

**CREEKSIDE PHYSICAL MEDICINE**

David E. Tanner D.O.

The following are registration forms you will need to complete, email to: info@creeksidemedical.com **and** bring to your appointment. If you have any questions or require assistance, please call the office 303.494.2705.

If you need to cancel or reschedule your appointment we would appreciate at least 48 hours notice. As a reminder, **you will be asked to pay your co-pay, co-insurance, and/or non-satisfied deductibles at the time of your visit. These fees will be calculated at applicable contracted rates.** We will verify your insurance benefits prior to your appointment to ensure accurate health benefit information.

**Please check in 10 minutes prior to your scheduled appointment and remember the following:**

- **Insurance card**
- **X-rays, MRIs, scans related to condition**
- **Completed paperwork**
- **I have read and understand the CPM Policies page**

**(PLEASE USE INK)**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MIDDLE: \_\_\_\_\_

INJURY OR CONDITION: \_\_\_\_\_

HOW DID THIS HAPPEN: \_\_\_\_\_ WHERE DID THIS HAPPEN: \_\_\_\_\_

WHEN DID THIS HAPPEN OR FIRST BEGIN BOTHERING YOU? \_\_\_\_\_

WORK RELATED? Y / N

DOB: \_\_\_\_\_ SS#: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

WORK ADDRESS: \_\_\_\_\_

EMERGENCY CONTACT NOT LIVING W/ YOU: \_\_\_\_\_ PHONE #: \_\_\_\_\_

RELATIONSHIP TO YOU: \_\_\_\_\_

.....  
[ ] I **would like** my insurance company (as listed below) billed for my services at Creekside Physical Medicine.

[ ] I **would not** like my insurance company billed for services provided by Creekside Physical Medicine.

[ ] I **do not have insurance** and will be paying Creekside Physical Medicine directly for services provided .

INSURANCE COMPANY: \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

ADDRESS (if different from patient) \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

PLAN/MEMBER # \_\_\_\_\_ GROUP # \_\_\_\_\_

INSURANCE CUSTOMER SERVICE PHONE NUMBER: \_\_\_\_\_

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**CONSENT TO MEDICAL TREATMENT**

I, \_\_\_\_\_, knowing that I am suffering from a condition requiring medical care, do hereby voluntarily consent to such medical care including but not limited to: diagnostic procedures, use of medications, local anesthesia, medical and surgical treatment by my attending physician, assistants or designees as is necessary in my physician's judgment.

I understand that the practice of medicine and surgery is not an exact science and that no guarantees can be made as to the results of medical treatment.

I understand that, if my treatment is being requested by my employer or any other agent or agency, information relevant to my evaluation will be sent to that employer, agent or agency. I also understand that all necessary information will be sent to my insurance carrier or other reimbursing agencies.

I understand that if I have been referred to Creekside Physical Medicine by another physician or health care provider, that information regarding my condition may be sent to the referring health care provider.

In the event that I am unavailable for direct contact , I authorize the medical and professional staff of Creekside Physical Medicine to release any medical information to the following person(s):

- 1. Name \_\_\_\_\_ phone number \_\_\_\_\_
- 2. Name \_\_\_\_\_ phone number \_\_\_\_\_

In addition, I authorize the staff to leave messages on voicemail at the following phone number(s):

\_\_\_\_\_

I hereby agree to the release of this information and release the medical and professional staff of the CREEKSIDE PHYSICAL MEDICINE, P.C. from all liabilities that may arise from the authorized release of this information

I also certify that I understand this consent form and have been given the opportunity to ask any questions regarding its meaning and utilization.

SIGNED \_\_\_\_\_  
Patient/Guardian Date

SIGNED \_\_\_\_\_  
Witness (In-office personnel only) Date

**AUTHORIZATION TO PAY BENEFITS TO PROVIDERS:**

I HEREBY AUTHORIZE **CREEKSIDE PHYSICAL MEDICINE, PLLC** TO BILL MY INSURANCE CARRIER FOR SERVICES AND AUTHORIZE MY INSURANCE COMPANY TO MAKE PAYMENT OF MEDICAL BENEFITS TO THE PROVIDERS OF **CREEKSIDE PHYSICAL MEDICINE, PLLC**.

