
# THE STEADMAN CLINIC REGISTRATION

**PATIENT INFORMATION** Today's Date _____

Patient Name _____
Last First (Legal) Initial Nickname

Date of Birth _____ Age _____ SS# _____ Sex ☐ M ☐ F

Race _____ Ethnicity _____ Language _____

Cell Phone _____ Work Phone _____ Home Phone _____

Fax _____ E-mail Address _____

Permanent Mailing Address _____

City _____ State _____ Zip _____

Occupation _____ Retired? ☐ Y ☐ N

Marital Status … _____ Spouse's Full Name _____

Spouse's Employer _____ Business Phone _____

Relative to Contact in Case of Emergency _____

(A relative not living with you)

Relationship _____ Phone _____

Primary Physician _____ Phone _____

Address _____ City _____ State _____ Zip _____

How were you referred to us? _____

**INJURY INFORMATION**

Date of Injury _____ Work Related: ☐ No ☐ Yes Auto Accident: ☐ No ☐ Yes

What is Injured? _____

Describe Injury _____

_____

**INSURANCE INFORMATION**

**PRIMARY INSURANCE COMPANY:**

Carrier _____ Address _____

City _____ State _____ Zip _____ Phone _____

Policy ID Number _____ Group _____

Name of the Policy Holder _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Social Security Number _____ Sex ☐ M ☐ F

Employer _____ Occupation _____

**SECONDARY INSURANCE COMPANY:**

Carrier _____ Address _____

City _____ State _____ Zip _____ Phone _____

Policy ID Number _____ Group _____

Name of the Policy Holder _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Social Security Number _____ Sex ☐ M ☐ F

Employer _____ Occupation _____

**WORKMAN'S COMPENSATION INSURANCE:**

Carrier _____ Address _____

City _____ State _____ Zip _____ Phone _____

Claim Number _____ Case Worker's Name _____

Case Worker's Phone Number _____ Fax _____

Employer at Time of Injury _____

Address _____

**ASSIGNMENT OF BENEFITS:**

Your signature is necessary for us to process any insurance claims and to ensure payment of services rendered. I authorize release of all medical information necessary to process my insurance claims or that is pertinent to my medical care. I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled to the above named physician or clinic. This agreement will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

Patient _____ Date _____

Responsible Party _____ Date _____

**Nondiscrimination**

The Steadman Clinic complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

*This information available in Spanish upon request. Solicite la versión en español de esta información.*

## AUTHORIZATION FOR TREATMENT AND PRACTICE ACKNOWLEDGEMENTS

### STATEMENT OF FINANCIAL LIABILITY

By my signature below, I acknowledge my receipt and acceptance of The Statement of Financial Liability for The Steadman Clinic and, when necessary in processing insurance claims for surgical and other services rendered to me, I authorize The Steadman Clinic to release information from my medical record to my insurance carrier(s), other third-party payers or their reviewing agencies, as reasonably necessary to expedite claim processing and procure payment from such parties for services rendered by The Steadman Clinic. I also authorize the payment by my insurance carrier(s) for services rendered directly to The Steadman Clinic.

I also understand that The Steadman Clinic physicians are investors in the Vail Valley Surgery Center, Edwards Surgery Center, Peak One Surgery Center, and a MRI facility at which I may receive services. I understand that some of The Steadman Clinic physicians utilize FDA approved equipment and devices which they have designed, developed and patented for the purpose of improve patient care. As a result they may receive royalties from their design efforts.

I understand that my insurance carrier (whether private, Medicare, or other third-party payer) may deny payment or consider some or all services performed by The Steadman Clinic, such assistant surgeons, and supplies, to be "non-covered," and that I will then be fully responsible for payment of all such non-covered services.

I acknowledge that the fees charged by The Steadman Clinic for services rendered to me, or to the person for whom I assume financial responsibility, may exceed the fees considered "usual, customary and reasonable," under the terms of my applicable benefit plan or other health insurance coverage documents; the specialized services and staff provided by The Steadman Clinic may not fall within third-party payer definitions of "usual and customary." However, I agree to pay all such fees in full, even if the amount is greater than the amount paid or allowed by my insurance company.

☐ By checking the box to the left, I hereby direct that The Steadman Clinic SHALL NOT bill my insurance company for services provided to me, and instead I agree to pay all fees for services furnished to me by The Steadman Clinic.

***Patient Signature:*** _____ ***Date:*** _____

### CONSENT TO TREATMENT

I hereby give consent to all providers of service at The Steadman Clinic to render such care and treatment as might be required by my condition. Such care can include, but is not limited to, diagnostic procedures such as laboratory and imagining, examinations, rehabilitation, medical and/or surgical treatment and injections. I also authorize The Steadman Clinic to obtain my prescription medication history from other healthcare providers or third-party pharmacy benefit payers for treatment purposes.

