Mile High Sports and Rehabiliation Medicine

Samuel Y. Chan, M.D.   Yusuke Wakeshima, M.D.   Haley Burke, M.D.
2490 W. 26th Ave. Suite 10A Denver, CO 80211
Ph: 303-331-6744   Fax: 303-331-6839

Patient Information			
Last Name	First Name	MI	
SSN	Date of Birth	Sex	
Street Address	City	State	Zip
Primary Phone	Email		
Occupation	Employer		
Emergency Contact Information			
Last Name	First Name	MI	
Relationship to Patient	Phone		
Private Insurance Information			
Primary Insurance	Insured Name		
Insured SSN	Insured Date of Birth	Sex	
Subscriber ID	Group ID	Claims Phone	
Claims Address	City	State	Zip

Would you like your medical notes faxed to any other medical providers?
***If yes*, please provide contact information**

Name of facility or provider	Office Fax

All information provided is accurate and up-to-date to the best of my knowledge. I authorize Mile High Sports and Rehabilitation Medicine to provide medical services on my behalf.

Patient Printed Name: ____________________ Date: ____________

Signature of Patient or Responsible Party: ______________________________

FOR OFFICE USE ONLY			
Workers Compensation / Auto Injury			
Name of Carrier	Adjuster Name		
Adjuster Phone	Adjuster Fax		
Claim Number	Date of Injury		
Claim Address	City	State	Zip
Nurse Case Manager	NCM Phone		
Interpreter / Translator	Phone		
Reason for Visit			
Referring Provider	Phone	Fax	

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HIPAA Notice of Privacy Practices

This Notice of Privacy Practices describes how we may use and disclose your **Protected Health Information (PHI)** to carry out treatment, payment, health care operations and other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health Information (PHI). "Protected Health Information (PHI)" is information about you, including demographic, medical, or billing information, that may identify you and that relates to your past, present or future physical or mental health or condition.

Your Protected Health Information (PHI) may be used and disclosed by your physician, our office staff and others outside of our office involved in your care and treatment for the purpose of providing health care services to you, to pay for services, to support the operation of the physician's practice, and any other use required by law. Medical records may be released to parties involved in your care, according to state guidelines including, employer (Occupational Medicine and Workers' Compensation), legal representation, or lien companies (Auto/Accident Injury) involved in your care.

We will use and disclose your Protected Health Information (PHI) to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI as necessary, to a primary care provider, diagnostic facility, or outside party that provides care to you. PHI may be provided to a physician or facility you have been referred to in order to properly coordinate care.

Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a treatment, referral, diagnostic test, or other medical service.

We may use or disclose, as needed, your PHI in order to support the business activities of this medical practice. These activities include, but are not limited to; quality assessment activities, employee review activities, training, licensing, marketing and fund raising activities, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical providers engaged in the delivery or review of medical services, medical vendors directly involved in the medical care plan, insurance agencies, or other parties involved in the management of medical services. We may ask you to sign your name at the patient registration desk, call you by name from the waiting area, or contact you via telephone. We may use or disclose your protected health information (PHI), as necessary, to contact you to remind you of your appointment, notify you of services, or other activities. We may use or disclose your PHI in the following situations without your authorization. These situations include: as Required by Law, Public health issues as required by law, Communicable Diseases, Health Oversight, Abuse, Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donation, Research, Criminal Activity, Military Activity and National Security requests, Workers' Compensation, and any other Required Uses and Disclosures. Under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services.

Other permitted and required uses and disclosures will be made only with your consent, authorization or when required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in this authorization.

You have the right to inspect and copy your Protected Health Information (PHI). Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction of your Protected Health Information (PHI). This means you may ask us not to use or disclose any part of your Protected Health Information (PHI) for the purposes of treatment, payment or healthcare operations. You may also request that any part of your Protected Health Information (PHI) not be disclosed to family -members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. If you request to restrict access to party responsible for payment of services, you will be responsible for payment in full in accordance with the Financial Policy of Mile High Sports and Rehabilitation Medicine.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your Protected Health Information (PHI), your Protected Health Information (PHI) will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your Protected Health Information (PHI). If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

We reserve the right to change the terms of this notice at anytime. This notice, in its most updated form, will be available electronically as well physically located at Mile High Sports and Rehabilitation Medicine. In the event of a change to the terms of this notice, you have the right to object or withdraw as provided in this notice.

You may file a complaint with us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact with your complaint.

