Redrock Integrative Rehabilitation Medicine
Dr. Ellen W. Price

Name: ____ **Today's Date:** _________________
First M.I. Last

DOB: ___________________ Age: _____ SSN: _________________ Marital Status: ☐S ☐M ☐D ☐W

Home Phone: _________________ Cell Phone: __________________ Work Phone: ____________________

Physical Address: ____________________________City: ______________State: _________Zip:________

Mailing Address: _____________________________City: ______________State: _________Zip:________

Employer: ___________________________________ Occupation: ______________________________

Employer Address: ____________________________ City: _____________ State: ________ Zip: ________

Spouse/Emergency Contact: _______________________________ Phone: ___________________________

Address: ____________________________________City: _____________ State: ________ Zip: ________

Date of Birth: _______________________

Referring Party: _____________________________ **(Please Circle):** Treating Dr. Insurance Attorney PCP

Please complete this section if someone other than the patient is financially responsible.

Responsible Party: _______________________________________ Relationship: _____________________

DOB: _____________________ SSN: ______________________ Phone: ___________________________

Address: ____________________________________City: _____________ State: ________ Zip: ________

Employer: ____ Occupation: _____________________

Employer Address: ______________________________ City: _____________ State: ________ Zip: ________

Employer Phone: ___________________________________ ext: _____________

Please List the Current Medications you are on:

1. ___________________________ ______MG
2. ___________________________ ______MG
3. ___________________________ ______MG
4. ___________________________ ______MG
5. ___________________________ ______MG
6. ___________________________ ______MG
7. ___________________________ ______MG
8. ___________________________ ______MG
9. ___________________________ ______MG
10. ___________________________ ______MG

Are you allergic to any medications? ☐ Yes ☐ No/ None Known

If so, please list the medications: ____

____

Please sign: ____ **Date:** ___________________________

WE WILL NEED A COPY OF YOUR INSURANCE CARD AND DRIVER'S LICENSE.

Redrock Integrative Rehabilitation Medicine
Dr. Ellen W. Price

INSURANCE INFORMATION

Is this a Work Comp or Motor Vehicle Accident? ☐ Yes ☐No

If YES, on what date did the injury occur? ________________________ (Please Circle) W/C MVA

Did you report the injury to your Employer or Motor Vehicle Insurance? ☐ Yes ☐No

PRIMARY INSURANCE:

Insurance Carrier: ____ Policy/Subscriber # ________________________

Address for Claims: ____ Group # __________________________________

City: ______________________________ State: ________ Zip: _______ Phone: __________________________________

Person Insured: Name: _____________________________________ Relationship: ______________________________

DOB: _______________________________________ SSN# ___________________________________

Address: _______________________________ City: ________________ St: ________ Zip: _________

SECONDARY INSURANCE:

Insurance Carrier: ____ Policy/Subscriber # ________________________

Address for Claims: ____ Group # __________________________________

City: ______________________________ State: ________ Zip: _______ Phone: __________________________________

Person Insured: Name: _____________________________________ Relationship: ______________________________

DOB: _______________________________________ SSN# ___________________________________

Address: _______________________________ City: ________________ St: ________ Zip: _________

WORKERS COMPENSATION:

Insurance Carrier: ____ CLAIM # ________________________________

Address for Claims: ____ Date of Injury: ____________________________

City: ______________________________ State: ________ Zip: _______ Phone: __________________________________

Employer injury occurred at: ___________________________________ Phone: __________________________________

Adjuster for Claim: ____ Phone:___________________________________

Address: ____________________________State: _________ Zip: _______

Nurse Case Manager: ____ Phone: __________________________________

Address: ____________________________State: _________ Zip: _______

MOTOR VEHICLE INSURANCE:

Insurance Carrier: ____ Policy/Subscriber # ________________________

Address for Claims: ____ Group # __________________________________

City: ______________________________ State: ________ Zip: _______ Phone: __________________________________

Person Insured: Name: _____________________________________ Relationship: ______________________________

DOB: _______________________________________ SSN# ___________________________________

Address: _______________________________ City: ________________ St: ________ Zip: _________

