Treatment Authorization: I authorize medical and health care treatment of ___ myself my minor child _____ by Dr. Edward W Carriere Jr., M.D.

Medical Records Release Authorization: I authorize Dr. Carriere to release my medical information to any physician or health practitioner to whom I am being referred for care and to any payer of my care including my insurance company or managed care program upon their specific request.

I also authorize any physician or health care provider I have seen, to release my medical records to Dr. Carriere. Such authorization is effective for a period of one year, and extends to records regarding my minor child, if applicable.

Privacy Statement: While Dr. Carriere is not required to follow the privacy requirements under the Health Insurance Portability and Accountability Act (HIPAA), he does respect your privacy and will only release information required to further your treatment, assist you in obtaining payment, managing her own internal operations, or specifically authorized by you.

Notice as to Possible Non-Coverage of Services: I understand that because of the nonconventional nature of Dr. Carriere's services, insurance reimbursement may not be available. My insurance company may not pay for acupuncture services, for example, and in some cases may not pay for office visits where the focus of the consultation is on wellness, herbal medicine, or other CAM services. Some of the lab tests that are ordered, particularly those that are used in support of wellness consultations or are kits sent to labs using innovative approaches to diagnostics may also not be reimbursed.

Financial/Insurance Responsibility: I understand that while Dr. Carriere does participate in insurance plans, he is not contracted with them and therefore may be considered out of network. I understand and agree that Dr. Carriere does take assignment, which means that payment will not be required at each visit, but an invoice will be sent after determining what services are covered by your insurance. I understand and agree that I am responsible for all charges incurred for all treatment rendered, including procedures and laboratory tests, even if my insurance company determines that any services are non-covered or excluded, or, in their opinion, are unreasonable or not medically necessary. I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for Dr. Carriere to take action to secure payment of an outstanding balance owed.

Claim Management: I understand that it is my responsibility to know my plan benefits. Dr. Carriere may offer some assistance, but given the uncertainty that pervades insurance decisions, cannot be responsible for any information that turns out to be incorrect. Dr. Carriere will respond to insurance requests for information, but will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim.

Cancellation Fee: A cancellation fee of $50 will be assessed for missed appointments not canceled with more than 72 hours' notice. OR Full payment is required if appointments are not canceled with more than 24 hours of appointment.

Notice to Medicare Patients:
Dr. Carriere does accept Medicare assignment for hospitalized patients but is not currently accepting new outpatient Medicare clients

No Guarantees. I am aware that no practice of medicine is an exact science, and acknowledge that there are and can be no guarantees as to accuracy or outcomes of any diagnoses or treatments I receive.

Duration/Revocation of Authorizations: The authorizations may be revoked by me in writing at any time. Such revocation will not affect my financial responsibility to pay for services rendered. I also certify that I am here to receive health care and for no other purpose.

Date: _____

_____ _____
Patient/Guardian Patient/Guardian Name Printed

INTEGRATIVE MEDICAL CONSULTANTS
EDWARD W. CARRIERE JR. MD

NOTICE THAT SERVICES ARE NOT PRIMARY CARE

I understand that Edward Carriere, M.D. is not acting as my primary care physician. I understand that even though he may address issues affecting my general health, the practice is focused on a complementary, holistic or integrative approach to medicine. It is in my best interest to also have a primary care physician to ensure that I fully informed about all available conventional means to address any medical conditions I may have. I understand that Dr. Carriere does not provide emergency, on-call assistance. Even should Dr. Carriere provide treatment for a condition, I understand this assistance does not mean he is taking primary responsibility for managing that condition, but is complementing the care I receive from my primary care physician. I understand that in addition to a primary care physician, it may be in my best interest to have appropriate specialists, such as a cardiologist if l have cardiac problems or a pediatrician if I am seeking treatment for my children.

I also understand that it is my responsibility on an ongoing basis to inform Dr. Carriere of the name of and contact information for my primary care physician and treating specialists, of any diagnoses I have received, and of any treatments I have had or am now undergoing for current conditions. I also understand that it is important for me to let my primary care physician know about any recommendations/treatments performed by Dr. Carriere, in order to ensure that my Care is properly coordinated.

My primary care physician is:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Date: _____

_____ _____

Patient/Guardian Patient/Guardian Name Printed

I understand that Carriere, M.D. is not my primary care physician. I understand that it is my best interest to have a primary care physician and to inform my primary care physician about any treatments I receive from Dr. Carriere to ensure that my care is properly coordinated.

