PMR
Physical Medicine of the Rockies

General Information

After visiting with the physician, you will receive a comprehensive treatment plan. We use a multidisciplinary approach to treat pain, so your plan may include diagnostic/therapeutic procedures, physical therapy, psychological evaluation/treatment, medication management, lab tests, and/or radiological examinations.

DIAGNOSTIC/THERAPEUTIC PROCEDURES
Depending on your situation, your physician may prescribe an injection that may be used for diagnosis and/or treatment. The details of the injection will be explained by your medical provider and through educational materials.

PHYSICAL THERAPY
Through exercise, massage, and stretching, physical therapy can increase your strength, improve the movement of your joints, decrease your pain, and improve your function.

PSYCHOLOGICAL EVALUATION/TREATMENT
Behavioral Health therapists working with patients that suffer with chronic pain are not trying to decide whether a patient’s pain is real or imaginary. We understand that we cannot visualize pain and that it is real to the person that suffers with it every day. Pain can affect multiple parts of your life, including your ability to participate in your hobbies or job, interact with your family members, or even perform simple household chores. This can lead to significant frustration and possibly even depression. Behavioral Health therapists can help with these problems by using psychology-based treatment approaches that can reverse some of these effects of pain. Our goal is to help you regain the life you had before you started experiencing pain.

MEDICATION MANAGEMENT
All medications have the potential for side effects and may require multiple adjustments to find the best dosage that reduces your pain while minimizing side effects. These adjustments will typically take place during your office visits.

All patients who are prescribed controlled substances are asked to undergo both announced and unannounced Urine Drug Tests as part of the chronic pain management process, without exception and without regard to age, race, sex, color, national origin, sexual orientation, gender identity, marital status, political beliefs, religious preference, disability, language barrier, or diagnosis.

PATIENT CENTERED OUTCOME ORIENTED CARE

Patient Information	
Name:	
Mailing Address:	City, State & Zip:
Primary Phone: ☐Home ☐Cell	Permission to Leave Messages: ☐Yes ☐No
Secondary Phone: ☐Home ☐Cell	Permission to Leave Messages: ☐Yes ☐No
Date of Birth:	SSN:
Employer:	Employer Phone:
Primary Care Physician:	Phone:
Referring Physician:	Phone:
Responsible Party (If different than above)	
Name:	Relationship to Patient:
Mailing Address:	
Primary Phone:	Secondary Phone:
Date of Birth:	SSN:
Employer:	Employer Phone:
Insurance Information	
Is your injury/illness the result of a Worker's Comp accident?	☐Yes ☐No
Is your injury/illness the result of an Auto Accident?	☐Yes ☐No
Work Comp / Personal Auto Insurance Company:	
Claim Number:	Date of Injury:
Adjuster:	Phone Number:
Claims Address:	
Please also provide Health Insurance information in addition to Work Comp /Auto	

Primary Health Insurance Company:	
Policy Holder (if different than self):	
ID Number:	Group Number:
Insurance Phone number:	
Claims Address:	

Secondary Health Insurance Company:	
Policy Holder (if different than self):	
ID Number:	Group Number:
Insurance Phone number:	
Claims Address:	

Note: We do not accept Medicaid. Sorry for any inconvenience	
Emergency Contact	
Name:	Phone:
Medical Disclosure	
I approve PMR to discuss my medical care with:	
Phone:	Relationship:
Signature:	**Date:**

Patient Financial Agreement

Thank you for choosing Physical Medicine of the Rockies. Our goal is to provide you with the highest quality care possible. We find that communication regarding our financial agreement assists us in providing the best service to you. Therefore, we take this opportunity to explain your financial responsibilities for the clinical services provided to you by Physical Medicine of the Rockies (hereafter referred to as the "Practice"). Please carefully review this Patient Financial Agreement, initial each section and sign the agreement to indicate your acceptance of its terms.

