INTEGRATED SPORTS & SPINE
INTERVENTIONAL NEUROMUSCULOSKELETAL MEDICINE

ESP SPORTS MEDICINE
Sports Medicine, Physical Rehabilitation & Performance Services

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_____ _____
Name Date of Birth

_____ _____ _____
Address City, State ZIP code

_____ _____ _____
Home Phone # Work # Cell #

May ***Integrated Sports & Spine/ESP Sports Medicine*** leave detailed messages on listed phone numbers? ☐ Yes ☐ No

E-mail address: _____

☐ Male ☐ Female Age_____

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed_____
(Spouse name)

Race_____ ☐ Declined to answer **Ethnicity**_____ ☐ Declined to answer

Preferred Language _____ ☐ Declined to answer

Occupation _____

If under 21, parent's name_____ Phone #_____

Preferred Pharmacy: _____ Address: _____

Please sign here to allow ISS to run your pharmaceutical benefits: _____

Referring Physician: _____ _____
Name Practice

_____ _____
Address Phone

Primary Physician: _____ _____
Name Practice

_____ _____
Address Phone

Current Specialist: _____ _____
Name Practice

_____ _____
Address Phone

What are they doing for you? _____

Emergency contact _____ _____ _____
Name Relationship Address/phone numbers

Insurance Information

Primary Insurance Name :_____ Policy #_____

_____ _____ _____
Policy Holder's Name Date of birth Group #

_____
Guarantor *Name*, address, phone number

_____
Insurance company address, phone #

Secondary Insurance Name: _____ Policy # _____

_____ _____ _____
Policy Holder's Name Date of birth Group #

_____
Guarantor N*ame*, address, phone number

_____
Insurance company address, phone #

Workers Compensation/Auto Claim _____Claim #_____

_____ _____ _____
Adjusters/Lawyer Address Phone

AUTHORIZATION

I certify to the accuracy of the above listed information. I hereby authorize the release of any medical information necessary to process my health insurance claims. I also request payment of insurance and/or Medicare benefits to ***Integrated Sports & Spine/ESP Sports Medicine***. A copy of this authorization may be treated as an original.

Patient or Representative Signature: _____Date _____

Relationship of Representative: _____

AGREEMENT AS TO GOVERNING LAW FORUM: I (we), the patient or patient's representative and Integrated Sports and Spine, rendering or providing medical care, health care, or safety or professional or administrative services directly related to health care to patient agree: (1) that all health care rendered shall be governed exclusively and only by Colorado Law and in no event shall the law of any other state apply to any health care rendered to patient; and (2) in the event of a dispute, any lawsuit, action, or cause of which in any county/district where all or substantially all of the health care was provided or rendered and in no event will any lawsuit , action or cause of action ever be brought in any other state. The choice of law and forum selection provisions of this paragraph are mandatory and are not permissive.

CHIEF COMPLAINT: (Describe in your own words why you came to the clinic today)

_____

_____

_____

_____

_____

_____

_____

What are you expecting from your visit to the clinic today?_____

_____

_____

_____

_____

_____

_____

_____

If this is an injury, please describe the events that occurred: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

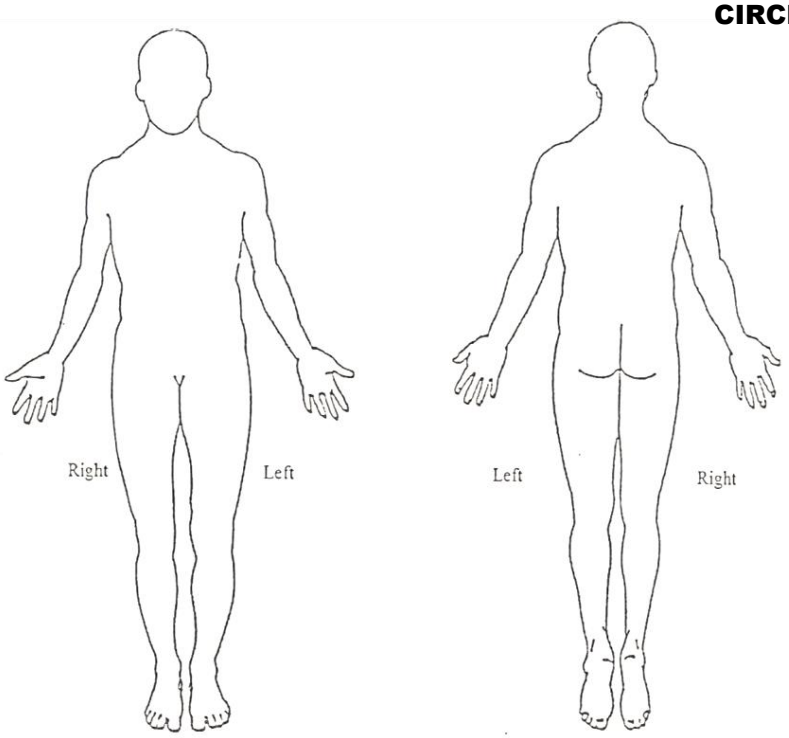
What 3 things are you unable to do now because of your pain/injury?