INFORMED CONSENT TO RECEIVE TREATM ENT

I hereby certify that I understand the above authorization and the risks of possible complications. I have been adequately informed, and questions I have asked have been satisfactorily answered. I represent that I am seeking [diagnosis and] treatment in order to further my own health and for no other reason. I am aware that I may withdraw this consent and stop treatment at any time.

Date: _____

_____ _____

Witness Signature Patient/Guardian Signature

_____

Patient/Guardian Printed

I understand that care I receive from Dr. Carriere may be non-traditional or non-conventional. Such services are commonly referred to as complementary or alternative medicine (ACM or CAM), holistic care, or integrative medicine. This can include a variety of innovative medical treatments as well as acupuncture, nutritional and herbal consultation, and mind-body approaches to care. Many of these services may not be recognized as standard medical practice, generally accepted by the medical community, or approved by the Food and Drug Administration or other regulatory agencies. While many of these approaches have long been practiced, they may still be considered investigational or experimental. I am seeking care form Dr. Carriere in order to benefit from his special training in integrative medicine and receive advice and treatment about such care.

Nutritional and Herbal Guidance: Consultations may include discussion of diet, dietary supplements, and herbal or botanical products. While herbs and botanical products are generally available over-the-counter and considered safe based upon their long history of use, many of them have not been widely tested. There is some risk that these products could prove harmful, particularly if I am allergic to them, which in rare circumstances could lead to serious consequences. I understand that interactions between herbs, and between herbs and drugs, are not yet well known. While unlikely, I could have an adverse reaction or experience a reduction or increase in the effect of other medications. This can have serious consequences for some medications, such as for high blood pressure or blood sugar. I will let Dr. Carriere and other physicians know what herbs I am taking. And I agree to notify Dr. Carriere if I experience any interactions or adverse experiences or reactions; if they are not serious I will notify him to ask for his assistance and if serious, I agree to seek emergency care first before notifying Dr. Carriere.

Recommendations could include fasting and other forms of detoxification. While this is generally safe, some people may experience a healing crisis, which may be a short period in which one's symptoms increase, or a period of a flu-like illness during which there could be some mild fever, chills, dizziness, loss of appetite, and so forth. Such an experience, while unpleasant, can signal that the body is effectively detoxifying or undergoing a healing effort.

Mind/Body Medicine: Mind/body medicine is an emerging medical view intended to improve patient well-being by improving lifestyle,, capacity to function in a meaningful and effective way, and reversing the impacts of stress. Because stress and emotional states may play an important role in my medical conditions, Dr. Carriere may assist me in recognizing more successful approaches to lifestyle and mind/body approaches such as meditation, massage, or other stress management techniques.

Energy Medicine: Energy medicine is a controversial approach to healing that has a long traditional history across many cultures, and for which there is some evidence can have a healing

benefit. It is a "hands off' approach in which the practitioner channels life energy for healing benefit, intended to affect the balance and flow of energy in a manner that might be thought of as similar to acupuncture, but without needles. It may be ineffective or it is possible that it could temporarily aggravate symptoms. I understand that while these approaches can provide an important complement to my health care, I should ensure, by discussing my health needs with Dr. Carriere and my primary care physicians, that appropriate mainstream care is provided. I understand that Dr. Carriere will discuss potential therapies that she recommends, and I agree to accept the risks explained to me about these procedures by agreeing to undertake these treatments.

I have read and understand the nature of the services provided by Dr. Carriere. I represent that I am seeking treatment in order to further my own health and for no other reason. I agree to take a responsible role in improving my own health and discuss advice and suggestions of Dr. Carriere as presented in a treatment plan. I acknowledge that if I do not follow the treatment plan as provided, I may not receive the full benefit of the treatments proposed by Dr. Carriere and I accept responsibility for less than satisfactory results. I am aware that I may withdraw this consent and discontinue following the recommendations at any time.

_____	_____
Signature of Patient or Legal Guardian	Witness
_____	_____
Patient's Printed Name	Date

INTEGRATIVE MEDICAL CONSULTANTS
EDWARD W. CARRIERE JR. MD

2020 Integrative Medical Consultants Fee Schedule
Effective October 2020

How we bill and why:
Due to our current national model of reactionary medicine and the all too common practice of purely masking symptoms with pharmaceuticals, we as Americans spend almost $8,000.00 per year per person on health care. Yet, we are last among developed countries as far as quality of care and health outcomes.