***Patient Signature:*** _____ ***Date:*** _____

### UNACCOMPANIED MINOR WAIVER

This section is required to be signed by a parent or legal guardian in order for an unaccompanied minor to be seen by any physician or clinical staff at The Steadman Clinic. By signing, you (parent/guardian) agree that The Steadman Clinic may evaluate and treat the unaccompanied minor in whatever way is medically necessary.

***Parent/Guardian Signature:*** _____ ***Date:*** _____

### NOTICE OF PRIVACY PRACTICES

By my signature below, I acknowledge my receipt and acceptance of the Notice of Privacy Practices for The Steadman Clinic.

***Patient Signature:*** _____ ***Date:*** _____

***Authorized Representative Name (Print):*** _____

***Authorized Representative Signature:*** _____

***Relationship to Patient:*** _____

### OFFICE USE ONLY

Patient was provided with a copy of The Steadman Clinic's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

☐ Patient refused to sign.
☐ Patient was unable to sign or initial because: _____.
☐ The patient had a medical emergency, and an attempt to obtain the acknowledgement will be made at the next available opportunity.
☐ Other reason (describe): _____.

***Staff Member Signature:*** _____ ***Date:*** _____

THE STEADMAN CLINIC

# The Steadman Clinic Patient History Form

**Name:** _____ **Nickname:** _____ **Today's Date:** _____

**Date of Birth:** _____ **Age:** _____ **Height/Weight:** _____ / _____ **Insurance:** _____

**History of Injury**

**Is this related to a:** ☐ Work injury? ☐ Motor vehicle accident? If so, what state? _____ or ☐ Sport accident?

**Which body part is injured?** _____ ☐Right / ☐Left **Hand dominance:** ☐Right / ☐Left

**Please list the injury/accident date:** _____ **If chronic list how long:** _____

**Please describe in your own words: (How the initial injury occurred and how it limits your activity)**

_____

_____

_____

_____

**Please rate your pain using the drop down menu below on a scale of 1 to 10:** (10 being the most painful)

**Rest:** 0 = No Pain **At its worst:** 0

**Is the pain:** ☐Constant or ☐Occasional **Has it been:** ☐Worsening ☐Stable ☐Improving

**Describe the pain:** ☐Sharp ☐Dull ☐Aching ☐Stabbing ☐Throbbing ☐Sensitive to Touch

**Do you have pain at night?** ☐Yes / ☐No **Does the pain keep or wake you from sleep?** ☐Yes / ☐No (☐Keep ☐Wake)

**What symptoms are you experiencing?**

☐Locking ☐Catching ☐Giving Way/Instability ☐Popping ☐Grinding ☐Bruising ☐Numbness ☐Tingling
☐Pain ☐Weakness ☐Swelling Other (Please describe): _____

**What, if anything, makes your symptoms better?**

☐Rest ☐Activity ☐Cold Therapy ☐Heat Therapy ☐Medication ☐Other (Please describe): _____

**What, if anything, makes your symptoms worse?**

☐Inactivity ☐Exercise (Describe): _____ Other (Please describe): _____

**What treatment have you tried for this injury?**

☐Nothing ☐Exercise ☐Ice ☐Decreased Activity ☐Bracing
☐Injections (i.e. Synvisc/Hyalgan/Cortisone) (Date Started): _____
☐Physical Therapy (Date Started): _____ ☐Acupuncture (Date Started): _____ ☐Other: _____
☐Medications: _____ ☐Chiropractic (Date Started): _____

**Have you seen another physician for this injury?** ☐Yes / ☐No **Were you referred?** ☐Yes / ☐No

**If yes, who/where?** _____

**Are you interested in surgery for this problem?** ☐Yes / ☐No / ☐Unsure

**Have you had any of the following tests/studies?**

| Test | Date (Month/Year) | Facility? (Clinic/Hospital) |
|---|---|---|
| X-Ray | | |
| CT Scan | | |
| EMG/NCV | | |
| Discogram | | |
| EKG | | |
| Blood Tests | | |
| Other | | |

**PAST MEDICAL HISTORY** Please check if you currently suffer or have previously suffered from:

| | When? | | When? |
|---|---|---|---|
| High Blood Pressure | | Osteoporosis | |
| Deep Vein Thrombosis (Blood Clot) | | Kidney Disease/Problem | |
| Liver Disease | | Seizures | |
| Heart Disease/Attack | | Arthritis | |
| Stroke | | Thyroid ☐Hyper ☐Hypo | |
| Cancer (Where?) | | Tuberculosis | |
| Elevated Cholesterol | | Pulmonary Embolism | |
| Ulcer Disease | | Polio | |
| Gastritis | | Rheumatic Fever | |
| Reflux Disease (GERD) | | Gout | |
| Asthma | | Depression | |
| Diabetes | | Psoriasis | |
| History of MRSA | | COPD | |
| Other: | | Sleep Apnea | |

