Welcome to the Colorado Spine and Sport!

1. Complete document electronically (minus signatures unless you know how to sign pdf file electronically) then save the file to your desktop then attach in an email (nonsecure) or fax (secure) back to us. You may click submit on final page to email it to us at least 2 days prior to your exam but this requires you have Outlook etc set up as email client. We need time for verification of benefits, ordering of imaging study reports, etc. You will sign the document at our office in person.

2.A second alternative is to complete the document electronically (minus signatures) then print, sign by hand, and scan back to us by email or fax.

3. A third alternative is to print the document and complete by hand then postal mail signed document to us signed at least 2 days prior to your exam.

3. We encourage having relevant diagnostic MRI reports etc faxed to us even if we don't directly request them after reviewing your case prior to your arrival.

****You may choose to print and retain the final page which is a map to our clinic!***

Mail to our address above, fax to 720 239 1160, or email the document to contact@coloradospineandsport.com.

Maureen Thomm, D.C.
General Family Practice

Jeremy Rodgers, D.C., A.T.C.
Board-Certified Sports Medicine

Christy Kohler, DPT
Physical Therapist

Eric Traister, MD
Board-Certified Sports Medicine

	Insurance verified
	Basic file/pin created
	Insurance info/fee schedule entered final
	Doc reviewed hx
	Pt. Seen, dictated
	Scanned into record
	Ready to shred

400 S. McCaslin Blvd. Suite 111 • Louisville, Colorado 80027 • 303-604-4358 • 720-239-1160 (fax)

Welcome to Colorado Spine and Sport!

We are happy you have chosen us for your health care needs. To serve you as **completely** as possible, we ask that you complete the following patient information. With this information we will know more about you as a patient, and we will have the ability to file insurance for you or make referrals where needed.

Patient Information

Date_____

Patient _____

Address _____

_____

City State Zip

Gender: _____ Date of Birth _____Age_____

____Single ____Married ____Divorced ____Separated ____Widowed

Patient SS# _____

Occupation _____

Employer _____

Employer address _____

Employer phone _____

Spouse's name _____

Birth date _____ SS#_____

Occupation _____

Name of Primary Care Physician:_____

Referral Source: Friend/Family_____(name)
Clinic website____Insurance website:_____ Clinic _____

Contact Information

Work Ph: _____ Cell: _____
Email Address (must have for scheduling reminder)

_____

Best place / time to reach you _____

IN CASE OF EMERGENCY, CONTACT:
Name _____ Relationship _____
Best # to call _____

Health Insurance Information

Who is responsible for this account? _____

Relationship to patient (self, spouse, etc.)_____

Insurance Co. _____

Member ID# _____

Group # _____

Subscriber's name if not patient _____

Birth date _____ SS # _____

Is the patient covered by additional insurance? ____ Yes ____ No

** Note: If uninsured or sky high deductible, we still ask to at least **be provided with insurance carrier name** for referral purposes.

Work/Auto Accident Information

Complete below if due to an accident:

Type of accident: Auto _____ Work _____ Other _____

If Work Comp: Claim # _____ Date of accident:_____

Ins. Co. Name: _____

Adjuster: _____ Phone: _____

If Auto: Has fault been established? Yours _____ Other _____

Date of accident:_____

Your Auto Insurance Company: _____

Adjuster: _____ Phone _____

Claim # _____

Other Driver's Insurance Co.:_____

Adjuster: _____ Phone _____

Policy holder: _____ Claim # _____

If you have an attorney, may we contact him/her regarding your care and payment? Name:_____

MISSED APPOINTMENTS/LATE RESCHEDULING:
Unless notice provided **at least 24 hours business days** in advance, we reserve the right to charge a **$30-45** missed appointment/late cancellation fee. We have voicemail available 24 hours a day, 7 days a week should you need to cancel during non-office hours. We may have patients waiting for an appointment on a cancellation list; your courtesy of a phone call allows us to schedule them. This charge is not covered by or billed to your insurance.
Place Initials _____

