BALLEN MEDICAL & WELLNESS

Patient Information/Intake Form

Appointment Date: ________________________

Patient Name: ___________________________________ Date of Birth: _______________ Age: _________

Biological Sex: ☐ M ☐ F Preferred Pronouns: ________________ Patient's SSN: _____________________

Address: ____

City: ____________________________________ State:_______________ Zip: ________________

Home Phone:____ Cell Phone: ______________________________

E-Mail: ____

Best way to reach you: ☐ E-Mail ☐ Home Phone ☐ Cell Phone

May we leave a message on your voicemail? ☐ Yes ☐ No

Can we email you clinic updates? ☐ Yes ☐ No

Current Height: ___________________________ Current Weight: ___________________________

Occupation:_____________________________________ Hours worked per week: ____________________

Marital Status: ___________________________________ Spouse's Name: _________________________________

Parent/Guardian: _________________________________ Parent/Guardian SSN: ____________________________

Patient Emergency Contact:

Name: ____ Phone: ____________________________

Relation: ____

How did you hear about us?

☐ Facebook ☐ Instagram
☐ Zocdoc ☐ Other (please specify): ____

Please briefly tell us what brought you here today:

____

____

____

____

Medical:

Drug or Food Allergies: ____

Current Medical Issues: ____

Past Medical Issues: ____

Family History of Mental Illness? Y or N If yes, who? ______________________________

Current Medications (All prescriptions, over the counter, and vitamins/supplements: ____________________

____

Appointment Reminders: Ballen Medical & Wellness' EMR (Electronic Medical Records System) initiates appointment reminder notices via email and text 4 days prior to your scheduled appointment.

Telehealth Appointment Policy (Please initial each line):

_____ Telehealth appointments may be requested, with the approval of the provider, as long as you are seen in the office once every three months. If requesting a telehealth, you may be charged at the time of the request.

_____ If you are expecting a telehealth appointment and your appointment time has passed, please call the office at 720-222-0550. At times, the providers call and get patient's voicemail. They will call and then wait for you to call the office. If you are unreachable, and do not call the office, you will be charged the normal provider fee.

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

Primary Care Physician Information:

Provider Name & Practice Name: ____

Phone Number: ____

Practice Address: ____

Pharmacy Information:

Patient's Legal Name: ____

Date of Birth: ____

Pharmacy Name & Phone Number: ____

Pharmacy Address: ____

Insurance Information:

****Ballen Medical & Wellness is 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: __________________________ Subscriber SSN: __________________________

Group # :__________________________ Relation to Subscriber: __________________________

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 & 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 & 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 Executive Director 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 & Wellness. I, ____ hereby acknowledge receipt of Ballen Medical & Wellness' Notice of Privacy Practices.

____ ____________________________________

Patient Signature Date

____

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

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are confidential. Both verbal information and written records about a client cannot be shared with another party outside of Ballen Medical & Wellness without the written consent of the client or the client's legal guardian. This is to optimize client experience and maintain continuity.

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Mental Health Care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the rights to access the client's records.

Insurance Providers (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes types of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meaning and ramifications.

____ ____________________
Patient Signature Date

____
Print name (Parent/Guardian if under 18)

Patient Medication Agreement

Patient Name: ____ **DOB:** _____________________

I agree to the following (Please initial each line):

______ I am responsible for my medicines.

______ I will not share, sell, or trade my medicine. I will not take anyone else's medicine.

______ I will not increase my medicine until I speak with a prescribing provider.

______ My medicine **may not be replaced** if it is lost, stolen, or used up sooner than prescribed.

______ I will keep all appointments (therapy, if applicable, and follow-ups).

______ I agree to give a blood or urine sample at the clinic, under supervision if asked, to test for drug use.

______ I agree to release information to my provider about any controlled substances I am taking.

______ I agree that I **will not** fill the same or similar controlled medications from alternative providers while under the care of Ballen Medical & Wellness.

______ I understand that is it my responsibility to make the necessary appointments for medication refills **BEFORE** my medication is due to run out (typically 1- or 3-month follow-up visits are required).

Refills:

______ Refills will be made only during regular office hours – No refill request will be processed on nights, holidays, or weekends. I must call at least three (3) working days ahead (M-F) to ask for a refill of my medicine. No exceptions will be made. I must keep track of my medications. No early or emergency refills may be made. **NO** pharmacy requested refills will be accepted as an appointment will be necessary for refills (per provider discretion). Ballen Medical & Wellness is not responsible if your pharmacy does not have your prescription in stock. It is my responsibility to call Ballen Medical & Wellness at 720-222-0550 during business hours if my prescription needs to be sent to different pharmacy. After my appointment with my provider, prescriptions will be sent to my pharmacy within 24 hours. I will schedule appointments accordingly. I understand that it is not a medical emergency to be without stimulants (Adderall, Vyvanse, Concerta, etc.). Stimulant medication refill requests will not be considered emergent and will not be addressed outside of office hours.

Termination of Agreement:

______ If I break any of the rules, or if my provider decides that this medicine is hurting me more than helping me, this medicine will be stopped by my provider in a safe way. I have talked about this agreement with my provider, and I understand the above rules.

