

**CREEKSIDE PHYSICAL MEDICINE**

David E. Tanner D.O.

Alex Reish D.O.

Following are registration forms you will need to complete and bring to your appointment. If you have any questions or require assistance, please call the office.

If you need to cancel or reschedule your appointment we would appreciate at least 24 hours notice. As a reminder, **you will be asked to pay your co-pay, co-insurance, and/or non-satisfied deductibles at the time of your visit. These fees will be calculated at applicable contracted rates.** We will verify your insurance benefits prior to your appointment to ensure accurate health benefit information.

**Please check in 30 minutes prior to your scheduled appointment and remember the following:**

- **Insurance card**
- **X-rays, MRIs, scans related to condition**
- **Completed paperwork**
- **I have read and understand the CPM Policies page**

**(PLEASE USE INK)**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MIDDLE: \_\_\_\_\_

INJURY OR CONDITION: \_\_\_\_\_

HOW DID THIS HAPPEN: \_\_\_\_\_ WHERE DID THIS HAPPEN: \_\_\_\_\_

WHEN DID THIS HAPPEN OR FIRST BEGIN BOTHERING YOU? \_\_\_\_\_

WORK RELATED? Y / N

DOB: \_\_\_\_\_ SS#: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

WORK ADDRESS: \_\_\_\_\_

EMERGENCY CONTACT NOT LIVING W/ YOU: \_\_\_\_\_ PHONE #: \_\_\_\_\_

RELATIONSHIP TO YOU: \_\_\_\_\_

.....  
[ ] I **would like** my insurance company (as listed below) billed for my services at Creekside Physical Medicine.

[ ] I **would not** like my insurance company billed for services provided by Creekside Physical Medicine.

[ ] I **do not have insurance** and will be paying Creekside Physical Medicine directly for services provided .

INSURANCE COMPANY: \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

ADDRESS (if different from patient) \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

PLAN/MEMBER # \_\_\_\_\_ GROUP # \_\_\_\_\_

INSURANCE CUSTOMER SERVICE PHONE NUMBER: \_\_\_\_\_

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**CONSENT TO MEDICAL TREATMENT**

I, \_\_\_\_\_, knowing that I am suffering from a condition requiring medical care, do hereby voluntarily consent to such medical care including but not limited to: diagnostic procedures, use of medications, local anesthesia, medical and surgical treatment by my attending physician, assistants or designees as is necessary in my physician's judgment.

I understand that the practice of medicine and surgery is not an exact science and that no guarantees can be made as to the results of medical treatment.

I understand that, if my treatment is being requested by my employer or any other agent or agency, information relevant to my evaluation will be sent to that employer, agent or agency. I also understand that all necessary information will be sent to my insurance carrier or other reimbursing agencies.

I understand that if I have been referred to Creekside Physical Medicine by another physician or health care provider, that information regarding my condition may be sent to the referring health care provider.

In the event that I am unavailable for direct contact , I authorize the medical and professional staff of Creekside Physical Medicine to release any medical information to the following person(s):

1. Name \_\_\_\_\_ phone number \_\_\_\_\_

2. Name \_\_\_\_\_ phone number \_\_\_\_\_

In addition, I authorize the staff to leave messages on voicemail at the following phone number(s):

\_\_\_\_\_

I hereby agree to the release of this information and release the medical and professional staff of the CREEKSIDE PHYSICAL MEDICINE, P.C. from all liabilities that may arise from the authorized release of this information

I also certify that I understand this consent form and have been given the opportunity to ask any questions regarding its meaning and utilization.

SIGNED \_\_\_\_\_  
Patient/Guardian

\_\_\_\_\_  
Date

SIGNED \_\_\_\_\_  
Witness (In-office personnel only)

\_\_\_\_\_  
Date

**AUTHORIZATION TO PAY BENEFITS TO PROVIDERS:**

I HEREBY AUTHORIZE CREEKSIDE PHYSICAL MEDICINE, PLLC TO BILL MY INSURANCE CARRIER FOR SERVICES AND AUTHORIZE MY INSURANCE COMPANY TO MAKE PAYMENT OF MEDICAL BENEFITS TO THE PROVIDERS OF CREEKSIDE PHYSICAL MEDICINE, PLLC.