EMAIL/PHONE CONSULTATION FEE
I understand that I may incur a nominal office fee for extended phone or **email consultations** requiring physical dictation in lieu of a normal office visit. I also consent to email communications of my medical records, MRI images, etc with other providers and myself as a convenience. No method of communication is completely secure so we do not email communications containing social security numbers, credit card numbers etc. Initials placed below consents to the convenience of email communications with the intent of more efficient doctor patient communication.
Place Initials _____

RELEASE OF INFORMATION:
I do _____/ do not _____ authorize other healthcare providers to **release or obtain any medical records**, images, or reports to/from Colorado Spine and Sport for the purpose of providing or obtaining medical information pertaining to my treatment. I will specify any restrictions to any party I authorize to receive said information from Colorado Spine and Sport. Note any limitations to that information ie time period, type of records, etc
_____

ASSIGNMENT OF BENEFITS/FINANCIAL POLICY:
I hereby assign payment directly to Colorado Spine and Sport, who represents this clinic to payor groups for medical benefits payable to Colorado Spine and Sport. I also understand that I am financially responsible for any charges not covered by this assignment, including denials for a properly submitted claim. We will submit one claim properly at no charge but charge $15 to resubmit a properly submitted claim due to an error on part of the insurance company. I will update billing information as soon as any changes occur in my insurance coverage including my address and personal contact information. I understand and authorize that any unpaid services at 90 days will be charged to the credit card on file from previous office visits unless such charges have been disputed in writing. I also understand applicable statement fees, late charges, 18% annual interest, and legal expenses will also be recovered to reconcile a seriously delinquent account (> 90 days beyond the date of service).

Health insurance will not be billed for **auto accident cases** due to the higher documentation standards necessary to document impairment, causation, etc. Auto cases that are awaiting settlement shall pay $100 month towards their balance if your medpay benefit is exhausted during care.

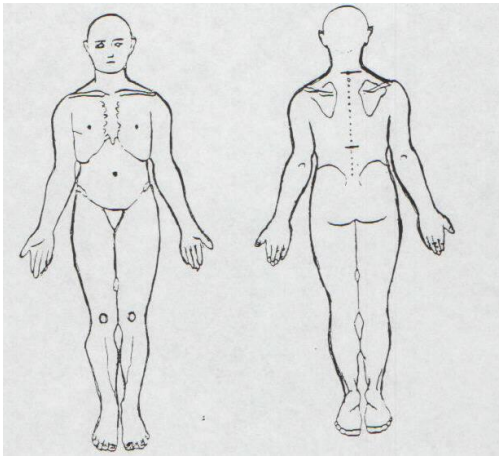
I understand my health insurance is a contract between myself and insurance carrier. No guarantees of coverage are implied by Colorado Spine and Sport. Unique plan requirements like pre-authorization, whereby such requirement is not clear in the initial verification of benefits process, are the responsibility of the patient to be compliant with as those requirements are not always clearly apparent at verification of benefits. Any denials over pre-authorization requirements default to our policy of billing patient's insurance one time correctly based upon our review of your benefits portal.
Place Initials _____

PHYSICAL THERAPY SERVICES; MEDICAL DIRECTOR AND ADVANCED BENEFICIARY (ABN) NOTICES:

1. I hereby understand and consent that ALL physical therapy services at CSS are billed under my medical benefit with supervision by **medical director Eric Traister, MD.** This allows for longer appointment duration and lower copays among other benefits. Your insurance explanation will reflect this medical director model of care by Dr. Traister. He reviews all exams and treatment plans in addition to being on call with PT staff for consultation on your case throughout care.
2. **Cigna PT patients** accept that this clinic will adjust my PT visits to $95 per visit for 45 minute appointments to allow for longer appointment times. Our contracted rate is closer to $60 per date of service. This will increase your copay slightly by about $25 additional. This does not apply to chiropractic patient services.
3. **BCBS PT patients**: Your PT benefit practically speaking covers a 30 minute therapy appointment. This is sufficient for non –surgical cases. More complicated cases will be scheduled for 45 minute appointments that require patient to pay a non-covered service fee of $25 in addition to their copay for this uncovered extra 15 minute contact time. We are focused on what you need not what your insurance covers. This does not apply to chiropractic patient services.

