Matthews-Vu
Healthcare for Children and Adults

Dear Patient or Legal Guardian:

Our records indicate that you have been scheduled today for a "Routine Physical Examination' and/or a "Well Woman Examination'.

This service will be coded by our office as a 'Routine Physical Examination or a 'Well Woman Examination'. Your insurance company benefits MAY NOT cover this exam. Your particular plan must have preventative benefits for this exam to be covered.

This type of examination is strictly a comprehensive preventative medical examination. Please be aware that any abnormality encountered or preexisting problem that needs addressed, will be billed separately and could require an additional copay or coinsurance amount from you.

If it is determined by our healthcare provider that Lab Work is necessary, please inform the phlebotomist what lab your insurance company prefers to use. Please note that the lab that processes the specimens will bill your insurance company separately for all labs done by them. These lab services MAY NOT be covered by your insurance plan as part of your 'Routine Physical Examination or 'Well Woman Examination'.

It is your responsibility to know if you have coverage for wellness, preventative, well woman or health screening benefits. All services for today's visit, whether billed by this office or the reference laboratory, not paid by insurance, are your financial responsibility.

The healthcare providers of Matthews-Vu Medical Group believe that a periodic, routine physical examination with certain diagnostic labs or other age-appropriate procedures, are an integral part of providing excellent patient healthcare.

By signing below, you acknowledge and accept financial responsibility for all charges not paid by your insurance company associated with your visit today.

Thank you –

Date of Physical Exam _____ Account #:_____

Patient Name (Printed) _____ Date of Birth _____

Signature of Patient or Legal Guardian _____

Annual Wellness Questionnaire

Patient Name:_____ Date of Birth:_____ Visit Date: _____

Please fill out the following information regarding your health:

General Health

In general, would you say your health is

Excellent Very Good Good Fair Poor

How would you describe the condition of your mouth and teeth?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

In the past 7 days, how much pain have you felt?

None Some A lot

Nutrition

In the past 7 days, did you eat fruits or vegetables each day?

Yes No

In the past 7 days, did you eat whole grain or high fiber foods each day?

Yes No

In the past 7 days, did you eat fried or high fat foods each day?

Yes No

In the past 7 days, how many sugar-sweetened beverages did you consume each day?

0 1-2 3-4 5 or more

Social/Emotional

In the past 2 weeks, how often have you felt nervous, anxious, or on edge?

Almost all of the time Most of the time Some of the time Almost never

In the past 2 weeks, how often were you not able to stop worrying or control your worry?

☐ Almost all of the time ☐ Most of the time ☐ Some of the time ☐ Almost never

How often is stress a problem for you in handling your health, finances, family or social relationships, or your work?

Never or Rarely Sometimes Often Always

How often do you get the social and emotional support you need?

Always Usually Sometimes Rarely Never

Patient Name:_____ Date of Birth:_____ Visit Date: _____

Activities of Daily Living and Instrumental Activities of Daily Living

In the past 7 days, did you need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking or using the toilet?

Yes No

In the past 7 days, did you need help from others to care for things such as laundry and housekeeping, banking, shopping, using the telephone, food preparation, transportation, or taking your own medications?

Yes No

Seat Belt

Do you fasten your seat belt when you are in a car?

☐ Yes ☐ No

Sleep

Each night, how many hours of sleep do you usually get?

_____ hours

Do you snore or has anyone told you that you snore?

Yes No

In the past 7 days, how often have you felt sleepy during the daytime?

Always Usually Sometimes Rarely Never

Vision

Have you seen your eye doctor within the last 12 months?

Yes No – If **no**, please schedule an appointment with your eye doctor as soon as possible

Please list any **DME** (durable medical equipment) companies you are currently using (Examples: Elevation Medical Supply, Apria, Major Medical, Advanced Medical):_____

Matthews-Vu
Healthcare for Children and Adults

Patient Name**:** _____ **Date of Birth:** _____

Financial Payment Policy

Thank you for choosing Matthews-Vu Medical Group as your primary care provider. As part of our commitment to offer quality medical and affordable health care, we are also committed to building a successful provider-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is part of that relationship. If you have any questions about our fees, or your responsibilities, please ask. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc.)