SIGNED \_\_\_\_\_  
Patient/Guardian

\_\_\_\_\_  
Date

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**ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY**

1. You are ultimately responsible for payment of medical charges regardless of the type of medical insurance which you may have.
2. If a deductible or coinsurance applies to office visits, x-rays, or any treatment performed by the doctor, payment is due at the time of service. If Creekside Physical Medicine is contracted with your insurance, the amount collected at the time of service will be based on the current contract rate. Our office will bill the carrier, and if the allowed amount on the explanation of benefits (this is a form we receive from the insurance carrier after your claim processes) is different than the amount collected at the time of service, you will be balance billed. If payment is not made at the time of service, a \$5.00 billing fee will be assessed.
3. Our office will submit a bill to your primary insurance carrier as a courtesy to you so that you will be credited for medical charges incurred.
4. Outstanding balances accrue a 1% interest fee per month, 12% per annum.
5. If you have insurance coverage with Medicare or an HMO/PPO which we are contracted with, you may need to pay any applicable copayment, coinsurance, or deductible at the time of your office visit.
6. Colorado law mandates that we receive payment within 45 days of submitting your insurance claim. If you have Medicare as your primary insurance coverage and crossover or medigap supplemental coverage such as AARP, and we do not receive payment from your supplemental carrier within that time, you will need to pay your account balance and receive reimbursement from your insurance carrier.
7. If you will be needing a procedure, your insurance benefits will be verified and you may need to remit a deposit for your scheduled procedure. You will then be responsible for payment of the balance of your account once your primary insurance pays on the procedure. Pre-verification is not a guarantee of payment to us; therefore, if your insurance does not pay on your procedure for any reason, you will be responsible for payment of all procedure charges.
8. Since our office offers specialized services, our charges are generally higher than the reasonable or customary fee schedules used by insurance companies to pay your claims. Therefore, you will be responsible for any difference between our charges and the reasonable and customary fees paid by your insurance company. This does not apply to insurance plans that the doctor is contracted with.
9. If your account is not paid and we need to turn your account over to our collection agency to pursue payment, you will be responsible for all charges incurred as well as all collection costs and fees.
11. Occasionally, patients request completion of miscellaneous forms for various purposes. Form completion fees are between \$15 - \$75, and are due and payable from the patient. These services are not billable to the insurance carrier.
12. We may charge a reasonable fee for copying of patient records and may ask for payment in advance. It is customary for physicians, when transferring care, to provide copies of the patient's records to another physician's office free of charge. The patient must complete a release of medical records form.

I acknowledge that I have read and understand the above financial policies of Creekside Physical Medicine, P.C.

Patient/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

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**PATIENT NOTIFICATION OF PRIVACY RIGHTS**

The Health Insurance Portability and Accountability Act (HIPAA) has created patient protections surrounding the use of protected health information. Commonly referred to as the “medical records privacy law”, HIPAA provides patient protections related to the electronic transmission of data, the keeping and use of patient records, and storage and access to health care records. HIPAA applies to all healthcare providers. Providers and health care agencies throughout the country are required to provide patients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices, such as this one, from your other health care providers.

The attached “NOTICE OF PRIVACY PRACTICES” informs you of your rights in a comprehensive fashion. Please read this document, as it is important you know what patient protections HIPAA affords all of us.

By law, we are required to secure your signature indicating you have had a chance to review our Notification of Privacy Rights Document and have been offered a copy.

I, \_\_\_\_\_, understand and have been offered a copy of Creekside Physical Medicine’s Notice of Privacy Practices which provides a detailed description of the potential uses and disclosures of my protected health information as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgement form.

\_\_\_\_\_  
Patient Signature or Guardian if Minor or Legal Charge

\_\_\_\_\_  
Date

If Legal Charge, describe representative authority: \_\_\_\_\_

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**EZ Pay Consent Form**

It is the policy of Creekside Physical Medicine to retain on file a credit/debit card number for all active patients. **This information is kept strictly confidential** and will only be used for payment of fees to Creekside Physical Medicine.