The ABN gives you information to make an informed choice about whether or not to receive these services, understanding that you are accepting this transparent, fully disclosed modification to our contracted rate.
Place Initials _____
Signature: _____ Date: _____

Colorado Spine and Sport
Chief Complaint Form and Timeline
(most important form, please be complete)



1. **Date _____**
2. **Any changes in medical or surgical history since last visit?**
   _____
3. **Chief complaint (please put primary concern only):**
   _____
   _____
4. **What was mechanism of injury?**
   _____
5. **When approximately did this issue begin?**
   _____
6. **Previous episodes/significant trauma in same area?**
   _____
   _____
7. **Relevant diagnostics: What month and diagnostic tests have been done by other providers ie xray, MRI, blood labs, etc? Please include major findings as you understood them from those tests and who ordered that test: (example: June 2013 lumbar MRI, mild disc herniation L4/5, ordered by Dr. Voss/ortho)**
   _____
   _____
   _____
   _____
8. **Relevant treatment: What month and type of treatments have been done by other providers ie physical therapy, injections, braces, etc? Rate each treatment as short term relief or no relief. (example: June 2013 PT core program, short term relief; July epidural steroid injection with physiatrist, short term relief in leg pain but not back pain.**
   _____
   _____
   _____
   _____
9. **Self treatment: What self treatment have you been doing for this issue ie heating, icing, past PT drills, oral antinflammatories, restricting aggravating activities and if so for how many weeks did you restrict activity? Rate each self treatment as short term relief or no relief.**
   _____
   _____
   _____
   _____
10. **Provokers: What activity, movement, or joint position provokes this issue specifically? Give us top 3 aggravators:_____**
    _____
11. **On a scale of 1-10 with 10 being unbearable, rate your current level of complaint: _____**
    (moderate nag) (unbearable)
    1 2 3 4 5 6 7 8 9 10
12. **Circle on the diagram above noting your exact location of your complaint. Label circle with pain, numbness, weakness, etc.**
13. **Any urgency involved in your issue (work trip, race, loss of sleep, etc)?**
    _____
    _____
    _____

Medical History Form Colorado Spine and Sport

Medical History/Review of Systems:

0. Other

_____

_____

1. General

Recent fever or chills ___
Recent weight loss greater than 20 lbs _____
Recent weight gain greater than 10 lbs_____
Sleep problems _____
Past or current cancer _____

2. Eyes

Wear corrective lenses _____
Eye infections _____
Uveitis _____
Eye injuries _____
Glaucoma _____

3. Ears, Nose, Throat

Recent profound loss of hearing____
Ringing in ears constantly
left____ right ____
Recurrent ear infections_____
Recent balance problems ____
Vertigo/spinning _____
Bleeding from nose _____
Recent difficulty swallowing ____
Difficulty breathing sleeping on left _____ right _____
Recent loss of smell _____
Recent sore throat _____
Large nodules in throat or armpits _____
Chronic sinus infections _____

4. Cardiovascular

Recent chest pain with exertion___
Recent chest pain with deep inspiration_____
Shortness of breath _____
Fainting _____
High blood pressure ____
Low blood pressure ____
Conduction block _____
Atrial fibrillation _____
Valve problem or murmur _____

4. Respiratory

History of blood clots _____
Recent coughing _____
Recent coughing up blood _____
Exertional chest tightness _____

5. Abdominal

Recent blood or change in color of stool without hemorrhoids _____
History of ulcerative colitis or Crohn's disease. _____
History of ulcer (s) _____
History of jaundice _____

6. Genitourinal

Recent blood in urine _____
Recent very frequent urination____
Recent incontinence _____
Past kidney stones _____
Past kink in ureter _____
Past prostate hypertrophy _____
Past endometriosis _____
Past uterine fibroids _____
Past ovarian cysts _____