SIGNED \_\_\_\_\_  
Patient/Guardian Date

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**ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY**

- 1. You are ultimately responsible for payment of medical charges regardless of the type of medical insurance which you may have. It is your responsibility as the patient to provide CreeksidePhysical Medicine (C.P.M) with active, up to date up to date insurance the time your services are rendered; it is also your responsibility to notify C.P.M. staff of any changes to your policy and/or coverage.**
- 2. Your insurance benefits will be verified by C.P.M. billing staff as a courtesy prior to your visit. If a deductible or coinsurance applies to office visits or any treatment performed by the doctor, payment is due at the time of service. The amount collected at the time of service will be based on the current contract rate. Our office will bill the carrier, and if the allowed amount on the explanation of benefits is different than the amount collected at the time of service, the balance will be billed directly to you.**
- 3. Outstanding balances need to be paid and/or addressed with the C.P.M. billing department within 30 days of the 1st issued billing statement unless prior arrangements have been made with the Practice Manager or Billing Manager.**
- 4. If you have insurance coverage with Medicare or an HMO/PPO which we are contracted with, you may need to pay any applicable copayment, coinsurance, or deductible at the time of your office visit.**
- 5. If you will be needing a procedure, your insurance benefits will be verified and you may need to remit a deposit for your scheduled procedure. You will then be responsible for payment of the balance of your account not paid by the primary insurance. Pre-verification is not a guarantee of payment; therefore, if your insurance does not pay the claim for any reason, you will be responsible for payment of all procedure charges.**
- 6. If your account past due with no resolution we reserve the right to attempt to collect any balance due using a collection agency's services. In this case you will be responsible for all charges incurred as well as any collection costs and fees.**
- 7. We reserve the right to charge a fee for completion of any documents that are requested by the patient. Form completion fees are between \$15 - \$75, and are due and payable from the patient at time of completion. These services are not billable to the insurance carrier.**
- 8. We may charge a reasonable fee for copying of patient records and may ask for payment in advance. It is customary for physicians, when transferring care, to provide copies of the patient's records to another physician's office free of charge. The patient must complete a release of medical records form before records can be sent.**

**I acknowledge that I have read and understand the above financial policies of Creekside Physical Medicine, P.C.**

**Patient/Guardian Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

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**PATIENT NOTIFICATION OF PRIVACY RIGHTS**

The Health Insurance Portability and Accountability Act (HIPAA) has created patient protections surrounding the use of protected health information. Commonly referred to as the medical records privacy law, HIPAA provides patient protections related to the electronic transmission of data, the keeping and use of patient records, and storage and access to health care records. HIPAA applies to any and all healthcare providers. Providers and health care agencies throughout the country are required to provide patients a notification of their privacy rights as it relates to their health care records.

The attached NOTICE OF PRIVACY PRACTICES informs you of your rights in a comprehensive fashion. Please read this document, as it is important you know what patient protections HIPAA affords.

By law, we are required to secure your signature indicating you have had a chance to review our Notification of Privacy Rights Document and have been offered a copy.

I, \_\_\_\_\_, understand and have been offered a copy of Creekside Physical Medicine's Notice of Privacy Practices which provides a detailed description of the potential uses and disclosures of my protected health information as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgement form.

\_\_\_\_\_  
Patient Signature or Guardian if Minor or Legal Charge

\_\_\_\_\_  
Date

If Legal Charge, describe representative authority: \_\_\_\_\_

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**AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION**

I, \_\_\_\_\_,  
DOB: \_\_\_\_\_,  
Address: \_\_\_\_\_

\_\_\_\_\_ hereby authorize Creekside Physical Medicine to request and receive my healthcare information.

**SENSITIVE INFORMATION:** I understand that the information in my record may include information relating to sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and/or drug abuse.

**REDISCLASURE:** I understand that any disclosure of information carries with it the potential for re-disclosure, and that the information may not be protected by federal confidentiality rules.

**RIGHT TO REVOKE:** I understand that I have the right to revoke this authorization at any time, and that my revocation must be in writing. I understand that the revocation will not apply to information already released based on this authorization.

**OTHER RIGHTS:** I understand that authorizing the disclosure of this health information is voluntary, and that I can refuse to sign this authorization. I understand that I may inspect or obtain a copy of the information to be used or disclosed.