**Do you have a pacemaker?** ☐Yes / ☐No **Have you ever had heart, brain or artery surgery?** ☐Yes / ☐No

**Do you have any chance of implants or metal shavings in your skin?** ☐Yes / ☐No

**GASTROINTESTINAL HISTORY**

Do you have a history of Peptic Ulcer Disease? ☐Yes / ☐No If Yes, When?_____

Do you have a history of GI, stomach bleed? ☐Yes / ☐No If Yes, When?_____

Do you take any medications for your stomach? (Please include over the counter medications; i.e. Pepcid, Tums, Zantac, etc. dose and frequency)

_____

**SURGICAL HISTORY**

Please list all surgeries to the area you are being seen for today:

| Type of Surgery | Date | Surgeon |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Please list all other surgeries you have had in the past:

| Type of Surgery | Date | Surgeon |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Have you ever had a reaction to anesthesia?** ☐Yes / ☐No If yes explain:_____

**ALLERGIES**

**Are you allergic to: Sulfa Drugs?** ☐Yes / ☐No **Latex?** ☐Yes / ☐No **Steroids?** ☐Yes / ☐No **Metal?** ☐Yes / ☐No

Please list any environmental allergies:

| Other Medication Allergies | What Happened? |
|---|---|
| | |
| | |

**MEDICATIONS** (Please list all prescription, over the counter medications and supplements)

| Medication | Dosage | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**SOCIAL HISTORY**

Occupation:_____ Are you currently working? ☐Yes ☐No ☐Retired ☐Limited Duty

Recreational activities:_____ ☐College or ☐Pro?

Current activity level:_____

Tobacco product use: ☐Never ☐Smoke ☐Chew **Freq:** ☐Everyday ☐Someday ☐Occasionally ☐Former ☐Unknown

Alcohol use (Drinks per day): ☐6 or More ☐4-5 ☐2-3 ☐1 ☐Less than 1 ☐0 In last year ☐Don't drink

Caffeine use: ☐Yes ☐No Type/Frequency:_____

Recreational drugs: ☐Yes ☐No Type/Frequency:_____

Is there a chance you could be pregnant? ☐Yes / ☐No

**FAMILY HISTORY** (Please check family history conditions as well as who had the condition)

Blood Clots:_____ Osteoporosis:_____ Rheumatoid Arthritis:_____

Diabetes:_____ Heart Disease:_____ Hypertension:_____

Seizures:_____ Stroke:_____ Anesthetic Problems:_____

Cancer:_____ Other:_____

**REVIEW OF SYSTEMS**

CONSTITUTIONAL/GENERAL ☐None ☐Weight Gain ☐Weight Loss ☐Chills ☐Fever ☐Weakness/Fatigue
Other:_____

EYES ☐None ☐Blurred Vision ☐Glasses ☐Contacts ☐Eye Pain ☐Redness
☐Vision Change ☐Cataracts ☐Glaucoma
Other:_____

EARS, NOSE, THROAT ☐None ☐Nose Bleed ☐Ear Ache or Infection ☐Ringing in Ear ☐Hoarseness
☐Loss of Hearing
Other:_____

CARDIOVASCLAR ☐None ☐Chest Pain ☐Swelling in Legs ☐Shortness of Breath ☐Palpitations
Other:_____

RESPIRATORY ☐None ☐Shortness of Breath ☐Wheezing/Asthma ☐Frequent Cough
Other: _____

GASTROINTESTINAL ☐None ☐Heartburn ☐Vomiting ☐Nausea ☐Abdominal Pain ☐Acid Reflux
Other:_____

MUSCULOSKELETAL ☐None ☐Arthritis ☐Stiffness ☐Muscle Aches ☐Swelling of Joints ☐Instability
Other:_____

SKIN ☐None ☐Rash ☐Itching ☐Redness ☐Abnormal Scars ☐Psoriasis ☐Ulcers/Sores
Other:_____

NEUROLOGICAL ☐None ☐Headaches ☐Numbness, Tingling, Loss of Sensation in ANY Body Part
☐Dizziness ☐Poor Balance ☐Fainting Spells ☐Seizures
Other:_____

