YELLOWSTONE SPORTS MEDICINE

PATIENT INFORMATION

New ___ Update___

Patient's Legal Name____ Today's Date____________

Address ______________________City__________State____ZipCode __________ Home Phone ______________
(Leave Message? **Y / N**)

Sex_______ Age _______ D.O.B. _________________ SS# ___________________ Work Phone______________
(Leave Message? **Y / N**)

E-mail____________________________________Marital Status ______________ Cell Phone ______________
(Leave Message? **Y / N**)

Employment Status___________Employer's Name _________________ Employer's Address_________________

Spouse Name _____________________________________D.O.B____________ Home Phone______________

Spouse Address (if different)______________City_________State___ZipCode_______Cell Phone_______________

Patient's Emergency Contact:___________________________ D.O.B. ____________ Phone___________________

Emergency Contact Relation to Patient: ____

Patient's Pharmacy/Location:____

Patient's Primary Care Physician _____________________ Patient's Referring Doctor: _______________________

How did you hear about us?____

PARENT INFO IF PATIENT IS UNDER 18 YEARS OF AGE:
Please list all parent names, work phone for each, home address & phone number if different from patient:

Name____________________Relationship_______Address__________________________Phone______________

Name____________________Relationship_______Address__________________________Phone______________

DO YOU HAVE INSURANCE? Yes ___ No ___ If Yes, Name of Carrier: __________________ID#________________
Insurance Card Holder Name ______________________________ Social # of Card Holder:__________________
Home Phone Number ___________________ D.O.B. ________________ Relation to Patient _________________
Home Address ____

SECONDARY INSURANCE? Yes ___ No ___ If Yes, Name of Carrier ___________________ID#________________
Insurance Card Holder Name ______________________________ Social # of Card Holder: _________________
Home Phone Number ___________________ D.O.B. ________________ Relation to Patient _________________
Home Address ____

WORKER'S COMPENSATION:
Workers' Comp Insurance Company _________________________________ Claim #:_____________________
Injured Body Part: ______________________________________ Date of Injury: ____________________________
Employer's Name & Phone Number (**at time of injury**) ____
Are you working now? **Yes** _____ **No** _____ Have you filed a claim with your employer?_____________________

******IS LEGAL ACTION OR LITIGATION PENDING FOR THIS INJURY? ___ Yes ____ No********
If so, due to time constraints, Yellowstone Sports Medicine may not be able to become involved in your care.

Yellowstone Sports Medicine, L.L.C. is committed to providing the best treatment possible for our patients at rates that are usual and customary for our area. You are responsible for payment in full regardless of the interpretation of what is "usual and customary" by a given insurance company.

PAYMENT IS EXPECTED AT TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS ARE MADE
ALL APPOINTMENTS NOT CANCELLED WITHIN 24 HOURS OR NO SHOWS ARE SUBJECT TO A $50.00 FEE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a Notice of Privacy Practices of Yellowstone Sports Medicine, L.L.C. I understand that my Protect Health Information (PHI) may be used and disclosed for the purposes of TREATMENT, PAYMENT and HEALTHCARE OPERATION of the practice.

____________________ ____________________

Date Patient Signature

____________________ ____________________

Signature of Patient Representative Relationship

(Required if the patient is a minor or an adult who is unable to sign)

WRITTEN AUTHORIZATION FOR RELEASE OF PHI

I hereby authorize Yellowstone Sports Medicine, L.L.C. to discuss my Protected Health Information (PHI) with the following person. Should I wish to revoke this authorization I understand I must do so in **WRITING**.

NAME____________________ PHONE ____________________

RELATIONSHIP ____________________

____________________ ____________________

Date Patient Signature

____________________ ____________________

Signature of Patient Representative Relationship

(Required if the patient is a minor or an adult who is unable to sign)

CONSENT TO ASSIGNMENT OF BENEFITS AND PROMISE TO PAY

Benefits to Physicians:

I hereby assign all of my rights to insurance benefits and instruct my insurance company to make payments directly to Yellowstone Sports Medicine, L.L.C. and/or its physicians for the benefits provided.

Promise to Pay:

I understand and agree that I am responsible to pay for all services provided to me by Yellowstone Sports Medicine, L.L.C. and its staff, and other orthopedic physicians and assistants that may be utilized during surgery. If I fail to pay for the services when they are rendered or on a signed agreed payment schedule, I will be responsible for all costs of collection, including but not limited to, interest at the rate of one and a half percent (1.5%) per month or eighteen percent (18%) per year, court costs and fees, attorney fees, and a collection fee of thirty five percent (35%) of the unpaid balance assigned for collection.

CLIENT IS SOLE RESPONSIBLE FOR PAYMENT OF ALL MEDICAL BILLS/LIENS, KNOWN AND UNKNOWN.