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Financial Policy

Insurance: Any co-pay, co-insurance or deductible will be due at the time of service. Our office cannot waive co-pay, co-insurance or deductible amounts as these are a requirement placed on you by your insurance company. If there is a question regarding the amount due, it will be sent to our billing department for processing and you will be billed the amount due.

You are responsible for any co-insurance, deductibles, or non-covered services not paid by your insurance. Any remaining balance will be processed using the credit card on file. In the event your medical insurance policy is not active, or we are not provided with sufficient information to bill your insurance for services rendered, you will be billed the amount due.

Auto Accident Injury: If your injury is due to an automobile accident, you will be required to provide us with any information necessary to process your claim. It is your responsibility to ensure all information is correct and up-to-date allowing for the timely processing of claims. The patient is responsible for any remaining balance not paid by the Insurance, Attorney or funding company.

Workers Compensation Claims: If your injury is due to an injury sustained while at work, you will be required to provide us with any Workers' Compensation claim information necessary for the timely processing of your claim. In the event that your claim is determined to not be work-related or is denied, you will be responsible for payment of any balance on your account.

Cash Services: If you elect not to use insurance, payment will be due at the time of service unless other arrangements have been made. If you are unable to pay your balance in-full according to our payment terms, please contact the billing department to make arrangements to pay.

Acupuncture Services may or may not be billed to your insurance company by our office depending on your insurance carriers' policies. Our office will attempt to obtain authorization for services from your insurance in-advance of your visit. The patient is responsible for any remaining balance not paid by insurance.

Outstanding Balances and Returned Checks: All accounts 30 days and older will be subject to a finance charge of 1.5% per month. There is a $35.00 fee for all returned checks.

Appointment Policy

Rescheduling or Cancelling an Appointment: If it is necessary to reschedule or cancel your appointment, we require notification at least 24-hours in advance of your appointment. To reschedule or cancel your appointment, please call 303-331-6744 and speak to a member of our team or to leave a voicemail. We will return calls promptly to reschedule.

No Show Policy: A "no-show" is documented when an appointment is missed or cancelled without providing a minimum of 24-hours advance notice. Failure to be present at the time of a scheduled appointment or arrive more than 15 minutes late will be recorded in your record as a "no-show. If you are receiving treatment for a work-related or auto accident injury, a "no-show" notification for a scheduled visit will be shared with your Adjustor or Claim Manager.

The following action will be taken in the event of a "no-show"

- **First missed appointment**: there will be no charge
- **Second missed appointment**: a $10* fee will be billed to your account or workers compensation payer**
- **Third missed appointment**: a $25* fee will be billed to your account or workers compensation payer** and we may be unable to schedule additional appointments for you

* No-Show Fees will be billed at the discretion of Mile High Sports and Rehabilitation Medicine. Failure to arrive to a scheduled appointment for a medical procedure or diagnostic testing may result in additional charges equal to 50% of the billed rate for the procedure or diagnostic test.

**No Show appointments billed to the workers compensation system will be billed in accordance with the State of Colorado Department of Labor and Employment Fee Schedule (Rule 18)

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Acknowledgement and Disclosure Form

HIPAA Disclosure: I have been provided with and read the HIPAA Notice of Privacy Practices for Mile High Sports and Rehabilitation Medicine. I consent to allow my Protected Health Information (PHI) and other information collected by Mile High Sports and Rehabilitation Medicine to be used in accordance with the HIPAA Notice of Privacy Practices I have been provided.

Patient Printed Name: ____ Date: ____________________

Signature of Patient or Responsible Party: ____

Appointment Policy: I have been provided with and read the Appointment Policy for Mile High Sports and Rehabilitation Medicine. I understand that it is my responsibility to provide a minimum of 24-hours notice in the event I am not able to attend my scheduled appointments. I understand that I may be billed for "no-show" appointments and that multiple "no-show" appointments may result in a discharge from the medical practice. In the event of a Workers' Compensation claim, a notification may be sent to my Nurse Case Manager or case Adjustor notifying them of any "no-show" appointments.

Signature of Patient or Responsible Party: ____

Financial Disclosure: I have read and understand the Financial Policy of Mile High Sports and Rehabilitation Medicine. I understand and acknowledge that my insurance coverage is a contract between my insurance company and me and that I am personally responsible for all medical expenses incurred during evaluation and treatment. I understand that as a courtesy, my primary insurance will be billed, however, it is my responsibility to follow up on any delinquent claims. I am required to make my co-pay and co-insurance payments at the time of service and I am responsible for keeping any required referrals current. I authorize Mile High Sports and Rehabilitation Medicine to release all medical information to my insurance carrier for the processing of my claims. I assign all benefits from the claims to Mile High Sports and Rehabilitation Medicine. I agree that a photocopy of this agreement shall be as valid as the original.