PSYCHIATRIC ☐None ☐Depression ☐Nervousness ☐Anxiety ☐Mood Swing
Other:_____

ENDOCRINE ☐None ☐Excessive Thirst or Hunger ☐Hot/Cold Intolerance ☐Hot Flashes
Other:_____

HEMATOLOGICAL ☐None ☐Easy Bruising ☐Easy Bleeding ☐Varicose Veins ☐Blood Clots ☐Anemia
Other:_____

Signature:_____ Date:_____

Print Name:_____

THE STEADMAN CLINIC

# AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

**Location:** 181 West Meadow Drive, Ste 400, Vail, Colorado 81657 | T 970.476.1100 | F 970.479.5835
**Email:** medicalrecords@thesteadmanclinic.com | **Hours of Operation:** 8 a.m. - 5 p.m. Monday - Friday

**Patient Information:**

Patient Name: _____ Date of Birth: _____/_____/_____

Phone: (_____) _____ Alias: _____ Email: _____

**I direct and hereby authorize The Steadman Clinic to deliver or communicate the Protected Health Information specified in this authorization to myself and the party or parties specified in the following medium:**

☐ Landline ☐ Cell Phone ☐ Text Message ☐ Fax
☐ Message on Voicemail ☐ Message on Voicemail ☐ E-mail ☐ Mail

**I request my protected health information (PHI) to be used or disclosed to the following person, class of persons, or organization:**

☐release of medical records ☐ verbal discussion ☐ no records sent at this time please keep

Name: _____

Address: _____
City: _____ State: _____ Zip: _____
Phone: (_____) _____ Email: _____

**I request my protected health information (PHI) to be released from my medical record(s): (Please check all that apply or describe the information specifically).**

☐ Discharge Summary ☐ ER Record ☐ Treatment Plan ☐ Operative Report
☐ Discharge Instructions ☐ Medication Records ☐ Clinic Note ☐ Pre-Operative
☐ History and Physical ☐ Lab Report ☐ Consultation ☐ Notes EKG / ECG
☐ Provider's Name: _____
☐ Other: _____
☐ Specific Date(s): _____ to _____ **or if no dates are specified, the last two (2) years will be released.**

**I authorize the release of information in my health record which may include information related to:**

☐ Behavioral or Mental Health Issues ☐ Sexually Transmitted Diseases ☐ Sexual Assault Nurse Examiner Reports
☐ Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus
☐ (HIV) Alcohol and Drug Treatment

**Purpose for requesting information: (Please check one)**

☐ Request of Patient ☐ Continuation of Care ☐ Other: _____

**By signing this authorization, I understand that:**

- The authorization form is in effect until revoked by me, or until any records retention period applicable to my records has expired, whichever is sooner.
- Electronic media and delivery methods such as e-mail, or text messages, pose certain risks to the privacy and security of my Protected Health Information that may be beyond the control of TSC/SPRI. I agree to assume such risks personally, and to hold TSC/SPRI harmless in the event my Protected Health Information is breached or compromised as a result of my directing and authorizing TSC/SPRI to transmit or deliver such information electronically.
- My refusal to sign this form will not adversely affect my ability to receive health services, reimbursement for services and an enrollment in a health plan or my eligibility for health benefits. However, information will not be released to the above indicated recipient without my signature. I acknowledge the information disclosed pursuant to this authorization may be subject to re-discloser by the recipient and no longer protected by Federal Law.
- I have the right to revoke this authorization by written notice to TSC/SPRI. I understand actions taken in reliance on the authorization cannot be reversed and my revocation will not affect those actions.
- There may be costs associated with this request in compliance with State copying laws.

Patient/Authorized Representative* Signature:_____ Date:_____

Printed Name of Authorized Representative:_____ Relationship to Patient:_____

* If signed by a patient's authorized representative, supporting legal documentation must accompany this authorization form.

**Nondiscrimination**

The Steadman Clinic complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

*This information available in Spanish upon request. Solicite la versión en español de esta información.*

