For Office Use
Updated By (Initial Here): __________

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 CROM to discuss my medical care with:	
Phone:	Relationship:

Signature:	**Date:**

CROM

COLORADO REHABILITATION & OCCUPATIONAL MEDICINE

Maximizing Function and Improving Lives

Financial Contract

Assignment of Benefits and Financial Responsibility

I understand that Colorado Rehabilitation and Occupational Medicine, PLLC hereafter known as CROM, will submit a bill to my insurance company as a courtesy. I understand that upon acceptance of services from CROM, I assume responsibility for any co-pay, deductible, co-insurance or other balance not covered by my insurance carrier. I authorize CROM to submit claims to my insurance company on my behalf, and my insurance company to pay benefits directly to CROM at 1390 S. Potomac St., Ste 128, Aurora, CO 80012. Should any insurance payment be made directly to the insurer on this account, I agree to immediately pay over these funds to CROM. I agree to pay reasonable attorney and/or collection agency fees in the event my account is delinquent and requires the actions of either/both parties. I understand that I must furnish a current copy of my insurance card(s) and a valid ID or I will be responsible for immediate payment of all charges in order to receive services.

Initial _____________

Co-Payment Policy (if applicable)

You are expected to pay your co-pay at the time of service. CROM will no longer bill for co-pays. In the event you are unable to pay your co-pay at your visit, you will be assessed and billed an additional $15.00 fee to cover the cost of processing the co-pay bill. If your insurance processes your claim and does not assess a co-pay for services provided, you may request a refund.

Account Payment Policy

Although we openly welcome and encourage payment in full, in order to keep your account current and to avoid any interruption with receiving care from CROM providers, a minimum of 20% of your account balance must be received on a monthly basis.

Cancellation, No-Show, Reschedule and Late Arrival Policy

As CROM providers are committed to providing you with quality care. In return, we ask that you please be respectful of their time. Failure to notify the office of your need to cancel or reschedule may result in the following fees.

Office Visits cancelled/rescheduled less than 24 hours before the appointment - **$50.00**
Injection procedures cancelled/rescheduled less than 5 business days before the appointment - **$150.00**

If you arrive 15 minutes (or more) late for your appointment, you may be asked to reschedule. Please make every effort to arrive at the given check-in time to avoid any disruption in your care.

NSF Checks

If your check is returned for nonsufficient funds, you will be assessed a $25.00 administrative fee.

A photocopy of this authorization shall be as valid as the original from the initial date of completion.
This consent is valid until specifically revoked in writing.

CROM

Colorado Rehabilitation & Occupational Medicine

Maximizing Function and Improving Lives

Insurance Disclaimer

CROM is committed to providing you with the highest standard of care which includes obtaining basic information regarding your insurance policy and how it applies to our services. When we contact an insurance company to verify eligibility and benefits, we are often told that the service in question is covered but based on 'Medical Necessity'. It has been our experience that different insurance groups define 'Medical Necessity' differently. On rare occasion this has resulted in a denial for payment on the service provided. While again, we strive to obtain and provide you with the most accurate information, ultimately the insurance policy belongs to you. We strongly encourage you to become familiar with your plan - What is covered? Are there any exceptions? What is considered Medically Necessary? What are my out of pocket expenses? Do I need a referral?

It is imperative that you are informed. Please contact your insurance company so that you are able to make the best decisions about your medical care as well as your financial responsibilities. In the event that a service is denied for a reason that is directed by your insurance policy, you will be responsible.

Insurance Complaints

In the event that my insurance company does not comply with state and federal laws, I hereby authorize CROM to file a complaint on my behalf to my insurance carrier, the appropriate State Insurance Commissioner as well as the National Association of Insurance Commissioners and/or The Division of Worker's Compensation.

Initial ______________

Consent to Treatment

I understand all CROM policies as listed above and hereby consent to diagnostic and medical treatment and/or examination by any of the Colorado Rehabilitation and Occupational Medicine, PLLC physicians and/or their technical assistants.

Initial ______________

Signature ______________________________ Date ______________

Print Name ______________________________

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This consent is valid until specifically revoked in writing.

CROM

COLORADO REHABILITATION & OCCUPATIONAL MEDICINE

Maximizing Function and Improving Lives

Additional Practice Information

Authorization to Release/Obtain Health Information

I authorize Colorado Rehabilitation & Occupational Medicine, PLLC 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 Colorado Rehabilitation & Occupational Medicine, PLLC at the following location(s):

☐1390 S Potomac St, Suite 100, Aurora, CO 80012 Ph (303) 341-0722 Fax (303) 341-0832
☐8200 E Belleview Ave, Suite 330C, Greenwood Village, CO 80111 Ph (720) 875-0551 Fax (720) 875-0556

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 ___________

Acknowledgement of Privacy Notice

I acknowledge receipt of the Notice of Privacy Practices for Colorado Rehabilitation & Occupational Medicine, PLLC.

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 3:00 p.m. Medications WILL NOT be refilled after these posted hours, on weekends, or on holidays. For symptoms requiring immediate medical evaluation, a physician is on call 24 hours a day, 7 days a week. **It is the patient's responsibility to anticipate the need for medication refills. Please allow two working days for routine medication refill requests.**

Initial ___________

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This consent is valid until specifically revoked in writing.