____________________ ____________________

Date Patient Signature

____________________ ____________________

Signature of the patient Representative Relationship

(Required if the patient is a minor or an adult unable to sign)

Medical History Form
(Please use black ink)

Patient Name: ______________________________ Date of Birth: __________ Appointment Date: ____________

Age:_____ Sex: ◻ F ◻ M Height: ______Weight: ______ Dominant hand: ◻ R ◻ L Latex Allergy? ◻ Y ◻ N

What body part is involved? (Please mark the table below)

Shoulder	Elbow	Wrist	Hand	Hip	Knee	Ankle	Foot	Neck	Back
◻ R ◻ L	◻ R ◻ L	◻ R ◻ L	◻ R ◻ L	◻ R ◻ L	◻ R ◻ L	◻ R ◻ L	◻ R ◻ L	◻ R ◻ L	◻ R ◻ L

How long ago did it start?_____ Days_____ Weeks______ Months______ Years.

Have you had a problem like this before: ◻ Y ◻ N

Check the ONE BOX which best described HOW your problem started. Then answer the questions below the box you checked. Use as much space to the right as needed.

- ☐ NO INJURY (or onset was: ◻ Gradual or ◻ Sudden)
- ☐ INJURY (◻ Sport ◻ Accident (NOT Auto or Work)
  Date:___________ What Sport?___________ School?_________________
- ☐ INJURY AT WORK
  Date:___________ From a: ◻ Lift ◻ Twist ◻ Fall ◻ Bend ◻ Pull ◻ Reach
- ☐ WORK RELATED BUT NO INJURY
  Date:___________ How did your job cause the problem?_________________________
- ☐ AUTO ACCIDENT
  Date:___________ How was your car hit?___________________________

On a scale of 0-10 (10 is the worst) how severe is your pain? 0 1 2 3 4 5 6 7 8 9 10

What is the quality of the pain? ◻ Sharp ◻ Dull ◻ Stabbing ◻ Throbbing ◻ Aching ◻ Burning

The pain is: ◻ Constant ◻ Comes and goes (intermittent)

Does your pain wake you from your sleep? ◻ Y ◻ N

Do you have: ◻ Swelling ◻ Bruises ◻ Numbness ◻ Weakness ◻ Tingling
◻ Loss of control of bowel or bladder ◻ Locking/Catching ◻ Giving way

Since my problem started, it is: ◻ Getting better ◻ Getting worse ◻ Unchanged

What makes your symptoms worse? ◻ Standing ◻ Walking ◻ Lifting ◻ Exercise ◻ Twisting ◻ Lying in bed
◻ Bending ◻ Squatting ◻ Kneeling ◻ Stairs ◻ Sitting ◻ Coughing ◻ Sneezing

Which makes your symptoms better? ◻ Rest ◻ Elevation ◻ Ice ◻ Heat ◻ Other:____________________

Have you had any of these treatments? Injection: ◻Y ◻N Brace: ◻Y ◻N Physical Therapy: ◻Y ◻N Cane/Crutch: ◻Y ◻N

Were you seen in the E.R. for this problem? ◻ Y ◻ N Which E.R.? _______________ Date: _______________

What tests have you had for this problem?
◻ X-Rays ◻ MRI ◻ CT Scan ◻ Bone Scan ◻ Nerve Test (EMG/NCV) Where? ____________________

Have you had a prior problem with this same orthopaedic condition in the past? ◻ Y ◻ N (explain below)

____

Have you already had surgery for a problem in this same area either recently or in the past? ◻ Y ◻ N

Please list below:

Procedure #1_______________ Surgeon _______________City_______________ Date__________
Procedure #2_______________ Surgeon _______________City_______________ Date__________

List all medications you are currently taking: ____

____

ALLERGIC TO ANY MEDICATIONS AND/OR FOODS? ◻ Y ◻ N If yes, please list and describe reaction:____

ALLERGIC OR SENSTIVE TO ANY METALS? ◻ Y ◻ N If yes, please list and describe reaction:____

Review of Systems

Do your other joint have: ◻ morning stiffness lasting over 30 minutes ◻ joint pain or swelling ◻ Back Pain
◻ Gout ◻ Rheumatoid arthritis ◻ Osteoarthritis
◻ prior fracture (which bone)________________ ◻ None of these

Have you had any of these symptoms? If no, mark None.