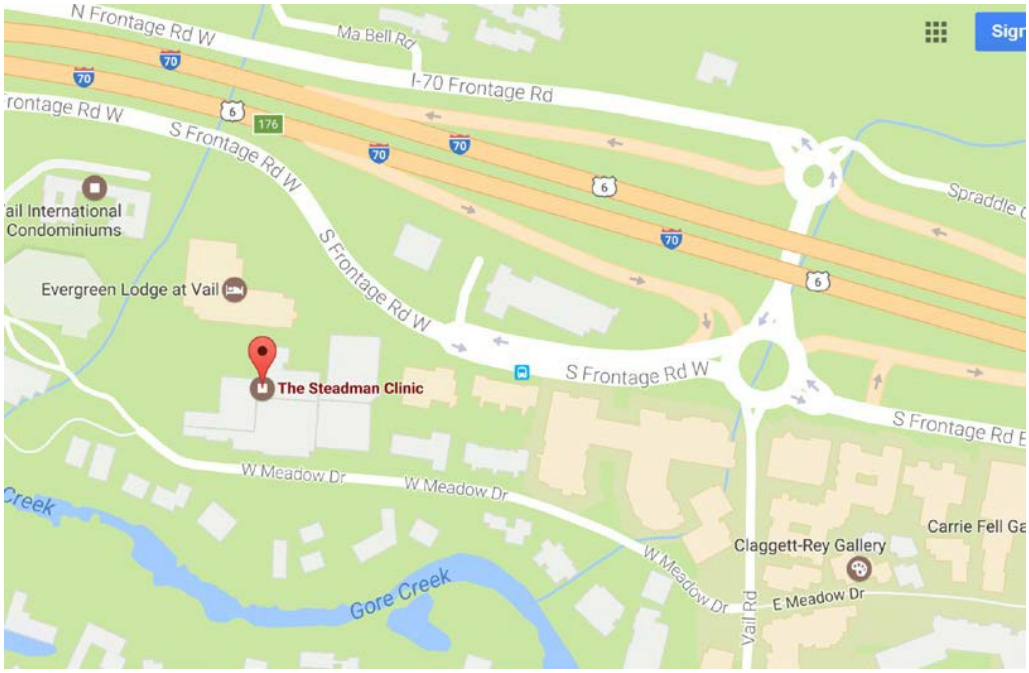
Directions – The Steadman Clinic Vail Location
181 West Meadow Drive, Suite 400
Vail, CO 81657
Phone: (970) 476-1100

From Denver (East) to Vail (West)

Exit the Denver International Airport and take Pena Boulevard to Interstate 70 heading West. Follow Interstate 70 West approximately 120 miles to Vail, Exit 176. Follow the roundabout half-way around and exit in the direction of Vail Village (under the Interstate). Enter the second roundabout and exit at the second right headed towards Vail Road. At the three-way stop sign take a right onto West Meadow Drive. Turn right into the parking area for the Steadman Clinic and Vail Valley Medical Center. Parking attendants are available for drop-off assistance and valet parking upon request. The Steadman Clinic is located on the 4th floor of Vail Valley Medical Center. Elevators to the clinic are located on the 1st floor lobby on the far West side of the building.

From Eagle (West) to Vail (East)

Exit the Eagle County Airport onto Cooley Mesa Road going East. At the stop light turn right (East) on Highway 6. Follow the signs to Interstate 70 East. Take Interstate 70 East approximately 30 miles to Vail, Exit 176. Enter the roundabout and exit at the second right headed towards Vail Road. At the three-way stop sign take a right onto West Meadow Drive. Turn right into the parking area for the Steadman Clinic and Vail Valley Medical Center. Parking attendants are available for drop-off assistance and valet parking upon request. The Steadman Clinic is located on the 4th floor of Vail Valley Medical Center. Elevators to the clinic are located on the 1st floor lobby on the far West side of the building.

