BALLEN MEDICAL & WELLNESS

COLORADO RECOVERY INFUSION CENTER

CRIC New Patient Intake Form

Thank you for your interest in Colorado Recovery Infusion Center and Ballen Medical, and most importantly, your interest in *your* wellness. As we move forward with your customized treatment plan, we will first take a deep look into your whole health picture. We appreciate your time as you complete this form and allow us to formulate the best plan for you.

Thank you,
The CRIC Team

Name: _____ Appointment Date: _____

Age: _____ Gender: M / F Date of Birth: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Email Address: _____ Can we contact you by email? Y N

Occupation: _____ Employer: _____

Work Phone: _____

Current Height: _____ Current Weight: _____

Emergency Contact: _____ Relation: _____

Emergency Contact Phone #: _____

☐ **Check this box to join our email list**. You'll receive occasional IV therapy announcements and featured offers, as well as our monthly integrative health newsletter created in partnership with *Ballen Medical & Wellness*. Your email will never be shared with any third parties.

How did you hear about us?

☐ 5280 Magazine Instagram
☐ Facebook Zocdocs
☐ Google Other (please specify): _____

Appointment Reminders: Ballen Medical & Wellness' scheduling platform, Power2Practice, initiates appointment reminder notices via email and text 3 days prior to your scheduled appointment.

Insurance Information: ****Ballen Medical & Wellness and Colorado Recovery Infusion Center are not contracted with any medical insurances, however there are instances where we may require your insurance information (i.e. Lab Orders, Prescription Prior Authorizations, Insurance calls for submitted superbills).**

Insurance Carrier: _____ Insurance Phone Number: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Subscriber ID #: _____ Group #: _____

Relation to Subscriber: _____

What are your biggest health concerns? Please list in order of priority.

1 _____

2 _____

3 _____

What areas of your lifestyle do you feel support your wellness?

_____

_____

What areas of your lifestyle do you feel harm your wellness?

_____

What else should we be aware of as we care for you?

_____

Doctor, Hospitalizations, Surgery:

Primary Care Physician: _____

Phone Number: _____

Please state if/when you have had each of the following:

X-Rays: _____ MRI/CT Scan: _____

EKG: _____ Surgery: _____

How much stress do you have?

Today: 0 (no stress) 1 2 3 4 5 6 7 8 9 10 (severe)

Usually: 0 1 2 3 4 5 6 7 8 9 10

Please Circle Y for Yes or N for No if you have ever been treated, diagnosed, or experienced problems with the following.

Energy and Weight:

Unexplained weight loss	Y or N	Weight gain	Y or N

Eyes & Vision:

Vision changes	Y or N

Ears/Nose/Mouth/Throat:

Ringing in the ears	Y or N	Frequent trouble swallowing	Y or N

Breathing (Respiratory):

Shortness of breath with minimal exercise Y or N

Heart (Cardiovascular):

Chest pain at rest	Y or N	Frequent irregular heartbeat	Y or N
Chest pain w/exertion	Y or N		

Digestion (Gastrointestinal):

Nausea or feeling that you may vomit	Y or N	Frequent constipation	Y or N
		Frequent loose stools	Y or N
Change in bowel habits	Y or N		

Hormonal (Endocrine):

Body temp below normal	Y or N	Frequent poor appetite	Y or N
Hot intolerance	Y or N	Night sweats	Y or N
Cold intolerance	Y or N	Hot flushes/sweating	Y or N

Kidney (Genitourinary):

Frequent bladder infections	Y or N	Bladder problems	Y or N

Brain and Nerves (Neurologic):

Headaches	Y or N	Light headedness	Y or N

Mood (Psychiatric):

Foggy thinking/brain fog	Y or N	Frequently irritable	Y or N
Mental exhaustion	Y or N	Frequently anxious	Y or N
Trouble concentrating	Y or N	Frequently sad/tearful	Y or N
Frequently forgetful	Y or N	Depressive moods	Y or N
Mood swings	Y or N	Thoughts of suicide/ better off dead	Y or N
Frequent panic attacks	Y or N		

Joint and Bone Problems:

Aching/painful joints	Y or N	Aching/painful muscles	Y or N
Back pain	Y or N	Physical exhaustion	Y or N
Neck pain	Y or N		

Skin/Hair:

Acne	Y or N	Rash/rashes	Y or N
Itching	Y or N		

Bleeding (Hematologic/Lymphatic):

Frequent prolonged or excessive bleeding	Y or N	Enlarged lymph nodes	Y or N

Allergic/Immunologic:

Frequent recurrent infections	Y or N	Hypersensitivity to medications, foods, environments, etc.	Y or N
Sensitive to chemicals	Y or N		
Allergies	Y or N		

Allergies:

Are you allergic to any drugs? _____

Environmental substances? _____

Foods? _____

Current Medications:

Please list **ALL** prescription, Over the Counter, and Vitamins/Supplements:

_____ _____

_____ _____

_____ _____

_____ _____

Respiratory:

Asthma	Y or N	Chronic sinusitis	Y or N
Chronic bronchitis	Y or N	Pneumonia	Y or N
Emphysema (COPD)	Y or N	Sleep apnea	Y or N
Pulmonary hypertension	Y or N	Tuberculosis	Y or N

Blood Pressure:

High blood pressure	Y or N	Low blood pressure	Y or N

Bleeding Problems:

Blood clots	Y or N	Factor V Leiden	Y or N
Hemophilia	Y or N		

Cardiovascular:

Coronary artery disease	Y or N	Coronary artery blockage	Y or N
Heart attack	Y or N	Carotid artery stenosis	Y or N
Congestive heart failure	Y or N	Arrhythmia	Y or N

Cholesterol Problems:

High cholesterol	Y or N	High triglycerides	Y or N

Gastrointestinal:

Reflux (heartburn)	Y or N	Inflammatory bowel disease	Y or N
Stomach ulcers	Y or N	Crohn's disease	Y or N
Gall bladder disease	Y or N	Ulcerative colitis	Y or N
Liver disease	Y or N	Celiac disease	Y or N

Blood Sugar Problems:

Elevated blood sugar (pre diabetic)	Y or N
Diabetes (onset in youth, treated w/insulin)	Y or N
Diabetes (onset as adult, treated w/diet)	Y or N
Diabetes (onset as adult, treated w/medication)	Y or N

Weight Problems:

Obesity	Y or N	Anorexia	Y or N
Overweight	Y or N	Bulimia	Y or N
Underweight	Y or N		

Thyroid Problems:

Low thyroid (hypothyroidism)	Y or N	Thyroid nodules	Y or N
Hashimoto's thyroiditis	Y or N	Graves' disease	Y or N
High thyroid (hyperthyroidism)	Y or N	Goiter (thyroid problems)	Y or N

Neurological History:

Stroke	Y or N	ADD/ADHD	Y or N
Migraines	Y or N	Brain injury/concussion	Y or N
Seizures	Y or N		

History of Mental Illness:

Depression	Y or N	Bipolar disorder	Y or N
History of suicide attempts	Y or N	Post-traumatic stress disorder	Y or N
Anger management problem	Y or N		

Joint and Bone Problems:

Arthritis	Y or N	Osteopenia (weakening bones)	Y or N
Rheumatoid arthritis	Y or N	Osteoporosis (weak bones)	Y or N
Gout (arthritis)	Y or N		

Immune System:

HIV	Y or N	Epstein-Barr virus	Y or N
Hepatitis	Y or N	Multiple Sclerosis	Y or N
Herpes	Y or N	Lupus SLE	Y or N
Mononucleosis (EBV)	Y or N	Lyme Disease	Y or N

Energy Problem:

Chronic fatigue syndrome	Y or N	Fibromyalgia	Y or N

Skin Disease:

Eczema	Y or N	Psoriasis	Y or N
Hives	Y or N	Acne	Y or N
Athlete's foot	Y or N	Vitiligo	Y or N

Social History:

How much/often do you use tobacco? _____

How much/often do you drink alcohol? _____

How much/often do you use recreational drugs? _____

Cancer History:

Primary cancer: _____

Date of onset: _____ Location: _____

Initial stage: _____ Current stage: _____

Previous treatments: _____

_____

Family History: (Please circle all that apply).

