Date of Injury: ___________________
Body Part: ______________________

Time In: _________

Time Out:_________

Name of Patient____
First Name *Middle Name* *Last Name*

Address____ **Apt** _______________________

City____**State**___________**Zip** _______________

Home Telephone ___________________________________ **Alt. Number** ___________________

Date of Birth___________________________**Sex**_____________**Marital Status** ___________________

Social Security #____

EMPLOYER INFORMATION

Employer Name___________________________________**Work Telephone** _____________________

Address____**Supervisor Name** ____________________

Work Fax : ____**Claim #:** ___________________________

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS: I understand that I am financially responsible and agree to pay all of COMP's charges that are not paid by or billed to insurance or any other third party payer. I authorize payment directly to COMP for all benefits otherwise payable to me, not to exceed COMP's regular charges.

RELEASE OF INFORMATION: I authorize COMP and my practitioner(s) to release [verbally or in writing] confidential medical, psychiatric and/or psychological information in my medical record to my employer (Workers' Compensation only) and to any person or entity which may be liable to me, COMP, or my Practitioner(s) for charges for this treatment, and for quality management/utilization review, discharge planning, transfer and follow-up purposes. I understand that following the release of this information COMP and its Practitioner(s) cannot control its confidentiality. I understand this release of information is subject to revocation at any time except to the extent that COMP or Practitioner(s) have already taken action in reliance on it. If not previously revoked in writing, this consent will terminate on (1) year from the date this agreement is signed.

CONSENTS AND DISCLOSURES: I hereby voluntarily agree to diagnostic procedures and medical and surgical treatment which may be administered to or performed on me under the general or special instructions of the attending Practitioner's care and service or the Practitioner's designee(s). I further understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks. No guarantees have been made to me as to the results of my treatment with COMP. I understand that COMP encourages me to ask questions and voice concerns about medical care or services and that asking questions or voicing my concerns will not compromise my care. NOTE: A copy of this agreement may be used with the same effectiveness as an original.

BY SIGNING BELOW I HEREBY CERTIFY THAT I HAVE READ THIS AGREEMENT AND/OR THAT IT HAS BEEN FULLY EXPLAINED TO ME, THAT I UNDERSTAND ITS CONTENTS, AND THAT I AM THE PATIENT, OR A PERSON DULY AUTHORIZED TO EXECUTE THIS AGREEMENT AND ACCEPT ITS TERMS.

Signature of Patient/
Responsible Party____**Date** ___________________________

Relationship (If other than patient)____

Colorado Occupational Medical Partners
Patient HIPAA Acknowledgment and Consent Form

Patient Name: ______________________________

Date of Birth: ______________________________

______(Patient/Representative initials) Notice of Privacy Practices.

I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

______(Patient/Representative initials) Release of Information.

I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- **Healthcare information regarding a prior admission(s) at other CMOP affiliated facilities may be made available to subsequent CMOP-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.**
- **If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.**
- **Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.**

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?"
I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Note: This clinic uses an Electronic Health Record that will update all your demographics to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship.

A photocopy of this consent shall be considered as valid as the original.

Patient Responsibility For Medical Treatment

Welcome to Colorado Occupational Medical Partners. In order for you to obtain optimal benefits from your treatment program, it is essential that you attend all scheduled visits.

Alcohol

Alcohol and non-prescribed substances are not allowed on the premises. If you have been drinking alcohol or using non-prescribed drugs before your appointment, treatment may be refused. And, if this is a workers' compensation injury, your employer will be contacted.

Visitors

Because of space limitations and for safety reasons, children, other family members and/or friends are not allowed in the treatment areas.

Appointments

If you are a Workers' Compensation patient, it is your responsibility to know your employer's policy regarding appointment times. If you are working (even part-time or in restricted duty), your employer may require that your visits be scheduled during non-working hours. Make sure that you advise the receptionist of your employer's scheduling requirements.
Keep all of your medical appointments (including your doctor, therapy, specialists and testing). If you are unable to keep a scheduled appointment, NOTIFY THE CLINIC AND RESCHEDULE. Please call at least 24 hours in advance to cancel and/or reschedule.