7. Muskuloskeletal

Scoliosis ____
Fused vertebra _____
Avacular necrosis _____

8. Neurological

Recent or multiple concussions _____
Recent facial numbness _____
Recent seizures _____
Recent excrutiating headaches almost sending you to emergency room _____
Recent difficulty speaking _____
Double vision _____
Recent imbalance or dizziness ____
Recent numbness into arm or hand left ____ right _____
Recent numbness into legs left ____or right ____
Recent cramping or weakness in arms ____ or legs ____
(Recent is defined as in the past 30 days)

9. Skin

Psoriasis_____
Gout _____
Recent rash _____
Recent hot swollen joint(s)_____
Chronic migratory swelling in joints unexplainably _____
Recent puncture wound near problem area _____

10. Blood and lymph

Anemia _____
Hemophilia _____
Deep vein thrombosis _____
Pulmonary clots _____
Swollen glands in armpits or groin ____

11. Endocrinological

Osteoporosis or compression fracture _____
Multiple stress fractures in legs or pelvis _____
Diabetes _____
Thyroid disease _____

12. Psychological

Recent depression _____
Recent suicidal thoughts _____
Recent dissatisfaction with relationships _____
Recent dissatisfaction with workplace _____

13. Males only

Recent lumps in testicles____
Heaviness or pain in testicles ____
Frequent urinary tract infections ____
Recent lumps in groin _____

14. Females only

Currently attempting pregnancy _____
Past lumps in breast biopsied____
Number of vaginal births _____
Number of C section births _____
Number of miscarriages _____
Recent abnormal menstruation _____
Problems getting pregnant _____
Recent abnormal vaginal bleeding (non menstual) _____
Uterine/cervical/or breast cancer _____

Chiropractic History: (state yes if you have had any of the following symptoms with previous care or past diagnosis with other doctors). Leaving blank means not applicable.

Dizziness, imbalance, or fainting _____
Dizziness when rotating head or in certain positions _____-
Visual black spots in vision for several seconds _____
Facial numbness _____
Anxiety simply about being adjusted _____
Numbness shooting down arms or legs _____
Spondylolisthesis _____
Rhematoid arthritis, lupus, reactive arthrtis, ankylosig spondylitis _____
Os odontoideum or atlantoaxial instability _____
Aggravation of disk herniation or arm/leg pain_____

Medications/Supplements: (name and condition treating)

_____
_____
_____

Surgical History: (Procedure, year, outcome ie successsful, not, or complications persist)

_____
_____
_____

Medical Screening History for Patients Over Age 40 : (leave blank if never performed)
Male
Last Prostate exam/PSA Year _____ Abnormal _____
Last Colonoscopy Year _____ Abnormal _____
Last EKG Year _____ Abnormal _____
Last Stress test EKG or echocardiogram _____ Abnormal _____
Last Chest xray _____ Abnormal _____
Last Kidney, Liver, Blood Labs _____ Abnormal _____

Female
Last Breast mammogram Year _____ Abnormal _____
Last PAP Smear/Gyno exam
Last Chest xray _____ Abnormal _____
Last Kidney, Liver, Blood Labs _____ Abnormal _____

Allergies: (Food/drug and reaction)

_____

Social History:
Occupation _____
Exercise (types and how many days per week total)

_____
_____
Alcohol, cigarettes, smokeless tobacco, or recreational drug use per week_____
Children (ages or not applicable)

_____
Mattress history for spinal pain cases only (age in years, type (spring loaded, memory latex, Sleep number, etc)

_____
Sleep position for spinal pain cases only (mostly side, back, or stomach)

_____
Running shoes if runner (primary shoe) _____
Orthotics currently worn (yes or no) _____

Colorado Spine and Sport

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.
- A method for doctor and patient to communicate by email (non secure) or fax (secure) electronically to improve outcomes and access to doctor for follow up recommendations.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations, and that the organization is not required to agree to the restrictions requested.