Breast cancer	Mother	Father	Brother	Sister	Grandmother	Grandfather	Aunt	Uncle
Ovarian cancer	Mother	Father	Brother	Sister	Grandmother	Grandfather	Aunt	Uncle
Uterine cancer	Mother	Father	Brother	Sister	Grandmother	Grandfather	Aunt	Uncle
Prostate cancer	Mother	Father	Brother	Sister	Grandmother	Grandfather	Aunt	Uncle
Colon cancer	Mother	Father	Brother	Sister	Grandmother	Grandfather	Aunt	Uncle
Heart attack	Mother	Father	Brother	Sister	Grandmother	Grandfather	Aunt	Uncle
Heart disease	Mother	Father	Brother	Sister	Grandmother	Grandfather	Aunt	Uncle
High cholesterol	Mother	Father	Brother	Sister	Grandmother	Grandfather	Aunt	Uncle
High blood pressure	Mother	Father	Brother	Sister	Grandmother	Grandfather	Aunt	Uncle
Diabetes	Mother	Father	Brother	Sister	Grandmother	Grandfather	Aunt	Uncle
Stroke	Mother	Father	Brother	Sister	Grandmother	Grandfather	Aunt	Uncle
Obesity	Mother	Father	Brother	Sister	Grandmother	Grandfather	Aunt	Uncle
Thyroid disease	Mother	Father	Brother	Sister	Grandmother	Grandfather	Aunt	Uncle
Kidney disease	Mother	Father	Brother	Sister	Grandmother	Grandfather	Aunt	Uncle
Liver disease	Mother	Father	Brother	Sister	Grandmother	Grandfather	Aunt	Uncle
Lung disease	Mother	Father	Brother	Sister	Grandmother	Grandfather	Aunt	Uncle
Osteoporosis	Mother	Father	Brother	Sister	Grandmother	Grandfather	Aunt	Uncle
Alzheimer/Dementia	Mother	Father	Brother	Sister	Grandmother	Grandfather	Aunt	Uncle
Mental illness	Mother	Father	Brother	Sister	Grandmother	Grandfather	Aunt	Uncle
Alcoholism	Mother	Father	Brother	Sister	Grandmother	Grandfather	Aunt	Uncle
Drug abuse	Mother	Father	Brother	Sister	Grandmother	Grandfather	Aunt	Uncle

Please describe any details pertinent to your treatment: _____

_____

_____

_____

Thank you so much for your time in completing this form! It will be very helpful in collaborating to make sure we are doing our best for your wellness.

BALLEN MEDICAL & WELLNESS | COLORADO RECOVERY INFUSION CENTER

Consent and Authorization for Intravenous Therapy

Patient Name: _____ **Date:** _____

Provider: **Beth Ballen, MD** **Leslie Vannucci, NP** **Leah Hughes, NP** **(circle one)**

Colorado Recovery Infusion Center provides facilities and personnel to assist your physician in the performance of intravenous therapy. You have the right to be informed of the procedure, any feasible alternative options, and the risks and benefits. Except in emergencies, procedures are not performed until you have had an opportunity to receive such information and to give your informed consent.

Please Initial Each Line

_____ I voluntarily consent to any and all health care treatment and diagnostic procedures, including but not limited to infusion therapy, medical examinations, prescription medications, intramuscular injections, blood draws, ozone insufflation treatments, intravenous ozone treatments, and tests, provided by Colorado Recovery Infusion Center, and its associated physicians, providers, nurses, and clinicians (collectively, the "Clinicians").

_____ I understand that in many instances the Clinicians are carrying out orders from my referring health care provider. Though I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of my care. I also understand that if I do not follow my referring provider's or the Clinician's recommendations as they may relate to my health that the Infusion Center and the Clinicians will not be responsible for any injuries or damages that are the result of my non-compliance.

_____ I understand that if any employee or any individual associated with the Infusion Center is exposed to my blood or body fluids, I will be tested for the hepatitis viruses and the Human Immunodeficiency Virus (HIV). I also understand that I will receive education related to this testing and that I will not be charged for testing and education related to the exposure.

_____ I agree that I have informed my provider/clinicians of all allergies, medications, and supplements that I am currently taking, and any health issues that I am having or had. I agree that if I have a change in allergies, medications, supplements, or health history I will inform my provider/clinician before receiving any treatment/infusion/injection. It is my responsibility to update my provider/clinicians of any changes in my health or medical history.

_____ I understand that any treatment/procedure/injection/infusion may be considered medically unnecessary, and is not currently FDA approved.

_____ I understand that forgoing any treatment recommended by alternative providers (primary care providers, specialty providers, oncologists) is my choice, and I do not hold Colorado Recovery Infusion Center responsible for any injuries, damages or death related to refusing their recommendations.

_____ I understand that I may refuse to sign this Patient Consent, however, I understand that without my legal signature, the Infusion Center cannot provide me with treatment and my appointment will be cancelled.

_____ The procedure involves inserting a needle into your vein or muscle and injecting the formula described above by your physician or nurse practitioner.

_____ Risks of intravenous therapy include:

- ☐ Discomfort, bruising and pain at the site of injection.
- ☐ Inflammation of the vein used for injection.
- ☐ Severe allergic reaction, anaphylaxis, cardiac arrest, and death.