Creekside Physical Medicine will submit claims to your insurance company following your visit. Once the billing office receives final payment and/or disposition from your insurance carrier the office will send a statement. Examples of these unpaid amounts may be co-pays, co-insurance, and deductible responsibilities not collected at the time of your visit.

**Unpaid amounts may be charged to your payment card once verbal permission has been received.** A receipt will be mailed to you along with a statement for any amounts billed to your payment card for your records.

***Authorization:***

I authorize Creekside Physical Medicine to charge my payment card for the balance of fees not paid by my insurance carrier. I understand that this will only happen once verbal permission has been given by me to Creekside Physical Medicine. In all instances a receipt will be mailed to me.

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Card Holder Name & Zip Code

Card Holder Signature

Date

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Card Number

Expiration Date

Card Type:   Master Card  
                  Visa

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**DIRECTIONS TO  
Creekside Physical Medicine  
5387 Manhattan Cir Suite 201 • Boulder, CO 80305  
Phone: (303) 494 2705 Fax: (303) 494 2706**

*CPM is located at the intersection of US-36, Foothills Pkwy, Table Mesa Rd and South Boulder Rd,  
just east of the PDQ gas station.*

**FROM DENVER / SUPERIOR / LOUISVILLE:**

Start out on I-25 North.

Merge on to US-36 West via exit 217 on the LEFT towards Westminster/Boulder.

Take the CO-157 North/Foothills Parkway exit towards CU Stadium.

Take the South Boulder Road ramp towards Table Mesa Drive (on the RIGHT).

Turn RIGHT on to South Boulder Road.

Take the SECOND RIGHT on to Manhattan Circle.

5387 Manhattan Circle, Suite 201

Boulder, CO 80303

**FROM LONGMONT:**

Start out on CO-119 South/Diagonal Highway.

It will become CO-157 South/Foothills Parkway.

Take the Table Mesa Drive/South Boulder Road exit.

Turn LEFT on to South Boulder Road.

Take the SECOND RIGHT on to Manhattan Circle.

5387 Manhattan Circle, Suite 201

Boulder, CO 80303

**FROM BOULDER:**

Start out on US-36 East.

Take the Table Mesa Drive exit towards South Boulder Road.

Turn LEFT on to Table Mesa Drive/South Boulder Road.

Take the SECOND RIGHT on to Manhattan Circle.

5387 Manhattan Circle, Suite 201

Boulder, CO 80303

**FROM LAFAYETTE:**

Start out heading WEST on South Boulder Road.

Turn LEFT on to Manhattan Circle (BEFORE Foothills Parkway).

5387 Manhattan Circle, Suite 201

Boulder, CO 80303

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**AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION**

I, \_\_\_\_\_,

DOB: \_\_\_\_\_,

Address:

\_\_\_\_\_ hereby authorize Creekside Physical Medicine to request and receive my healthcare information.

**SENSITIVE INFORMATION:** I understand that the information in my record may include information relating to sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and/or drug abuse.

**REDISCLASURE:** I understand that any disclosure of information carries with it the potential for re-disclosure, and that the information may not be protected by federal confidentiality rules.

**RIGHT TO REVOKE:** I understand that I have the right to revoke this authorization at any time, and that my revocation must be in writing. I understand that the revocation will not apply to information already released based on this authorization.

**OTHER RIGHTS:** I understand that authorizing the disclosure of this health information is voluntary, and that I can refuse to sign this authorization. I understand that I may inspect or obtain a copy of the information to be used or disclosed.

**EXPIRATION:** Unless otherwise revoked, I understand that this release will be effective for all past, present, and future periods of treatment at Creekside Physical Medicine.

