Mile High Sports and Rehabilitation Medicine

Samuel Y. Chan, M.D. Yusuke Wakeshima, 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		
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 / Personal 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	

Mile High Sports and Rehabiliation Medicine

Samuel Y. Chan, M.D.   Yusuke Wakeshima, M.D.

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 twenty-five dollar ($25) late fee per month and 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 clinic visit and three (3) days' notice for procedure and EMG appointments. 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. Procedure and EMG appointments require a minimum of three (3) business days' notice. Failure to be present at the time of a scheduled appointment or arrival more than 15 minutes late will be recorded 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
- **Two or more missed appointments**: a $25 fee will be billed to your account for any missed appointments after your first missed appointment. Missed appointments or repeat rescheduling may result in discharge from the practice.
- **Missed Procedure or EMG appointment**: a $75 fee will be billed to your account for any Procedure or EMG appointments that are not cancelled or rescheduled with more than three (3) business days' notice.

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 required by my insurance company current. I authorize Mile High Sports and Rehabilitation Medicine to release all medical information to my insurance company 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: ______________________________

Delinquent Balances: I understand that I am financially responsible for any remaining patient balance on my account after the claim has being processed by my insurance company. I understand that my account balance is to be paid in full within thirty (30) days of the mailing of a Patient Statement. Any balance not paid in-full within thirty (30) days is subject to a twenty-five dollar ($25) late fee per month and a finance charge of 1.5% per month.

In the event that a referral for services has expired, that services are determined to be out-of-network or that insurance payment is denied for any reason, I understand that I remain financially responsible for any patient balance due that is denied by my insurance company.

Signature of Patient or Responsible Party: ______________________________

Practice Discharge: I understand that I may be discharged from care and will no longer be eligible to receive services at Mile High Sports and Rehabilitation Medicine in the event that I am non-compliant with the treatment plan as prescribed by my physician, if my financial account balance is more than ninety (90) days past due, or, if I am non-compliant with the Appointment Policy.

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: ______________________________

____

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):

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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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: ______________________________ Date: ______________

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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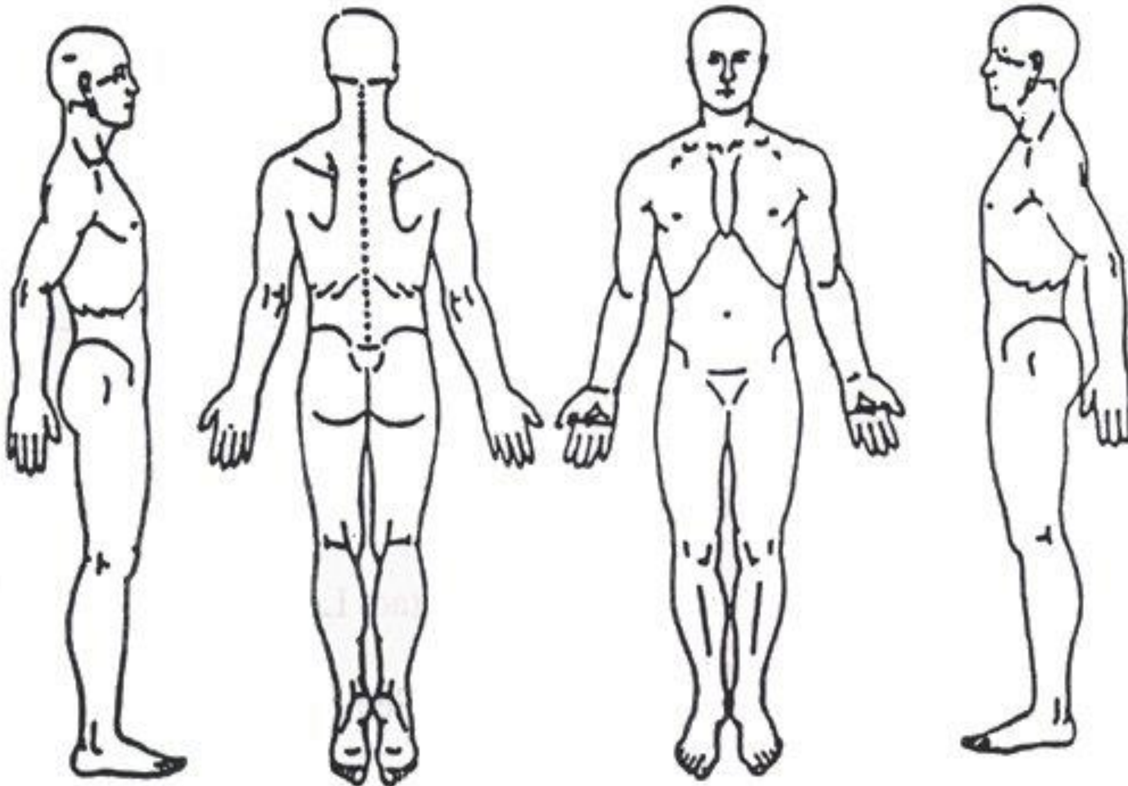
Pain Diagram

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 ________Sp02 ________ R ________

Rate the severity of your pain at its least and greatest by <u>circling two (2) numbers</u> 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***