Many of us are paying exorbitant amounts for health insurance, or stay in an unfulfilling job just to keep coverage. I understand, I pay almost 2000.00 a month for a healthy family of five, that is of no use until we meet another 6500.00 per person in deductibles!
I want you to be able to get the most from your insurance. At the same time these same companies do not value nor compensate adequately for the time and effort an Integrative practice puts into its clients, typically an hour per visit.
Despite the fact that treating the underlying cause of disease gets people off costly pharmaceuticals, prevents hospitalizations and improves quality of life, Insurance companies don't care.
We have developed a hybrid model that seems to work for most clients.
We will send in all documentation and coding to a professional billing service who will submit all claims on your behalf at your request. Medicare and Blue Cross will be billed automatically. They will also submit appeals for any denied claims, sometimes all it takes is a little extra effort to get them to cough up the money. We will bill the highest code that documentation allows to get you the greatest reimbursement if you have out of network coverage.

FEES:
ALL PROFESSIONAL SERVICES ARE TIME DRIVEN (includes a 5-7min documentation time per hour)

SCHEDULED OFFICE VISITS /PHONE FOLLOW UPS BILLED AT HOURLY RATE
Please be conscious of time and considerate of other clients. If you feel you will need more than an hour, please schedule a longer appointment. You will be billed in 15min increments for time spent.
(Simple, brief questions, emails-no charge. Please do not send me 3 page emails. With hundreds of clients I cannot read these)

HOURLY RATE ----------$400.00/HR PAYABLE **AT TIME OF SERVICE**

MALE HORMONE REPLACEMENT ----------$2,600.00 (Includes initial consult and all follow up visits)
REQUIRES ANNUAL CONTRACT

FEMALE HORMONE REPLACEMENT ---------- Standard office rates

INSURANCE BILLING, CODING, COLLECTION SERVICE:

FOR MEDICARE PATIENTS ---------- Annual Contract Required ($1,000/year or $83/monthly)
ABN form (Advanced Beneficiary Notice of Non coverage) must be signed prior to each visit (separate attachment)

FOR BLUE CROSS BLUE SHIELD ---------- Annual Contract Required ($1,000/year or $83/monthly)

BLOOD WORK, SPECIALIZED TESTING:
(Most basic blood work will be covered by insurances, most specialized testing will not. We have included average out of pocket costs for these tests, there will be some variation.)

Micronutrient Testing ---------- $299.00
LabCorp ---------- $400-$700 *average OOP cost, entirely based on insurance
4 point Salivary Cortisol testing ----------$250.00

CANCELLATION POLICY: We are currently booking out for several months. Many of our clients are newly diagnosed cancer patients and are on a waiting list for cancellations. Please be considerate. Any appointment that is not canceled within 48hrs of the appointment will be charged a $200.00 cancellation fee. **Appointments will not be rescheduled until paid.**

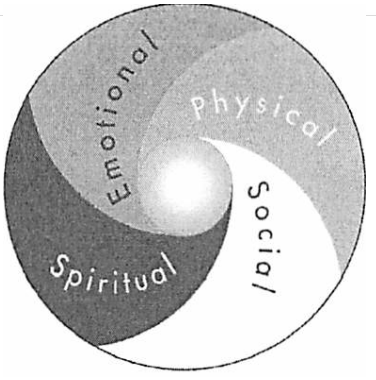
Name on Card_____

AUTHORIZED SIGNATURE_____

I, _____, authorize payment in the amount of $_____ or $_____ monthly for a period of one year or twelve payments for services rendered by Edward W Carriere, MD, Integrative Medical Consultants, DBA Internal Aesthetic Medicine.

INTEGRATIVE MEDICAL CONSULTANTS

EDWARD W. CARRIERE JR. MD



PLEASE COMPLETE THIS FORM TO THE BEST OF YOUR ABILITY.

ALL QUESTIONS ARE OPTIONAL; SKIP QUESTIONS THAT DO NOT APPLY TO YOU. THANK YOU.

Name: _____

Sex: _____ DOB: _____

Date: _____Email: _____

Address: _____

Phone: Cell: _____Home: _____Work: _____

Preferred Pharmacy: _____

Pharmacy Phone Number: _____

Please describe your goals and expectations regarding your appointment at the Integrative Medicine Clinic:

_____

_____

_____

_____

_____

_____

If you are experiencing pain now or having on-going pain please fill out the following section.