**Signature of Patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If signed by a legal representative, relationship to patient: \_\_\_\_\_

**FOR OFFICE USE ONLY:**

CPM's contact information:

Creekside Physical Medicine  
5387 Manhattan Circle, Suite 201  
Boulder, CO 80303

Fax: 303-494-2706 Phone: 303-494-2705

**Facility:**

**Requesting:**

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**HEALTH HISTORY FORM**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

SS# \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Sex M/F Height \_\_\_\_\_ Weight \_\_\_\_\_ Occupation \_\_\_\_\_

Referred By: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Other Physicians \_\_\_\_\_

Reason(s) for Visit: \_\_\_\_\_

How and when did this problem begin? \_\_\_\_\_

How long does it last? \_\_\_\_\_

What makes it better? \_\_\_\_\_

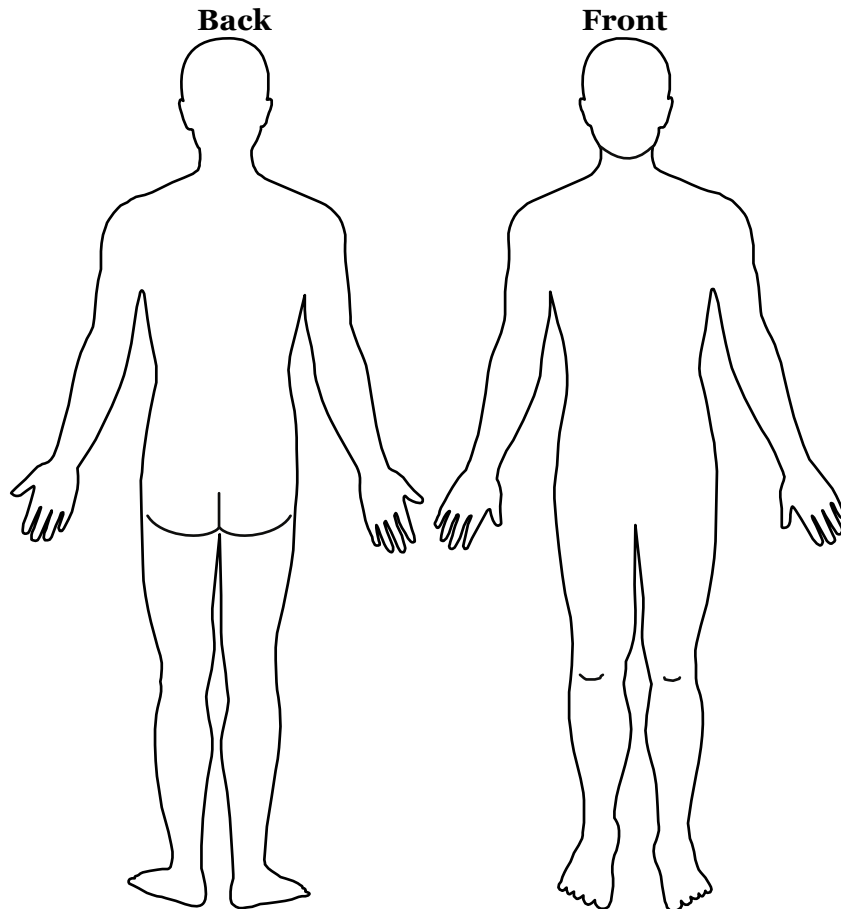
What makes it worse? \_\_\_\_\_

What treatments have you had for this problem? Include medications. \_\_\_\_\_

List any diagnostic tests for this problem? \_\_\_\_\_

If so, please bring films AND reports.

Do you have body pain? Mark X's for aches, O's for sharp pain, and .'s for electrical.



**CREEKSIDE PHYSICAL MEDICINE**

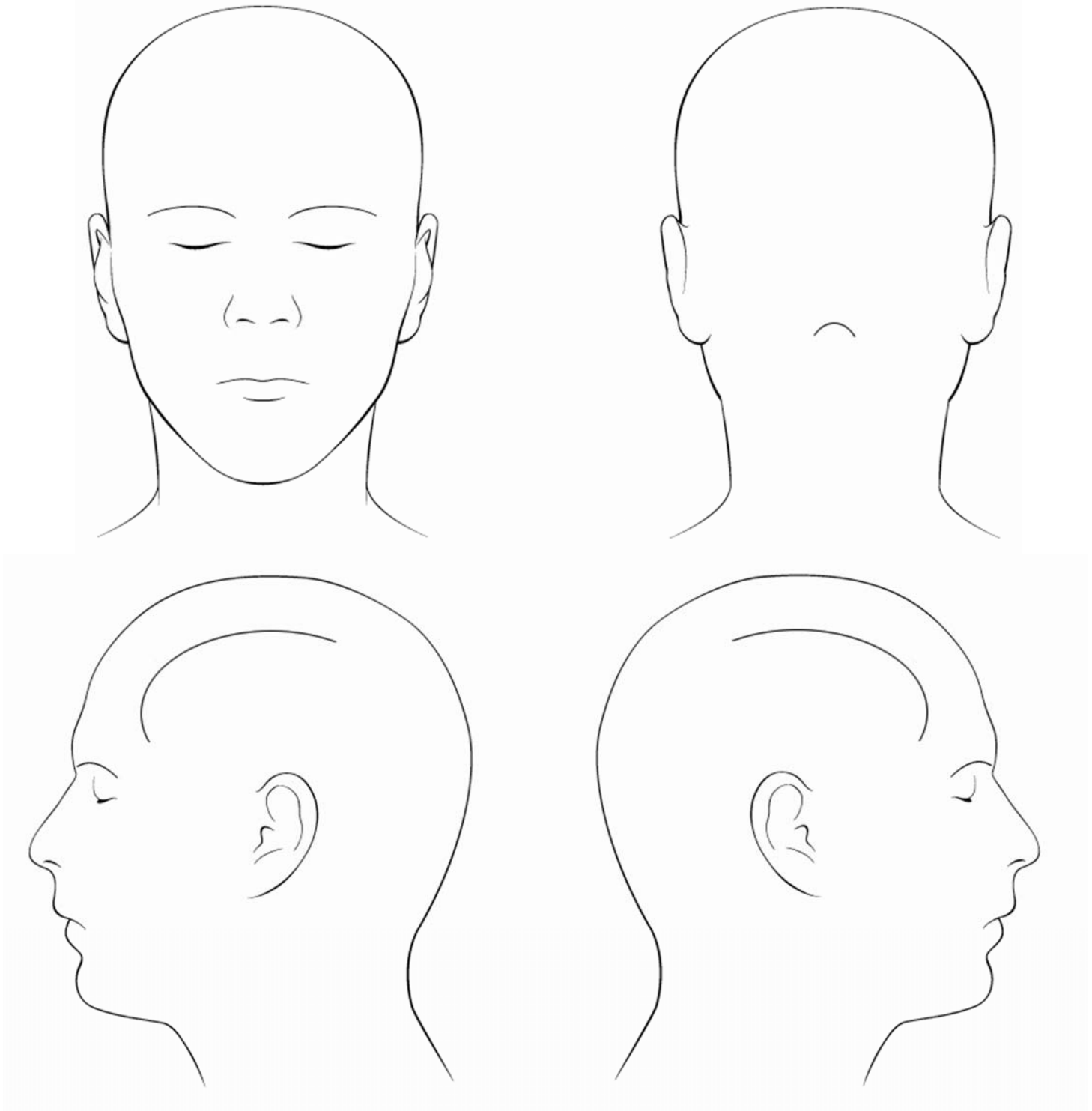
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**If you have headaches or neck pain, please state where they begin and how they progress.**

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**Draw pain progression with (X)'s for aching pain, (V)'s for sharp pain, (.)'s for electrical pain/sensitive areas, (O)'s for pressure. Use arrows to indicate where the pain begins and where it goes.**



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**Past Medical History - Please check all that apply.**

- pain disorders (fibromyalgia, chronic pelvic pain, etc);
  - respiratory disease (sleep apnea, COPD, asthma)
  - sleep disorders (treated insomnia/daytime fatigue, sleep apnea, shift work )
  - cancer history
  - cardiovascular disease (MI, cardiac chest pain, hypertension)
  - diabetes/metabolic syndrome
  - blood borne disease (HIV/AIDS/Hepatitis B or C)
  - migraine
  - cluster headache
  - tension/stress headache
  - cerebrovascular disease (TIA/stroke)
  - depression diagnosis
  - anxiety diagnosis
  - irritable bowel syndrome
  - chronic fatigue syndrome
  - sinus disease/headache
  - arthritis
  - rheumatological disease
  - seizure diagnosis
  - arrhythmias
  - thyroid disease
  - bleeding disorders
  - anti coagulant therapy (coumadin, aspirin)
  - MAOI therapy
  - kidney disease
  - liver disease
  - peptic ulcer disease
  - Other \_\_\_\_\_
- 

**Review of Systems - Please circle current symptoms and underline previous symptoms.**

**GENERAL** insomnia, fatigue, weight change, chills, fever

**EYES** blurred vision, double vision, light sensitivity, eye pain, eye discharge, eye redness

**GI** abdominal pain, nausea, vomiting, diarrhea, constipation

**HEAD** chronic sinus congestion, post nasal drip, snoring, persistent dental problems

**EARS** hearing loss, ear pain, sound sensitivity

**NEUROLOGICAL** bowel incontinence, bladder incontinence, scintillating scotoma,  
visual floaters, scalp sensitivity, buzzing in ears, dizziness, limb weakness,

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**Review of Systems Continued** - Please circle current symptoms and underline previous symptoms.

**NEUROLOGICAL** limb numbness, tingling, sensory changes, speech changes, focal weakness, headaches, seizures, loss of consciousness

**PSYCHIATRY** anxiety, depression, suicidal ideas, substance abuse, hallucination, memory loss

**MUSCULOSKELETAL** jaw pain, neck pain/pressure

**GYNECOLOGICAL**

Women Only:

Date of Last Menstrual Period? \_\_\_\_\_ Are you Pregnant? \_\_\_\_\_

Do you Have a history of Irregular Periods? \_\_\_\_\_

Is there a correlation between your complaints and your menstrual cycle? \_\_\_\_\_

If so,

**Past Surgical History(Procedure and Date):** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medication/Herbal Supplements	Dose	Reason for Medication

**Medication Allergies:** \_\_\_\_\_

(Allergies are indicated by the presences of hives, throat constriction or difficulty breathing.)

**Social History:**

Do you work at home? \_\_\_\_\_ Employed? \_\_\_\_\_

Are you Married? \_\_\_\_\_ Do you have children? \_\_\_\_\_ Ages \_\_\_\_\_

Do you exercise? \_\_\_\_\_ If so, what do you do and how often? \_\_\_\_\_

Smoke currently?  No  Yes \_\_\_\_\_ Packs per day for \_\_\_\_\_ years.

Quit smoking?  This year  >1 year  >5years  > 10 years

Previously smoked \_\_\_\_\_ packs per day for \_\_\_\_\_ years.

Drink alcohol?  Daily  1-2x/week  1-2x/month  1-2x/year

History of substance abuse?  No  Yes What? \_\_\_\_\_

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**Family History**

**Please indicate if any have a history of headache, psychiatric disorders fibromyalgia, chronic fatigue syndrome, seizure, cardiovascular disease or stroke.**

	<b>Alive</b>	<b>Deceased</b>	<b>Age</b>	<b>Health status or cause of death</b>
<b>Maternal Grandmother</b>	<b>A</b>		<b>D</b>	
<b>Maternal Grandfather</b>	<b>A</b>		<b>D</b>	
<b>Paternal Grandmother</b>	<b>A</b>		<b>D</b>	
<b>Paternal Grandfather</b>	<b>A</b>		<b>D</b>	
<b>Father</b>	<b>A</b>		<b>D</b>	
<b>Mother</b>	<b>A</b>		<b>D</b>	
<b>Sister/Brother</b>	<b>A</b>		<b>D</b>	
<b>Sister/Brother</b>	<b>A</b>		<b>D</b>	
<b>Sister/Brother</b>	<b>A</b>		<b>D</b>	
<b>Sister/Brother</b>	<b>A</b>		<b>D</b>	

**Patient Name (Please Print):** \_\_\_\_\_

**Patient /Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Reviewed By:** \_\_\_\_\_ **Date:** \_\_\_\_\_