**EXPIRATION:** Unless otherwise revoked, I understand that this release will be effective for all past, present, and future periods of treatment at Creekside Physical Medicine.

**Signature of Patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If signed by a legal representative, relationship to patient: \_\_\_\_\_

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**HEALTH HISTORY FORM**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age: \_\_\_\_\_  
Sex M/F Height \_\_\_\_\_ Weight \_\_\_\_\_ Occupation \_\_\_\_\_  
Referred By: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Other Physicians \_\_\_\_\_

Reason(s) for Visit: \_\_\_\_\_

How and when did this problem begin? \_\_\_\_\_

How long does it last? \_\_\_\_\_

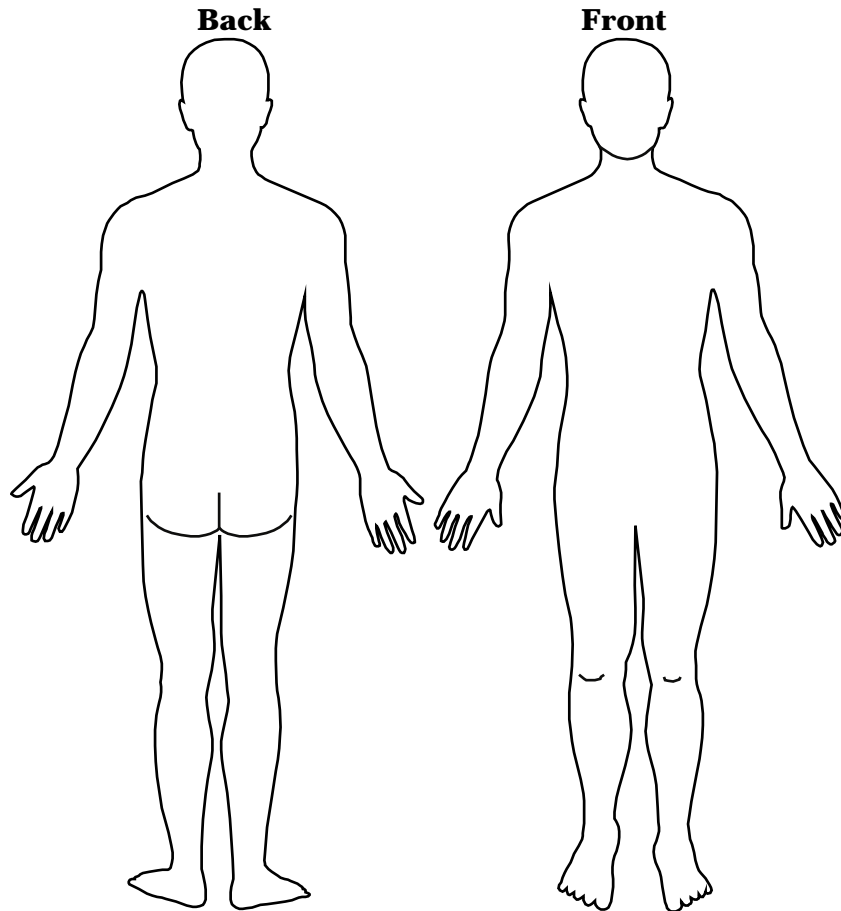
What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

What treatments have you had for this problem? Include medications. \_\_\_\_\_

List any diagnostic tests for this problem? \_\_\_\_\_

Do you have body pain? Mark X's for aches, O's for sharp pain, and .'s for electrical on the anatomical drawing below:



**CREEKSIDE PHYSICAL MEDICINE**

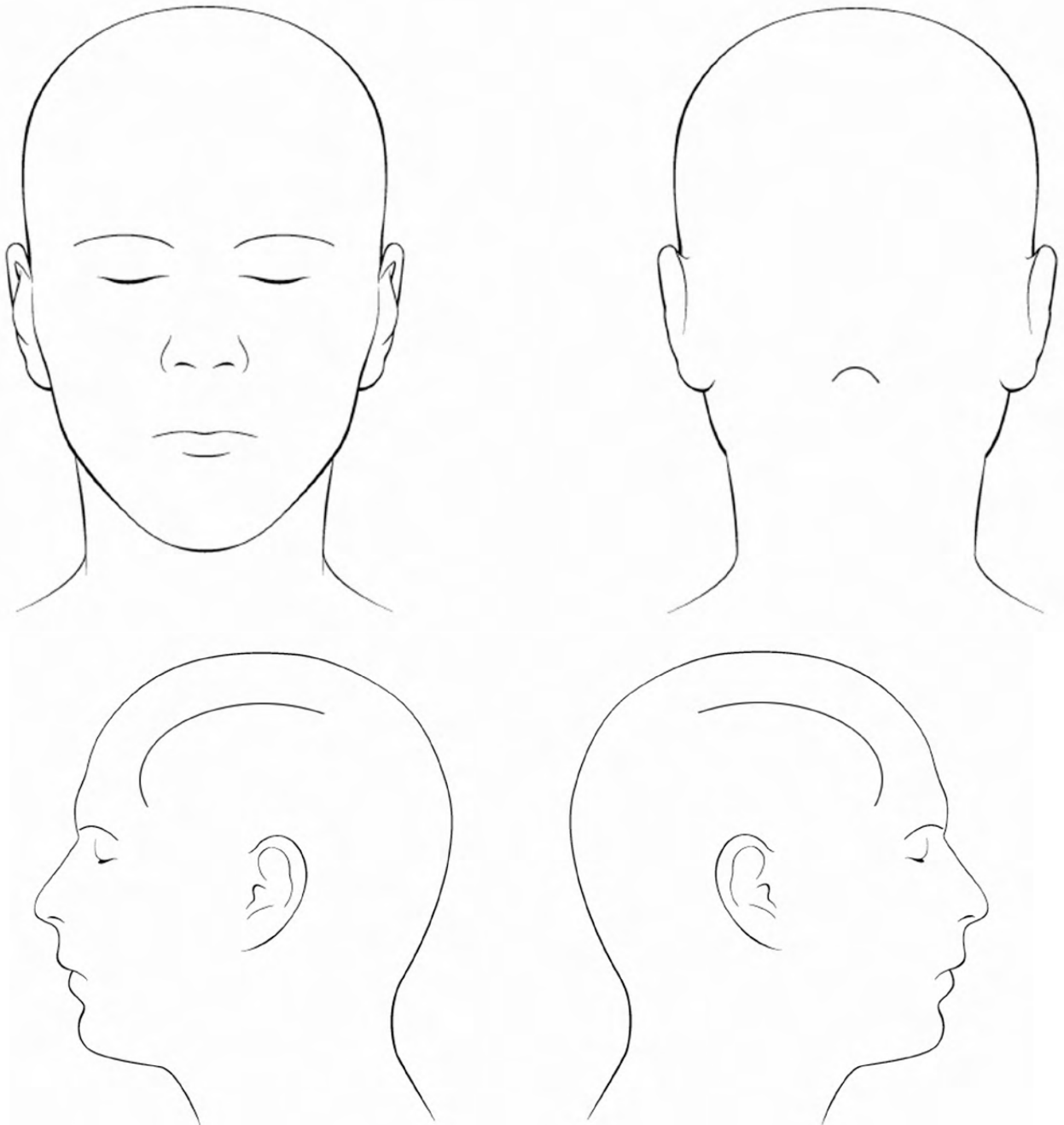
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**If you have headaches or neck pain, please state where they begin and how they progress.**

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**Draw pain progression with (X)'s for aching pain, (V)'s for sharp pain, (.)'s for electrical pain/sensitive areas, (O)'s for pressure on the anatomical drawing below. Use arrows to indicate where the pain begins and how it travels.**



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**Past Medical History - Please check all that apply.**

