Uptown Brain Injury and Pain Management

1601 E 19th Ave #4400 Denver, CO 80218

P. 303-863-0501 F. 303-863-0497

Patient Registration

Patient Name (Last, First Middle) ____

Street Address ____

City/State/Zip____________________________ Home Phone ______________________

Cell Phone ______________________

Date of Birth ____________________________ Work Phone ______________________

Soc Sec # ________-_________-_____________

Gender: M__ F__ Email Address ______________________________

Current Treatment: __MD __CHIROPRACTOR __PT __OPTOMETRIST __DENTIST

Auto Accident Billing Information

Name of Law Firm/Funding Company:_________________________ Date of Accident: ______________

Name if Attorney / Case Manager____

Claim / Case#: ____________________________

Adjustor / Case Manager: ______________________ Phone: ________________

Attorney: ______________________________ Phone: ________________

I hereby authorize Dr. Feldman MD and Jared Yarnell, MD to treat the above identified patient.

I acknowledge that I am responsible to pay all charges for all treatments administered by the physician to the above identified patient. I understand that insurance may not pay for all charges, and I understand that I am obligated to pay for all charges not paid by insurance. I also agree to pay reasonable attorney fees if my account is turned over to an attorney or collection agency.

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the physician and I am financially responsible for non covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims.

Patient/Patient Representative Signature: ________________________ Date: ______________

Uptown Brain Injury and Pain Management

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Name (Last, First, Middle): ____
Street Address: ____
City/State/Zip ____ DOB: __________________
Home Phone: ________________ Cell Phone: ______________ Work Phone: _______________

I authorize the release of the following protected health information to:

To:
Uptown Brain Injury
Address: 1601 19th Ave, Suite 4400, Denver, Co 80218
Phone: 303-863-0501 Fax:303-863-0497

From: _______________________________
Address: _____________________________
____
Phone: ____________________________
Fax: _____________________________

I request the release of the specific categories of information that I have initialed below:

Acquired immunodeficiency syndrome (AIDS)/human immunodeficiency virus (HIV) infection

Diagnosis and/or treatment relating to drug or alcohol abuse

Diagnosis and/or treatment relating to mental health conditions confidential details of:

__Psychotherapy Notes (Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist)
__Social Work Counseling/Therapy __Discharge Summary __Lab Reports
__Operative Reports __Pathology Reports __Imaging Reports __Orders/Progress Notes
__H&P and Consultation(s) __Other: ______________________________________

The purpose of this disclosure is:

__ Medical Care __ Legal Matter __ Insurance __ Personal __Other(please specify): _______________

I understand that:

- By signing this form, I am authorizing the use or disclosure of protected health information as indicated above.
- I may refuse to sign this authorization, which will not affect my treatment or payment for health care.
- I may revoke this authorization at any time before the information I have requested is released by providing written notice of revocation as specified in the Notice of Privacy Practices.
- lf the receiving party is not subject to medical records privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law. Advanced Neurological Evaluation and Treatment Center shall not be held liable for any consequences resulting from re-disclosure.
- This Authorization expires on __/__/__ {if date not completed / one year after signed}

Patient/Patient Representative Signature: ___________________________ Date: _____________

Uptown Brain Injury and Pain Management

NOTICE AND ACKNOWLEDGMENT OF PRIVACY POLICIES AND PROCEDURES

Patient Name: ____ Date Of Birth: _______________

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA), UPTOWN BRAIN INJURY (Practice) may not use or disclose your personal health information without your authorization. The Practice has policies and procedures to comply with HIPAA Law. Every attempt has been made to keep the process for patients and staff as efficient as possible. However, the requirements are extensive and take time, effort and cooperation to process required tasks.

Notice of Privacy Practices: This notice describes how medical information about you may be used and disclosed and how you can get access this information.

Authorization for Use or Disclosure of Protected Health Information: The Practice may not use or disclose your health information for purposes other than treatment, payment or health care operations, without your authorization. Your signature on this form indicates that you are giving permission to the people listed on the form, for the use and disclosure of the health information listed on the form, for the purpose listed on the form, to the people/organizations listed on the form. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning to this office.

Complaint: You have the right to complain about the Practice's privacy policies, procedures or actions. The Practice will not engage in any discriminatory or other retaliatory behavior against you because of a complaint. Request to Amend Protected Health Information: You have a right to request that health information that pertains to you be amended if you believe that it is incorrect or incomplete. The Practice will review your request and either grant your request or explain the reason why it will not be granted. In the event that your request is not granted, you have the right to submit a statement of disagreement that will accompany the information in question for all future disclosures.

Request for Inspection of Protected Health Information: You have a right to request the opportunity to inspect and copy health information that pertains to you. The Practice will evaluate your request and will either grant it or explain why the request will not be granted. In the event your inspection is not granted, you may request that the decision be reviewed by someone other than the person who originally denied the request.

Request for Accounting of Disclosure of Protected Health Information: You have a right to request an accounting of disclosure of health information that pertains to you.

Confidential Channel Communication Request: You have a right to request that communications concerning your personal health information be made through confidential channels. The Practice will do its best to accommodate all reasonable requests.

Designation of Personal Representative: You have a right to nominate one or more persons to act on our behalf with respect to the protection of health information that pertains to you. By making this request, you are informing the Practice of your wish to designate the named person as your personal representative. You may revoke this designation at any time by signing and dating the revocation of your copy of this form and returning it to this office.

Acknowledgment of Receipt of Notice of Privacy Practices: I acknowledge that I have received and read the above Notice of Privacy Policy and Procedures and that I have had any questions regarding this notice answered to my satisfaction.

Patient/Patient Representative Signature: ___________________________________ Date: ___________________

Uptown Brain Injury and Pain Management

NO SHOW/LATE CANCELLATION POLICY

Welcome to UPTOWN BRAIN INJURY and PAIN MANAGEMENT. It is our philosophy and commitment to deliver high quality care to our patients. Our staff will do all that they can to give you the best treatment available. In order for you to obtain optimal benefit from your treatment program, it is essential for you to promptly attend each scheduled appointment.

This policy has been established to help us serve you better.

A "no show" is missing a scheduled appointment. A "late cancellation" is canceling an appointment without calling us to cancel 24 hours in advance of an office visit and/or a procedure. Please communicate cancellations during our business hours, 8 AM to 5 PM, for emergencies we do have an answering service.

We understand that situations such as medical emergencies occasionally arise when an appointment cannot be kept and adequate notice is not possible. These situations will be considered on a case by case basis.

<u>A charge of $50.00 will be assessed for each no show or late cancellation office visit appointment if less than 24 hours notice is given.</u>

<u>A charge of $150.00 will be assessed for each no show or late cancellation test and / or procedure appointment if less than 24 hours notice is given.</u>

If you are more than 15 minutes late, you will be asked to reschedule.

If your appointment is not confirmed by 12 PM the day before you will be seem only if the providers are available.

After 2 "NO SHOWS" appointments, you will be dismissed from our practice by certified letter.

Please understand that insurance companies consider this charge to be entirely the patients responsibility.

I certify that I have read and understood the above policy.

Patient/Patient Representative Signature: ______________________________ Date: ________________

Patient/Patient Representative Printed Name: ____

Uptown Brain Injury and Pain Management

I, ______________________________, do hereby authorize Uptown Brain Injury to furnish you, ________________________, my attorney, with prepaid copies of medical records relevant to my injury or accident dated _______ for which he/she is representing me.

I further authorize and direct my attorney to pay directly to Uptown Brain Injury, such sums of monies as may be due and owing to them, (a) for medical services rendered to me for the injury and/or, (b) for any other services, supplies, or reports, and/or (c) legal medical (i.e. impairment rating reports, attorney-physician conferences, and depositions) and to withhold such sums from any settlement or judgment as may be necessary to adequately protect and pay for my treatment. I hereby grant Alexander Feldman, MD DBA Uptown Brain Injury a lien on my claim against any and all proceeds of any settlement or judgment which may be paid to you, my attorney, or myself as a result of the injuries for which I have been treated for/or other related services.

I fully understand that i am directly and fully responsible to the above health care provider for all medical bills submitted by them for services rendered to me and that this arrangement is made solely for their additional protection and in consideration of services provided. i further understand that such payment is not contingent on any insurance company's determination, with the exception of a recognized workers compensation case, as to the appropriateness of services rendered and/or fees charged.

By my signature below, I hereby waive and/or relinquish my right to contest and/or otherwise make any legal objections to the appropriateness of this agreement and that my attorney has advised me of the same.

Patient/Patient Representative Signature: ________________________________ Date: _________________

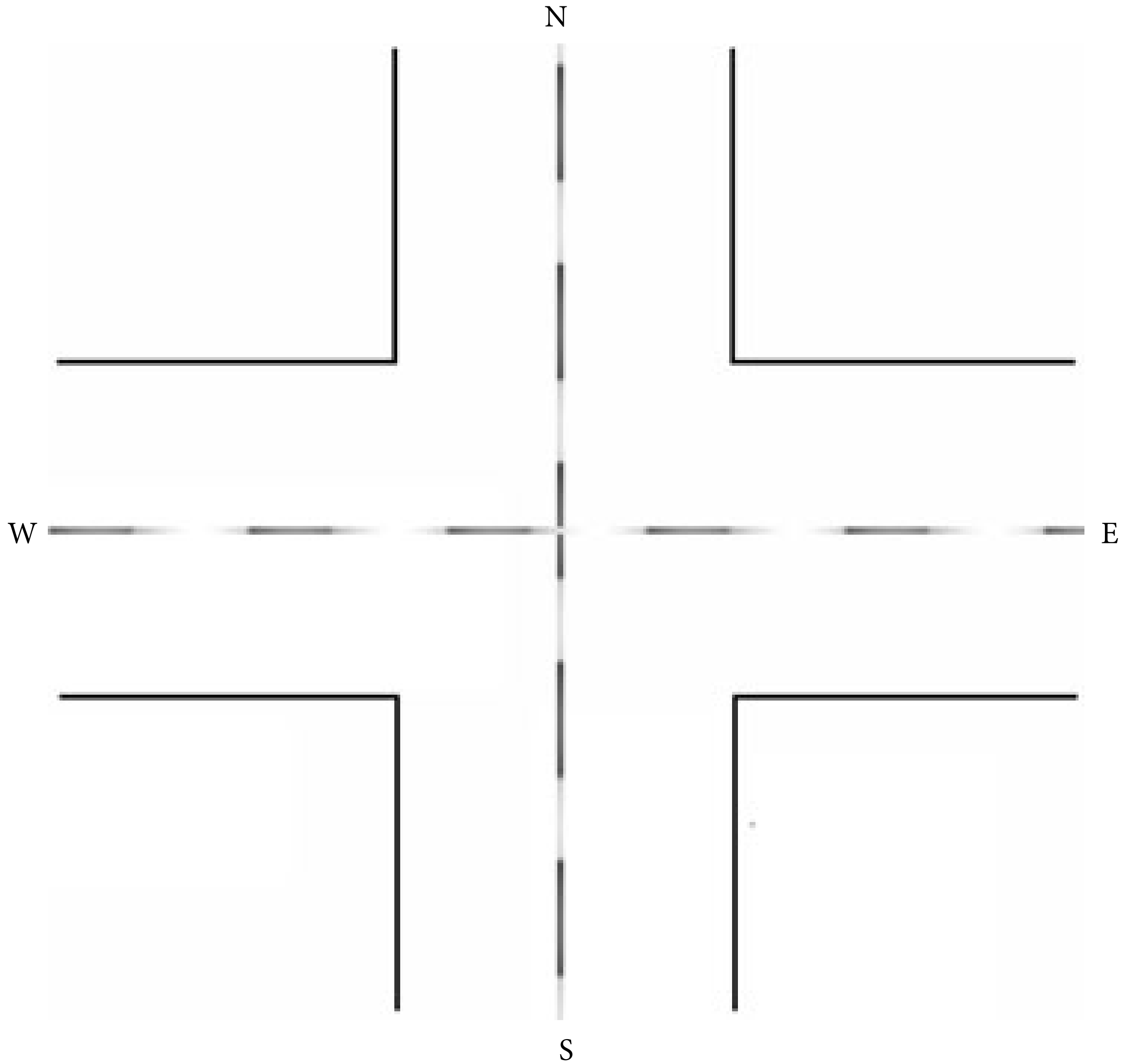
The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor above named. A photocopy of this form shall be considered as valid as the original.

Attorney's Signature: ____ Date: _________________

Uptown Brain Injury and Pain Management

Diagram of Accident

Draw a diagram of the accident showing the direction of both cars and the point of collision. Show street names and location of street signs (stop signs, etc.) Describe any other damage or pertinent details below



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Uptown Brain Injury and Pain Management

Auto Accident Questionnaire

Patient's Name: ________________________________

DOB: ________________________________

Date of Appt: ________________________________

Date of Accident: ________________________________

Time of Accident: ________________________________

What caused your accident:

____

____

____

____

Vehicle Type: ☐ Car ☐ Van ☐ Truck ☐ SUV
☐ Wagon ☐ Other ______________________

Vehicle Size: ☐ Subcompact ☐ Compact ☐ Mid-size
☐ Full-size ☐ Other ______________________

What was your location in the Vehicle:
☐ Driver ☐ Front Passenger ☐ Rear Passenger
☐ Rear Left ☐ Rear Middle ☐ Rear Right

What was the vehicle doing just before the accident:
☐ Accelerating ☐ Cruising ☐ Slowing Down
☐ Stopped ☐ Turning ☐ Other__________________

Estimated speed of the vehicle you were in: _____ mph

What damage did the vehicle you were in sustain:
☐ Minimal ☐ Moderate ☐ Extensive ☐ Totaled
☐ Unsure ☐ Other____________________________

First vehicle to strike the vehicle you were in:

Vehicle Make: _______________ Model: _____________

How did this vehicle strike the vehicle you were in:
☐ Head-on ☐ Rear-ended ☐ From Right ☐ From Left
☐ Sideswiped from Right ☐ Sideswiped from Left
☐ Other____

What type of damage did this vehicle sustain:
☐ Minimal ☐ Moderate ☐ Extensive ☐ Totaled
☐ Unsure ☐ Other____________________________

What time of day did the accident occur:
☐ Daylight ☐ Dawn ☐ Dusk ☐ Night

What was the condition of the road:
☐ Dry ☐ Wet ☐ Snow ☐ Ice ☐ Other____________

How was visibility at the time of the accident:
☐ Excellent ☐ Fair ☐ Poor (explain)_______________

Were you aware of the impending impact? ☐ Yes ☐ No

Was your foot on the brake pedal at impact: ☐ Yes ☐ No

Were you wearing a restraint belt: ☐ Yes ☐ No

What type of restraint: ☐ Lap ☐ Shoulder ☐ Lap-Shoulder

Did the vehicle you were in have head rests? ☐ Yes ☐ No

What position were the head rests in?

☐ Low ☐ Middle ☐ High ☐ Unsure

Did the vehicle have air bags? ☐ Yes ☐ No ☐ Unsure

Did the air bags deploy? ☐ Yes ☐ No

What was your body position at impact? ☐ Straight

☐ Slouched froward ☐ Rotated L/R (circle one)

☐ Unsure ☐ Other ______________________

What direction was your body thrown at impact:

☐ Backward/Forward ☐ Forward/Backward ☐ Sideways

☐ Unsure ☐ Other ______________________

What direction was your head/neck thrown at impact:

☐ Backward/Forward ☐ Forward/Backward ☐ Sideways

☐ Unsure ☐ Other ______________________

Did any part of your body strike or get hit by any part of teh vehicle or a loose object in the vehicle: ☐ Yes ☐ No

If yes, describe: ________________________________

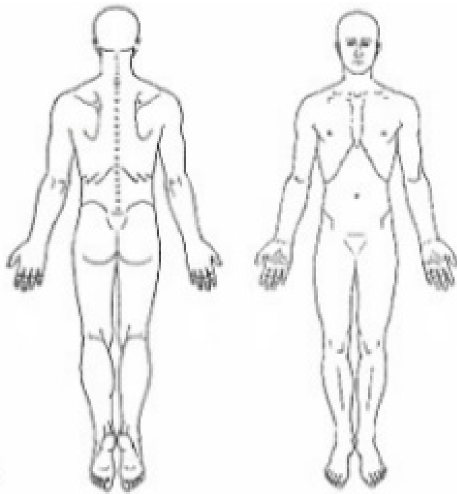
____

____

Did you lose consciousness? ☐ Yes ☐ No ☐ Unsure

How did you feel immediately after the accident?
☐ Confused ☐ Dazed ☐ Dizzy ☐ Nervous
☐ Weak ☐ Other ________________

Shade on the picture below where you immediately had pain.
Using the letter "X" mark the location on the picture below of any lacerations (cuts or scrapes)



Describe any other significant injuries: ____________
____
____

Did you receive emergency care: ☐ Yes ☐ No

If yes, what type: ☐ Bandages ☐ Splints ☐ Brace
☐ Neck Collar ☐ Other: ____________________

Where did you go following the accident? ☐ Hospital
☐ Home ☐ Work ☐ School ☐ Other" ___________

How did you go following the accident? ☐ Myself
☐ Family Member ☐ Ambulance/ground ☐ Friend
☐ Other: ________________________________

When did you go to the hospital?
☐ Immediately ☐ Later that day ☐ Next Day
☐ Days Later ☐ Other ___________ Date: ________

Hospital Name: ______________________________

Were you admitted: ☐ Yes ☐ No
Date: ___________

5. Were x-rays taken? ☐ Yes ☐ No
If yes, of what body part(s)?_______________

6. Was an MRI taken? ☐ Yes ☐ No
If yes, of what body part(s)?_______________

Was a CAT Scan taken: ☐ Yes ☐ No
If yes, what part of the body?_______________

What was the diagnosis given at the hospital:
____

What treatment was given at the hospital:
☐ Oral Medication ☐ Injection ☐ Sutures ☐ Bandages
☐ Topical Anesthetic ☐ Ice packs ☐ Hot packs ☐ Splint
☐ Brace ☐ Collar ☐ Cast ☐ Support ☐ Surgery
☐ Other: ____________________

What recommendations were made at the hospital:
☐ Rest ☐ Ice ☐ Heat ☐ Time off work
☐ Collar ☐ Support ☐ Observation ☐ No further care
☐ No follow up instructions ☐ Other: _______________

Were you told to see any of the following when discharged?
☐ General Practitioner ☐ Neurologist ☐ Chiropractor
☐ Physical Therapist ☐ Orthopedist ☐ Plastic Surgeon
☐ General Surgeon ☐ Internist ☐ Other: ______________

Were medications prescribed: ☐ Yes ☐ No
☐ Anti-inflammatory ☐ Pain reducer ☐ Antibiotic
☐ Muscle Relaxant ☐ Anti-anxiety ☐ Other: ____________

Additional comments
____
____
____

Have new symptoms developed since the accident?

☐ Yes ☐ No

2. If yes, how much later did they develop?

☐ Immediately ☐ Hours ☐ That evening

☐ Next Morning ☐ Days ☐ Weeks ☐ Months

Describe all symptoms that have developed since the accident:

____

____

____

____

____

____

____

Since your accident have you suffered from any of the following:

☐ Fatigue ☐ Weight Gain ☐ Reduced Appetite

☐ Head Injury ☐ Headache ☐ Clenching Teeth

☐ Blurred Vision ☐ Double Vision ☐ Reduced Vision

☐ Ringing Ears ☐ Sensitivity to light ☐ Difficulty Reading

☐ Depth Mis-perception ☐ Hearing Changes

☐ Sensitivity to noise ☐ Reduced smell or taste perception

☐ Dizziness ☐ Vertigo ☐ Loss of Balance

☐ Nausea ☐ Vomiting ☐ Chest Pain

☐ Shortness of breath ☐ Flashbacks of the Accident

☐ Seizures ☐ Poor memory ☐ Confusion

☐ Startling ☐ Driving Anxiety ☐ Attention Defects

☐ Insomnia ☐ Depression ☐ Palpitations

☐ Anxiety ☐ Incontinence ☐ Cognitive Decline

☐ Forgetfulness ☐ Decreased Libido ☐ Neck Pain

☐ Mid-back Pain ☐ Lower Back Pain ☐ Numbness

☐ Tingling ☐ Muscle Spasm ☐ Weakness

☐ Cold Hands ☐ Cold Feet ☐ Other: ________________

Are you restricted in any of the following areas as a result of this accident?

☐ Occupation / Work ☐ Recreational Activities

☐ Activities of Daily Living

☐ Other: ____

How much work have you missed because of this accident?

☐ Missed No Work ☐ Limited / restricted work activity

☐ Missed work from: ____/____/____ to: ____/____/____

☐ Other: ____

What self treatments have you tried?

☐ Ice ☐ Heat ☐ Bed rest ☐ Over-the-counter medication

☐ Nothing ☐ Other: ______________________

8. Have you been seen by orreceived medical care from any of the following?

☐ General Practitioner ☐ Name: ______________________

☐ Neurologist ☐ Name: ______________________

☐ General Surgeon ☐ Name: ______________________

☐ Orthopedist ☐ Name: ______________________

☐ Dentist ☐ Name: ______________________

☐ Psychiatrist ☐ Name: ______________________

☐ Plastic Surgeon ☐ Name: ______________________

☐ Chiropractor ☐ Name: ______________________

☐ Massage Therapist ☐ Name: ______________________

☐ PT ☐ Name: ______________________

☐ Other: ___________ ☐ Name: ______________________

Have you had any of the following tests?

☐ X-Ray ☐ MRI ☐ CT Scan

☐ Electrodiagnostic Studies ☐ None

☐ Other: ____

Why are you seeking treatment at this office?

☐ Persistent Complaints ☐ Worsening Symptoms

☐ Other: ____

____

____

____

____

Please list any medical illness or disease:

____
____
____
____

Please list all past surgeries.

Type:__________________ When:________________

Type:__________________ When:________________

Type:__________________ When:________________

Type:__________________ When:________________

Previous trauma (automobile, accident, fracture, strains)

Year: _________ Injury/Accident:_________________

Year: _________ Injury/Accident:_________________

Year: _________ Injury/Accident:_________________

Year: _________ Injury/Accident:_________________

Please list any social habits:

☐ Alcohol ☐ Tobacco ☐ Caffeine ☐ Drugs

Education completed:

☐ Elementary School ☐ High School ☐ Vocational

☐ Some College ☐ College Degree ☐ Advanced Degree

Please list any medications you take

Medication	Dosage	Frequency

Doctors Notes

____
____
____
____
____
____
____
____
____