5280 ADVANCED HEALTH

PATIENT INFORMATION:

First Name_____ **M.I**_____ **Last Name**_____

Birth Date_____ **Age**_____ **Email**_____

Home Tel. _____ **Cell** _____

Sex: ☐ Male ☐Female **| Have you ever been a patien of our practice?** ☐Yes ☐No

Marital Satus: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐Other

Address_____ **City**_____**State**_____ **Zip**_____

Referred By_____ **Telephone**_____

Medical Dr. _____ **Telephone**_____

Employer_____ **Occupation**_____

Personal Payment (Circle One): Cash Check Credit Card

WORK COMPENSATION OR AUTO ACCIDENT INFORMATION:

Injury Description_____

Date of Injury_____**Case Manager**_____

Company Name _____**Claim Number**_____

Telephone Number_____

FINANCIAL AGREEMENT: Our goal is to provide you with quality, personal medical care and still maintain a viable business enterprise. This financial policy is intended to help us reach our goal as well as well as help you receive the best possible treatment. Please be advised, you are responsible for all charges incurred.

Payment for any medial service, is due in full at the time of service, we DO NOT accept any insurance. We accept cash, check, Visa, Master Card and Discover. If you are unable to make a payment at the time of service, please contact our office prior to the visit to make payment arangements. Balances older than 30 days will incur a $5.00 billing fee. Balances older than 90 Days will be considered for collections. Any legal/collections fees incurred will be your responsibility. An 8% interest charge may be added to any accounts over 90 days. Any Returned checks will be assessed a $20.00 fee.

☐ I have read & agree to this Financial Agreement. Failure to comply may result in discharge from the practice.

X Signature:_____ **Date**:_____

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MEDICAL HISTORY

Patient Name: _____ Age: _____ DOB: _____

1. Main reason for visit? ☐ pain ☐ weakness ☐ loss of function
   Briefly state history of problem and when symptoms began:
   _____
   _____
   _____

2. Location of Pain:

Neck ☐ and radiates to ☐ R Arm ☐ L Arm	Shoulder ☐ R ☐ L	Arm ☐ R ☐ L	Elbow ☐ R ☐ L	Wrist ☐ R ☐ L	Hand ☐ R ☐ L	Fingers ☐ R ☐ L
Back ☐ and radiates to ☐ R Leg ☐ L Leg	Low back/pelvis ☐ R ☐ L	Hip ☐ R ☐ L	Knee ☐ R ☐ L	Ankle ☐ R ☐ L	Foot ☐ R ☐ L	Toes ☐ R ☐ L

3. How long has this pain been present? _____
4. The onset was ☐ gradual or ☐ sudden. _____
5. Severity of pain? ☐ Mild ☐ Moderate ☐ Severe ☐ Extremely Severe
6. Quality of pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching
   ☐ Electrical ☐ Burning
7. Timing of pain? ☐ Constant ☐ Intermittent

8. Does pain wake you from sleep? ☐ Yes ☐ No
9. Do you have? ☐ Swelling ☐ Bruising ☐ Numbness/Tingling ☐ Weakness
   ☐ Loss of Bowel or Bladder control ☐ Fever ☐ Night Sweats ☐ Weight loss
10. What makes symptoms better? ☐ Rest ☐ Heat ☐ Ice ☐ Elevation ☐ Other
    _____
11. What makes symptoms worse? ☐ Standing ☐ Walking ☐ Lifting ☐ Exercise
    ☐ Twisting ☐ Lying in bed ☐ Bending ☐ Squatting ☐ Kneeling ☐ Stairs
    ☐ Sitting ☐ Coughing ☐Sneezing ☐ Other _____
12. Since my problem started, it is: ☐ Getting better ☐ Getting worse
    ☐ Unchanged
13. What medications have your tried for this problem?
    _____
    _____
14. Which treatments have your tried? ☐ Injections ☐ Physical Therapy
    ☐ Manipulation ☐ Acupuncture ☐ Massage ☐ Other _____
15. Have you had surgery for this problem? ☐ No ☐ Yes Surgeons Name:
    _____
16. What diagnostic test have you had? ☐ X-rays ☐ MRI ☐ CAT scan
    ☐ Bone Scan ☐ EMG/NCV When & where: _____
17. How does this problem impair your function or quality of life? Explain
    _____
    _____
    _____
18. Do you exercise regularly? ☐ Yes ☐ No
19. What type of exercise and how often? _____
20. Do you know of any health reason that should limit you from participating in physical activity? ☐ Yes ☐ No Describe: _____