APPOINTMENTS

1. **Copayments and Deductibles**. Copayments and deductibles for clinic visits are due at the time of service, in accordance with your insurance carrier's plan. If you are unable to make your copayment at the time of service, the Practice reserves the right to reschedule your appointment until you are able to pay your estimated responsibility. Initial: _____
2. **Procedure Prepayment**. The Practice will collect your payment for a procedure at the time the procedure is scheduled or prior to your appointment. Your prepayment is based on an **estimate** of your expected financial responsibility. ***We reserve the right to reschedule your procedure until prepayment arrangements have been made.*** You are responsible for any unpaid balance after your insurance carrier has processed your claim. Should your insurance carrier pay more than was expected resulting in a credit on your account, we will apply the credit to any unpaid balances that may exist and then refund any amount due to you. Initial: _____
3. **Self-Pay.** If you do not have health insurance, or if your health insurance will not pay for services rendered by the Practice, or if you notify us not to contact or bill your insurance company, you are considered a self-pay patient. Your charges will be based on our current self-pay fee schedule. Payment is due in full at the time of service. Initial: _____
4. **Missed Appointments and Late Arrivals.** Patient cancellations that occur within 24 hours of appointment time, late arrivals (more than 15 minutes) and no-show events are subject to a fee of $50.00 for office visits and $150.00 for procedures. Patients who consistently fail to show up for their scheduled appointments without providing 24 hour advanced notice may be terminated from the practice. Initial: _____

INSURANCE PAYMENTS

5. **Financial Responsibility.** Your insurance policy is a contract **between you and your insurance carrier.** You are ultimately responsible for payment-in-full for all medical services provided to you. Any charges not paid by your insurance carrier will be your responsibility, except as limited by the Practice's specific network agreement with your insuracne carrier, if such an agreement is in place. Initial: ____
6. **Coverage Changes and Timely Submission.** If there are any changes in your insurance, it is your responsibility to inform us and provide the detailed changes of your insurance. We request that you inform us at least 24 hours prior to your appointment. Your insurance carrier places a time limit within which the Practice can submit a claim on your behalf. If the Practice is unable to process your claim within this period due to your providing incorrect insurance information or not responding to insurance carrier inquiries, you will be responsible for all charges. Initial: ______

BENEFITS AND AUTHORIZATION

7. **Insurance Plan Participation.** The Practice has specific network agreements with many insurance carriers, but not all insurance carriers. It is your responsibility to contact your insurance carrier to verify that your assigned provider participates in your plan. Be aware, our participation can change at any time and you are responsible to contact your insurance carrier to ensure we are contracted with your insurance plan. Your insurance carrier's plan my have out-of-network charges that have higher deductibles and copayments, which you will be responsible for. Initial: ____

8. **Referrals.** Referral and prior authorization requirements vary among insurance carriers and plans. If your insurance carrier requires a referral for you to be seen by the Practice, **it is your responsibility to obtain this referral prior to your appointment.** Pursuant to HIPAA, your referring health care provider, and the Practice, are expressly permitted to disclose your Protected Health Information (PHI) to each other and other healthcare providers and facilities for your treatment.
   As a matter of course, the practice will inform your referring physician of your patient care plan and progress either by using any secure electronic transmission machine or by an employee of the Practice.
   Initial: _____
9. **Prior Authorization and Non-Covered Services.** The Practice may provide services that your insurance carrier's plan excludes or requires prior authorization. The Practice as a courtesy to our patients, will make a good-faith effort to determine if services we provide are covered by your insurance carrier's plan, and, if so, determine if prior authorization for treatment is required. If determined that a prior authorization is required, we will attempt to obtain such authorization on your behalf. If we are unable to obtain prior authorization, we will either reschedule the procedure or offer a self-pay option. Ultimately, it is your responsibility to ensure that services provided to you are covered benefits and authorized by your insurance carrier. Initial: _____
10. **Out-of-Network Payments and Direct Insurer Payments.** You are personally responsible for all charges. If the Practice is not part of your insurance carrier's network (out-of-network) or your insurance carrier pays you directly, you are obligated to forward the payment or payment proceeds to the Practice immediately. Initial: _____

