APPLICATION FOR CARE AT IMPACT CHIROPRACTIC

Colorado: Now a Fault Insurance State

Since Colorado's transition to a "fault" insurance state in 2003, injured drivers and passengers now have multiple options when trying to get compensation for medical bills and other losses stemming from a car accident, including:

1. Filing a claim with their own car insurance company (medpay)
2. Filing a claim with the at-fault driver's insurance company (often called a "third party claim")*
3. Going to civil court and filing a lawsuit against the other driver, seeking a specified amount of damages.*

* **If filing third party or going to civil court you will be responsible to *pay in full* for services if payment is never received by either party.**

Information needed to bill auto policy:

Auto Insurance Information			
Name of Insurance Company:			
Policy Number:	Claim Number:		
Adjustor's Name:	Adjustor's Phone Number:		
Insurance Companies Billing Address			
Street:	City:	State:	Zip:

If this is a 3rd party claim, please fill out information below.

Driver of the Other Vehicle (if known)	
Name:	Phone:
Name of Insurance Company:	
Policy Number:	Claim Number:

If filing a lawsuit, please fill out the information below.

Lawyer Information, if applicable			
Office Name:	Lawyer's Name:		
Office Address			
Street:	City:	State:	Zip:
Case Number:			

Today's Date: _____

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: _____/_____/_____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ Home Phone: _____ Mobile Phone: _____

Marital Status: ☐ Single ☐ Married Do you have Insurance: ☐ Yes ☐ No Work Phone: _____

Social Security #: _____ Height: _____ Weight: _____

Employer: _____ Occupation: _____

Spouse's Name _____ Number of children and Ages: _____

Name & Number of Emergency Contact: _____Relationship: _____

HISTORY OF COMPLAINT

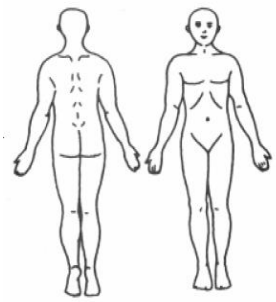
Please identify the condition(s) that brought you to this office:
Primary: _____ Secondary: _____
Tertiary: _____ Quaternary: _____
On a scale of **1** to **10,** with **10** being the worst pain and **0** being no pain, rate your above complaints by ***circling the number*****:**
Primary complaint is: 0 1 2 3 4 5 6 7 8 9 10
Second complaint is: 0 1 2 3 4 5 6 7 8 9 10
Third complaint is: 0 1 2 3 4 5 6 7 8 9 10
Fourth complaint: 0 1 2 3 4 5 6 7 8 9 10
When did the problem(s) begin? _____ When is the problem at its worst? ☐ AM ☐ PM ☐ mid-day ☐ late PM
How long does it last? ☐ It is constant ☐ I experience it on & off during the day ☐ It comes & goes throughout the week

How did the injury happen? _____

Condition(s) ever been treated by anyone in the past? ☐No ☐ Yes **If yes,** when: _____ & by whom? _____

How long were you under care: _____ What were the results? _____

Name of Previous Chiropractor: _____ ☐ **N/A**



***PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:
R = Radiating **B= B**urning **D =D**ull **A =** Aching **N = N**umbness **S =S**harp/ **S**tabbing **T= T**ingling
What relieves your symptoms? _____

What makes them feel worse? _____

LIST RESTRICTED ACTIVITY:	**CURRENT ACTIVITY LEVEL**	**USUAL ACTIVITY LEVEL**
_____	: _____	
_____	: _____	
_____	: _____	
_____	: _____	

Is your problem the result of ANY type of accident? ☐ Yes ☐ No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about?

_____

_____

HISTORY

Have you suffered with any of this or a similar problem in the past? ❑ No ❑ Yes **If yes** how many times? _____
When was the last episode? _____ How did the injury happen? _____
Other forms of treatment tried: ☐ No ☐ Yes **If yes,** please state **what** type of treatment: _____
and who provided it: _____ How long ago? _____ Were the results? ☐ Favorable ☐ Unfavorable
Please Explain:

_____

Please identify any type of job(s) that you have had in the past that have imposed any physical stress on you or your body:

