CROM (303) 685-CROM (2766)

COLORADO REHABILITATION & OCCUPATIONAL MEDICINE

Advanced Rehabilitation Medicine

Patient Information

Name:	
Email:	

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:

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:
COPY OF CARD (S) IS REQUIRED AT EVERY VISIT	
Primary Medical Insurance Company	Secondary Medical Insurance Company

Note: We do not accept Medicaid. Sorry for any inconvenience

Emergency Contact

Name:	Phone:

Medical/Billing Disclosure

I approve CROM to discuss my medical care/billing issues with:	
Phone:	Relationship:
Signature:	**Date:**

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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 7951 E Maplewood Ave, Ste 225, Greenwood Village, CO 80111. 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 required to pay any co-payment at the time of your visit. **In the event you are unable to pay your co-pay at your visit, you may be asked to reschedule**. If your insurance processes your claim and does not assess a co-pay for services provided, you may request a refund.

Initial_____

Account Balance Policy

We will bill you once your insurance has processed your claim. Payment is due in full at that time, to avoid any interruption with your care from CROM providers. If you are unable to pay in full, please contact our billing office to arrange a payment plan, they may be reached at 303-685-2766.

Initial_____

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.

Initial_____

NSF Checks

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

Initial_____

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.

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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

A copy of this authorization shall be as valid as the original from the initial date of completion.
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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 our main location:

☐ 7951 E Maplewood Ave, Ste 225, Grenwood Village CO 80111 Ph (303) 341-0722 Fax (720) 255-0667

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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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: _____

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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 (Check One)

Reason for your visit today? Describe what occurred: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

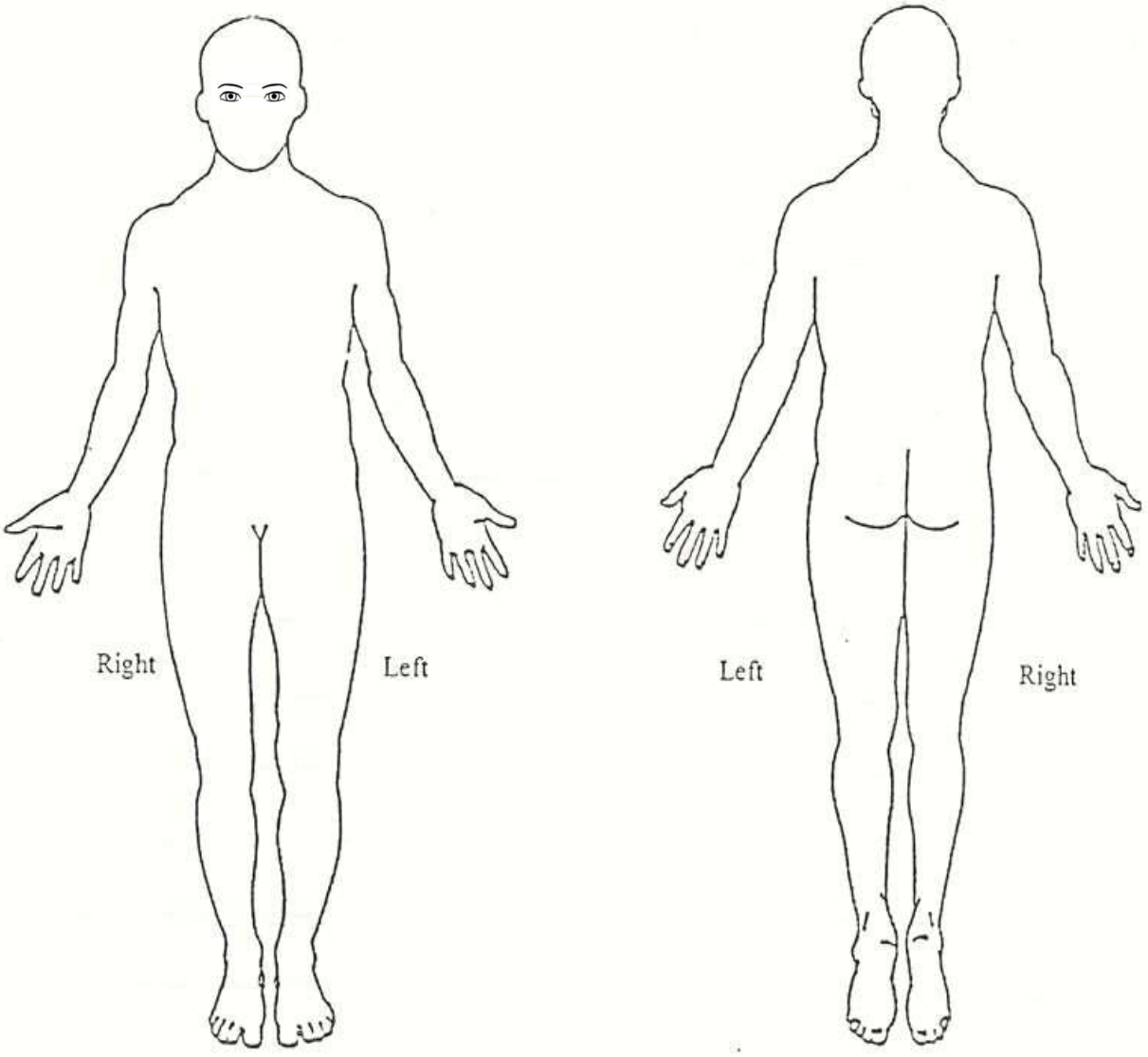
_____

_____

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? ☐ Yes ☐ No

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 (Select 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**