Medication and Allergy History

1. Are you allergic to any substance? ☐ Yes ☐ No

Name of Medication/Substance	Reaction

2. Do you take any prescription or non-prescription medication including supplements? ☐ Yes ☐ No

Medication	Dose	Frequency

Past Medical History

1. Have you had or currently have any of the following (check all that apply):

☐ High Blood Pressure	☐ Diabetes	☐ Heart Disease	☐ Thyroid Disease
☐ Asthma	☐ Arthritis	☐ Cancer	☐ Liver/Gallbladder Disease
☐ HIV/AIDS	☐ COPD/Emphysema	☐ Bleeding Disorder	☐ Anxiety/Depression
☐ Drug/Alcohol Abuse	☐ Anemia	☐ Blood clots	☐ Radiation/chemotherapy
☐ Breathing problems	☐ Hepatitis	☐ Stomach or digestive problems	☐ Kidney Disease
☐ Seizures	☐ Stroke	☐ Rheumatoid Arthritis	☐ Other

2. Have you ever had Surgery? ☐ Yes ☐ No

Surgery	Date	Surgeon

3. Have you ever had problems with anesthesia? ☐ Yes ☐ No
   Describe:
   _____
   _____

Review of Systems

1. Have you ever had a prior problem with the same orthopedic condition that brought you in today? ☐ Yes ☐ No
2. Do you have other joints with ☐ morning stiffness ☐ swelling ☐ pain?
3. Please check any conditions that apply to you.

☐ Vision problems	☐ Shortness of breath, chronic cough	☐ Chest pain, palpations	☐ Nausea, vomiting	☐ Weight loss
☐ Loss of appetite	☐ Fever	☐ Night Sweats	☐ Blood in urine	☐ Blood in stool
☐ Easy bleeding/bruising	☐ Anemia	☐ Immune system problems	☐ Hot/cold intolerance	☐ Skin rash

Family History

1. Has any direct relative had any of the following? ☐ Yes ☐ No

☐ Rheumatoid arthritis	☐ Reaction to anesthesia	☐ Heart disease	☐ High Blood Pressure
☐ Cancer, type	☐ Diabetes	☐ Same orthopedic problems as you	☐ Bleeding problems

Social History

1. Marital history: ☐ M ☐ S ☐ D ☐ W
2. Level of education: ☐ high school ☐ some college ☐ college degree
   ☐ advanced degree
3. Occupation: _____
4. Do you use tobacco? ☐ Yes ☐ No Packs per day _____
5. Do you use alcohol? ☐ Yes ☐ No How often? ☐ daily ☐ other _____
6. Is there anything else you would like for us to know about your medical history?
   _____
   _____
   _____

Patient Signature: _____ **Date**: _____

I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability.

Physician Review

Physician Signature: _____ **Date**: _____

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Patient Contact Form

Patient Name: _____ Date: _____

All calls regarding your medical care, test results, appointments and financial information will be made to your preferred telephone number. Please indicate that number here: _____

_____ I hereby authorize this medical practice to contact me by phone. If I am unavailable, they may leave a message on my answering machine/voicemail

_____ Do NOT leave messages on answering machine/voicemail other than name of caller and a call back number.

Other Contact Information

The following people other than a duly designated guardian or conservator are authorized to discuss my medical condition or billing information with a healthcare professional in this practice:

Name: _____ Relationship: _____ Phone_____

Name: _____ Relationship: _____ Phone_____

Name: _____ Relationship: _____ Phone_____

Patient signature: _____ Date: _____

Print Name: _____ Phone Number: _____

5280 ADVANCED HEALTH

Cancellation and No Show Policy

You should notify our office at least 48 business hours in advance to cancel an appointment. If you do not, you will be considered a No Show and you will be charged $125.00 No Show/Late Cancel fee.

Late cancellation (less than 28 business hours) or no showing for a procedure will result in a $150.00 No Show/Late Cancel fee.

These fees must be paid before you can schedule another appointment. We DO NOT accept insurance therefore these fees will not be covered by your medical insurance. Repeated cancellations or no shows may result in discharge from our care for non-compliance.

Arriving 10 minutes after our scheduled appointment time will be considered a No Show and No Show/Late Cancel fees will apply.

Print your name: _____

Patient signature: _____ Date: _____

5280 ADVANCED HEALTH
720-961-5280

This notice describes how your health information may be used and disclosed. Please Review it carefully.

