal all balances become due immediately, will be charged to your credit card and are subject to monthly interest charges.

CREDIT CARD: ____Visa ____Master Card ____Discover ____AMEX

Cardholder Name (as it appears on card):_____

Card No._____Exp._____

I agree to the above terms and authorize you to bill the charge card. I understand that should payment not be received within 6 months after termination of my care or should I terminate care before being dismissed by my physician. I will be charged the amount outstanding on my account.

Patient Name: _____ Date: _____
(Please Print)

Signature: _____

Attorney/Insurance Lien and Release

To: Attorney/Insurance:_____

Address:_____Tel._____

Re: Patient:_____ Date of Injury:_____

Health Care Provider: Belleview Spine and Wellness
Donald W. Gibson, D.C., DAAMLP
5191 S Yosemite St. Unit A
Greenwood Village, CO 80111

I do hereby authorize Donald W. Gibson, D.C., hereinafter to as the health care provider, to receive payment for the examination, diagnosis, treatment and prognosis of myself in regards to the accident in which I was recently involved in.

I hereby authorize and direct you, my attorney, or insurance company to pay directly to the health care provider for services rendered me both by reason of this accident and by reason of any other bills which are due to the office and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect the health care provider. I hereby further give you a lien on my case to the health care provider against any and all proceeds of my settlement, my judgment or verdict which may be paid to you, my attorney, insurance company or myself, as a result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney or insurance company. I hereby instruct that in the event another is substituted in this matter, the new attorney or insurance company, honor this lien as inherent to the settlement an enforceable upon the case as if it were executed by him/her.

I fully understand that I am directly and fully responsible to the health care provider including billing, collection and interest changes on the unpaid balance for all bills submitted by them for services rendered me and/or supplies provided to me and that this agreement is made solely for said health care provider's additional protection and in consideration of their awaiting payment. I further understand that such payment is not contingent upon any settlement, judgment, or verdict by which I may eventually recover said fees.

Please acknowledge this letter by signing below and returning to Donald W. Gibson, D.C. the health care provider, at the address above captioned. I have been advised that if my attorney does not wish to cooperate in protecting the health care provider's interest, the health care provider will not await payment, but will require me to make payments on a current basis.

Patient's Signature:_____Date:_____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums above and beyond attorney's fees, costs and prior liens from any settlement, judgment, or verdict, as may be necessary to adequately protect said provider above named.

Attorney's Signature:_____ Date_____

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN
APPOINTMENT AND/OR DESIGNATION AS AN ERISA/PPACA REPRESENTATIVE AND A BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Belleview Spine and Wellness, as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as BSW) the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to BSW for any and all medical/healthcare services, supplies, tests, and/or medications that *have been* or *will be* rendered or provided; as well as designating and appointing BSW as my beneficiary under all health insurance or medical plans which I may have benefits under.

I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same.

I hereby assign directly to BSW all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA plan, PPACA plan, or insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our representative, ERISA representative, or PPACA representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals to obtain benefits and/or payments that are due to either BSW, myself, and/or my family members as a result of services rendered by BSW, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan or insurer. I hereby also declare that BSW is my/our beneficiary regarding my/our health plan as contemplated by ERISA and PPACA, and that BSW can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment and/or designation will remain in effect unless revoked in writing. A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this_____day of_____20____.

_____ _____

Patient Signature Patient Name Printed

_____

Signature of Legal Guardian/Representative (if applicable)

Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

Sign here: X_____I have read and understand the above consent form.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

This serves a notice that as part of our efforts to deliver the most consistent healthcare we can to every patient, we use an electronic healthcare system that enables us to retrieve up to 13 months of prescription history through your insurance carrier.

I acknowledge that it is the policy of this office to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication (within reason) in writing.

Patient Name:_____ Signature:_____ Date: _____

Parent or Guardian:_____ Signature:_____ Date: _____

Witness (Office Staff): _____ Signature: _____ Date: _____

Informed Consent to Chiropractic Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as "informed consent" and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stoke. This occurs in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injection, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about this consent, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office. I understand that I will receive appointment reminders via text message.

Patient Name:_____ Signature:_____ Date: _____

Parent or Guardian:_____ Signature:_____ Date: _____

Witness (Office Staff): _____ Signature: _____ Date: _____