Signature of Patient or Responsible Party: ____

Insurance Billing: I agree to allow Mile High Sports and Rehabilitation Medicine to bill my insurance company for services rendered. I authorize Mile High Sports and Rehabilitation Medicine to disclose medical, billing, demographic, or other information to my insurance company or party responsible for payment as necessary to receive reimbursement for services rendered.

Signature of Patient or Responsible Party: ____

Credit Card Authorization: I understand that my credit card will be billed for any remaining balance due as the patient responsibility after the claim has been processed by my insurance company. I understand that I will receive a monthly statement reflecting the charge that was applied to my credit card. I certify that the below is my credit card and that I am legally authorized to give permission for its use. By signing this form, I authorize Mile High Sports and Rehabilitation Medicine to charge my credit card up to the amount due on my account or in the amount of the No-Show fee that is charged to my account. In the event there is an issue with processing my credit card, I agree to pay all reasonable collection costs and attorney fees incurred in the collection of my account balance.

Name on Card: ____ Billing Zip Code: __________________

Type: Visa MC Amex   CC Number: ________________________________ Exp: __________ 3 digit code: _________

Signature of Patient or Responsible Party: ____

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Authorization to Share LIMITED Health Information

In an effort to protect your privacy and conform to the Health Information Portability and Accountability Act (HIPAA), Mile High Sports and Rehabilitation Medicine has developed a policy on releasing and communicating medical information.

Without your written consent, we will not:

1. Discuss medical care with anyone except the patient;
2. Leave information with anyone except the patient;
3. Leave medical information in a voicemail;
4. Mail or fax any information

Individuals below may receive information as listed:

Date of Permission	Name of Individual and Relationship to Patient	Comments/Instructions i.e. may pick up medications, may be given test results, etc.	Patient/Representative Signature

Disclaimers: Mile High Sports and Rehabilitation Medicine will disclose medical information and medical records with medical providers or payers involved in your treatment (workers' compensation providers, primary care providers, etc.). When receiving medical treatment for a work-related injury, limited medical information may be disclosed, to the extent allowed and required under the Colorado Department of Labor and Employment, with an employer or payer of services.

Mile High Sports and Rehabilitation Medicine may contact you via phone, text, or email to provide appointment reminders or information.

By signing this authorization form, I give permission to the person(s) listed to receive limited information regarding my care. I understand that my healthcare provider will use their professional judgment to ensure that information shared with my family/friends is only in order to assist with my continuing care. Any information requested that does not pertain to assisting with my healthcare, and any requests for copies of medical records, will require a signed HIPAA compliant Authorization for Disclosure of Medical Information. This permission will be considered ongoing until it is revoked in writing by myself, or, a legally authorized representative.

Patient Printed Name: ______________________________ Date: ______________

Signature of Patient or Responsible Party: ______________________________

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Patient History Form

Name: ____ Date: ______________
Last First Middle

Date of Birth: ______________ SSN: ______________ Sex: ☐ Female ☐ Male Age: ______

☐ Right Handed ☐ Left Handed

Problem related to:

☐ Job Date of Injury/Onset ______________ Employer: ______________________

☐ Accident Date of Injury ____________ Type of Accident: ________________ State: ____

Briefly describe your present symptoms/chief complaint: ______________________

____

____

How long have you had this problem / complaint: ______________________________

Previous Treatments: Please check which treatments you have had for your main problem and indicate whether or not the treatment was helpful

Treatment	Helpful Yes / No	Treatment	Helpful Yes / No
Physical Therapy		Surgery	
Pool Therapy		Injections	
Massage		Medication	
Chiropractic / OMT		Hot Packs	
Acupuncture		Cold Packs	
Exercise		Whirlpool	
Other			
Previous Diagnostics (Please note all that apply) ☐ **XRAY** ☐ **CT** ☐ **MRI** ☐ **US** ☐ **EMG**			

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ALLERGIES TO MEDICATIONS

☐ No Known Drug Allergies
☐ Yes, please list

________________ ________________ ________________

________________ ________________ ________________

CURRENT MEDICATIONS

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of Medication	Dose / Strength	Directions	Duration
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