Please sign: ____ **Date:** ____________________________

1. **CONSENT FOR HEALTH CARE SERVICES:** I authorize consent for medical treatment at Redrock Integrative Rehabilitation Medicine.
2. **AUTHORIZATION FOR RELEASE OR INFORMATION:** Redrock Integrative Rehabilitation Medicine, Dr. Ellen Price, D.O., may release information from my medical records to any health care provider involved in my care and treatment. My physician may also release my information to any person or organization liable for all or part of my charges, such as my insurance carrier, any third party payer, the Medicare program, and my workers' compensation carrier. I acknowledge that upon the disclosure of medical records information to an insurance company or other payer pursuant to this authorization, Redrock Integrative Rehabilitation Medicine is no longer responsible for the confidentiality of any information known or possessed by the payer.
3. **FINANCIAL AGREEMENT:** I understand that there is no guarantee of payment from any insurance company or other payer even though my insurance will be billed. I agree to pay all charges for the services provided by Redrock Integrative Rehabilitation Medicine which are not paid for by my health insurance or other payer. All charges are due and payable when I receive the bill. If payment is not made within 90 days from the date the bill was mailed from Redrock Integrative Rehabilitation Medicine, I understand that a delinquent charge of interest may be applied. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I understand that any credit or refund that I may be owed will be forwarded to the address on file with Redrock Integrative Rehabilitation Medicine.
4. **PREAUTHORIZATION REQUIREMENTS:** I accept the responsibility to obtain all referrals or preauthorization's and to comply with all requirements of any insurance or medical coverage plan upon which I am relying for medical coverage from Redrock Integrative Rehabilitation Medicine.
5. **ASSIGNMENT FOR DIRECT PAYMENT:** I authorize that payment of any insurance (including auto insurance and health care insurance) benefits for health care services or goods may be made directly to Redrock Integrative Rehabilitation Medicine.
6. **OFFICE POLICIES AND PROCEDURES:** As a courtesy, our office makes reminder calls the day prior to each appointment. Patients that cancel their appointments less then 24 hours prior to their scheduled time may be charged a $25 fee. Patients that arrive to their appointment time more than 15 minutes late may not be seen and may need to reschedule their appointment. Our office will note the late arrival as a "no show" and a $25 fee may be charged. We realize that there are emergencies that cause you to cancel/no show to your appointment, but the office will not be able to reschedule the appointment if there are three or more cancel/no show appointments. This includes the initial or any follow up visits. Please inform the receptionist if your phone number, address, and/or insurance information have changed. This information is necessary to allow the office to accommodate your care. If your insurance plan requires co-pay's to the provider, it must be paid at the time of service. If you would like the doctor to review your x-ray films at your appointment, please pick up the films at the radiology department prior to your appointment. Please advise the staff/doctor if you have retained an attorney. It is necessary for the office to obtain their name, address, phone number, and fax number. If your attorney would like a copy of your medical records, he/she must do so formally. For a fee, your doctor will complete your disability forms. Please provide the forms two weeks in advance of the deadline. Please supply a pre-addressed stamped envelope unless you desire to pick up the forms. If prescription refills are needed, please call the pharmacy directly. They will forward all information to our office. **Please call for all refills two days in advance. No narcotics will be refilled after hours or over the weekend. Please note, the doctor will not prescribe any narcotics (i.e. vicoden, darvocet, oxycontin) during the first, second and perhaps the third visits. In some cases, narcotics might not be prescribed at all. Please make arrangements with your referring physicians if there is a current need for narcotics**
7. **MEDICARE BENEFICIARY SIGNATURE AUTHORIZATION**: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Ellen Price, D.O., for any services furnished to me by that physician. I authorized any holder of medical information about me to release to the Health Care Financing Administration and its agents any information need to determine these benefits or the benefits payable for related services. I understand my signature requests that payments be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assignment cases, the physician or the Medicare carrier as the full charges, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

I acknowledge that:

I have read this form and understand its contents.
I am the patient, or person duty authorized either by the patient or otherwise to sign this agreement, consent to, and accept its terms.
I am responsible for the payment and/or that is due at the time of service.

Please sign: ____ Date: _________________________

What treatment have you had in the past? ______________

____

____

Who treated you first for this problem?

Dr. ____________________ City ___________________

What treatment did you have then? _________________

____

____

What tests have you had? ☐ CT scan ☐ MRI ☐X-ray ☐EMG

Have you have any injections for your problems?

☐ Yes ☐ No Describe: ___________________________

Did these injections help?

☐ Yes ☐ No Describe: ___________________________

Did you have previous back or neck surgery?

☐ Yes ☐ No Describe: ___________________________

List any previous surgeries you've had and the dates:

____

____

____

What is your goal? _______________________________

____

____

____

What medications have you tried previously? __________

____

____

____

What concerns do you have? _______________________

____

____

How is your general health? ____________________

____

____

____

Do you smoke? ☐Yes ☐ No How many packs a day? _______

Do you drink alcohol? ☐ Yes ☐ No How many day a week? ___

Do you have any of the following medical problems?

AIDS/HIV	☐ Yes	☐ No
Arthritis or join pain	☐ Yes	☐ No
Bleeding disorders	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Migraines/Headaches	☐ Yes	☐ No
Muscle Disease	☐ Yes	☐ No
Nerve problems	☐ Yes	☐ No
Psychiatric problems	☐ Yes	☐ No
Stomach problems	☐ Yes	☐ No
Thyroid problems	☐ Yes	☐ No

Recently, have you experienced?