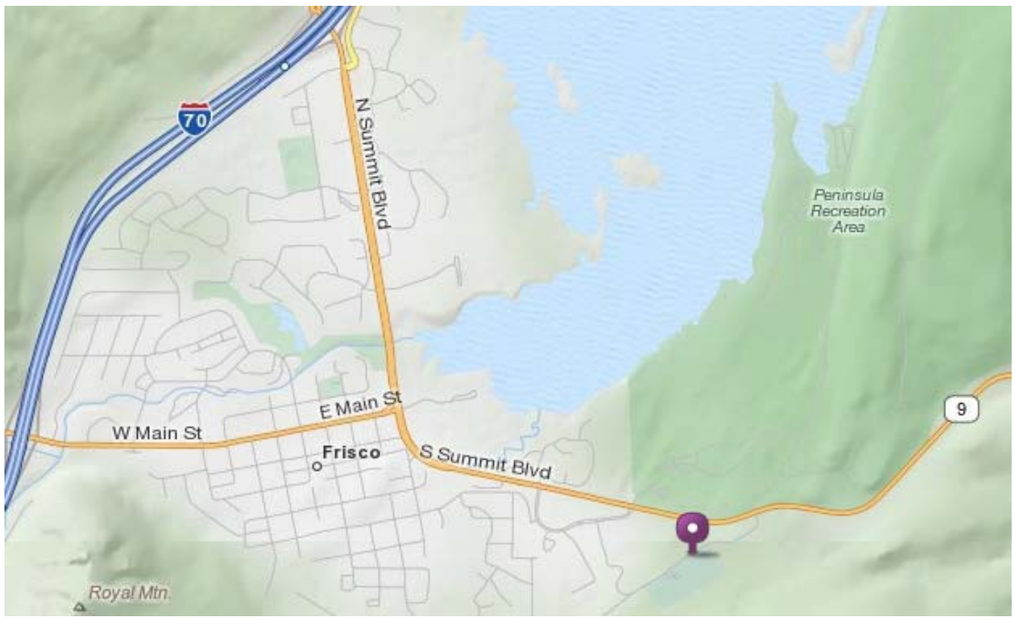


# Directions – Frisco Clinic

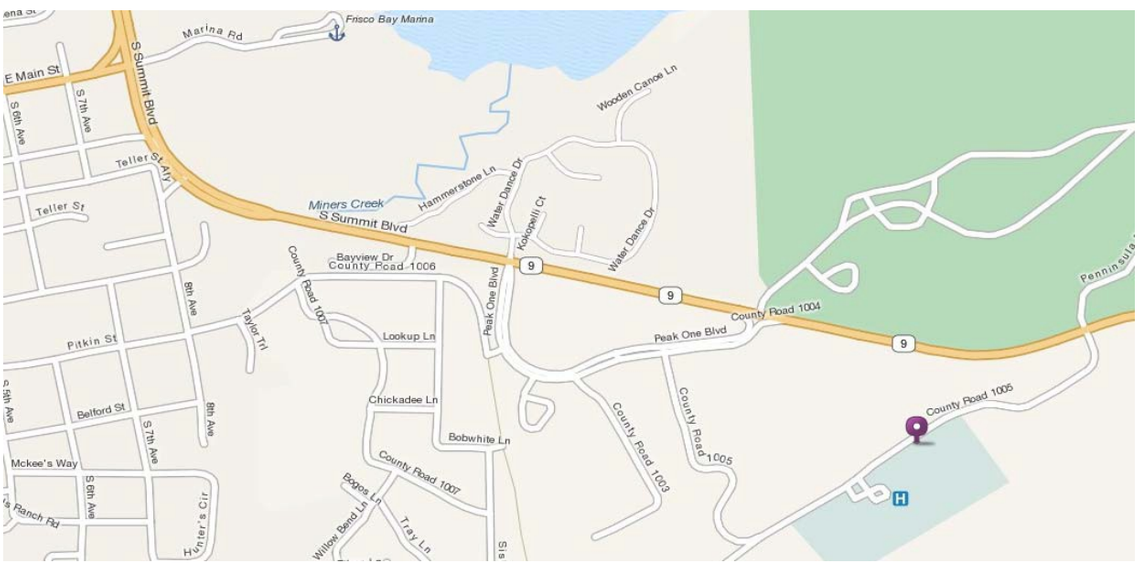
360 Peak One Drive, Suite 340,
Frisco, CO
970-668-6760

**FROM INTERSTATE 70 (EXIT 203)**

Exit Interstate 70 (East or West) at EXIT 203. Drive South on Highway 9 (N. Summit Blvd) approximately 2.5 miles until you reach PEAK ONE DRIVE. Take a RIGHT at the light onto Peak One Drive**. Steadman Clinic** is located in the Summit Medical Center Building (farthest building to the left as you park in front).