_____

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past*, C** for ***Currently*** have and **N** for ***Never** have had*:
___ Broken Bone ___ Dislocations ___ Tumors ___ Rheumatoid Arthritis ___ Fracture ___ Disability ___ Cancer
___ Heart Attack ___ Osteoarthritis ___ Diabetes ___ Cerebral Vascular ___ Other serious conditions:

PLEASE identify ALL PAST and any **CURRENT** conditions you feel may be contributing to your present problem:

	HOW LONG AGO	TYPE OF CARE RECEIVED	BY WHOM
INJURIES →			
SURGERIES →			
CHILDHOOD DISEASES →			
ADULT DISEASES →			

SOCIAL HISTORY

1. Smoking: ❑ cigars ❑ pipe ❑ cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
2. Alcoholic Beverage: How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
3. Recreational Drug use: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never
4. Hobbies/Recreational Activities/Exercise Regime: How does your present problem affect the following*
*See pg. 2- Activities of Daily Living

FAMILY HISTORY

1. Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes
If yes whom: ❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sister(s) ❑ brother(s) ❑ son(s) ❑ daughter(s)
Have they ever been treated for their condition? ❑ No ❑ Yes ❑ I don't know
2. Any other hereditary conditions the doctor should be aware of? ❑ No ❑ Yes: _____

I hereby authorize payment to be made directly to Impact Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Impact Chiropractic for any and all services I receive at this office.

_____ _____ - _____ - _____
Patient or Authorized Person's Signature **Date Completed**

_____ _____ - _____ - _____
Doctor's Signature **Date Form Reviewed**

Activities of Daily Living/Symptoms/Medications

Daily Activities: Effects of Current Conditions on Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing computer Work	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Gardening	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Playing Sports	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Recreation Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Shoveling	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dancing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Rolling Over	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Working	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Climbing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Working out	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting to Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform

List Prescription & Non-Prescription drugs you take: _____

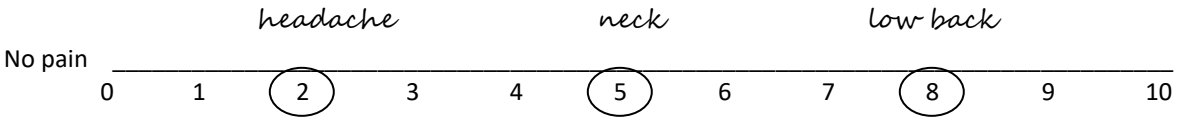
_____

_____

Please read carefully:
Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:



1 – What is your pain RIGHT NOW?

No pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain _____ worst possible pain
0 1 2 3 4 5 6 7 8 9 10

Score: _____

<u>Have you ever suffered from (please check all that apply)?</u>

___ Headache	___ Pregnant (Now)	___ Dizziness	___ Prostate Problems	___ Ulcers
___ Neck Pain	___ Frequent Colds/Flu	___ Loss of Balance	___ Impotence/Sexual Dysfun.	___ Heartburn
___ Jaw Pain, TMJ	___ Convulsions/Epilepsy	___ Fainting	___ Digestive Problems	___ Heart Problem
___ Shoulder Pain	___ Tremors	___ Double Vision	___ Colon Trouble	___ High Blood Pressure
___ Upper Back Pain	___ Chest Pain	___ Blurred Vision	___ Diarrhea/Constipation	___ Low Blood Pressure
___ Mid Back Pain	___ Pain w/Cough/Sneeze	___ Ringing in Ears	___ Menopausal Problems	___ Asthma
___ Low Back Pain	___ Foot or Knee Problems	___ Hearing Loss	___ Menstrual Problem	___ Difficulty Breathing
___ Hip Pain	___ Sinus/Drainage Problem	___ Depression	___ PMS	___ Lung Problems
___ Back Curvature	___ Swollen/Painful Joints	___ Irritable	___ Bed Wetting	___ Kidney Trouble
___ Scoliosis	___ Skin Problems	___ Mood Changes	___ Learning Disability	___ Gall Bladder Trouble
___ Numb/Tingling arms, hands, fingers		___ ADD/ADHD	___ Eating Disorder	___ Liver Trouble
___ Numb/Tingling legs, feet, toes		___ Allergies	___ Trouble Sleeping	___ Hepatitis (A,B,C)

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:
I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Impact Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ ____/____/____  *Witness Initials*

Patient or Authorized Person's Signature **Date**

REGARDING: X-rays/Imaging Studies

FEMALES ONLY →*please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ ____/____/____  *Witness Initials*

Patient or Authorized person's Signature **Date**

Impact Chiropractic NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -**we may call your home and leave messages** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours). **X-rays** are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please call Martin Rigney at (970) 690-9899. If he is unavailable, you may make an appointment with our receptionist to see him within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

Patient initials: _____-retaining page 1 of 2

Impact Chiropractic NOTICE OF PRIVACY PRACTICE CONT.