PAST MEDICAL HISTORY

Do you now or have you ever had:

☐ Diabetes
☐ High blood pressure
☐ High cholesterol
☐ Hypothyroidism
☐ Goiter
☐ Cancer (type) ____________
☐ Leukemia
☐ Psoriasis
☐ Angina
☐ Heart problems
☐ Heart murmur
☐ Pneumonia
☐ Pulmonary embolism
☐ Asthma
☐ Emphysema
☐ Stroke
☐ Epilepsy (seizures)
☐ Cataracts
☐ Kidney disease
☐ Kidney stones
☐ Crohn’s disease
☐ Colitis
☐ Anemia
☐ Jaundice
☐ Hepatitis
☐ Stomach or peptic ulcer
☐ Rheumatic fever
☐ Tuberculosis
☐ HIV/AIDS

Other medical conditions (please list):

________________ ________________

________________ ________________

________________ ________________

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SURGICAL HISTORY	
Please list any surgeries that you have had, include the year of the surgery	
Surgery	**Year**

FAMILY HISTORY					
	Current Health Good/Average/Poor	Age	Alive Yes / No	Age Deceased	History or Cause of Death
Father					
Mother					
Sibling # 1					
Sibling # 2					
Sibling # 3					
Sibling # 4					

SOCIAL HISTORY

Education: What is the highest level of education you have completed?
☐ High School / GED ☐ Some College ☐ College Graduate ☐ Advanced Degree. Please List ___________________________

Marital Status: ☐ Married ☐ Single ☐ Widowed

Substance Use: Have you used, or do you currently use any of the following? If yes, please list

Type/Amount/Frequency

Caffeine: ☐No ☐Yes ____

Tobacco: ☐No ☐Yes ____

Alcohol: ☐No ☐Yes ____

Recreational/Street drugs: ☐No ☐Yes ____

Other: ____

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SYSTEMS REVIEW

In the past month, have you experienced any of the following problems?

GENERAL
☐Recent weight gain; how much____
☐ Recent weight loss: how much____
☐ Fatigue
☐ Weakness
☐ Fever
☐ Night sweats

MUSCLE/JOINTS/BONES
☐ Numbness
☐ Joint pain
☐ Muscle weakness
☐ Joint swelling
Where?

EARS
☐ Ringing in ears
☐ Loss of hearing

EYES
☐ Pain
☐ Redness
☐ Loss of vision
☐ Double or blurred vision
☐ Dryness

THROAT
☐ Frequent sore throats
☐ Hoarseness
☐ Difficulty in swallowing
☐ Pain in jaw

HEART AND LUNGS
☐ Chest pain
☐ Palpitations
☐ Shortness of breath
☐ Fainting
☐ Swollen legs or feet
☐ Cough

NERVOUS SYSTEM
☐ Headaches
☐ Dizziness
☐ Fainting or loss of consciousness
☐ Numbness or tingling
☐ Memory loss

STOMACH AND INTESTINES
☐ Nausea
☐ Heartburn
☐ Stomach pain
☐ Vomiting
☐ Yellow jaundice
☐ Increasing constipation
☐ Persistent diarrhea
☐ Blood in stools
☐ Black stools

SKIN
☐ Redness
☐ Rash
☐ Nodules/bumps
☐ Hair loss
☐ Color changes of hands or feet

BLOOD
☐ Anemia
☐ Clots

KIDNEY/URINE/BLADDER
☐ Frequent or painful urination
☐ Blood in urine

Women Only:
☐ Abnormal Pap smear
☐ Irregular periods
☐ Bleeding between periods
☐ PMS

PSYCHIATRIC
☐ Depression
☐ Excessive worries
☐ Difficulty falling asleep
☐ Difficulty staying asleep
☐ Difficulties with sexual arousal
☐ Poor appetite
☐ Food cravings
☐ Frequent crying
☐ Sensitivity
☐ Thoughts of suicide / attempts
☐ Stress
☐ Irritability
☐ Poor concentration
☐ Racing thoughts
☐ Hallucinations
☐ Rapid speech
☐ Guilty thoughts
☐ Paranoia
☐ Mood swings
☐ Anxiety
☐ Risky behavior

OTHER PROBLEMS:

All information provided is accurate and up-to-date to the best of my knowledge.