YOUR RIGHTS. You have certain rights with respect to your health information, subject to legal limitations, including:

- Obtaining an electronic or paper copy of your record or a summary, usually within 30 days. We may charge a reasonable fee.
- Requesting correction of incorrect or incomplete information. If we say "no," we'll tell you why in writing within 60 days.
- Requesting confidential or specific contact methods (e.g., home or office phone). We will say "yes" to reasonable requests.
- Asking us to limit what we use or share for treatment, payment, or operations. We are not required to agree, and we may say "no." If, however, you pay for a services or item out-of-pocket in full, you can request that we not share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- Obtaining a list of those with whom we've shared your information for six years prior to the request and why. The list will not include disclosures for treatment, payment, and health care operations, and certain other disclosures (e.g. made at your request). We'll provide one free accounting a year, but will charge a reasonable, cost-based fee if you ask for additional accountings.
- Obtaining a paper copy of this notice at any time, even if you agreed to receive it electronically.
- Designating someone to act for you (e.g., a medical power of attorney or legal guardian), to exercise your rights and make choices about your health information. We will make sure the person has this authority and can act on your behalf before we take any action.
- Filing a complaint by contacting: Privacy Officer, 3810 N. Grant Avenue, Loveland, CO 80538, 970-221-9451; or HHS, 200 Independence Ave, S.W., Washington, DC 20201, www.hhs.gov/ocr/privacy/hipaa/complaints, 1-877-696-6775. We will not retaliate against anyone for filing a complaint.

YOUR CHOICES

- You have the right to have us share information with family, friends, or others involved in your care; share information in a disaster situation; or include your information in a directory.
- We will not sell your information or share it for marketing unless you give us written permission. We may, however, contact you for fundraising efforts, but you can tell us not to contact you again.
- We will not share psychotherapy notes for unless you give us written permission.

If you are not able to choose, we may share information if we believe it is in your best interest. We may also share information when needed to lessen a serious and imminent threat to health or safety.

OUR USES AND DISCLOSURES

- We can use or disclose your health information for treatment, payment, and health care operations. This includes sharing information with others who are treating you, to bill and get paid, and to run our practice and improve care.
- We are also allowed or required to share your information in other ways, such as:
  - Providing you with information related to your health;
  - Contacting you regarding appointments, treatment alternatives, or other health related services;
  - Incidental uses or disclosures (*e.g.*, listing your name on a sign-in sheet, etc.);
  - Legal compliance (including reports of adverse reactions, suspected abuse, neglect or violence);
  - Providing information to the Physician Drug Monitoring Program;
  - Providing information to law enforcement correctional institutions;
  - Providing information to a coroner, medical examiner, funeral director, or for organ procurement;
  - Responding to health oversight agencies or public health authorities or the FDA.
  - Responding to court or administrative orders, subpoenas, discovery requests or lawful process;
- Research activities;
- When necessary to avert a serious threat to health or safety;
- Military affairs, veterans affairs, national security, intelligence, Department of State, or presidential protective service activities;

- Providing information regarding your location, general condition or death to disaster relief agencies;
- Providing information for workers' compensation claims; or
- Informing a family member, other relative, or close personal friend when:
  - Information is relevant to the individual's involvement with your care;
  - Notification of your location, general condition or death;
  - To assist in your care (pick-up prescriptions or documents, follow-up care instructions, etc.).
- Our practice will make other uses and disclosure of your protected health information only after obtaining your written authorization. If you authorize a use not contained in this notice, you may revoke your authorization at any time by notifying us in writing.

OUR RESPONSIBILITIES

- We are required to maintain the privacy and security of your protected health information and to let you know promptly if a breach occurs that may compromise such privacy or security.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us in writing that we can. If you tell us we can, you may change your mind at any time, but please let us know in writing if you change your mind.

CHANGES TO THE TERMS OF THIS NOTICE. We reserve the right to change the terms of this notice. The newly effective notice will be posted in our office, on our website, and will be available upon request. This Notice is effective November 15, 2015.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

5280 ADVANCED HEALTH

Patient Acknowledgement and Receipt of Notice of Privacy Practices

Pursuant to HIPAA and Consent for Use of Health Information

Name (print)_____ Date_____/_____/_____

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request. The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law. If patient is a minor or under a guardianship order (as defined by State law), signature of legal guardian is required.

Signature_____Date_____/_____/_____

Relationship to Patient (if NOT Patient) _____