I have received a copy of Impact Chiropractic's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____

Patient's Name **DOB**

_____ _____

Patient signature **Date**

_____ _____

Witness ***Date***

Impact Chiropractic PI/Automobile Accident Addendum

Dear Patient,
This information is considered confidential. We need this information because your answers will help us determine if chiropractic can help you. If we do not, sincerely believe, that your condition will respond satisfactorily, we will not accept your case. For us to understand your condition properly, please be as accurate as possible while completing this form.

Impact Chiropractic Team

Please answer all questions as completely and thoroughly as possible

Date of accident? _____

Please explain *in detail* how your accident happened. _____

_____

_____

_____

Where did you feel pain immediately after the accident? _____

List the extent of your injuries as you know them: _____

_____

Check symptoms you have noticed since the accident:

☐ Headache	☐ Dizziness	☐ Depression	☐ Fatigue	☐ Light bothers eyes
☐ Head seems to heavy	☐ Memory Loss	☐ Cold hands/feet	☐ Stiff neck	☐ Pins & needles in arms
☐ Face flushed	☐ Loss of balance	☐ Pins & needles in legs	☐ Constipation	☐ Cold sweats
☐ Fever	☐ Irritability	☐ Numbness in toes/fingers	☐ Loss of taste	☐ Chest pain
☐ Diarrhea	☐ Sleep disturbance	☐ Back pain	☐ Shortness of breath	☐ Neck Pain
☐ Loss of smell	☐ Upset stomach	☐ Ringing in ears	☐ Fainting	☐ Nervousness

Any other symptoms than those listed above? _____

_____

Did you require post-accident hospitalization? ☐ Yes ☐ No

If **yes**, How long? _____ Name of the Hospital? _____

Name of Doctors? _____

What treatment was given? _____

Was any other doctor consulted after your accident? ☐ Yes ☐ No

If so, what was the doctor's name? _____ Doctor's Specialty? _____

Diagnosis? _____ What treatments were given?_____

How often did you see the doctor? _____ How long did you see the doctor? _____

Have you ever had any complaints in the involved area before? ☐ Yes ☐ No

If so, what were the complaints? _____

Before the injury were you capable of working on an equal basis with others your age? ☐ Yes ☐ No

Are your work activities restricted because of this accident? ☐ Yes ☐ No

Since this injury are your symptoms: ☐ Improving ☐ Getting worse ☐ The same

Direction you were heading? ☐ North ☐ East ☐ South ☐ West on _____ (street or highway)

The other vehicle was heading? ☐ North ☐ East ☐ South ☐ West on _____ (street or highway)

Were the police notified? ☐ Yes ☐ No

Were you knocked unconscious? ☐ Yes ☐ No If so, for how long? _____

You were struck from ☐ Behind ☐ Front ☐ Left Side ☐ Right Side_____

Were you? ☐ The driver ☐ The passenger ☐ In the front seat ☐ In the back seat ☐ Using seat belts

_____ _____

Patient's Name **DOB**

_____ _____

Patient's Signature **DATE**

_____ _____

Doctor's Signature **DATE**

ASSIGMENT, LIEN, RELEASE & POWER OF ATTORNEY

THIS AGREEMENT, entered this date and between _____ called "PATIENT" and IMPACT CHIROPRACTIC.

WHEREAS Patient desires to receive chiropractic services from IMPACT CHIROPRACTIC and desires to assign certain rights and benefits to IMPACT CHIROPRACTIC as consideration for IMPACT CHIROPRACTIC awaiting payment of such benefits.

Accordingly, it is hereby agreed that:

A. Patient hereby authorizes IMPACT CHIROPRACTIC to furnish a full report and records regarding case history, examination, diagnosis, treatment and prognosis, x-rays, laboratory reports and the results of all tests of any type or character of patients such persons as IMPACT CHIROPRACTIC deems appropriate.