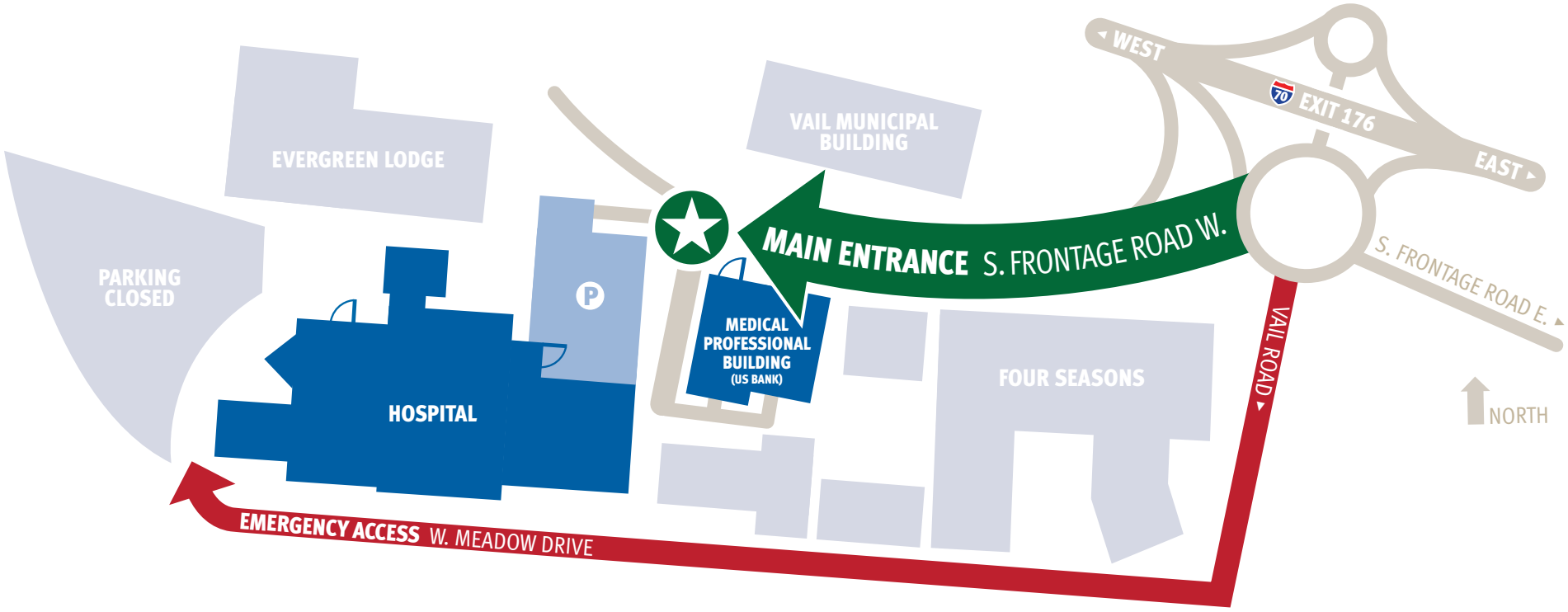

Detail Map



NEW ENTRANCE OPENS AUGUST 3

# New Hospital Entrance

## ACCESS VAIL VALLEY MEDICAL CENTER DURING CONSTRUCTION



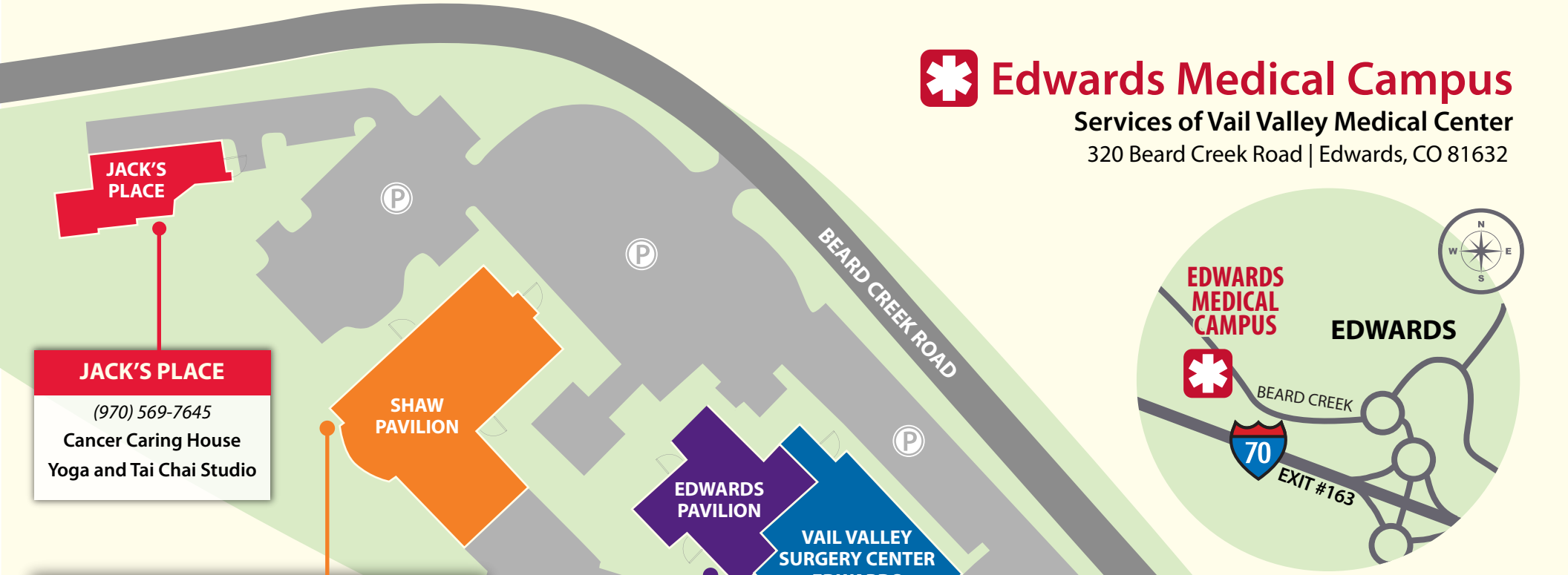

**VAIL VALLEY MEDICAL CENTER IS EXPANDING AND RENOVATING** the west wing of the Vail hospital for the next two years. During this upgrade, all medical services will remain fully functional. To access the Emergency Department, please use West Meadow Drive. All other patients and visitors will access VVMC via South Frontage Road. **For more information call (970) 476-2451 or visit vvmc.com/build.**