_____ _____ _____

Complete the following diagram drawing the symbols below to show your typical pain:

Ache >>>> **Numbness - - - - -** **Pins/Needles 0 0 0 0** **Burning X X X X** **Stabbing / / / /**
>>>> **- - - - -** **0 0 0 0** **X X X X** **/ / / /**

Front **Back**



CIRCLE WORDS THAT DESCRIBE YOUR PAIN:
(Circle all that apply)

DEEP **SUPERFICIAL** **DULL**

ACHING **SHARP** **STABBING**

SHOOTING **ELECTRICAL** **THROBBING**

CONSTANT **INTERMITTENT** **BURNING**

NUMBNESS **WEAKNESS** **PUNISHING**

KNIFE-LIKE **CRUEL** **RADIATING**

At BEST, my pain is: **1 2 3 4 5 6 7 8 9 10**
Hardly Noticeable **Noticeable & Wearing** **I Can Barely Tolerate It**

At WORST, my pain is: **1 2 3 4 5 6 7 8 9 10**
Hardly Noticeable **Noticeable & Wearing** **I Can Barely Tolerate It**

CURRENTLY, my pain is: **1 2 3 4 5 6 7 8 9 10**
Hardly Noticeable **Noticeable & Wearing** **I Can Barely Tolerate It**

Things that make my pain better include:

_____

_____

_____

Things that make my pain worse include:

_____

_____

_____

List date and location of pain-related evaluations: (XRays, Cat Scans, MRIs, EMGs, Myelograms)_____

_____

_____

What therapeutic interventions have you had for these symptoms? (Circle all that apply)

ACUPUNCTURE PHYSICAL THERAPY OCCUPATIONAL THERAPY MASSAGE THERAPY

CHIROPRACTIC/OSTEOPATHIC TENS INJECTIONS PSYCHOTHERAPY SURGERY

PAST MEDICAL HISTORY:

_____

_____

_____

_____

PAST SURGICAL HISTORY:

_____

_____

_____

_____

ALLERGIES (including foods and/or medications with reaction):

_____

_____

Current Medications (including over-the-counter and herbals): [use reverse for additional space]

Medication:	**Dosage (mg):**	**How Often:**

Other Medications tried and discontinued:

_____

_____

_____

SOCIAL HISTORY:

Marital Status: SINGLE MARRIED WIDOWED PARTNERED DIVORCED

Children? YES NO How Many? _____

Who provides you with social support? _____

Do you smoke? YES NO Packs per day: _____ **# of years:** _____

Do you drink alcohol? YES NO Drinks per week: _____ **# of years:** _____

Medical Marijuana? YES NO Card # _____

Recreational Drugs? YES NO _____

Do you have a personal history of drug and/or alcohol abuse? YES NO

Explain: _____

FAMILY HISTORY: (Please circle yes if still alive, no if deceased; describe illness):

Mother YES NO _____

Father YES NO _____

Siblings # _____ **YES NO** _____

Family History of drug and/or alcohol abuse? YES NO _____

OCCUPATIONAL HISTORY:

Are you currently working? YES NO DUTY: FULL MODIFIED DISABILITY

Who is your employer? _____ **How long have you worked here?** _____

What is your occupation and job duties? _____

_____

_____

Do you have any work restrictions? Please list: _____

_____

_____

How much time from work have you missed due to your injury?_____

Have you had a previous work related injury? _____

Did you receive an impairment rating or settlement? _____

REVIEW OF SYSTEMS

How Many Hours Of Sleep Do You Get Nightly? _____

Do You Have Trouble Falling Asleep? YES NO Staying Asleep? YES NO

Do You Feel Well Rested When You Awaken? YES NO Do You Snore? YES NO

Have you had any of the following symptoms in the past six months?

(Circle and describe only those that apply to you)

FEVER SWEATS WEIGHT CHANGE _____

VISION CHANGES BALANCE PROBLEMS HEADACHES _____

DEPRESSION ANXIETY MEMORY PROBLEMS _____

CHEST PAIN SHORTNESS OF BREATH COUGH _____

ABDOMINAL PAIN NAUSEA CONSTIPATION _____

BOWEL OR BLADDER PROBLEMS _____

SKIN CONDITIONS _____

LOWER LEG/ANKLE SWELLING _____

SEXUAL DIFFICULTIES_____

(FEMALES) MENSTRUAL PROBLEMS _____

LAST MENSTRUATION? _____ **Any Chance of Pregnancy or breastfeeding? YES NO**

HEIGHT: _____ **WEIGHT:** _____

Patient Signature: _____ **Date:** _____

Clinician's Signature: _____ **Date:** _____

P: **O2%:** **RR:** **BP:**

The following policy applies to all providers of ***Integrated Sports & Spine/ESP Sports Medicine.***