_____ Benefits of intravenous therapy include:

- ☐ Higher rates of absorption and metabolization yielding more effective healing.
- ☐ The pressure gradient created by the IV fluids greatly assist in absorption of the infused nutrients through the cell wall and into the cell where the restorative actions can begin.
- ☐ Higher doses of nutrients can be given beyond what can be absorbed orally and without intestinal upset.

_____ Alternatives to intravenous therapy are oral supplementation or dietary and lifestyle changes.

_____ The procedure will be performed by or under the direction of the provider named above with qualified registered nurses or paramedic.

_____ Additional medications may be administered on an as-needed basis. These medications may include but are not limited to anti-nausea medications, anti-anxiety medications, or antihistamines.

You have the right to consent to or refuse any proposed treatment at any time prior to its performance. Your signature below means that:

- You understand the information provided on this form and agree to the foregoing.
- The procedure(s) set forth above has been adequately explained to you by a team member.
- You have received all the information and explanation you desire concerning the procedure.
- **You verify that you have no medical conditions that have not been disclosed and that you are not currently pregnant.**

Signature: _____ **Date:** _____ **Time**: _____

BALLEN MEDICAL & WELLNESS

COLORADO RECOVERY INFUSION CENTER

Notice of Privacy Practices (HIPAA)

****This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please read it carefully.****

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a Federal program that requires that all medical records and other individually identifiable health information used or disclosed by Ballen Medical and Wellness in any form, whether electronically, on paper, or orally are kept properly confidential. HIPAA gives you, the patient, the right to understand and control how your personal health information (PHI) is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for the following purposes: treatment, payment, and health care operation.

- Treatment means providing, coordinating, or managing healthcare and related services by one or more healthcare providers. An example of this is if you are referred to a primary care doctor or another specialist.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit. (Please note that Ballen Medical and Wellness does not submit to insurance.)
- Health Care Operations include the business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be patient survey cards.
- The practice may also be required or permitted to disclose your PHI for law enforcement or other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related enemies and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of your PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes (these are not part of your medical record under HIPAA).
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations.
- Disclosures that constitute a sale of PHI under HIPAA.
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You may have the following rights with respect to your PHI

- The right to request restrictions in certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of the initial date of service and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Director, Elizabeth Reece, RN BSN, for more information, in person or in writing.

Receipt of Notice of Privacy Practices and Written Acknowledgement Form

Patient Name: _____ Date of Birth: _____

I am a patient of Ballen Medical and Wellness. I, _____ hereby acknowledge receipt of Ballen Medical & Wellness' Notice of Privacy Practices.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(if patient is under the age of 15)

BALLEN MEDICAL & WELLNESS

COLORADO RECOVERY INFUSION CENTER

Credit Card Authorization & Cancellation Policy

****Highlighted sections MUST be completed**

Patient Name: _____ Name on Card: _____

Credit Card Number: _____

Expiration: _____ CVV: _____

Billing address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email address: _____

_____ I understand that payment is due at the time of service and will be collected prior to my appointment.

_____ Any outstanding balance on my account **MUST** be paid **BEFORE** scheduling the next appointment and may affect any medication refill requests. **Any returned check will be subjected to a $25 NSF fee; including the amount of the check.**

_____ In the event that my outstanding balance is not paid in full in a reasonable amount of time, I realize Ballen Medical may take further legal action as necessary to recover the amount outstanding. Should Ballen Medical find it necessary to take legal action to recover any amount due, I agree to be liable for all reasonable collection costs incurred, including but not limited to, reasonable attorneys' fees.

_____ I hereby authorize Ballen Medical to use the provided credit card information to charge my account for appointments, cancellations with less than 24 business hour notice, or no shows.

NO SHOW/LATE CANCELLATION POLICY

As you are aware, medical offices tend to be very busy and often have waiting lists for emergency cases. To better serve our patients and assure they have a fair opportunity to have an appointment as soon as possible, we ask for the following assistance:

1. If you are going to be more than 10 minutes late for an appointment, please call us to ensure that we can still work you into our schedule. There is no guarantee that we can hold your appointment, but we will do our best.

2. If you need to cancel or reschedule an appointment, please call us 24-business hours prior to your appointment. We can often get patients in who are in need of our care.

_____ We compound your customized IV formulas in the morning, therefore, you **MUST cancel 24-business hours prior to your appointment, or you will be charged**.

_____ I understand the importance of the 24-business hour cancellation policy and that I will be charged if Ballen Medical/Colorado Recover Infusion Center does not receive the proper notice.

_____

Signature Date

_____

Printed Name