- \_\_\_ pain disorders (fibromyalgia, chronic pelvic pain, etc);
  - \_\_\_ respiratory disease (sleep apnea, COPD, asthma)
  - \_\_\_ sleep disorders (treated insomnia/daytime fatigue, sleep apnea, shift work )
  - \_\_\_ cancer history
  - \_\_\_ cardiovascular disease (MI, cardiac chest pain, hypertension)
  - \_\_\_ diabetes/metabolic syndrome
  - \_\_\_ blood borne disease (HIV/AIDS/Hepatitis B or C)
  - \_\_\_ migraine
  - \_\_\_ cluster headache
  - \_\_\_ tension/stress headache
  - \_\_\_ cerebrovascular disease (TIA/stroke)
  - \_\_\_ depression diagnosis
  - \_\_\_ anxiety diagnosis
  - \_\_\_ irritable bowel syndrome
  - \_\_\_ chronic fatigue syndrome
  - \_\_\_ sinus disease/headache
  - \_\_\_ arthritis
  - \_\_\_ rheumatological disease
  - \_\_\_ seizure diagnosis
  - \_\_\_ arrhythmias
  - \_\_\_ thyroid disease
  - \_\_\_ bleeding disorders
  - \_\_\_ anti coagulant therapy (coumadin, aspirin)
  - \_\_\_ MAOI therapy
  - \_\_\_ kidney disease
  - \_\_\_ liver disease
  - \_\_\_ peptic ulcer disease
  - \_\_\_ Other \_\_\_\_\_
- 

**Review of Systems - Please circle current symptoms and underline previous symptoms.**

**GENERAL** insomnia fatigue weight change chills fever

**EYES** blurred vision double vision light sensitivity eye pain eye discharge eye redness

**GI** abdominal pain nausea vomiting diarrhea constipation

**HEAD** chronic sinus congestion post nasal drip snoring persistent dental problems

**EARS** hearing loss ear pain sound sensitivity

**NEUROLOGICAL** bowel incontinence bladder incontinence bright spots in vision

tunnel vision visual floaters scalp sensitivity ringing in ears dizziness limb weakness



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**Review of Systems Continued** - Please circle current symptoms and underline previous symptoms.

NEUROLOGICAL limb numbness tingling sensory changes speech changes  
focal weakness headaches seizures loss of consciousness

PSYCHIATRIC anxiety depression suicidal ideas substance abuse hallucination

MUSCULOSKELETAL jaw pain neck pain/pressure

GYNECOLOGICAL

Females only:

Date of last menstrual period? \_\_\_\_\_ Are you Pregnant? \_\_\_\_\_

Do you have a history of irregular periods? \_\_\_\_\_

Is there a correlation between your complaints and your menstrual cycle? \_\_\_\_\_

**Past Surgical History(Procedure and Date):** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medication/Herbal Supplements                      Dose                      Reason for Medication**

Medication/Herbal Supplements	Dose	Reason for Medication

**Medication Allergies:** \_\_\_\_\_

**Social History:**

Do you work at home? \_\_\_\_\_ Employed? \_\_\_\_\_

Are you Married? \_\_\_\_\_ Do you have children? \_\_\_\_\_ Ages \_\_\_\_\_

Do you exercise? \_\_\_\_\_ If so, what do you do and how often? \_\_\_\_\_

Smoke currently?     No     Yes    \_\_\_\_\_ Packs per day for \_\_\_\_\_ years.

Quit smoking?  This year     >1 year     >5 years     > 10 years

Previously smoked \_\_\_\_\_ packs per day for \_\_\_\_\_ years.

Drink alcohol?  Daily     1-2x/week     1-2x/month     1-2x/year

History of substance abuse?  No     Yes    What substances used?

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**Family History**

**Please indicate if any have a history of headache, psychiatric disorders, fibromyalgia, chronic fatigue syndrome, seizure, cardiovascular disease or stroke.**

	<b>Alive</b>	<b>Deceased</b>	<b>Age</b>	<b>Health status or cause of death</b>
<b>Maternal Grandmother</b>	<b>A</b>	<b>D</b>		
<b>Maternal Grandfather</b>	<b>A</b>	<b>D</b>		
<b>Paternal Grandmother</b>	<b>A</b>	<b>D</b>		
<b>Paternal Grandfather</b>	<b>A</b>	<b>D</b>		
<b>Father</b>	<b>A</b>	<b>D</b>		
<b>Mother</b>	<b>A</b>	<b>D</b>		
<b>Sister/Brother</b>	<b>A</b>	<b>D</b>		
<b>Sister/Brother</b>	<b>A</b>	<b>D</b>		
<b>Sister/Brother</b>	<b>A</b>	<b>D</b>		
<b>Sister/Brother</b>	<b>A</b>	<b>D</b>		

**Patient Name (Please Print):** \_\_\_\_\_

**Patient /Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Reviewed By:** \_\_\_\_\_ **Date:** \_\_\_\_\_