☐ **I request the following information restrictions to the use or disclosure of my health information:**

_____

_____

_____

PATIENT:
Signature/Guardian _____ Date _____

OFFICE USE ONLY:
☐ Accepted

☐ Denied _____ Signature _____ Title _____ Date

Informed Consent and Authorization for Care

Nature and Purpose of Procedures

The practice of physical therapy and chiropractic care includes many standard examination, testing, and therapeutic procedures. These include physical examination, orthopedic and neurological testing, specialized screening examinations, radiological (X-Ray) examinations, and laboratory testing. Procedures performed by our physical therapy staff include various modality and rehabilitation procedures. Procedures performed by chiropractic staff include similar rehabilitation techniques and the procedure unique to the chiropractic profession - the chiropractic adjustment. Adjustments are delivered to patients by chiropractic staff or manual therapy by physical therapy staff to correct spinal or extremity (knee, shoulder, wrist, etc.) joint dysfunction. This joint restriction exists when one or more bones of the spine (or extremity) are misaligned or the soft tissues are contracted sufficiently to cause lack of motion within corresponding joints arthritis and degenerative disk disease then eventual disk herniation. The primary goal of these joint mobilizations is to restore joint flexibility, strength, and circulation post-injury or post-operatively following an extended period of disuse and immobilization.

It is not enough that you understand the benefits of these treatment options in restoring normal joint motion and nervous system health; you must also be aware of the risks involved and inherent limitations to care compared to other medical procedures with their own inherent risks. Risks associated with modalities and mobilizations may include thermal burns from heat packs or icing improperly, muscular sprain/strain of adjacent tissues, aggravation of an unstable disk herniation in the treatment of adjacent facet joint problem, aggravation of undiagnosed fracture, aggravation of undiagnosed vertebral artery dissection, and complications arising from preceding risks. Dry needling presents a unique set of risks including aggravation of muscular condition, injury to underlying neurovascular tissues, localized infection, and temporary partial lung collapse in rare circumstances.

The incidence of **severe injury** due to chiropractic care and physical therapy is exceedingly low (1 in 800,000 range) compared to comparable medical options to treat similar conditions such as steroid injections (1 in 10,000), arthroscopic surgery (1 in 10,000), and micro discectomy (1 in 4500). These medical options have higher incidence and severity of complications including infection, paralysis, stroke, complications of anesthesia, non union of fusion, post surgical fibrosis requiring revision, failure to improve patient's functional status, or permanent neurological symptoms. While seldom are the risks significant enough to contraindicate medical, chiropractic, or physical therapy care, these incidence and severity complication rates should be weighed against each other rather than in isolation in making the decision to receive or not receive any type of care.

If you are at risk, based on identifiable signs or history, you will be notified. It is possible, however, that risks may not be identifiable or apparent to your provider or that your insurance carrier has placed barriers for providers to obtain necessary diagnostic exams. As such, you are encouraged to ask about risks associated with any treatment option offered in both in this office and at other specialties who treat similar neuromuskuloskeletal conditions.

Informed consent is a dynamic partnership process and we welcome your questions before, during, or after your care here at our clinic.

Authorization for Care

I have been informed of the nature and purpose of care, the possible consequences of care, and the potential risks of care; including the risk that care I receive in this clinic may not accomplish the desired objective. I acknowledge that no guarantees have been provided to me with regard to the results of the care I will receive and that questions regarding risks are encouraged at any point in the management of my case.

Signature _____ Date_____

If patient is a minor, signature of parent or guardian (or last six digits of your social sec. number if signed electronically):
_____ Date ___Same as above___

Colorado Spine and Sport
400 S. McCaslin Blvd., Suite 111
Louisville, CO 80027
303 604 4358 office
720 239 1160 fax
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Northeast corner of McCaslin Blvd and Cherry/Centennial Pkwy.
McCaslin Healthcare Plaza (Large brick medical complex)

Save first then submit to contact@coloradospineandsport.com

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