Fever or chills	☐ Yes	☐ No
Weight loss	☐ Yes	☐ No
Chest pain	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Worse pain at night	☐ Yes	☐ No

Tell us about your family

Do any family members have a history of:

Back or neck problems	☐ Yes	☐ No
AIDS/HIV	☐ Yes	☐ No
Arthritis or join pain	☐ Yes	☐ No
Bleeding disorders	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Migraines/Headaches	☐ Yes	☐ No
Muscle Disease	☐ Yes	☐ No
Nerve problems	☐ Yes	☐ No
Psychiatric problems	☐ Yes	☐ No
Stomach problems	☐ Yes	☐ No
Thyroid problems	☐ Yes	☐ No

Other Problems? ___________________________

____

____

Have you ever had an Impairment Rating? __________

____

____

Redrock Integrative Rehabilitation Medicine

Dr. Ellen W. Price

Today's Date: ___________ Referring Dr: _________________

First Name: _______________ Last Name: ________________

DOB: ____________________ Age: __________ Sex: M/F

Height: __________ Weight: _______ Marital Status: S M D W

Tell us about your symptoms
Date of injury: ____

Is this a work related injury? ☐ Yes ☐ No

What are your symptoms? ______________________________

____

____

Is this pain mostly in back, neck or elsewhere? _____________

____

How long ago did the symptoms begin? __________________

____

Is the pain constant, or dose it come and go? ______________

____

How do these symptoms limit you? ______________________

____

What things make the pain better (rest, ice, heat, pills)? ______

____

What makes the pain worse? ___________________________

____

Do you have pain that radiates into the arm or leg?

☐ Yes ☐ No Describe: _________________________________

Have you lost any control over bowel or bladder functions?

☐ Yes ☐ No Describe: _________________________________

Do you have any weakness or numbness in an arm or leg?

☐ Yes ☐ No Describe: _________________________________

How long can you: Sit _______ Stand _______ Walk _______

Is your pain the result of a: ☐ fall ☐ Auto Accident ☐ Injury on the job

☐ Other: ____

Which of the following describes you currently?

- ☐ Working
- ☐ Not working because of back or neck problems
- ☐ Not working because of another heath problem
- ☐ Homemaker, retired, or unemployed

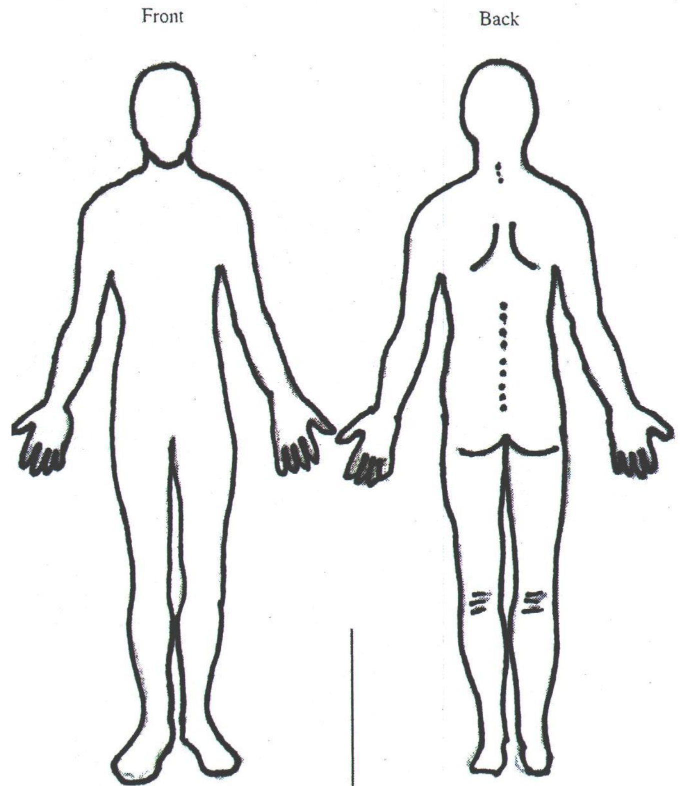
How long have you been at that job? ____________________

Does your job require lifting, standing, sitting? _____________

Employer at the time of injury? _________________________

Do you have a law suit pending on this injury? ☐ Yes ☐ No

Draw your pain on the diagrams shown. Use the corresponding symbols to show the type of pain you feel.



What is your pain level on a scale of 1 to 10?
1 being no pain and 10 being worst imaginable.