1. **Insurance** – Our office participates in many insurance plans. If you are not insured by a plan we have a contract with, payment in full is expected at each visit. If you are insured by a plan we are contracted with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Your insurance benefits is a contract between you and your insurance company; we are not party to that contract. Failure to provide complete insurance information results in patient responsibility for the entire bill. Please contact your insurance company with any questions you may have regarding your coverage. As a courtesy, we will file all applicable office charges with your insurance company. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If the provider deems **medical necessity** for certain services/test and these services/tests are not covered or not considered reasonable or necessary by insurers, the patient is financially responsible.

2. **Co-payments and deductibles** – **All co-payments, deductibles and/or co-insurance must be paid at the time of service**. We accept Cash, Checks, Master Card, Visa, American Express or Discover. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us uphold the law by paying your co-payments at each visit. Patients with **high deductible health insurance plans** will be required to pay a deposit of $70 for each visit (unless you have a letter from your insurance company stating you have reached your deductible). Patients are responsible for working with their insurance company to know if they have reached their deductible. If a patient pays $70 and the insurance company determines the patient has already met this year's deductible, the business office will issue a refund. If you are not able to pay at the time of service you must call the business office and set up a payment plan prior to your appointment.

3. **Self-pay Accounts** – Patients without insurance coverage, or patients without an insurance card on file with our practice. It is the patients' responsibility to know if Matthews-Vu Medical Group participates with their health insurance plan. Self-pay patients will be required to make a deposit of $70 prior to appointment. After the visit, the patient will be required to pay the estimated remaining balance. After the claim has been reviewed by the business office coding team, a final bill will be determined and reconciled against the payment paid at time of service. If a balance is due from patient, the business office will submit a statement to the self-pay patient. If a credit balance is owed to the patient, the business office will issue a refund.

4. **Missed Appointments** – Matthews-Vu Medical Group requires 24-hour notice of appointment cancellation. Appointments missed that are not previously canceled may be charged a fee of $50.00. Please help us to serve you better by keeping your regularly scheduled appointment. If we determine a patient is an habitual offender of missed appointments, then we will request a $50.00 deposit prior to scheduling the next appointment.

5. **Return Checks** – The charge for a returned check is $30 payable in cash or credit card. This will be applied to your account in addition to any bank-insufficient-funds charge incurred by the practice. You may be placed on a cash or credit card only basis following any returned check.

6. **Outstanding Balance Policy** – Patients will receive a monthly statement with any outstanding balance of $5.00 or more. Please be aware that the balance after insurance pays is the patient's responsibility. If your insurance company does not pay your claim in 60 days, the balance may be billed to you. Patients can make payments by paying with check or by going online and using the patient portal to process a credit card payment. Patients can also call the billing office at (719)884-2799 to process a credit card payment over the phone. We accept Checks, Master Card, Visa, American Express or Discover. If your account becomes past due over 60 days, you will receive a phone call. On a case by case basis, a payment plan can be established with a credit card on file.

7. **Nonpayment** - If there was no attempt on the patient's behalf to contact and set up a payment plan, and your account is over 90 days past due, you will receive a letter stating you have 20 days to pay your account in full. Please be aware that if the balance remains unpaid, we may refer your account to a collection agency (patient responsible for collection fees) and you and your immediate family members may be discharged from this practice. If this occurs, you will be notified by regular mail that you have 30 days to find alternative medical care. During that 30-day period, our providers will only be able to treat you on an emergency basis.