Signature of Patient or Responsible Party: ____________________________________

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OCCUPATIONAL HISTORY (IF INJURY IS WORK RELATED)

Occupation: ______________________ Employer: ______________________

Are you currently working? ☐ No ☐ Yes. How many hours per week? __________

Work Status: ☐ Full Duty ☐ Light Duty ☐ Off work

What is your current job status? ☐ Retired ☐ Student ☐ Homemaker ☐ Unemployed

Have you ever suffered a work related injury in the past? ☐ No ☐ Yes
If yes, please explain past injuries

All Occupational Information provided is accurate and up-to-date to the best of my knowledge.

Signature of Patient or Responsible Party: ______________________________

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MILEHIGHSPORTS
AND REHABILITATION MEDICINE

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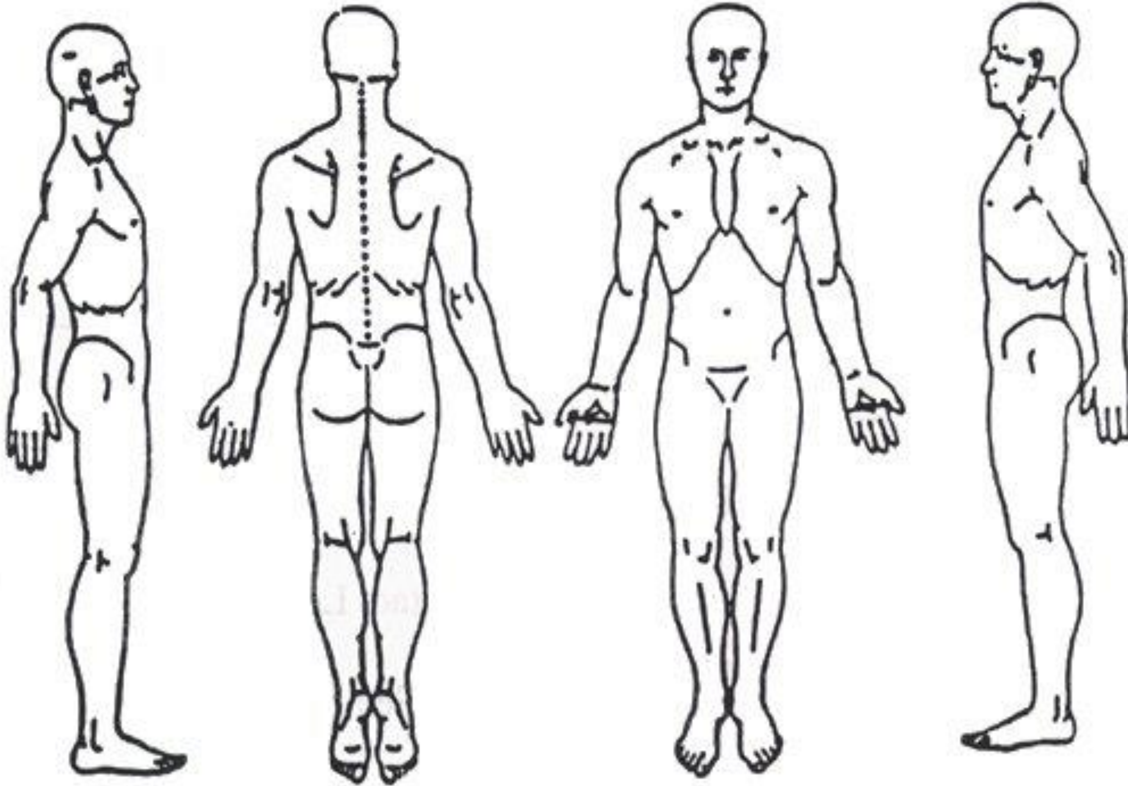
Pain Diagram

Patient Name: ______________________ Signature: ______________________ Date: __________

On the figure below, please indicate the location of your symptoms:

S = Stiffness   A = Aching   P = Pain   N = Numbness   T = Tingling   B = Burning



Neck Pain: ________ % of pain is **neck** pain

Back Pain: ________ % of pain is **back** pain

Arm Pain: ________ % of pain is **arm** pain

Leg Pain: ________ % of pain is **leg** pain

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Height __________ Weight __________ T ________

BP ________ / ________ P ________ R ________

Rate the severity of your pain at its least and greatest by circling two (2) numbers on the pain scale

Pain level (scale 0-10 with zero being no pain and 10 being excruciating pain)

No Pain **0 1 2 3 4 5 6 7 8 9 10** ***Excruciating Pain***