1___2___3___4___5___6___7___8___9___10
No pain Extreme Pain

Today ________

Worst ________

Least ________

Which hand is dominate? Please circle

Right / Left

Please read: This questionnaire is designed to enable us to understand how much your low back has affected your ability to manage everyday activities. Please answer each Section by circling **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but please **just circle one choice which closely describes your problem *right now*.**

SECTION 1- PAIN INTENSITY

A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate.
D. The pain is moderates and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much

SECTION 2- PERSONAL CARE

A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increase pain, but I manage not to change my way of doing it.
D. Washing and dressing increase the pain. It was necessary to change my way of doing it.
E. Because of the pain, I am unable to do any washing and dressing without help.

SECTION 3- LIFTING

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on the table.
E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F. I can only lift very light weights at the most.

SECTION 4- WALKING

A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than one mile.
C. Pain prevents me from walking more than ½ mile.
D. I can only walk while using a cane or on crutches.
E. I am in bed most of the time and have to crawl to the toilet.

SECTION 5- SITTING

A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me from sitting more than one hour.
D. Pain prevents me from sitting more than ½ hour.
E. Pain prevents me from sitting more than ten minutes.
F. Pain prevents me from sitting at all.

SECTION 6- STANDING

A. I can stand as long as I want without pain.
B. I have some pain while standing, but it does not increase with time.
C. I cannot stand for longer than one hour without increasing pain.
D. I cannot stand for longer than ½ hour without increasing pain.
E. I can't stand for more than 10 minutes without increasing pain.
F. I avoid standing because it increases pain right away.

SECTION 7- SLEEPING

A. I get no pain in bed.
B. I get pain in bed, but it does not prevent me from sleeping.
C. Because of my pain, my normal night's sleep is reduced by less than one-quarter.
D. Because of my pain, my normal night's sleep is reduced by less than one-half.
E. Because of my pain, my normal night's sleep is reduced by less than three-quarters.
F. Pain prevents me from sleeping at all.

SECTION 8- SOCIAL LIFE

A. My social life is normal and gives me no pain.
B. My social life is normal, but increases the degree of my pain
C. Pain has no significant effect on my social live apart from limiting my more energetic interests, e.g. dancing, etc.
D. Pain has restricted my social life and I do not go out very often.
E. Pain has restricted my social life to my home.
F. Pain prevents me from sleeping at all.

SECTION 9- TRAVELING

A. I get no pain while traveling
B. I get some pain while traveling, but none of my usual forms of travel make it any worse.
C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D. I get extra pain while traveling which compels me to seek alternative forms of travel.
E. Pain restricts all forms of travel.
F. Pain prevents all forms of travel except those that are done lying down.

SECTION 10- CHANGIN DEGREE OF PAIN

A. My pain is rapidly getting better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better, but improvement is slow at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.

DISABILITY INDEX SCORE: ________%

HIPPA NOTICE OF PRIVACY PRACTICES

Redrock Integrative Rehabilitation Medicine

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IN CAREFULLY.

This notice of Privacy Practices describes how we may used and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information.

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for you health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose you PHI as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization. These situations include : as Required by Law, Public Health issues are required y law, Communicable Diseases; Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates, Required Uses and Disclosures: Under the law we must make disclosures to you and when required by the Secretary of the Department of Health and Human services to investigate or determine our compliance with the requirements of Sections 164.500.

Other permitted and Required Uses and Disclosures will be made only with your consent, Authorization or Opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights:

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information: Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of , or use in, a civil, criminal , or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information: This means that you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may involved in your care of for notification purposes as described in this notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in you best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Health Care Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your PHI. If we deny your request to object or withdraw as provided in this notice.

Complaints:

You may complain to us or to the Secretary of Health and Human services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This Notice was published and became effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of Privacy Practices

Print Name: ____ **Date:** ___________________

Signature: ____

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the “Privacy Rule.” We strive to achieve the very highest standard of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent and inappropriate use of PHI.

We also know that we are not perfect. Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

The Department of Health and Human Services has established a “Privacy Rule” to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard of certain health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your healthcare information and information about treatment, payment or health care operation, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use of disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent by signing the “CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

You have the right to review our privacy notice, to request restrictions and to revoke consent in writing after you have reviewed our privacy notice.

Redrock Integrative Rehabilitation Medicine
551 Kokopelli Blvd, Suite I
Fruita CO 81521
PHONE (970) 858-2585

To Our Patients,

We have enclosed some forms that we need to have you complete. There are government laws and regulations that we need to be in compliance with, which include getting consents from patients.

Enclosed is the HIPAA Privacy Practice Notice. We need you to sign it, acknowledging that you have read it. If you would like a copy of the notice, please ask our receptionist.

We have also enclosed patient information forms that are needed to complete your chart. Please bring all forms with you when you come to see Dr. Price.

If you have any questions, please do not hesitate to call our office.

Thank you for taking the time to complete this information for us.

Thank You,

The office staff for Dr. Ellen Price