Worker's Compensation Notice

It is your responsibility to return your written Work Status Form to your supervisor after each visit to the physician.
The frequency of your appointments is determined by your physician, based upon your injury. Appointments should be scheduled at least one week in advanced.

If you are 15 minutes late for an appointment or if you fail to attend a scheduled appointment (and did not call to cancel and/or reschedule), then you will be considered a "NO-SHOW." If you are a Worker's Compensation patient, your employer and adjuster will be notified that you did not attend your scheduled visit. Not keeping your appointment is as serious as an unexplained absence from work and may result in loss of rights to worker's compensation benefits.

Please sign below indicating you have read and understand the above information and agree to follow these guidelines while in treatment.

____

Patient Print Name **Signature** **Date**

COLORADO OCCUPATIONAL MEDICIAL PARTNERS POLICIES

MEDICAL RECORDS FEE:

- $18.53 for first 10 or fewer paper page(s)
- $0.85 per paper page for the next 11-40 paper page(s)
- $0.57 per paper page for remaining paper page(s)

FORM COMPLETION:

There will be a $25.00 fee for all insurance and disability forms needing to be filled out by the physician.

VISITORS:

ONLY the patient is permitted into the examination areas.

Due to safety concerns, children are NOT permitted into the examination areas.
NO EXCEPTIONS

Children must be accompanied and supervised by an adult at all times. ***NO EXCEPTIONS***

We reserve the right to reschedule your appointment if necessary.

I have read and understand these office policies and agree to abide by them.

Patient Print Name	**Signature**	**Date**

Patient Name:______________________________

Date of Service: ______________________________

Date Injury Occurred:____/____/____Time of Injury:______________Time Arrived at Clinic:________________

Did your employer authorize your visit today? □ Yes □ No Name:______________________________

Describe how your injury occurred: ______________________________

____

Could the injury have been prevented: □ Yes □ No How: ______________________________

____

Have you been treated for this injury? □ Yes □ No Explain: ______________________________

OCCUPATIONAL HISTORY

JOB TITLE:

How Long have you done this type of work:______________**How long have you worked for this employer:** ____________

How do you feel about your job? **Not Satisfied** (0 1 2 3 4 5 6 7 8 9 10) **Extremely Satisfied**

How do you feel about your supervisor? **Not Satisfied** (0 1 2 3 4 5 6 7 8 9 10) **Extremely Satisfied**

Do you have another employer? □ Yes □ No Explain:______________________________

Does your job description or daily work require you to do any of the following? Check and complete all that apply.

□ Bending or twisting at the waist	□ Lifting pounds	□ Repetitive work: Lower extremity
□ Carrying Pounds	□ Operating machines or equipment	□ Repetitive work: Upper extremity
□ Climbing ladders poles stairs	□ Pushing or pulling	□ Sitting hours per day
□ Crawling	□ Reaching above chest	□ Squatting
□ Driving a vehicle hours per day	□ Reaching away from chest	□ Standing hours per day
□ Keystroking hours per day	□ Reaching over head	□ Walking hours per day
□ Kneeling	□ Repetitive lifting	□ Work with hazardous materials

PAST MEDICAL HISTORY:

Do you have a history of any of the following: Check all that apply.

□ Allergies	□ Headaches	□ Liver disease
□ Asthma	□ Head injuries	□ Neurologic problems
□ Bone, joint, or spine problems	□ Heart problems	□ Seizures
□ Bronchitis	□ High blood pressure	□ Sprains or strains
□ Colon problems	□ Hormone problems	□ stomach problems
□ Depression	□ Kidney problems	□ Urinary problems
□ Diabetes		

What medications do you take? ______________________________

When was the last time you took a prescription pain Medicine?______________________________

Do you have any allergies to medications?______________________________

Last tetanus:______________

Have you had a previous injury to the same area?______________________________

Have you had injuries from a motor vehicle accident? □ Yes □ No Explain:______________________________

Have you ever applied for disability? □ Yes □ No Explain:______________________________

Have you ever had an impairment rating? □ Yes □ No Explain:______________________________

