CONSENT FOR TREATMENT/ HIPAA AGREEMENT- 2024

I, THE UNDERSIGNED, A PATIENT OF COLORADO INSTITUTE OF SPORTS MEDICINE, LLC, DO HEREBY AUTHORIZE THE COLORADO INSTITUTE OF SPORTS MEDICINE, LLC PERSONNEL TO ADMINISTER TREATMENT AS IS NECESSARY TO TREAT MY CONDITION. I ALSO UNDERSTAND THAT UNAUTHORIZED USE OR DISCLOSURE OF MY INFORMATION SHALL BE REPORTED TO THE COLORADO INSTITUTE OF SPORTS MEDICINE, LLC PRIVACY OFFICER WHO WILL INVESTIGATE AND WILL RESULT IN DISCIPLINARY ACTION UP TO AND INCLUDING TERMINATION OF EMPLOYMENT/CONTRACT/ASSOCIATION AND THE IMPOSITION OF FINES UNDER APPLICABLE STATE AND FEDERAL LAWS.

I UNDERSTAND THAT AS A PATIENT I HAVE THE RIGHT TO MAKE INFORMED DECISIONS REGARDING MY PLAN OF CARE AND THAT I HAVE THE RIGHT TO FURTHER ADVICE, IF NECESSARY, TO HELP ME MAKE DECISIONS. I HAVE THE RIGHT TO REFUSE MEDICAL CARE AND TO KNOW THE POSSIBLE RESULTS OF REFUSING THE TREATMENT AND CARE OFFERED. I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND ME. FURTHERMORE, I UNDERSTAND THAT AS A COURTESY, COLORADO INSTITUTE OF SPORTS MEDICINE, LLC WILL PREPARE INSURANCE FORMS AND BILL MY INSURANCE COMPANY UTILIZING THE SERVICES OF INTEGRITY BILLING. I HEREBY REQUEST THE ASSIGNMENT OF ALL INSURANCE BENEFITS TO COLORADO INSTITUTE OF SPORTS MEDICINE, LLC. I AM ULTIMATELY RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED UNLESS OTHERWISE PROVIDED BY LAW. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR PAYING MY CO-PAY AT THE TIME OF SERVICE. IN ADDITION, I UNDERSTAND THAT I AM RESPONSIBLE FOR MY DEDUCTIBLE AND CO-INSURANCE.

CANCELATION/ NO-SHOW POLICY – PLEASE BE COURTEOUS TO OTHER PATIENTS. WE TRY OUR BEST TO ACCOMMODATE EVERYONE'S SCHEDULE AND REQUEST THAT YOU HELP US TO DO THAT. OUR CLINIC IS VERY BUSY, SO PLEASE DO NOT REQUEST TIMES THAT YOU ARE UNSURE OF BEING ABLE TO MAKE. I AGREE THAT ALL CANCELLATIONS MUST BE MADE 24 HOURS BEFORE THE SCHEDULED APPOINTMENT TIME. I ALSO UNDERSTAND THAT THE COLORADO INSTITUTE OF SPORTS MEDICINE, LLC WILL CHARGE $50 FOR NONCOMPLIANCE TO THIS POLICY. I AM AWARE THAT THESE CHARGES WILL BE DIRECTLY BILLED TO ME AND THAT I AM RESPONSIBLE FOR THESE CHARGES AND MY INSURANCE COMPANY WILL NOT COVER A NO-SHOW/CANCELATION FEE.

PATIENT NAME: (PLEASE PRINT)	**IS THE PATIENT A MINOR? (CIRCLE ONE)** **YES or NO**
PARENT/GUARDIAN NAME (IF PATIENT IS A MINOR): (PLEASE PRINT)	**RELATIONSHIP TO PATIENT (IF PATIENT IS A MINOR):**
PATIENT (OR PARENT/ GUARDIAN, IF MINOR) SIGNATURE:	**TODAY'S DATE:**

PATIENT DEMOGRAPHICS (REQUIRED):

PATIENT NAME:			PATIENT DATE OF BIRTH:	
SEX:	HEIGHT/WEIGHT:		RESPONSIBLE PARTY (INSURED) SSN:	
PHYSICAL ADDRESS:		CITY:	STATE:	ZIP CODE:
MAILING ADDRESS (IF DIFFERENT FROM ABOVE):		CITY:	STATE	ZIP CODE:
PRIMARY PHONE #:	OK TO LEAVE A MESSAGE? (CIRCLE) **YES or NO**		SECONDARY PHONE #:	
EMERGENCY CONTACT NAME:		EMERGENCY CONTACT PHONE #:		
EMAIL:		OCCUPATION:		

REQUIRED FOR AUTO/WORK-COMP. RELATED INJURIES <u>ONLY</u>:

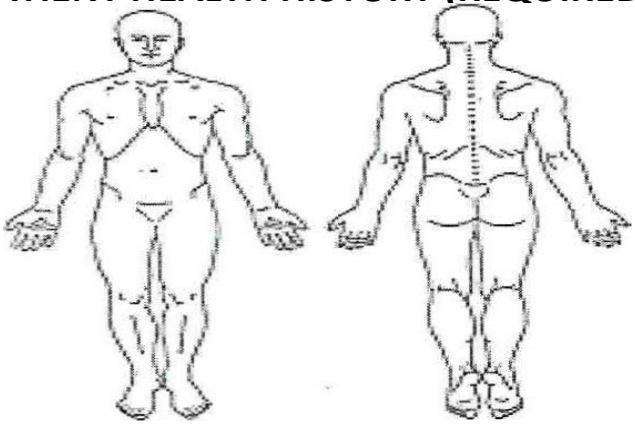
IS THIS AUTO OR WORK-COMP RELATED? YES OR NO	IF YES, WHAT WAS THE DATE OF INJURY?
DO YOU HAVE AN ATTORNEY? YES OR NO	IF YES, PLEASE LIST ATTORNEY NAME AND PHONE #:
PLEASE LIST YOUR CLAIM ADJUSTER INFORMATION: NAME: _____ CONTACT #: _____ EMAIL: _____	PLEASE LIST YOUR WORK COMP OR AUTO CLAIM INFORMATION: CARRIER NAME: _____ CLAIM #: _____

INSURANCE INFORMATION (REQUIRED):

PLEASE LIST THIS INFORMATION EVEN IF YOU ARE BEING SEEN FOR A WORKER'S COMPENSATION/ AUTO ACCIDENT CASE

PRIMARY INSURANCE (NAME OF COMPANY):	SECONDARY INSURANCE (NAME OF COMPANY): (OR WRITE N/A IF NOT APPLICABLE)
PRIMARY INS. MEMBER ID #:	SECONDARY INS. MEMBER ID#:
PRIMARY INS. POLICYHOLDER NAME:	SECONDARY INS. POLICYHOLDER NAME:

PATIENT HEALTH HISTORY (REQUIRED):



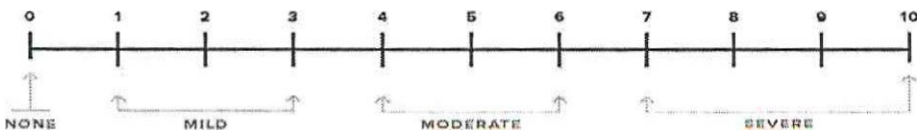
WHAT ARE WE SEEING YOU FOR? (ALSO CIRCLE AREA ON PICTURE ABOVE)	HOW DID THIS INJURY OCCUR?
REFERRING PHYSICIAN NAME:	PRIMARY CARE PHYSICIAN NAME:

HAVE YOU HAD IMAGING DONE? (CIRCLE)	**X-RAY** DATE:	**MRI** DATE:	OTHER: _____ DATE:

HAVE YOU SOUGHT MEDICAL TREATMENT FOR THIS PROBLEM BEFORE? **YES OR NO**	IF YES, WHAT TYPE OF MEDICAL PROFESSIONAL? _____
DO YOU HAVE A HISTORY OF FALLS? **YES OR NO**	IF YES, HOW RECENTLY?

CURRENT PAIN LEVEL:
O= NO PAIN,
10= EXCRUCIATING PAIN

0-10 NUMERIC PAIN RATING SCALE



HAVE YOU HAD ANY SURGERIES? **YES** **NO** IF YES, PLEASE LIST (INCLUDING DATES):

_____

_____

RELEASE OF PATIENT INFORMATION/MEDICAL RECORDS/TREATMENT:

PHYSICIAN(S):	DR.
SPOUSE/SIGNIFICANT OTHER:	
LAWYER:	
OTHER:	

PLEASE CIRCLE *ANY* OF THE FOLLOWING MEDICAL DIAGNOSES THAT YOU ***HAVE HAD*** OR ***CURRENTLY HAVE***:

HEART DISEASE	ANXIETY	CANCER	FIBROMYALGIA	ARTHRITIS
HEART ATTACK	BACK PAIN	BROKEN BONES	TRAUMATIC BRAIN INJURY (TBI)	ULCERS
DEPRESSION	NAUSEA/VOMITING	DIABETES	HIGH BLOOD PRESSURE	ASTHMA
OSTEOPOROSIS	PREGNANCY	CHEST PAIN	LUNG DISEASE/COPD	OTHER:
HEADACHES	PSYCHOLOGICAL DISORDER(S)	INFECTION	STROKE	

MEDICATION LIST:

PLEASE LIST ALL MEDICATIONS INCLUDING OTC, VITAMINS, PRESCRIPTIONS, ETC.

Aspirin	*1 pill 200mg*	*4x per day*	*oral*

PROTECTED HEALTH INFORMATION VERIFICATION – HIPAA:

I, THE UNDERSIGNED, HAVE READ AND UNDERSTAND THE COLORADO INSTITUTE OF SPORTS MEDICINE, LLC'S "PRIVACY NOTICE". I ALSO UNDERSTAND THAT UNAUTHORIZED USE OR DISCLOSURE OF MY INFORMATION SHALL BE REPORTED TO THE COLORADO INSTITUTE OF SPORTS MEDICINE, LLC PRIVACY OFFICER WHO WILL CONDUCT AN INVESTIGATION THAT WILL RESULT IN DISCIPLINARY ACTION UP TO AND INCLUDING TERMINATION OF EMPLOYMENT/CONTRACT/ASSOCIATION AND THE IMPOSITION OF FINES ACCORDING TO APPLICABLE STATE AND FEDERAL LAWS.

PATIENT SIGNATURE (OR PARENT/ GUARDIAN, IF PATIENT IS UNDER 18):	TODAY'S DATE:

TRIGGER POINT DRY NEEDLING:

I UNDERSTAND THAT I WILL RECEIVE TRIGGER POINT DRY NEEDLING AS PART OF MY PHYSICAL THERAPY TREATMENT IF AGREED UPON BY BOTH MY THERAPIST AND ME.

DRY NEEDLING IS AN EFFECTIVE PHYSICAL THERAPY MODALITY USED IN CONJUNCTION WITH OTHER INTERVENTIONS IN THE TREATMENT OF MYOFASCIAL PAIN AND DYSFUNCTION. A SOLID FILAMENT NEEDLE IS INSERTED INTO THE SKIN AND MUSCLE DIRECTLY AT A MYOFASCIAL TRIGGER POINT. A TRIGGER POINT CONSISTS OF MULTIPLE CONTRACTION KNOTS, WHICH ARE RELATED TO THE PRODUCTION AND MAINTENANCE OF THE PAIN CYCLE.

THE BENEFIT OF DRY NEEDLING IS THAT IT PRECISELY DEACTIVATES THE TRIGGER POINT, LEADING TO BIOCHEMICAL CHANGES THAT REDUCE PAIN.

YOU SHOULD UNDERSTAND THAT THIS TECHNIQUE SHOULD NOT BE CONFUSED WITH A COMPLETE ACUPUNCTURE TREATMENT PERFORMED BY A LICENSED ACUPUNCTURIST.

ALTHOUGH PRECAUTIONS ARE TAKEN TO AVOID ALL COMPLICATIONS, RISKS OF DRY NEEDLING INCLUDE BUT ARE NOT LIMITED TO; POST-NEEDLING SORENESS, ALLERGIC REACTION, SYNCOPE (FEELING FAINT) NERVE INJURY, PENETRATION OF A VISCERAL ORGAN, INFECTION, AND HEMATOMAS.

BY SIGNING BELOW I HAVE READ AND UNDERSTAND THE DISCLAIMER IN ITS ENTIRETY AND UNDERSTAND THE RISKS AS DETAILED ABOVE.

IN ADDITION TO THE ABOVE, I ALSO UNDERSTAND THAT IF TRIGGER POINT DRY NEEDLING IS PERFORMED, THERE WILL BE *AN ADDITIONAL $15 CHARGE*, IN ADDITION TO MY NORMAL COPAY/CO-INSURANCE/DEDUCTIBLE (THIS CHARGE DOES NOT APPLY TO SELF-PAY OR MEDICAID PATIENTS):

PATIENT SIGNATURE (OR PARENT/ GUARDIAN, IF PATIENT IS UNDER 18):	TODAY'S DATE:

WHEN THESE FORMS ARE COMPLETED, PLEASE RETURN THEM TO THE FRONT DESK/ OFFICE STAFF AND BE SURE TO PRESENT YOUR INSURANCE CARDS AND PHOTO ID. ALSO PLEASE VERIFY WITH US WHETHER OR NOT YOU HAVE A PAYMENT DUE FOR YOUR SERVICE.

THANK YOU FOR BEING A PATIENT OF OURS, WE LOOK FORWARD TO WORKING WITH YOU.

Colorado Institute of Sports Medicine

***OPTIONAL* Copay/Deductible Auto-Pay Consent**

Each visit I agree my credit card will be charged $_____. I understand that this will ONLY apply for PT visits I attend, and will not be charged for cancel or no-show appointments.

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____ CVV (3 digit code) :_____
Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize ***CISM/ Phenix Therapies*** to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date

Patient Name: _____