Our Policy of Payment

Insurance

- Your insurance policy is a contract between you and your insurance company. We are not a party in that contract.
- We are **not** contracted with **Medicaid**. If, during your course of treatment, Medicaid becomes your ***primary insurance,*** we will no longer be able to participate in your care under your Medicaid plan. You are responsible for notifying us immediately, so that we can assist with transferring your care to a Medicaid provider. If you intentionally or unintentionally receive medical care from us during any period of time that Medicaid becomes your primary insurance, you will be **solely responsible** for those costs. Your signature here represents your agreement to accept full financial responsibility for any services rendered during your Medicaid enrollment: Sign: _____
- We will file your insurance claim two times, if necessary. If it is denied, it will be your responsibility to follow up with your insurance company to resolve the claim.
- Not all services are a covered benefit in all insurance contracts. *All charges are your responsibility whether your insurance company pays or not.*
- **Co-pays must be paid at the time of your appointment.** *If you are unable to pay your co-pay you may be required to reschedule your appointment.*
- If a patient does not give 24-hour notice to cancel or reschedule an appointment, **a $50 no show office visit fee and a $150.00 no show injection fee and $100 EMG & Botox fee** will be charged to their account and payment will be required at the next office visit.
- Patient balances must be paid at the time of your appointment. A minimum of 20% of that balance will be due prior to receiving service.
- Accounts become past due 30 days after your insurance pays. Statements are sent out weekly and the balance is due within 10 days of receipt. We reserve the right to send the account to a collection agency if the balance is not paid in full 45 days after your insurance pays its portion.
- In the event of your non-payment, you agree to pay, whether or not legal proceedings are instituted, a reasonable *collection agency fee* which shall be 35% of the principal balance for any debt incurred hereunder and to pay all reasonable costs of collection including but not limited to *court costs, attorney fees and interest* as a result of your default.

Cash Patients

- All cash patients must pay the cash fee at the time of service or be rescheduled for a later date.

Payment Options

We accept cash, money order, or credit card (Visa, Master Card, Discover) for payment.
We do not accept personal checks.

I hereby acknowledge that I have read, understand, and agree to the terms of this document relating to insurance coverage and payment of my bill.

Patient Name (printed): _____

Patient or Representative Signature: _____Date:_____

Relationship of Representative: _____

Integrated Sports & Spine/ESP Sports Medicine
Patient Policies & Code of Conduct

1. All patients must have a primary care physician.
   Name of Primary Care Physician: _____
   Phone Number: _____
2. Patients must allow one business day for a return phone call. If patient has an emergency, the patient will need to go to the nearest emergency room.
3. Patients may be asked to do random urine/blood drug screening tests.
4. If a patient is more than 15 minutes late for their appointment, they will be rescheduled.
5. If a patient cannot pay their co-pay they will be rescheduled.
6. Patient will adhere to Medication Agreement and Financial Policy, or they may be discharged from the practice.
7. If current medication regimen is not working, patient must bring in any unused medication to the office for disposal.
8. Prescriptions will NOT be refilled without an appointment. Prescriptions will not be replaced if lost.
9. Patients are responsible for scheduling a monthly follow up appointment at each visit.
   Same-day appointments are not available.
10. Our office hours are 8am-5pm Monday through Friday.
11. ***Integrated Sports & Spine/ESP Sports Medicine*** is committed to treating our patients with a multi-disciplinary approach.
    Patients are expected to follow the treatment plan designed by their physician. This may include diagnostic studies, psychological evaluations, laboratory tests, physical therapy, massage therapy and other treatments that the physician feels is necessary for treating pain
12. If patient has a balance on their account they are responsible for paying it in full or making a payment with a payment plan at their next visit.

Patient Name: _____

Patient Signature: _____ Date: _____

_____
Name of patient (please print) Date of birth

I hereby acknowledge that I am aware of the ***Notice of Privacy Practices (HIPAA)*** for ***Integrated Sports & Spine/ESP Sports Medicine*** and that a copy is available for my records.

****

So that the physician(s) and/or office staff may address privacy issues, please indicate with whom we may discuss your routine and/or emergent care and treatment and/or billing issues regarding your balance.

□ Spouse (name) _____

□ Family member (name) _____

□ Guardian (name) _____

□ Other (name) _____

□ Do not discuss my medical care and treatment with anyone other than healthcare providers and/or Representatives.

Please note that if there is question in regards to diversion, abuse, or misuse of medications, as dictated by Federal and Colorado State laws, we must cooperate fully with Legal Authorities and Regulatory Agencies. As stated in our Medication Management Agreement, you agree to waive any applicable privilege or right of privacy or confidentiality with respect to the prescribing and use of your pain medication.

Patient or Representative Signature: _____Date: _____

Relationship of Representative: _____

****

(FOR OFFICE USE ONLY)

Documentation of Good Faith Effort to obtain patient's acknowledgement that they were made aware of the provider's Notice of Privacy Practices and could obtain a copy of the document)

The patient presented to the office on _____ and was made aware of the Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgement of his/her of the Notice. However, such acknowledgement was not obtained because:

□ Patient refused to sign

□ Patient was unable to sign or initial because: _____

□ Other reason: _____

_____

_____ _____
Signature of employee completing form Date