B. Patient's assigns to IMPACT CHIROPRACTIC all benefits payable by Patient's insurance or health care plan(s) as a result of charges incurred by Patient for services rendered by IMPACT CHIROPRACTIC. Patient also assigns to IMPACT CHIROPRACTIC all contractual rights Patient has against insurance company, health care benefit plan, or any other party possibly liable to Patient for payment of health care costs incurred by Patient as a result of services rendered by IMPACT CHIROPRACTIC.

C. Patient fully understands that Patient is directly and fully responsible to IMPACT CHIROPRACTIC for all bills submitted for services rendered and that this agreement is made solely for additional protection and consideration for awaiting payment. Patients further understands that such payment is not contingent on any settlement, claim, judgment, or verdict which Patients may eventually recover. In the event of non-payment by any insurance company, health care benefit plan, or any other party possible liable to Patient for payment of health care costs incurred by Patient as a result of services rendered by IMPACT CHIROPRACTIC, Patient agrees to be responsible for any such outstanding balance, including interest at a rate 9%, reasonable attorney's fees and costs.

D. Patient fully understands that the lien and assignment given to IMPACT CHIROPRACTIC herein is irrevocable.

E. By executing this agreement, Patient hereby instructs and directs any attorney-representing Patient to honor the above lien and assignments and make payment under the lien and assignment directly to IMPACT CHIROPRACTIC. Patient directs that attorney be bound by this lien and treat it, irrevocably, as an assignment due to IMPACT CHIROPRACTIC. IMPACT CHIROPRACTIC is relying upon this lien, assignment and directive to any attorney, and as a result of such reliance, IMPACT CHIROPRACTIC is providing care and treatment for which this lien, assignment and directive provides security for payment. *Moreover,* Patient agrees that IMPACT CHIROPRACTIC is to be viewed as a third-party beneficiary of this direction to Patient's attorney and it is Patient's intent to impose upon Patient's attorney an obligation to comply with the terms of this directive.

F. Patient hereby directs all insurers and other persons possibly responsible for Patient's healthcare costs to make all payments for healthcare services rendered by IMPACT CHIROPRACTIC directly to IMPACT CHIROPRACTIC.

G. Patient agrees that in the event Patient receives any check, draft, or other payment subject to this agreement, Patient agrees to act as fiduciary agent for IMPACT CHIROPRACTIC and will immediately deliver said check, draft, or payment to IMPACT CHIROPRACTIC to be applied to Patient's debt for services rendered.

H. Patient hereby appoints IMPACT CHIROPRACTIC as Patient's true and lawful attorney, irrevocable, and with full power of substitution, for Patient and in Patient's name, to ask, demand, sue for, collect, endorse, sign and receive proceeds from insurance, other health benefits, and third-party claims relating to services rendered to Patient by IMPACT CHIROPRACTIC. IMPACT CHIROPACTIC is not obligated or compelled to exercise such powers but may do so in IMPACT CHIROPRACTIC'S sole discretion. Patient agrees to fully cooperate with IMPACT CHIROPRACTIC in collecting said amounts.

I. IMPACT CHIROPRACTIC agrees to submit a copy of this agreement with
the initial claim form(s) which IMPACT CHIROPRACTIC submits to third party payor(s) as notice to the third-party payor(s) of the assignment and other agreements contained herein. At the time each claim is submitted, a copy of the claim will be stored for safekeeping in Patient's file and may be picked up by the Patient, upon reasonable request and during normal business hours, or upon written request by Patient, be mailed to designated address.

ASSIGMENT, LIEN, RELEASE & POWER OF ATTORNEY CONT.

J. Patient hereby authorized IMPACT CHIROPRACTIC to receive a complete copy of Patient's insurance policy, including any endorsements, conditions, limitations or exclusions.

K. A copy of these documents shall be as binding as the document bearing the original signatures.

_____ _____
Date Patient's Signature

_____ _____
Date IMPACT CHIROPRACTIC

REFERENCES:

Valley State Bank V. Dean, 97 Colo. 151, 47 P. 2nd 924 (1935*)*
Fort Lupton State Bank v. Murata, 626 P.2d 757 (Colo. App. 1981)
Barcucas v. Bohemia Import Co., Inc., 518 P.2d 850 (Colo. App. 1974)
Thomas v. Oken, 699 P2d (Colo. App. 1984)