Pain:

Location: _____

Quality: _____

Radiation: _____

What makes it better? _____

What makes it worse? _____

How long have you had it? _____

Mark an X on the line where your pain is currently:

No Pain **Worst Pain**

0 1 2 3 4 5 6 7 8 9 10

Please describe how your pain affects your daily activities:

_____

_____

_____

Please describe any accidents you have had (include dates, injuries)

_____

_____

_____

Medical conditions/Illnesses/Past medical history:

_____

_____

_____

_____

_____

Menstrual history (Women) including last menstrual period:

_____

_____

_____

Psychiatric Hospitalizations:

_____

_____

Surgeries (provide dates of procedures):

_____

_____

_____

Current medications (not herbs or supplements):

_____

_____

_____

_____

_____

Please list any natural health products (herbs, supplements, vitamins, special foods) you are currently using:

Product: _____Brand: _____Dose: _____How often: _____
Product: _____Brand: _____Dose: _____How often: _____
Product: _____Brand: _____Dose: _____How often: _____
Product: _____Brand: _____Dose: _____How often: _____
Product: _____Brand: _____Dose: _____How often: _____
Product: _____Brand: _____Dose: _____How often: _____
Product: _____Brand: _____Dose: _____How often: _____
Product: _____Brand: _____Dose: _____How often: _____
Product: _____Brand: _____Dose: _____How often: _____

Allergy/intolerances to medication or substances:

_____

_____

_____

Current/recent medical and other health care providers (please give names; include physical therapy, psychology, etc.):

_____

_____

_____

_____

_____

Please list which Complementary and Alternative therapies or practitioners (give names) you have tried:

_____

_____

_____

Please list year of most recent:

Colonoscopy _____
Stool test _____
Flu shot _____
Mammogram _____
PAP smear _____

How would you describe your health (circle one): Poor Average Good

Family history of health problems or conditions (parents, spouse, siblings, children, grandparents if applicable):

_____

_____

Social History:

How many sexual partners have you had in the last year? _____

Describe the current state of your finances: _____

Education level: _____

Occupation: _____

Please describe your religion/spirituality: _____

_____

_____

Hobbies: _____

Housemates/living situation: _____

If you presently follow any regular exercise program, please list what it is, when you started, and how many times per week you do the exercise: _____

_____

_____

_____

Please list the types of volunteer work and hobbies that you do (both current and previous).

Volunteer work or hobbies	Year
_____	_____
_____	_____
_____	_____

List the things that cause you the most stress in your life now (e.g. relationships, family, health, money, job, etc.) and number them in order of significance

_____	_____
_____	_____
_____	_____
_____	_____

How would you rate your stress level in the past month? Place an X or circle the appropriate spot on the line below:

No Stress **Completely Stressed Out**

0 1 2 3 4 5 6 7 8 9 10

How would you rate your emotional state in the past month? Place an X or circle the appropriate spot on the line below:

Sad **Happy**

0 1 2 3 4 5 6 7 8 9 10

Would you consider yourself to be more of an optimist or a pessimist? Place an X or circle the appropriate spot on the line below:

Pessimist **Optimist**

0 1 2 3 4 5 6 7 8 9 10

What do you do for relaxation/coping?

_____

_____

Mark an X on the line where your energy level is currently:

No Energy **Highest energy**

0 1 2 3 4 5 6 7 8 9 10

Mark an X on each line for your energy level at various times of the day:

Morning

Low Energy High Energy

0 1 2 3 4 5 6 7 8 9 10

Afternoon

Low Energy High Energy

0 1 2 3 4 5 6 7 8 9 10

Evening

Low Energy High Energy

0 1 2 3 4 5 6 7 8 9 10

Please describe how fatigue or low energy affects your daily activities:

_____

_____

_____

Describe your sleep (in general):

_____

_____

_____

Please describe how sleep deprivation affects your daily activities:

_____

_____

_____

Diet and Nutrition History:

Do you use coffee? _____If yes, how much per day? _____

Do you use soda? _____ If yes, how much per day? _____

Do you now or have ever used tobacco? _____If yes, how much per week? _____

Do you now or have ever used alcohol? _____If yes, how much per week? _____

Do you now or have ever used marijuana? _____If yes, how much per week? _____

Do you now or have ever used other drugs (non-prescribed drugs)? _____ If yes, which ones and how much per week?