Maximizing Function and Improving Lives

Contact Information

In the event our office needs to contact you regarding your medical care:

What phone number should we contact you at? (______) ______ - ________

Is it okay to leave a voicemail message? **Y** **N**

Is it okay to leave a message with someone at this number other than you? **Y** **N**

Who can we leave a message with? ____

If there is anyone that you want us to have permission to speak with regarding your care, please list

here: ____

Patient's Signature: ____

A photocopy of this authorization shall be as valid as the original from the initial date of completion.
This consent is valid until specifically revoked in writing.

CROM

COLORADO REHABILITATION & OCCUPATIONAL MEDICINE

Advanced Rehabilitation Medicine

PATIENT QUESTIONNAIRE

Name: ______________________________ Today's Date: ______________________

Social Security #: ______________________ Date of Injury: _____________________

Date of Birth: ____________ Age: ________ Referral Source: ____________________

Insurance: ___________________________ Claim # (if applicable): _________________

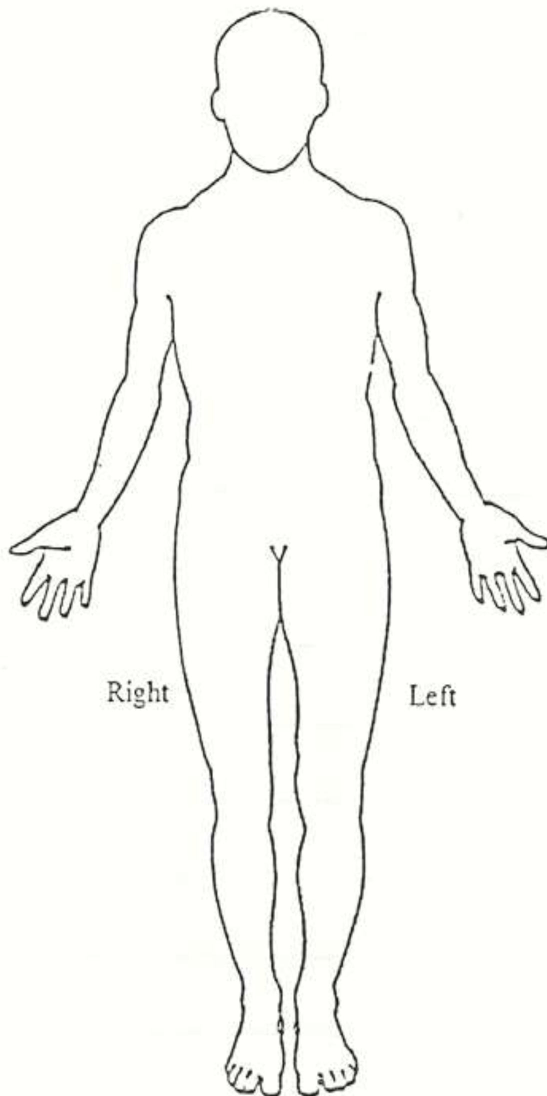
Height: ___________ Weight: __________ Right / Left Handed (Circle One)

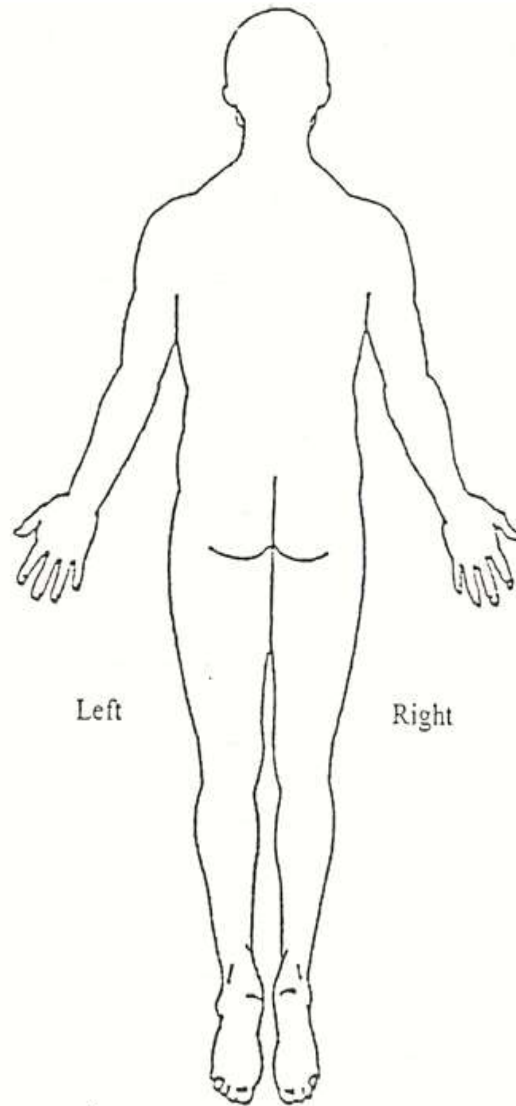
Reason for your visit today? Describe what occurred: ___________________________________
____
____
____
____
____
____
____
____
____
____
____
____
____

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**