



## FINANCIAL AGREEMENT

We are glad you have entrusted our office with your health care. To provide you with quality, timely care, we need your cooperation with certain matters to make sure every patient has his/her needs met.

### **Insurance**

We are not participating providers with any insurance companies. At your request, we can provide you with a receipt of services that you can send to your insurance company for your reimbursement.

### **Payment**

Payment for services is due at the time of service. We accept cash, checks, MasterCard, Visa, DiscoverCard, and American Express.

### **Medicare**

Medicare requires that the doctor's office submits all claims and we would be happy to do that for you. Medicare limits reimbursement for services performed by a chiropractor to spinal adjustments only. Payment for other services will be due at the time of service.

### **Cancellation and Missed Appointment Policy**

We require a minimum of 24 hours notice when a patient cancels or reschedules their appointment. Cancelled new patient appointments will be subject to 80% of the value of the visit. When a patient does not show up for an appointment or cancels / reschedules with less than 24 hours notice, a fee will be applied to the patient's account based on the following schedule:

One reminder in a 12-month period at no charge

\$25 fee for a second offense

\$50 fee for a third offense

Credit card number required to schedule future appointments and charged at full cost.

### **Individual Consideration Contract**

If there is a financial hardship associated with receiving care in our office, payment arrangements can be negotiated with the Business Manager at the time of services.

### **Past Due Accounts**

If you have made a payment arrangement with our Business Manager and your account becomes past due, we will take necessary steps to collect this debt. Outstanding balances will be billed monthly and considered past due 10 days after the invoice date. We will pass along the fee of \$25 our bank charges us for any returned checks. Balances beyond 30 days will be charged an additional 1.5% of your total balance per month plus any additional costs necessary to collect the balance owed.

If we have to refer your account to a collection agency, you agree to pay all of the collection agency fees or commissions that are incurred. We reserve the right to refuse future services until your account is in current status.

### **Workers Compensation**

We cannot accept Workers Compensation Claims at this time.

### **Agreement**

This is the entire agreement between Gateway Natural Medicine and Diagnostic Center and the patient below. Policy is subject to change without notice. I have read this agreement, understand it and agree with its provisions.

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Responsible Party's Signature: \_\_\_\_\_

# Gateway Natural Medicine & Diagnostic Center

## Consent to the use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my health and medical care, Gateway Natural Medicine & Diagnostic Center originates and maintains medical and health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I further understand that this information serves as:

- a basis for planning my care and treatment,
- a means of communication among the health professionals who contribute to my care,
- a source of information for applying my diagnosis and treatment information to my bill,
- a means for a third-party payer to verify that services were billed as actually provided,
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future. This agreement to release future information shall remain in force until such time as I shall revoke it in writing.

I understand and have been provided with a **PATIENT PRIVACY NOTICE** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the **PATIENT PRIVACY NOTICE** prior to signing this consent. I understand that Gateway Natural Medicine & Diagnostic Center reserves the right to change their notice and practices, but that prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Gateway Natural Medicine & Diagnostic Center is not required to agree to the restrictions requested. I understand that I must revoke this consent in writing, except to the extent the organization has already taken action in reliance thereon.

By Colorado law we are required to notify you ... that the information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

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Signature of Patient or Legal Representative

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Date Notice Effective

# Gateway Natural Medicine & Diagnostic Center

## Welcome

### Patient Account and Insurance Information

PATIENT INFORMATION	ACCOUNT INFORMATION
Legal Name:	Person Responsible:
Nickname: <span style="float: right;">Male ___ Female ___</span>	Relationship to Patient: Self ___ Spouse ___ Parent/Guardian ___
Address:	Physical Address:
City, State & ZIP:	Mailing Address:
Home Ph: <span style="float: right;">Work Ph:</span>	City, State & ZIP:
Birthdate: <span style="float: right;">Age:</span>	Home Ph: <span style="float: right;">Work Ph:</span>
Social Sec. #:	Birthdate: <span style="float: right;">Age:</span>
Employer: <span style="float: right;">Position:</span>	Social Sec. #:
If Full-time Student, School Name:	Email Address:
Spouse Name: <span style="float: right;">Work Ph:</span>	

EMERGENCY CONTACT (not living with you)	
Name:	Relationship:
Phone:	Address:
	City, State & ZIP:

HOW DID YOU HEAR ABOUT US? Many of our patients are referred by their friends, family members, co-workers and other doctors. These individuals are concerned for your health and have shown their trust and confidence in our doctors and staff to provide you with the very best care possible. Please let us know how you heard about us so we can send them a "Thank You" for introducing you to us.