ACCOUNT BALANCES AND PAYMENTS

11. **Reassignment of Balances.** If your insurance carrier does not pay for services within a reasonable time, according to the provisions of our agreement with your insurance carrier, we may transfer the balance to your sole responsibility. Please follow up with your insurance carrier to resolve non-payment issues. **Balances are due within 30 days of receiving an initial statement.** Initial: _____
12. **Collection of Unpaid Accounts.** If you have an outstanding balance over 120 days old and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency and/or an attorney for collection. This may result in adverse reporting to credit bureaus and additional legal action. In addition, any fees charged by the collection agency or attorney will be added to your account balance as your responsibility. **The Practice reserves the right to refuse treatment to patients with outstanding balances over 120 days old.** You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you at any telephone number associated with your account, including cellular numbers, which could result in charges to you. We may also contact you by text message or e-mail, using any e-mail address you provide. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device. Initial: _____
13. **Returned Checks.** You will be charged $35 per incident for returned checks (including any Bank Fees).
   Initial: _____
14. **Refunds.** Refunds for overpayment are processed only after full insurance reimbursement of all medical services has been received. Please allow up to 60 days for your refund to be processed. You may also email questions you have about your refund to Billing@PMRcare.com
   Initial: _____
15. **Statements.** Charges shown by statement are agreed to be correct and reasonable unless protested in writing within 30 days of the receipt. Depending on services rendered, your account balance may be split between multiple statements. Initial: _____

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ADDITIONAL FEES

16. **Medical Records Requests**. The HIPAA Privacy Rule and state law allows you to receive a copy of your personal medical and billing records, and allows the Practice to require individuals to complete and sign an Authorization for Disclosure and Release of Medical Records Form. There is no charge to transfer a copy of your medical records to a new Provider. Initial: _____
17. **Other Forms.** During your visit, the Provider will determine a response to requests for the completion of certain medical forms (FMLA , Short Term Disability & Temporary Disability Parking Permit) according to the medical discretion of your Provider. Depending upon the circumstances, we charge a fee for completing certain forms. Initial: _____
18. **Acknowledgment of Notice of Privacy Practice**. By initialing this section, I acknowledge that I have received and reviewed a copy of the Practice's Notice of Privacy Practice. Initial: _____
19. **Public Fee Schedule.** By initialing this section, I acknowledge that I have received a copy of the Practice's Public Fee Schedule. Initial: _____

Public Fee Schedule

Physical Medicine of the Rockies and its affiliates has adopted this Public Fee Schedule in order to comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and applicable state law.

ITEM	FEE CHARGED
Failure to **Cancel** your Appointment with in 24 hours of the scheduled time	$50.00 per Clinic Incident $150.00 per Procedure, EMG or Ultrasound
No Show for your appointment	$50.00 per Clinic Incident $150.00 per Procedure, EMG or Ultrasound
Late Arrivals: If you arrive 15 minutes past your arrival time, and we must reschedule your appointment	$50.00 per Clinic Incident $150.00 per Procedure, EMG or Ultrasound
Completion of Disability Forms:	Costs below are per each occurrence: FMLA **-** $50.00 Short Term Disability - $30.00 Life Insurance - $30.00 Other forms requested by third party/patient - $30.00

Agreement and Assignment of Benefits

I have read and understand the Financial Policy of the Practice and I agree to abide by its terms. I hereby assign all of my medical and surgical insurance benefits and authorize my insurance carrier(s) to issue payment directly to the rendering facility for services provided by the Practice. I understand that I am financially responsible for all services I receive from the Practice. This financial agreement is binding upon me and my estate, executors and/or administrators, if applicable.

Printed Name: ____

Signed: ____

Date: ______________________

PATIENT CENTERED OUTCOME ORIENTED CARE

Additional Practice Information

Authorization to Release/Obtain Health Information

I authorize Physical Medicine of the Rockies to obtain my health information containing my complete medical records for the purpose of medical evaluation and treatment. This information should be disclosed to and use by Physical Medicine of the Rockies at the following location(s):

☐ 13111 E Briarwood Ave Suite 100 Centennial, CO 80112 Ph (719) 465-0069 Fax (720) 930-4252
☐ 9025 Grant Street Suite 200 Thornton, CO 80229 Ph (719) 465-0069 Fax (720) 930-4252
☐ 3910 S Carefree Circle Suite B Colorado Springs, CO 80917 Ph (719) 465-0069 Fax (720) 930-4252

Exclude the following information: ____

Signature Date Date of Birth

Address

PURPOSE OF DISCLOSURE: We may use and disclose your medical records only for each of the following purposes: (1) treatment, (2) payment, and (3) health care operations. We may also create and distribute de-identified health information by removing all references to individually identifiable information.

