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: ______________________________

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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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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: ____

☐ **Credit Card Opt-Out:** I decline to provide my credit card information for payment processing. I understand that I am financially responsible for any patient balance after insurance has processed my claim, any balance due as a result of no-show or cancelled appointments or any balance that is denied by my insurance.

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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: ______________________________

____

Cause of symptoms, if known: ____

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 ____________________

Occupation: ____

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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MILEHIGHSPORTS
AND REHABILITATION MEDICINE

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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
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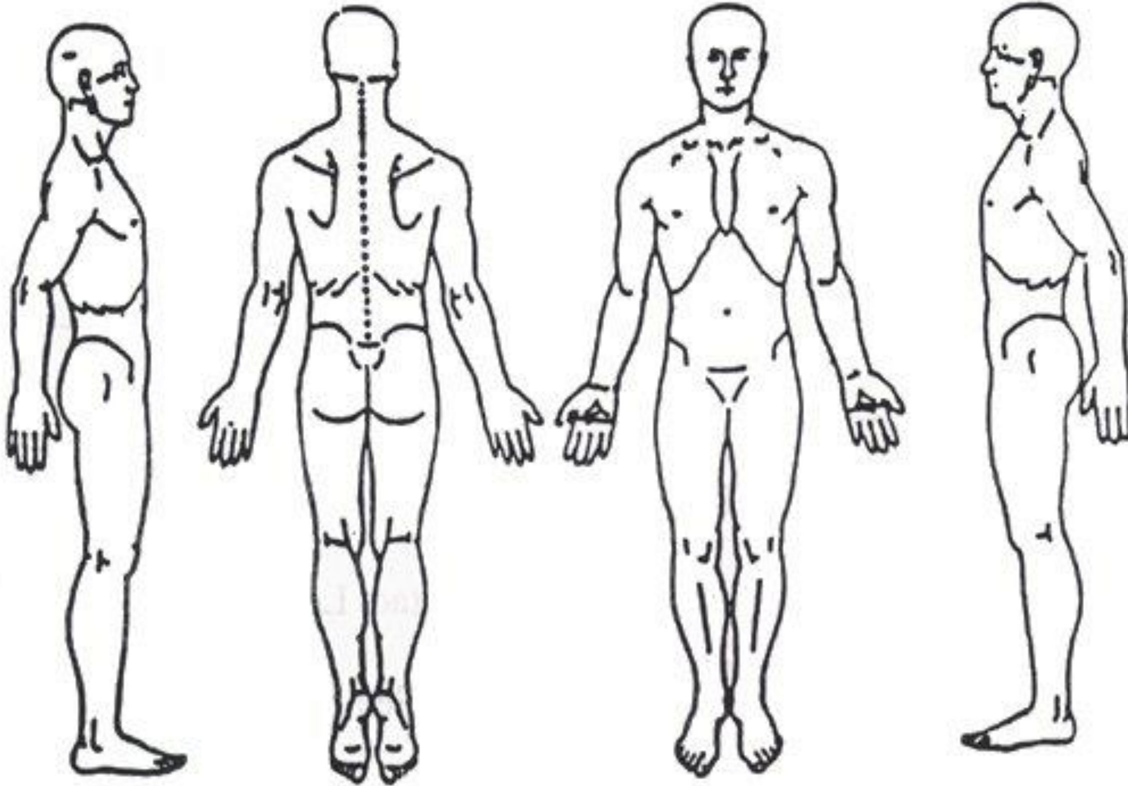
Pain Diagram

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***