Steadman Hawkins Clinic – Denver

Practitioner's Initials: ___________

PATIENT HISTORY

Please Print and Fill Out Front and Back Completely

Name: ______________________________ **Today's Date:** ____________________

Occupation: ______________________________ **Height:** _____ **Weight:** _____ **Age:** ____

1. Reason for seeing doctor: ______________________________
2. How long have you had this problem? ______________________________
3. Was the onset **gradual** or **sudden**? *(please circle)* **GRADUAL** **SUDDEN**
4. Did you have an **injury**? **YES or NO** Date of Injury or onset of problem: ____________
   ☐Work Injury? ☐Auto Accident? ☐Other Type of Accident? What State? __________
   What happened? ______________________________
5. If you have pain, where is it located? ______________________________
6. Describe the pain *(please circle)* Sharp Dull Electric Burning Throbbing
7. Do have any of the following symptoms? *(please circle)*
   Clicking Popping Locking Swelling Giving Way Weakness
   Dislocation Stiffness Looseness of Joint Numbness/Tingling
8. How bad is the pain on a scale of 1 – 10 (0 = no pain; 10 = worst possible pain)? __________
9. Do you have pain at night? **YES or NO**
10. What makes your problem **worse**? ______________________________
11. What makes your problem **better**? ______________________________
12. What does your problem limit you from doing? ______________________________
13. Is your problem (*please circle*) Getting **Better** Getting **Worse** Staying the **Same**
14. Have you had physical therapy? *(please circle)* **YES or NO** Did it help? **YES or NO**
15. Have you had injections? *(please circle)* **YES or NO** Did they help? **YES or NO**
16. Were you given medicines? *(please circle)* **YES or NO**
    What medicine? ______________________________ Did the medicine help? **YES or NO**

Current Medications (please list all of your current prescribed and over-the-counter medications)

____

____

____

Allergies: ______________________________

Do you have?		
	High blood pressure	YES or NO
	Ulcers	YES or NO
	Diabetes	YES or NO
	Heart Problems	YES or NO
	Other serious illnesses:	______________________________

Turn over →

 Patient Name:______________________________ **Date:**______________

Please list previous surgeries:____
____

Do you have problems with:	*(please circle)*	If yes, please explain:
1. Headaches	YES or NO	______________________
2. Eye, Ear, Nose, or Throat	YES or NO	______________________
3. Heat problems	YES or NO	______________________
4. Stomach or Intestines	YES or NO	______________________
5. Kidney or Liver	YES or NO	______________________
6. Urinary problems	YES or NO	______________________
7. Pain in Joints	YES or NO	______________________
8. Phlebitis or Leg Swelling	YES or NO	______________________
9. Infections	YES or NO	______________________
10. AIDS or HIV	YES or NO	______________________
11. Bleeding problems	YES or NO	______________________
12. Neurological problems	YES or NO	______________________
13. Psychological problems	YES or NO	______________________

Family History

Please circle if any member of your family has had problems with:

High Blood Pressure	Cancer	Diabetes	Heart Disease	
Kidney Problems	Stroke	Arthritis	Blood Clots	Other:______________

Social History		
Do you live alone?	YES or NO	
Are you working?	YES or NO	
Do you have a special diet?	YES or NO	Any Restrictions?______________
Do you drink caffeine?	YES or NO	Frequency:______________
Do you drink alcohol?	YES or NO	Frequency: How much per week?__________
Do you take drugs?	YES or NO	Frequency/Type:______________
Do you smoke?	YES or NO	Frequency: How many cigarettes per day?______
Did you smoke?	YES or NO	How long? ________ Quit Date:__________

Family Physician:______________________________ Phone:______________

Address:____

Referring Physician:______________________________ Phone:______________

Address:____

-----------------------------FOR OFFICE USE ONLY-----------------------------

Reviewed by physician:__________________________ Date: ____/____/____

Steadman Hawkins Denver Clinic

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand that I am responsible for the payment of this account, and hereby assume and guarantee prompt payment of all expenses incurred. I understand that I am responsible for payment of outpatient office charges at the time of the visit, unless other arrangements have been made. The Steadman Hawkins Denver Clinic will bill my insurance, provided all of the necessary information is given to the clinic. If any insurance company does not submit payment within 45 days, I understand that I will be responsible for any outstanding balance. I understand the Steadman Hawkins Denver Clinic will bill my insurance for any surgical charges, though I will be required to provide a deposit prior to the surgery based on an estimated financial responsibility.