REVOCATION RIGHTS: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time by sending a written notice of revocation to Releaser. I understand that the revocation will become effective upon receipt by Releaser. Any health information disclosed by Releaser pursuant to this Authorization, before the effective date of the revocations is not subject to the revocation.

Initial ___________

Acknowledgment of Privacy Notice

I acknowledge receipt of the Notice of Privacy Practices for Physical Medicine of the Rockies

Print Name Signature Date

Prescription Refill Policy

All routine prescription refills must be requested during regular office hours. Refill requests will be accommodated Monday through Thursday, 8:30 a.m. to 5:00 p.m. and Friday from 8:30 a.m. to 12:00 p.m. Medications WILL NOT be refilled after these posted hours, on weekends, or on holidays. **It is the patient's responsibility to anticipate the need for medication refills. Please allow two working days for routine medication refill requests.**

Initial ___________

General Consent and Authorization for Treatment, Evaluation, and Information Release

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. The consent will remain fully effective until it is revoked in writing. You have the right to discontinue services at any time.

I certify that the Medical History I provided is complete and accurate to the best of my knowledge and ability.

I voluntarily request that Physical Medicine of the Rockies (hereafter referred to as the "Practice") and any associates, assistants, and other health care providers it may deem necessary, provide general pain management care, treatment, and services to me, as deemed reasonable and necessary by the assigned healthcare provider(s). I consent to reasonable and necessary medical examination, evaluation, testing and treatment which may include diagnostic, radiology and laboratory procedures. I understand I may be asked to provide urine, oral swab, and/or blood samples. I also understand that, if my health care practitioner believes the use of opiates is appropriate to treat my specific pain and condition, I may be asked to enter into a separate pain management agreement which outlines specific obligations and rights related to such treatment as a condition to continued care. I have the right to refuse specific tests or to refuse to enter into an agreement, but understand this may impact my pain management treatment and/or render me ineligible to receive care from Physical Medicine of the Rockies. If an invasive procedure or other surgical intervention is recommended, I will be informed of the benefits and risks of the procedure/intervention prior to performance and will be provided with a separate consent form outlining such benefits and risk.

I understand that the Practice has physician assistants and/or nurse practitioners to assist in the delivery of interventional pain management care. Under the supervision of a physician, a physician assistant and/or nurse practitioner can diagnose, treat and monitor common acute and chronic diseases as well as provide you with health maintenance care. Supervision does not require the constant physical presence of a physician, but rather overseeing the activities of and accepting responsibility for the medical services provided. I hereby consent to the services of a physician assistant and/or nurse practitioner for my health care needs. I understand that I can refuse to see a physician assistant and/or nurse practitioner and request to see a physician at any time. I understand that this may require my appointment to be rescheduled or require a longer wait time for an appointment.

RELEASE OF INFORMATION I give permission to Physical Medicine of the Rockies and its affiliated health care providers to release any information about me, my health, the health services provided to me, or payment for my health services, that may be necessary: (1) for my treatment (to health care providers or facilities that need the information for my continued care); (2) for any purposes related to payment by me or a third party for services (to determine eligibility, to process an insurance claim, for utilization and quality review, or for billing or collection purposes, as necessary to obtain payment); (3) for the health care operations of Physical Medicine of the Rockies or another health care provider that has had a relationship with me (quality assessment, training programs, planning, and fundraising); or (4) as otherwise described in the Notice of Privacy Practices and as permitted by law.

BY SIGNING BELOW, I AM AGREEING TO THE CONSENTS AND RELEASES DESCRIBED ON THIS FORM. I HAVE READ THIS CONSENT AND HAVE BEEN ABLE TO ASK QUESTIONS.