This financial policy helps the office provide quality care to our valued patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

_____ _____

Patient/Guardian Signature Date

Matthews-Vu
Healthcare for Children and Adults

PLEASE TAKE HOME AND DISCUSS WITH YOUR LOVED ONES BEFORE COMPLETING THE ATTACHED DOCUMENT

Dear Patient,

It is important to Matthews-Vu Medical Group to ensure you understand the importance of completing, and regularly updating your advanced directives (i.e. Living Will, Power of Attorney, Colorado MUST form), no matter how old you are. Patients have the right to control their medical treatment as long as they are physically and mentally able to do so. Advance directives are a way for you to give consent to certain situations where you might or might not want treatment. They can also be used to appoint someone to make decisions for you if you are unable to do it for yourself. An advance directive gives you a better chance of having your wishes carried out, even if you can't talk to the doctors about what you want. It is important for your primary care doctor to have a copy of your advance directives on file.

Attached, you will find the Colorado MOST (Medical Orders for Scope of Treatment). We would like you to understand that completing this form is voluntary, but if you choose to complete the form, you can change it as m any times as you would like to. If you already have another directive such as a living will or a power of attorney, the MOST form does not need to be completed.

We ask that our patient review the attached MOST form with their family members and loved ones. Discuss your wishes and try to determine what is important to you. Then, please schedule an appointment with any of our providers to discuss any questions you may have and at that time, you can both sign and date the form together.

Respectfully,

Your Healthcare Team

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Colorado Medical Orders for Scope of Treatment (*MOST*)

- **FIRST follow these orders, THEN contact Physician, Advanced Practice Nurse (APN), or Physician Assistant (PA), for further orders if indicated.**
- These Medical Orders are based on the person's medical condition & wishes.
- Any section not completed implies full treatment for that section.
- May only be completed by, or on behalf of, a person 18 years of age or older.
- **Everyone shall be treated with dignity and respect.**

Last Name		
First Name/Middle Name		
Date of Birth		Sex
Hair Color	Eye Color	Race/Ethnicity

A — Check One Box Only

CARDIOPULMONARY RESUSCITATION (CPR) **Person has no pulse and is not breathing.**

☐ **No CPR** Do Not Resuscitate/DNR/Allow Natural Death

☐ **Yes CPR** Attempt Resuscitation/ CPR

*When not in Cardiopulmonary arrest, follow orders **B**, **C**, and **D***

B — Check One Box Only

MEDICAL INTERVENTIONS **Person has pulse and/or is breathing.**

☐ **Comfort Measures Only:** Use medication by any route, positioning, and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort.
Do not transfer to hospital for life-sustaining treatment.
Transfer only if comfort needs cannot be met in current location; **EMS**-Contact medical control.

☐ **Limited Additional Interventions:** Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. ***Transfer*** *to hospital if indicated. Avoid intensive care;* **EMS**-Contact medical control.

☐ **Full Treatment:** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.
Transfer *to hospital if indicated. Includes intensive care.* **EMS**-Contact medical control.

Additional Orders: _____ (**EMS=*Emergency Medical Services***)

C — Check One Box Only

ANTIBIOTICS

☐ No antibiotics. Use other measures to relieve symptoms.

☐ Use antibiotics when comfort is the goal.

☐ Use antibiotics.

Additional Orders: _____

D — Check One Box Only

ARTIFICIALLY ADMINISTERED NUTRITION AND HYDRATION

*******Always offer food & water by mouth if feasible********

☐ No artificial nutrition/hydration by tube. **(NOTE: Special rules for *proxy by statute* on page 2)**

☐ Patient has executed a "Living Will" ☐ Patient has not executed a "Living Will"

☐ Defined trial period of artificial nutrition/hydration by tube.
(Length of trial: _____ Goal:_____)

☐ Long-term artificial nutrition/hydration by tube.