<input type="checkbox"/> Friend, Family or Co-Worker	Name: _____
<input type="checkbox"/> Doctor	Name: _____
<input type="checkbox"/> Yellow Pages	
<input type="checkbox"/> Other (please specify)	_____

**Please carefully read the following and sign your acknowledgement below:**

I do clearly understand that I am ultimately responsible for the payment of fees for services rendered to me, or my family at this clinic. I authorize the doctors and their assistants to administer such treatment as necessary. I do understand that no guarantees have been made as to the results of treatment. I confirm that I have come to this facility for help with my medical problems and have no intent to mislead or defraud my treating doctor, any insurance carrier, or other party.

\_\_\_\_\_  
Signature (if under 18, signature of parent or Legal Guardian required)

\_\_\_\_\_  
Today's Date

# Gateway Natural Medicine & Diagnostic Center

Patient Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Number of Children: \_\_\_\_\_

Have you been seen by a Chiropractor before? Yes \_\_\_\_\_ No \_\_\_\_\_

For What? \_\_\_\_\_

Have you had Acupuncture before? Yes \_\_\_\_\_ No \_\_\_\_\_

For What? \_\_\_\_\_

What is your primary reason for seeking care at our office? \_\_\_\_\_

How long has this been a problem? \_\_\_\_\_ Is it getting worse? Yes \_\_\_\_\_ No \_\_\_\_\_

What seems to make it better? \_\_\_\_\_

What seems to make it worse? \_\_\_\_\_

Does it bother your: Sleep \_\_\_\_\_ Work \_\_\_\_\_ Other \_\_\_\_\_

What do you believe is wrong with you and what seemed to be the initial cause? \_\_\_\_\_

**Your General Health – please check those that apply:**

Appetite: poor/heavy

Migraines

Blood clots

Gas / bloating

Neck / shoulder pain

Low back pain

Eczema

Irritability

List any other current health conditions:

How long have you had this condition?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

List previous treatments you have received for each condition listed above:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

List any current allergies: \_\_\_\_\_

What, if any, medications are you allergic to? \_\_\_\_\_

List all prescribed medications you are now taking, the reason you are taking it, and who it was prescribed by:

Medication	Reason	Prescribed By	Medication	Reason	Prescribed By

List all over-the-counter medications / supplements you are now taking and the reason you are taking it:

Medication/Supplement	Reason	Medication/Supplement	Reason

Please identify if you and / or anyone in your family have any of the following medical conditions?

Condition	You?	Family Member / Type of Illness?	Condition	You?	Family Member / Type of Illness?
Cancer			Diabetes		
Arthritis			Stroke		
High blood pressure			Heart disease		
Lung disease/asthma			Mental illness		
Kidney disease			Liver disease		
High cholesterol			Seizures		
Allergies			Glaucoma		
Hepatitis			Other		

## Gateway Natural Medicine & Diagnostic Center

Have you ever been hospitalized?

Year	Illness or Operation

Please list any other of your past medical conditions, serious illness, injury or fractures:

Year	Illness or Injury

Childhood Diseases: Measles \_\_\_\_\_ Mumps \_\_\_\_\_ Chicken Pox \_\_\_\_\_ Other \_\_\_\_\_

Unusual Childhood Diseases: \_\_\_\_\_

Indicate below your usage of each item listed:

	Soda Pop	Coffee	Pain Relievers	Drugs	Exercise	Tobacco Products	Alcoholic Beverages	Artificial Sweeteners	Sleep
Heavy									
Moderate									
None									

Previous Auto Accidents: \_\_\_\_\_  
 \_\_\_\_\_

Previous Work-Related Injuries: \_\_\_\_\_  
 \_\_\_\_\_

List below any other health information you feel is important: \_\_\_\_\_  
 \_\_\_\_\_

When was your last visit to a Physician (MD/DO)? \_\_\_\_\_ For What? \_\_\_\_\_

Who is your Physician? \_\_\_\_\_ Phone: \_\_\_\_\_

Are you under their care now? Yes \_\_\_\_\_ No \_\_\_\_\_ For What? \_\_\_\_\_

**For Women Only:**

List the first day of your last period: \_\_\_\_\_ How long are your periods? \_\_\_\_\_ Are your cycles regular? \_\_\_\_\_

How long is your cycle? \_\_\_\_\_ Date of last PAP smear: \_\_\_\_\_ Any abnormal results? \_\_\_\_\_

Birth control methods: \_\_\_\_\_ Number of pregnancies: \_\_\_\_\_ How many deliveries? \_\_\_\_\_

Any complications during labor and delivery? \_\_\_\_\_ Can you Explain? \_\_\_\_\_