NOTICE OF "NON-COVERED" SERVICES

I am aware that my insurance carrier or Medicare may consider some services performed by the Steadman Hawkins Denver Clinic "non-covered", therefore I will become fully responsible for payment of these services.

WAIVER OF "USUAL, CUSTOMARY AND REASONABLE" CLAUSES

(For patients with "UCR" coverage) I acknowledge that the fees charged by Steadman Hawkins Denver Clinic for services rendered to me, or to the person for whom I assume financial responsibility, may exceed the fees considered "usual, customary and reasonable," due to specialized services and staff. However, I agree to pay fees in full, even if the amount is greater than what I am reimbursed for from my insurance company.

☐

BILL TO/PAYMENT INSTRUCTIONS

Initial

I hereby authorize and request the Steadman Hawkins Denver Clinic to bill my insurance company for all services provided to me. I also authorize payment of medical benefits to the Steadman Hawkins Denver Clinic for any services provided to me and billed by the Steadman Hawkins Denver Clinic.

PERMISSION TO RELEASE MEDICAL INFORMATION

I authorize the Steadman Hawkins Denver Clinic to release information from my medical record, or from the medical record of the person for whom I am legally responsible, to my/their insurance company, other third-party payers or their reviewing agencies. This information must be limited to that which is necessary to expedite claim processing. This authorization is valid for every visit to the Steadman Hawkins Denver Clinic or its affiliates until written notice revoking it is provided.

I release the Steadman Hawkins Denver Clinic of all responsibility for loss of confidentiality through access and or copies made of records released in compliance to this authorization.

I have read all of the above and understand/agree to all provisions therein regarding responsibility for payments and release of information.

Patient's Name ______________________________

Patient's or Legal Guardian's Signature: ______________________________ Date______________

If Legal Guardian, Relationship to Patient______________________________

Steadman Hawkins Clinic - Denver

Request for Confidential Communications Regarding Medical Information

I , ________________________,wish to request that the communication about my health and medical care, which contains Protected Health Information (PHI) , be communicated to me in the following manner:

(Please check how you would like to receive your Protected Health Information and provide the information we will need to send the information to you at your preferred location)

_____ By telephone at my home number:_______________________________

______ By telephone at a different number:______________________________

______ By FAX at this number provided:________________________________

_____ By EMAIL at this email address:_________________________________

______ By mail at an address other than the one on the record

____

____

____

______Please do not leave messages regarding my PHI on my answering machine

_____ SHCD may leave an appointment reminder message on my answering machine

_____SHCD may discuss and/or leave messages about my PHI and/or accounting issues with the following individuals:

Name	Phone Number
Name	Phone Number
Name	Phone Number
Name	Phone Number

If you cannot be reached at the designated alternative location you specify, SHCD may use other means to contact you.

By signing this form, this communication request will remain in force until revoked in writing.

Printed Name	Signature	Month/Day/Year
Patient Account Name	Patient Account Number	Relationship to Patient
SHCD Employee	Signature	Month/Day/Year

THE STEADMAN HAWKINS CLINIC DENVER

Name of Patient (please print) ______________________ **Date of Birth** ______________

Acknowledgment of Notice of Privacy Practices

I hereby acknowledge that I received The Steadman Hawkins Clinic Denver's Notice of Privacy Practices.

______________________ ______________
Signature of patient or patient representative Date

Documentation of Good Faith Efforts
To obtain patient's acknowledgment that they received provider's Notice of Privacy Practices

(For use when acknowledgment cannot be obtained from the patient.)

The patient presented to the office/hospital on __________ and was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgment was not obtained because:

- ☐ Patient refused to sign.
- ☐ Patient was unable to sign or initial because:
  ____
  ____
- ☐ The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.
- ☐ Other reason (describe below):
  ____
  ____

______________________ ______________
Signature of Employee Completing Form Date

[Note: Providers are required to make good faith efforts to obtain acknowledgement that each patient has received their Notice of Privacy Practices. Should the individual refuse to acknowledge receipt of provider's Notice of Privacy Practices, the provider should document the "Good Faith Efforts" taken to obtain such acknowledgment. The regulation does not specify how those "Good Faith Efforts" should be documented. This example form is meant to serve as an example of one way that a provider could satisfy this requirement.]