_____

Recall of dietary intake

Please list all foods and drinks you have consumed in the previous 24 hours. Include meals, snacks, beverages and condiments.

Breakfast: _____

_____

Lunch: _____

_____

Dinner: _____

_____

Snacks: _____

_____

Is this a typical day? If not, why not? Please describe:

_____

_____

Are there any types or groups of foods you crave or eat a lot?

_____

_____

Are there any types or groups of foods you dislike or rarely eat?

_____

_____

What do you drink on a typical day?

_____

_____

What type of oil do you cook with? _____

What type of spreads do you add to your foods? _____

How many cups (8 oz) of water do you drink on a typical day? _____

How many servings of fruit do you eat on a typical day?
(1 serving = 1 small piece, or _ cup juice, or _ cup canned or chopped, or cup dried)

_____

How many servings of vegetables do you eat on a typical day?
(1 serving = 1 small piece, or 1 cup fresh leafy greens, or _ cup raw or cooked, or cup dried)

_____

Please describe your relationship to food:

_____

_____

_____

Highest weight ever: _____ Desired weight: _____

Please describe your mood:

_____

_____

_____

_____

_____

Please describe your childhood:

_____

_____

_____

_____

How would you rate your own health as a child? Good Fair Poor

Please list any major traumas (emotional, verbal, physical, and sexual) you have experienced:

_____

_____

_____

_____

Current symptoms (circle if problematic, explain if necessary):

Allergy _____
Arthritis (*where*?) _____
Asthma_____
Bitter taste in mouth_____
Blurry vision_____
Breathing problems_____
Brittle nails_____
Bruising_____
Bursitis (*where*?) _____
Cancer/tumor_____
Chest pain/tightness_____
Cough_____
Diabetes_____
Difficulty concentrating_____
Digestive problems (*type*?) _____
Ear ringing_____
Easily angered_____
Emphysema_____
Fatigue_____
Frequent colds/flu _____
Hearing problems_____
Heart condition (*type*?) _____
Hemorrhoids_____
High blood pressure_____
Hot flashes_____
Infections (*where*?) _____
Inflammation (*where*?) _____
Irregular heartbeat_____
Low blood pressure_____
Nightmares_____
Night sweats_____
Numbness/tingling (*where*?) _____
Menstrual or Gynecological symptoms _____
Poor appetite_____
Poor memory_____
Rapid heartbeat_____
Red/dry eyes_____
Sciatica_____
Seizures/convulsions_____
Shortness of breath_____
Skin condition/rash (*where*?) _____
Stroke_____
Trouble sleeping_____
Urinary problems_____
Varicose veins_____
Weak immune system (describe) _____

Is there any other information that you would like to share with us?

_____

_____

_____

_____

_____

_____

Thank you for taking the time to complete this extensive form. This information will be very helpful in your evaluation and assessment.

We look forward to your visit and working with you to meet your goals.

INTEGRATIVE MEDICAL CONSULTANTS

EDWARD W. CARRIERE JR. MD

Thank you for choosing Internal Aesthetic Medicine and Integrative Medical Consultants. We are located in Franktown Co., in the middle of nowhere. My wife and I converted a small adobe farm house into a medical day spa and office.

The address is **2400 S Russellville Rd Franktown Co. 80116**

There is no sign as the property is zoned agricultural and county restrictions forbid signage. Look for metal sunflowers on the fence and large solar panels about a quarter mile past the Gesco Tree farm on the East side of the road. Russellville Rd is located about a mile South of the Franktown intersection (hwy 86/hwy 83, South Parker rd) off Hwy 83. The Spa is about 5 mi down the road. Please come in and have a seat if no one greets you as we may be with patients, although we strive to be on schedule. Allow about 35min travel time from 1-25/Lincoln Ave area much more for bad weather. Please bring all intake forms and signed consents with you for your initial consultation. All initial visits are scheduled for 60 min. We are looking forward to working with you to achieve your health goals.

New office address: **99 Inverness Drive East Suite 100 Englewood Co 80112**

"Resilience Code" office is shared with Dr Prusmack of Rocky Mountain Spine. Please arrive 15 min prior to your scheduled appointment, our receptionist will make copies of your insurance card and driver's license. Please note as described in the consents, depending on your out of network benefits our services may or may not be covered by your insurance. Thank you for choosing Integrative Medical Consultants to help guide you to better health and happiness.

Sincerely,
Edward W Carriere Jr. MD