What other work related injuries have you had?______________________________

Were you off work for the work injury?______________________________

Do you have any other medical conditions?______________________________

Who is your primary care physician? ______________________________

Have you had any surgeries? □ Yes □ No Explain:______________________________

SOCIAL HISTORY:

Do you serve in the military? □ Yes □ No Explain:______________________________

Are you Married / Single / Divorced. Do you have kids?______________________________

Do you smoke? □ Yes □ No Explain:______________________________

Do you drink alcohol? □ Yes □ No Explain:______________________________

Do you exercise regularly? □ Yes □ No Explain:______________________________

Do you have hobbies? □ Yes □ No Explain:______________________________

Do you have family members with medical problems? □ Yes □ No Explain:______________________________

All answers given by me on this history questionnaire are true and correct.

Patient Signature:______________________________**Date:** ______________

Name: ___________________________________

Date: ___________________________________

Where is your pain now?

Mark the areas on your body where you feel discomfort, using the symbols found below include ALL affected areas. Circle the area where your pain is the worst:

↓↓↓↓
Aching

====
Numbness

●●●●
Pins & Needles

XXXX
Burning

//////
Stabbing

Right Left Left Right

List any current symptoms related to this injury:

____

____

____

How bad is your pain now? Mark on the line below how bad your pain is now.

0	1	2	3	4	5	6	7	8	9	10
No Pain									Worse Possible	

Name:________________________________

Date:________________________________

Review of Systems

Have you had any of the following in the last 1 to 2 weeks (Mark clearly with an X")

General: □ **No Problems**
- □ Fever/ Chills
- □ Weight loss
- □ Weight gain
- □ Fatigue/ weakness

Eyes: □ **No Problems**
- □ Blurry vision
- □ Double vision
- □ Change in vision
- □ Glasses/ contacts/ LASIK

Ears, Nose Mouth Throat: □ **No Problems**
- □ Congestion
- □ Ringing in ears
- □ Hearing loss
- □ Sore throat
- □ Teeth/ Gum disease
- □ Allergies
- □ Nose Bleeds
- □ Swollen Glands

Cardiovascular: □ **No Problems**
- □ Chest pain
- □ Swollen ankles/ feet / hands
- □ Palpitations
- □ Blood Pressure Problems
- □ Heart problems

Respiratory: □ **No Problems**
- □ Wheezing
- □ Coughing
- □ Shortness of breath
- □ Asthma
- □ Spitting up Blood

Skin/Breasts: □ **No Problems**
- □ Dry Skin
- □ Skin lesions/ Rash / moles
- □ Pigmentation changes
- □ Nipple discharge
- □ Change in Skin Color
- □ Itching

Neuro/Psych: □ **No Problems**
- □ Numbness/Tingling
- □ Fainting / Dizziness
- □ Tremor
- □ Depression
- □ Anxiety / Stress
- □ Memory loss/ Confusion or Cloudiness
- □ Sleep disorder/Insomnia
- □ Head injuries
- □ Headaches
- □ Seizures
- □ Balance issues

Hematology/Endocrine: □ **No Problems**
- □ Anemia
- □ Bleeding/Bruise tendency
- □ Blood clots
- □ Heat/cold intolerance
- □ Hormone problems
- □ Diabetes
- □ Excessive Thirst or Urination
- □ Slow healing cuts
- □ Night sweats

Gastrointestinal: □ **No Problems**
- □ Abdominal pain
- □ Nausea/vomiting
- □ Heartburn
- □ Blood in stool
- □ Constipation/diarrhea
- □ Liver disease
- □ Loss of Appetite

Genitourinary: □ **No Problems**
- □ Painful urination
- □ Frequent urination
- □ Blood in urine
- □ Urine incontinence
- □ Kidney disease/Stones
- □ Sexual Difficulty

Musculoskeletal: □ **No Problems**
- □ Joint pain / arthritis
- □ Joint Swelling
- □ Muscle weakness
- □ Back pain
- □ Chest wall pain
- □ Cold Extremity
- □ Extremity pain
- □ Loss of motion
- □ Amputation
- □ Difficulty Walking