If you are post menopausal, are you taking any hormone replacement? \_\_\_\_\_

**For Men Only:**

Have you ever had a prostate exam (digital rectal exam)? Yes \_\_\_\_\_ No \_\_\_\_\_ When was your last exam: \_\_\_\_\_

Have you ever had a PSA blood test? Yes \_\_\_\_\_ No \_\_\_\_\_ Date of last test: \_\_\_\_\_

Have you had any alteration in urinary frequency, flow or caliber of urine stream? Yes \_\_\_\_\_ No \_\_\_\_\_ Can you explain: \_\_\_\_\_

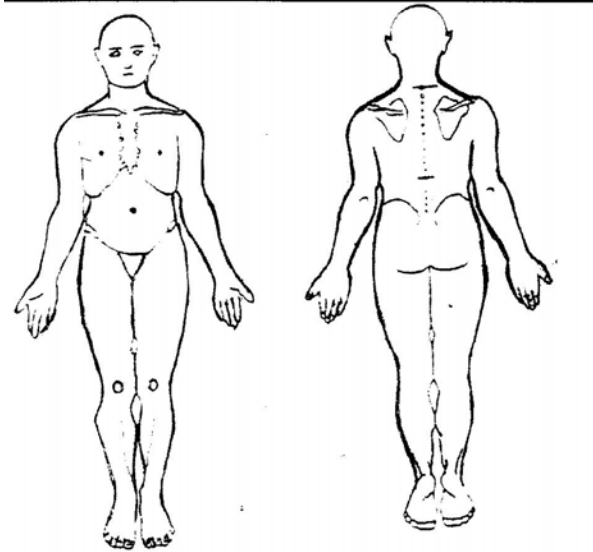
Have you experienced any erectile dysfunction? Yes \_\_\_\_\_ No \_\_\_\_\_ When? \_\_\_\_\_

# Gateway Natural Medicine & Diagnostic Center

## Pain Diagram, Rating and Scale

Please use the diagram below to indicate the symptoms you have experienced over the past week.

Mark below which term(s) best describes your symptoms and indicate the intensity with a (1)=mild, (2)=moderate, (3)=severe



- Numbness \_\_\_\_\_
- Tender \_\_\_\_\_
- Tingling \_\_\_\_\_
- Splitting \_\_\_\_\_
- Stabbing \_\_\_\_\_
- Heavy \_\_\_\_\_
- Dull-Aching \_\_\_\_\_
- Hot-burning \_\_\_\_\_
- Other \_\_\_\_\_

## Visual Analog Scale

Use the line below to mark the current intensity of your pain:

No Pain \_\_\_\_\_ Worst Possible Pain

Use the line below to mark the intensity of your pain at its worst:

No Pain \_\_\_\_\_ Worst Possible Pain



**Gateway Natural Medicine and Diagnostic Center**  
 1211 Lake Avenue \* Berthoud CO 80513  
 Phone: 970 532-2755

**COLORADO MANDATORY DISCLOSURE STATEMENT**

Education and Experience

Igor Zielinski earned his Master of Acupuncture and Oriental Medicine degree from Emperor’s College of Oriental Medicine in Santa Monica, California. This four-year program consists of 3500 hours of education including 1,000 hours of clinical practice. He was certified as a Diplomat in Acupuncture and Traditional Chinese Medicine by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in October 2008. This includes certification in Clean Needle Technique and Chinese Herbology. Igor was certified by the Acupuncture Board of California in October 2007. Igor’s training includes adjunctive therapies such as moxibustion, tui na, acupressure, cupping, auriculotherapy, and dietary and lifestyle recommendations. Igor is a registered and licensed acupuncturist in Colorado since 2009 and a licensed acupuncturist in California since 2007. He also holds a national license and state licenses in California and Colorado for occupational therapy. None of these licenses, certificates, or registrations have ever been suspended or revoked.

This clinic complies with the rules and regulations promulgated by the Colorado Department of Health, including the proper cleaning and sterilization of needles and the sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized needles are utilized.

Fee Schedule

New Patient Intake Consultation and Treatment	\$70 + cost of treatment, herbs, and/or nutrition
Initial Treatment and Follow-up Treatment	\$65 + cost of herbs and/or nutrition
Herbal Consultation	\$45

Patient’s Rights

- The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known.
- The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time.
- In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.

The practice of acupuncture is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints, contact the Acupuncturists Registration Office, 1560 Broadway, Suite 1350, Denver, Colorado 80202. Telephone (303) 894-2440.

I have read and understand this document.

	<b>X</b>	
(Name of Patient / Representative)	(Signature)	(Indicate relationship if signing for patient)
Acupuncturist	<b>X</b>	Gateway Natural Medicine & Diagnostic Center