______________________________	______________________________
Printed Name of Patient or Representative	Signature of Patient or Representative
______________________________	____________
Relationship to Patient	Date

PMR

Physical Medicine of the Rockies

PATIENT CENTERED OUTCOME ORIENTED CARE

PATIENT QUESTIONNAIRE

Name: ______________________________________ Today's Date: ____________________________

Social Security #: _____________________________ Date of Injury: ___________________________

Date of Birth: _______________ Age: __________ Referral Source: __________________________

Insurance: ___________________________________ Claim # (if applicable): ______________________

Height: ______________ Weight: _____________ Right / Left Handed (Circle One)

Reason for your visit today? Describe what occurred: ____

____

____

____

____

____

____

____

____

____

____

____

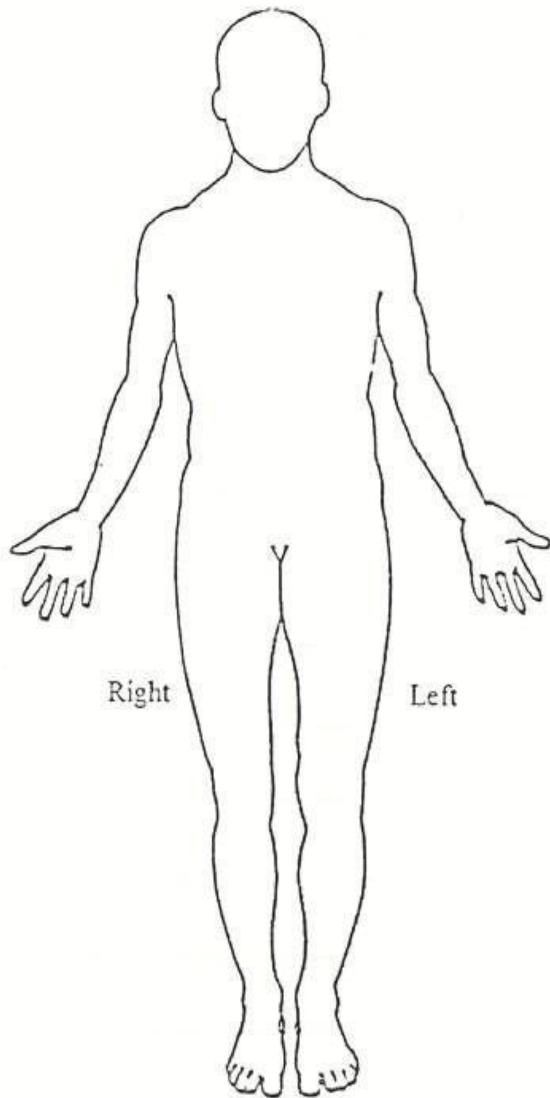
____

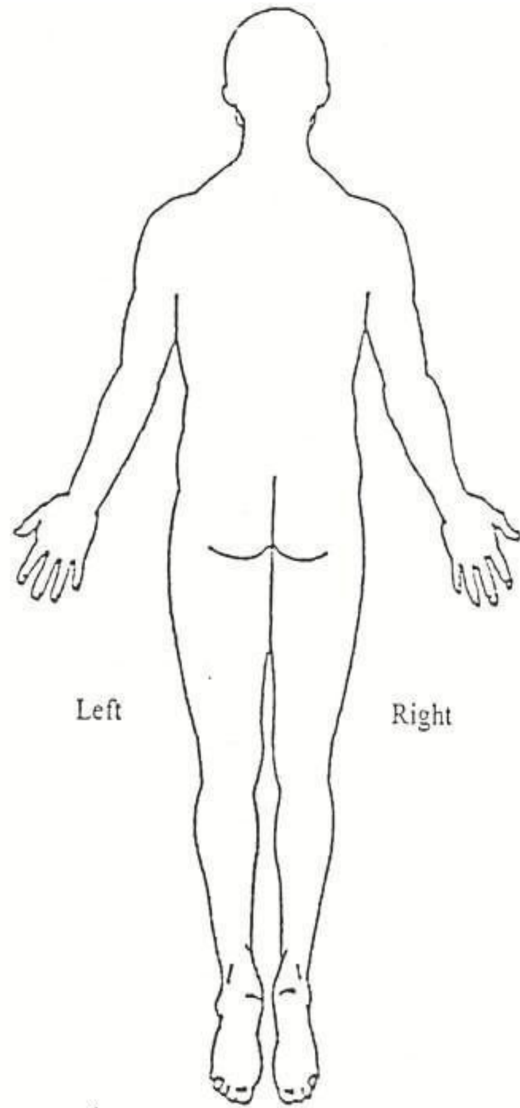
____

Complete the following diagram drawing the symbols below to show where you have your typical pain.