Vail Valley Medical Center

# Edwards Medical Campus

**Services of Vail Valley Medical Center**

320 Beard Creek Road | Edwards, CO 81632







## JACK'S PLACE

*(970) 569-7645*

Cancer Caring House

Yoga and Tai Chai Studio

## SHAW PAVILION

**Affiliated Physicians Offices** *(1st)*

**Café** *(1st)*

**Cardiac Rehabilitation** | *(970) 569-7780* | *(G)*

**Colorado Mountain Medical** | *(970) 926-6340* | *(2nd)*

**Edwards Pharmacy** | *(970) 569-7676* | *(1st)*

**Fit For Survival** | *(970) 569-7493* | *(G)*

**General Medical Library** | *(970) 569-7607* | *(G)*

**PET/CT Imaging Center** | *(970) 569-7429* | *(G)*

**Rocky Mountain Urology** | *(970) 928-0808* | *(1st)*

**Shaw Regional Cancer Center** | *(970) 569-7429* | *(G)*

**Sonnenalp Breast Center** | *(970) 569-7690* | *(1st)*

**The Steadman Clinic** | *(970) 476-1100* | *(1st)*

## VAIL VALLEY SURGERY CENTER EDWARDS

*(970) 569-7400*

## EDWARDS PAVILION

**Eagle Care Clinic** | *(970) 569-7520* | *(G)*

**Howard Head (PT)** | *(970) 569-7777* | *(1st)*

**Vail Institute for Aesthetic and Reconstructive Surgery** | *(970) 569-7656* | *(2nd)*

## MAP KEY

*(G)* GROUND FLOOR

*(1st)* FIRST FLOOR

*(2nd)* SECOND FLOOR

Ⓟ PARKING

ENTRANCE

## DIRECTIONS

**From the East (Vail, Denver)**

1. Head west on I-70
2. Take Exit #163 toward Beard Creek Rd
3. Take your first right in the roundabout
4. Take the second right in the second roundabout, up Beard Creek Rd
5. Travel up the hill .4 miles
6. Edwards Medical Campus will be on your left

**From the West (Eagle, Grand Junction)**

1. Head east on I-70
2. Take Exit #163
3. Take your third right in the roundabout, heading north under I-70
4. Take the first right in the second roundabout
5. Take the second right in the third roundabout, up Beard Creek Rd
6. Travel up the hill .4 miles
7. Edwards Medical Campus will be on your left


**ACCOMMODATIONS and TRANSPORTATION**

| **Accommodations:** | |
|---|---|
| Four Seasons Hotel, Vail | 303-389-3301 |
| The Sonnenalp Resort, Vail | 970-476-5656 |
| The Sebastian, Vail | 800-354-6908 |
| The Lodge at Vail | 970-476-5011 |
| Antlers at Vail | 970-476-2471 |
| Vail Mountain Haus | 800-237-0922 |
| Evergreen Lodge | 970-476-7810 |
| Vail Cascade Resort | 800-420-2424 |
| Holiday Inn, Vail | 970-476-2739 |
| The Arrabelle/Rock Resorts, Vail (hotel/condo) | 866-662-7625 |
| Comfort Inn (Avon, CO) | 800-545-8422 |
| Simba Run Resort (Condos-Vail) | 800-746-2278 |
| Sitzmark Lodge | 970-476-5001 |
| | |
| **Transportation:** | |
| | |
| **Airport Shuttle Services:** | |
| Colorado Mountain Express (CME) | 800-525-6363 |
| Airport Shuttle of Colorado | 800-222-2112 |
| | |
| **Rental Cars:** | |
| Thrifty-Eagle Airport | 800-367-2277 |
| Dollar – Eagle Airport | 970-524-7334 |
| Hertz – Eagle Airport | 800-654-3131 |
| | |
| **Limousines, Taxis & Bus Service:** | |
| Silent Partner – Limo-Rick Silverman | 970-470-2587<br>www.silentpartnerimousine.com |
| RJ Limousine/Suburban's | 800-442-5422<br>www.rjlimo.com |
| | |
| Vail Valley Taxi | 970-476-8294 |
| Here-to-Help Vail | 970-949-4248 |