Additional Orders: _____

E — Check All That Apply

DISCUSSED WITH:

☐ Patient

☐ Agent under Medical Durable Power of Attorney

☐ Proxy (per statute C.R.S. 15-18.5-103(6))

☐ Guardian

☐ Other:_____

(SECTION RESERVED FOR FUTURE USE)

SUMMARY OF MEDICAL CONDITION(S):

Physician/APN /PA Signature (mandatory)	**Print Physician/APN/PA** ***Name, Address and Phone Number***	**Date**
Colorado License #:		

HIPAA PERMITS DISCLOSURE OF THIS INFORMATION TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

SIGNATURE OF PATIENT, AGENT, GUARDIAN, OR PROXY BY STATUTE (MANDATORY)

Significant thought has been given to the desired scope of end-of-life treatment and these instructions. Preferences have been discussed and expressed to a health care professional. This document reflects those treatment preferences, which may also be documented in a MDPOA, CPR Directive, Living Will, or other advance directive (attached if available). To the extent that my prior advance directives do not conflict with these *Medical Orders for Scope of Treatment*, my prior advance directives shall remain in full force and effect.

(If signed by surrogate, preferences expressed must reflect patient's wishes as best understood by surrogate.)

Signature	*Name (Print)*	*Relationship/ Surrogate status (write "self" if patient)*	*Date Signed (Revokes all previous MOST forms)*
Primary Contact Person for the Patient	*Relationship and/or **MDPOA**, **Proxy***	*Phone Number/Contact Information*	
Health Care Professional Preparing Form	*Preparer Title*	*Phone Number*	*Date Prepared*
Hospice Program (if applicable)	*Address*	*Phone Number*	*Date Enrolled*

DIRECTIONS FOR HEALTH CARE PROFESSIONALS

COMPLETING THESE *MEDICAL ORDERS*

- Must be completed by a health care professional based on patient preferences and medical indications.
- These *Medical Orders* must be signed by a physician, advanced practice nurse, or physician assistant to be valid. *Physician Assistants must include physician name and contact information.*
- Verbal orders are acceptable with follow-up signature by physician or advanced practice nurse in accordance with facility policy.
- Original form strongly encouraged. Photocopy, fax, and electronic image of signed *MOST* forms are legal and valid.

USING THESE *MEDICAL ORDERS*

- Any section of these *Medical Orders* not completed implies full treatment for that section.
- A semi-automatic external defibrillator (AED) should not be used on a person who has chosen "Do Not Attempt Resuscitation."
- Comfort care is never optional; Oral fluids and nutrition must always be offered if medically feasible.
- When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort (e.g., pinning of a hip fracture).
- A person who chooses "Comfort Measures Only" or "Limited Additional Interventions," should not be entered into a trauma system. *EMS should contact Medical Control for further orders or direction regarding transfers.*
- IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."
- Treatment of dehydration is a measure that may prolong life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment."
- If a health care provider considers these orders medically inappropriate, he or she may discuss concerns with the patient or authorized surrogate and revise orders with consent of patient or surrogate.
- If a health care provider or facility cannot comply with the orders due to policy or personal ethics, the provider or facility must arrange for transfer to the patient to another provider or facility and provide appropriate care in the meantime.
- **Proxy by statute is a decision maker selected through a proxy process** according to C.R.S. 15-18.5-103(6), who *may not* decline artificial nutrition/hydration (ANH) without an attending physician and a second physician trained in neurology certifying that provision of ANH would merely prolong the act of dying and is unlikely to result in the restoration of the patient to independent neurological functioning.

REVIEWING THESE *MEDICAL ORDERS*

These *Medical Orders* should be reviewed regularly and when the person is transferred from one care setting or care level to another, there is a substantial change in the person's health status, the person's treatment preferences change, or when contact information changes.

REVIEW OF THIS *MOST* FORM

Review Date	Reviewer	Location of Review	Review Outcome
			☐No Change ☐Form Voided ☐New Form Completed
			☐No Change ☐Form Voided ☐New Form Completed
			☐No Change ☐Form Voided ☐New Form Completed
			☐No Change ☐Form Voided ☐New Form Completed

HIPAA PERMITS DISCLOSURE OF THIS INFORMATION TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY