THE CENTER FOR MANUAL MEDICINE & REGENERATIVE ORTHOPEDICS

"We help you, help yourself"

Doug Frye MD,RMSK– Regenerative Orthopedics
Dani D. Steffen, DC–Chiropractic
C. Matt Elniff PT, FAAOMPT– Physical Therapy
Tracie J. Nolan PT, FAAOMPT- Physical Therapy
Seth Harrison, CSCS- Clinic Manager

5000 SW 21ST STREET
TOPEKA, KS 66604
PHONE: 785-271-8100
FAX: 785-271-9257
WEBSITE: www.ctrmm.com

PATIENTS REQUEST FOR RECORDS

TO: ____

ADDRESS: ____

CITY: ___________________________ STATE: _______ ZIP: __________ DATE: ___________

I HERE BY AUTHORIZE THE RELEASE OF MY RECORDS OR COPIES OF SUCH AND REQUEST THAT THEY BE TRANSFERRED TO:

DOUG FRYE, MD, RMSK
DANI STEFFEN, DC
C. MATT ELNIFF PT, FAAOMPT
TRACIE NOLAN PT, FAAOMPT

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&
REGENERATIVE ORTHOPEDICS
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TOPEKA, KS 66604
PHONE: 785-271-8100
FAX: 785-271-9257

PRINT NAME: ____ DOB: _______________

SIGNATURE: ____________________________________ SIGNATURE DATE: _____________

This release is valid for up to 3 years from the Signature Date above.

RECORDS PERTAINING TO: ____

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CONFIDENTIAL PATIENT CASE HISTORY

Full Name: ____Date: _________________________

Address: ____ City: ______________________ State: ______ Zip: _________

Birthdate: _______________ Race: ___________________________ Age: ________ Sex: _______ Marital Status: M__ S__ W__ D__

Home Phone: ____________________ Cell Phone: ______________________ Work Number: _________________

Email: ____

How would you prefer to be contacted for our Appointment Reminders? Call ____ Text _____ Preferred Contact Number: ___________________

Employer: ______________________________ Occupation: _____________________ ___

Spouse/Significant Other:

Name: _______________________Employer: _________________________ Work Phone: _________________Cell Phone: ______________

Insurance: ____

Cardholders Name: ______________________________Card holders DOB: _________________

Emergency Contacts:

1) Name: _______________________ Relationship to you: ___________________ Phone #: ___________________

2) Name: _______________________ Relationship to you: ___________________ Phone #: ___________________

General Information:

How did you hear about us? _____________________________ Were you referred? YES NO By whom? ________________

Hospital Preference: ____________________________________

Do your give us permission to discuss your records with someone else? YES NO

Name: ____ Relationship: __________________________

Name: ____ Relationship: __________________________

Is your condition due to an active Motor Vehicle Accident (MVA), Worker's Compensation (WC), or Personal Injury Claim? YES NO

If yes please explain:

____

____

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I UNDERSTAND & AGREE THAT HEALTH & ACCIDENT POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER & MYSELF. FUTHERMORE, I UNDERSTAND THAT THE CENTER FOR MANUAL MEDICINE & REGENERATIVE ORTHOPEDICS WILL PREPARE ANY NECESSRY REPORTS & FORMS TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY. ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO THIS OFFICE WILL BE CREDITED TO MY ACCOUNT UPON RECEIPT. HOWEVER, I UNDERSTAND & AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME & THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT SHOULD MY INSURANCE NOT COVER MY TREATMENT.

Signature: ____ Date: ___________________________________

Guardian or Spouse's Signature: ____Date: _________________________________

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Name:____

What is your main complaint today?______________________________

____

Date current problem started: __________________________________

Are you experiencing any other joint pain today?

Yes No

Explain: ____

Do you have a durable power of attorney?

Yes No

Do <u>YOU PERSONALLY</u> have any of the following conditions?

Please Circle YES or NO

Yes No History of Cancer?

Type: ______________________________________

Yes No Have Diabetes? Last A1C: ___________________________

Yes No Past/Current use of cortisone or prednisone?

Yes No Osteoporosis?

Yes No Bowel or Bladder Issues?

Yes No Recent Fever?

Yes No Gastro-Intestinal Issues?

Yes No Unexplainable Weight Loss/Gain?

Yes No Heart Condition?

Yes No High Blood Pressure?

Yes No Epilepsy?

Yes No History of stroke?

Date (s):_________________________

Yes No Do you use tobacco products (Circle all that apply)

Vape Cigarettes Smokeless (Chew)

Yes No History of tobacco products?

Year quit:________________

Yes No History of Drug/Alcohol abuse?

Yes No Are you pregnant or nursing?

Due Date: _______________________________

Yes No History of breathing issues or Lung Disease?

Yes No Depression/Anxiety/Psychiatric History?