____ ____________________________

Patient Signature Date

____

Printed Name

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

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

Ears/Nose/Mouth/Throat:

Ringing in the ears Y or N

Breathing (Respiratory):

Shortness of breath with minimal exercise Y or N

Heart (Cardiovascular):

Chest pain at rest Y or N

Chest pain w/exertion Y or N

Frequent irregular heartbeat Y or N

Digestion (Gastrointestinal):

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

Bleeding (Hematologic/Lymphatic):

Frequent prolonged or excessive bleeding	Y or N	Enlarged lymph nodes	Y or N
		Are you currently taking a blood thinner	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? ______________________________

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

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

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		

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		

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: ______________________________

____

Please describe any details pertinent to your treatment: ______________________________

____

____

____

____

____

Consent and Authorization for Intravenous Therapy

Patient Name: ____ **Date:** ____________________

Ordering Provider: ____

Ballen Medical & Wellness 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 Ballen Medical & Wellness, 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 Ballen Medical & Wellness and the Clinicians will not be responsible for any injuries or damages that are the result of my noncompliance.

_______ I understand that if any employee or any individual associated with Ballen Medical & Wellness 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 Ballen Medical & Wellness 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, Ballen Medical & Wellness 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.**

______________________________	____________________	__________
Patient Signature	Date	Time

Cancellation Policy

****Highlighted sections MUST be completed**

Patient Name:____

______ I understand that payment is due at the time of service and will be collected prior to my appointment. Please note, any prepayment made for services provided by Ballen Medical & Wellness will be nonrefundable and nontransferable after 180 days from payment unless other arrangements have been made.

______ Any outstanding balance on my account **MUST** be paid **BEFORE** scheduling the next appointment and may affect any medication refill requests. **Any returned check or disputed payment by cardholder will be subjected to a $25 processing fee: in addition to the amount of the check or payment.**

______ In the event that my outstanding balance is not paid in full in a reasonable amount of time, I acknowledge Ballen Medical & Wellness may take further legal action as necessary to recover the amount outstanding. Should Ballen Medical & Wellness 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 & Wellness to use the provided credit card information or the credit card on file 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:

______ 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. If you do not call until your appointment has passed, you will still be charged for the appointment time.

______ 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**.

**You MUST cancel 24 business hours PRIOR to your appointment, or you will be charged.

______ I understand the importance of the 24 business hours cancellation policy, and that I will be charged the full price of the scheduled appointment if Ballen Medical & Wellness does not receive the proper notice. **All Monday appointments needing to be canceled, need to be canceled by 12:00 pm the Friday prior**.

____ _______________________

Patient Signature Date

Financial Responsibility

The following page, Release of Information (ROI), MUST be completed for anybody other than the patient providing ANY payment for ANY service.

Name: _______________________________________ Relation: ___________________________

Address:____

Phone: __________________________________ SSN: _________________________________

Credit Card (optional): ______________________________ Expiration:___________ CVV: ________

Billing address : ____

6081 S. Quebec Street, Suite 100
Centennial, CO 80111
Phone: (720) 222-0550
Fax: (720) 496-4948
www.ballenmedical.com

Authorization for Release of Healthcare Information

Patient Name: ____ Date of Birth: _______________________

Maiden/Previous Name: _____________________________________ Phone Number: ______________________

Full Address: ____

I authorize Ballen Medical & Wellness to release and receive my healthcare information to and from the following healthcare provider(s)/person(s).

Number of Entities/Individuals specified below: ___________

1. Name: ____ Type of Provider: ____________________________

   Phone: ___________________________________ Fax: ______________________________________

   Address: ____

2. Name: ____ Type of Provider: ____________________________

   Phone: ___________________________________ Fax: ______________________________________

   Address: ____

3. Name: ____ Type of Provider: ____________________________

   Phone: ___________________________________ Fax: ______________________________________

   Address: ____

Information to be Released/Received:

☐ Service Dates: From: _______________ To: _______________ **OR** ☐ All future records until this authorization expires

☐ Entire Medical Record
☐ Abstract *(history & physical, discharge summary, operative reports, consults, outpatient visit notes, test results, labs, ER notes, provider notes related to specific timeframe).*

☐ Discharge Summary
☐ ER Records
☐ History & Physical
☐ Clinic Visit Notes
☐ Psychological Evals/Assessments
☐ EKG/Cardiology Reports
☐ Immunization Records
☐ Lab/Pathology Reports
☐ Radiology Images
☐ Radiology Reports
☐ Billing Statements
☐ Alcohol/Drug Treatment Records: ____
☐ Other: ____

☐ **Do not release alcohol or drug treatment records protected under federal law**

I understand that this healthcare information may include mental health, alcohol, and/or drug treatment and will be used for the purposes of evaluation and treatment. I also understand that the authorization is completely voluntary and may be revoked at any time by submitting a written request to revoke the authorization to the office of Ballen Medical & Wellness (address listed above). I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment or my eligibility for benefits.

This authorization will expire on ________________ (**or one year from date signed**).

____ ___________________________

Patient Signature Date