Ache	>>>>	Numbness	------	Pins &	0000	Burning	XXXX	Stabbing	/////
	>>>>		------	Needles	0000		XXXX		/////
	>>>>		------		0000		XXXX		/////

Front **Back**





Please mark the scales below to indicate your level of pain:

"0" on the left side of the scale indicates NO PAIN and "10" on the right side indicates pain so severe it would cause you to lose consciousness or faint.

What is your worst pain?	0	1	2	3	4	5	6	7	8	9	10
What is your least pain?	0	1	2	3	4	5	6	7	8	9	10
What is your pain today?	0	1	2	3	4	5	6	7	8	9	10

List any physical activities or positions that make your pain BETTER:

____

____

____

List any physical activities or positions that make your pain WORSE:

____

____

____

Have you had any tests or surgeries for your current symptoms? (x-ray, MRI, EMG, blood tests):

____

____

How much physical therapy, occupational therapy, massage therapy, acupuncture, chiropractic or osteopathic treatment have you had for these symptoms?

____

____

Have you had any similar symptoms in the past? ______________________________

____

____

____

Past Medical History

List any other medical conditions you currently have (i.e.diabetes, hypertension, asthma, blood or thyroid disorder, ulcers, pulmonary, gastrointestinal, urological, cardiac, skin problems):

____

____

____

____

Previous surgeries:

____

____

____

____

Current medications (including over-the-counter and herbals):

Name of Medication	Dosage (# of mg)	How Often

Do you have any **allergies** to medications and/or foods? ☐ Yes ☐ No

If yes, to what and what type of reaction do you have?

Medication/Food	Reaction

Other medications for this condition tried and discontinued: ______________________________

____

Occupational History

Who is your current employer? ____________________

If currently employed, please list your occupation and job duties: ____________________

____

____

How long have you worked for this employer? ____________________

Have you lost any time from work because of this injury? ____________________

Do you have any work restrictions? Please list: ____________________

____

____

Please list all jobs you have had over the past five years: ____________________

____

Have you ever had a previous work related injury? ____________________

____

If so, did you receive an impairment rating or settlement? ____________________

Social History

Married / Single / Divorced / Widowed (Circle One)

Children? ____________ How many? ____________

Do you smoke or use tobacco? ____________ How much? ____________

Do you drink alcohol? ____________ How much? ____________

Have you ever been a heavy drinker? ____________________

Do you or have you used illicit drugs? ____________________

Family Medical History

List any medical problems in your immediate family: ____________________

____

Review of Systems

How many hours do you sleep at night? _______________

Any trouble falling asleep? **Yes**/**No**

Any trouble staying asleep? **Yes**/**No**

Do you feel well rested when you wake up? **Yes**/**No**

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

	Symptom	**Explanation**
Yes/**No**	Unexplained weight loss or gain	
Yes/**No**	Vision problems	
Yes/**No**	Memory problems	
Yes/**No**	Headaches	
Yes/**No**	Balance problems	
Yes/**No**	Depression	
Yes/**No**	Anxiety	
Yes/**No**	Swallowing problems	
Yes/**No**	Lumps in neck or groin	
Yes/**No**	Shortness of breath	
Yes/**No**	Persistent cough	
Yes/**No**	Chest pain	
Yes/**No**	Abdominal pain	
Yes/**No**	Nausea	
Yes/**No**	Problems with bladder function	
Yes/**No**	Problems with bowels function	
Yes/**No**	Bloody stools or black tarry stools	
Yes/**No**	Skin conditions	
Yes/**No**	Lower leg/ankle swelling	
Yes/**No**	Sexual dysfunction	
Yes/**No**	Females only: menstrual problems	

Last menstruation __________ Any possibility you are pregnant or breastfeeding? **Yes**/**No**