Elaborate:

____

Yes No Have you fallen in the last 3 months?

Yes No Were you injured?

Elaborate: ____

____

DOB: ______________________ Today's Date:_________________

Primary Care Physician: _______________________________________

Would you like access to our patient portal? Yes No

If yes please provide preferred email address:

____

Occupation: ____

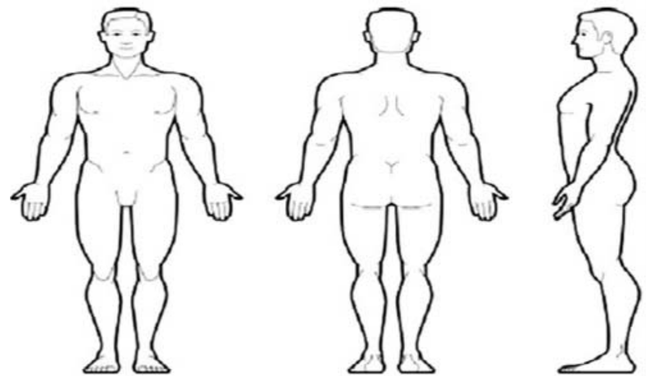
Is today's visit due to work or motor vehicle accident? Yes No

Explain: ____

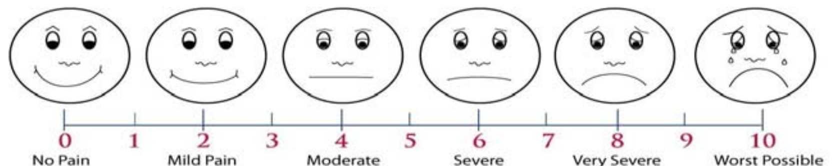
Have you had any recent diagnostic studies (imaging) done for THIS issue?

Type:	Yes	No	Date Taken:	Where were they taken?
X-ray	Yes	No	_________	_______________
MRI	Yes	No	_________	_______________
CT Scan	Yes	No	_________	_______________
EMG	Yes	No	_________	_______________

Mark the area of your body on the diagram where you are experiencing pain or discomfort.



Please rate your pain Today AND at its worst.



FOR OFFICE USE ONLY:

Height:	Blood Pressure:
Weight:	Pulse:

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Name:____ DOB:_________________________ Todays Date:__________________

Medication/Dosage:	Medication/Dosage:	Surgery/Date of Surgery:	Surgery/ Date of Surgery:

Allergies: ____

Do you have an ACTIVE infection? If so, please explain? ____

When was your last flu shot? ___________________________ Have you had the pneumonia shot? Yes No Date: _____________

Family History:

Father: Living Age: _________ Deceased Age:___________
Cause of Death if applicable: Please Circle

Stroke/Heart Condition Hypertension Diabetes Cancer: _____________________
(Type)

Autoimmune/Rheumatologic Disease Other COD:__________________________________

Mother: Living Age: _________ Deceased Age:___________
Cause of Death if applicable: Please Circle

Stroke/Heart Condition Hypertension Diabetes Cancer: _____________________
(Type)

Autoimmune/Rheumatologic Disease Other COD:__________________________________

Sibling 1: Living Age: _________ Deceased Age:___________
Cause of Death if applicable: Please Circle

Stroke/Heart Condition Hypertension Diabetes Cancer: _____________________
(Type)

Autoimmune/Rheumatologic Disease Other COD:__________________________________

Sibling 2: Living Age: _________ Deceased Age:___________
Cause of Death if applicable: Please Circle

Stroke/Heart Condition Hypertension Diabetes Cancer: _____________________
(Type)

Autoimmune/Rheumatologic Disease Other COD:__________________________________

Sibling 3: Living Age: _________ Deceased Age:___________
Cause of Death if applicable: Please Circle

Stroke/Heart Condition Hypertension Diabetes Cancer: _____________________
(Type)

Autoimmune/Rheumatologic Disease Other COD:__________________________________

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Cancellation/No Show Policy

The treatment provided at The Center for Manual Medicine is strongly based upon an educational component and your active participation. We encourage you to be consistent with your appointments because continuous treatment brings faster results. For the teamwork to be effective, your provider will work with you to set goals to be achieved, and to actively follow-up with a home program. Your home program will depend on the nature of your problem/dysfunction, the goals of treatment, and individual circumstances.

Appointment times are reserved exclusively for you. If you are unable to keep your appointment, we request you call at least 24 hours in advance to allow us to offer that time to another patient in need of treatment. Please keep in mind that not only you, but also our other patients and our staff are affected by your failure to keep appointments. **Our primary goal is to help you get better. Your full participation is critical in helping you reach this goal.**

The following charges will apply for late cancellations/no show appointments:

Cancellation with less than 24 hour notice: $25

No Show appointment: $25

Please note that 3 **cancellations and /or no show appointments** may result in your discharge from treatment and notification will be sent to your physician.

I have read the Policy and agree to the terms.

Signature: ____________________________________ Date: _____________________

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NOTICE OF PRIVACY PRACTICE FOR PROTECTED HEALTH INFORMATION FOR THE CENTER FOR MANUAL MEDICINE

The Center for Manual Medicine & Regenerative Orthopedics is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations during the time we maintain your records. Protected health information is the information we create and obtain in providing our services to you. Such information my include documenting your symptoms, examination, and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of Uses of Your Health Information for Treatment Purposes are:

- A medical assistant obtains treatment information about you and records it in a health record.
- During the course of your treatment, the physician determines they will need to consult with another specialist in the area. They will share the information with such specialist and obtain their input.
- The pharmacy calls to discuss the prescription given to you earlier that day to discuss side effects with other medications you are taking, including medicines given to you by other doctors.

Examples of Use of Your Health Information for Payment Purposes:

- We submit requests for payment to your health insurance company
- We will provide information to them about you and the care given.

Examples of Use of Your Information for Health Care Operations:

- We obtain services from our insurers of other business associates such as quality assessment, quality improvement, credentialing, medical review, legal services, and insurance.
- We will share information about you with such insurers or other business associates as necessary to obtain these services.

YOUR HEALTH INFORMATION RIGHTS

The health and billing records we maintain are the physical property of the office. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request to our office. We are not required to grant the request, but we probably will comply with any request granted;
- Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office;
- Request that you be allowed to inspect and copy your health record and billing record by making a request at our office;
- Appeal a denial of access to your protected health information, except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by making a request at our office. We may deny your request if you ask us to amend information that:
    - The record was no created by us;
    - Is not part of the health information kept by or for the office;
    - Is not part of the information that you would be permitted to inspect and copy; or,
    - Is accurate and complete.

  If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records;
    - Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a request to our office. An accounting will not include uses and disclosures of information for treatment, payment, or operations; disclosures or uses made to you at your request; uses or disclosures made pursuant to an authorization signed by you; uses or disclosures made in a facility directory or to family members or friends relevant to that person's involvement in your care or in payment for such care; or, uses or disclosures to notify family or others responsible for your care of location or your condition.
    - Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office, except to the extent information has been disclosed or action has already been taken.

If you wish to exercise any of the above rights, please contact The Center for Manual Medicine & Regenerative Orthopedics, 5000 SW 21st Street, Topeka, Kansas 66604
(785) 271-8100 in person or in writing, during regular business hours. You will be informed of the steps that need to be taken to exercise your rights.

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Our responsibilities: Our office is required to;

- Maintain the privacy of your health information a required by law;
- Provide you with a notice as to our duties and privacy practices as to duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and,
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy or by visiting our office to receive a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact The Center for Manual Medicine & Regenerative Orthopedics, (785) 271-8100. Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the complaint to The Center for Manual Medicine & Regenerative Orthopedics. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from this office.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

OTHER DISCLOSURES AND USES

Notification: Unless you object, we may use or disclose your protected health information to notify you on your telephone message center and notify a family member, personal representative, or other person responsible for your care, about your condition.
Research: We may disclose information to researchers and ensure the privacy of your protected health information.
Disaster Relief: We may use and disclose your protected health information to assist in disaster relief efforts.
Food and Drug Administration (FDA): We may disclose to the FDA your protected health information relating to adverse events with respect to food, supplements, medications, products and product defects, or post– marketing surveillance information to enable product recalls, repairs, or replacements.
Worker Compensation: If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.
Public Health: As authorized by law, we may disclose your protected health information to the public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; to notify a person who may have been exposed to a disease or who is at risk for contraction or spreading a disease or condition.
Abuse & Neglect: We may disclose your protected health information to public authorities as allowed by las to report abuse or neglect. **Employers:** Except in cases involving workers' compensation, disclosures to your employer will be made only if you execute a specific authorization for the release of that information to your employer.
Correctional Institutions: If your are an inmate of a correctional institution, we may disclose to the institution or its agents the protected health information necessary for your health and the health and safety of other individuals.
Law Enforcement: We may disclose you protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecution, or to the extent an individual is in the custody of law enforcement. **Health Oversight:** Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities. **Judicial/Administrative Proceedings:** We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order. **Serious Threat:** To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public. **For Specialized Governmental Functions:** We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel. **Coroners, Medical Examiners, and Funeral Directors:** We may release health information to a coroner, medical examiner or funeral director. **Other uses:** Other uses and disclosures, besides those identified in the Notice, will be made only as otherwise required by law or with your written authorization and you may revoke the authorization as previously provided in this Notice under "Your Health Information Rights."

⇒ **Patient Signature:** ____**Date:**_____________________