				NONE	YEAR
1) GI	◻ Heartburn, ulcers ◻ Hepatitis	◻ Nausea, Vomiting ◻ Liver disease	◻ Blood in Stool	◻	______
2) ENDO	◻ Thyroid Disease	◻ Osteoporosis	◻ Heat/Cold Intolerance	◻	______
3) CON	◻ Weight Loss	◻ Loss of Appetite		◻	______
4) EYE	◻ Blurred Vision	◻ Double Vision	◻ Vision Loss	◻	______
5) ENT	◻ Hearing Loss	◻ Hoarseness	◻ Trouble Swallowing	◻	______
6) CV	◻ Chest Pain	◻ Palpitations		◻	______
7) RS	◻ Chronic Cough	◻ Shortness of Breath		◻	______
8) GU	◻ Painful Urination	◻ Blood in Urine	◻ Kidney problems	◻	______
9) SK	◻ Frequent Rashes	◻ Skin Ulcers	◻ Lumps ◻ Psoriasis	◻	______
10) NEU	◻ Headaches	◻ Dizziness	◻ Seizures	◻	______
11) PSY	◻ Depression	◻ Sleep Disorder	◻ Drug/Alcohol Addiction	◻	______
12) HEM	◻ Easy Bleeding	◻ Easy Bruising	◻ Anemia	◻	______

13) ARE YOU HIV POSITIVE: ◻ Y ◻ N

COMMENTS:____

PAST MEDICAL HISTORY:

Are you Diabetic? ◻ Y ◻ N If Yes, treatment: ◻ Insulin ◻ Oral Medications ◻ Diet ◻ None

Are you taking, or have you ever taken, blood thinners? ◻ Y ◻ N If yes, which one?______________________

PAST SURGICAL HISTORY: What operations have you had and when? Please list:

____

____

Have you or a family member ever had a reaction to anesthesia? ◻ Y ◻ N EXPLAIN:

____

Past Hospitalizations (Not for Surgery) List Below: ◻ None

____

____

Have you ever had: ◻ Heart attack (year_____) ◻ High Blood Pressure ◻ Blood Clots (year______) ◻ Stroke
◻ Heart Failure ◻ Ankle Swelling ◻ Kidney failure ◻ Cancer (location____________) ◻ Colorectal Cancer
◻ Stomachache while taking anti-inflammatories (including Advil/Aleve) What anti-inflammatories have you already had a problem with?____
◻ Influenza Vaccine ◻ Pneumovax ◻ Mammogram ◻ Incontinence

FAMILY HISTORY:

Have any direct relatives had any of the following disorders? If so, which relatives?
◻ Diabetes ________________ ◻ High Blood Pressure ______________ ◻ Rheumatoid Arthritis ____________ ◻ NONE
Do any direct relatives have the same condition you are being seen for today? ◻ Y ◻ N

____

SOCIAL HISTORY:

Do you use tobacco? ◻ Y ◻ N If yes, packs per day _____ Patient informed of Smoking Risk? ◻ Y ◻ N
Alcohol use? ◻ Y ◻ N If yes, how often? ◻ Daily ◻ Other _____/week
Marital History: ◻ M ◻ S ◻ D ◻ W How many people live with you? ______________
Occupation: ______________________ ◻ Student
Employer:____
Current work status: ◻ Regular ◻ Light duty – (how long?____________) ◻ Not working due to this problem
◻ Disabled ◻ Retired ◻ Student
When is the last day you worked your regular job?____
Do you plan to be working 6 months from now? ◻ Y ◻ N

PLEASE SIGN: This information on this form is accurate to the best of my knowledge.

____
Signature Date

____
Provider

Patient Name: ______________________ Date: ____________

Physician Name: ______________________

DO YOU USE A CPAP OR BI-PAP? YES NO

STOP BANG SCORING MODEL

#	Question	Yes	No
1.	**Snoring** - Do you snore loudly (louder than talking or loud enough to be heard through closed doors?	Yes	No
2.	**Tired** - Do you often feel tired, fatigued, or sleepy during daytime?	Yes = 1	No = 0
3.	**Observed** - Has anyone observed you stop breathing during your sleep?	Yes = 1	No = 0
4.	**Blood Pressure** - Do you have or are you being treated for high blood pressure?	Yes = 1	No = 0
5.	**BMI** - BMI more than 35 kg/m?	Yes = 1	No = 0
6.	**Age** - Age over 50 years?	Yes = 1	No = 0
7.	**Neck Circumference** - Neck circumference over 16 inches?	Yes = 1	No = 0
8.	**Gender** - Male?	Yes = 1	No = 0

High Risk of OSA: answering yes to three or more items

Low Risk of OSA: answering yes to less than three items

Total Score = # of yes

Height (Inches) ____ BODY WEIGHT (Pounds) ____

*****************Height in inches*****************

	NORMAL						OVERWEIGHT					OBESE										EXTREME OBESITY														
BMI	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54
58	91	96	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167	172	177	181	186	191	196	201	205	210	215	220	224	229	234	239	244	248	253	258
59	94	99	104	109	114	119	124	128	133	138	143	148	153	158	163	168	173	178	183	188	193	198	203	208	212	217	222	227	232	237	242	247	252	257	262	267
60	97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179	184	189	194	199	204	209	215	220	225	230	235	240	245	250	255	261	266	271	276
61	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185	190	195	201	206	211	217	222	227	232	238	243	248	254	259	264	269	275	280	285
62	104	109	115	120	126	131	136	142	147	153	158	164	169	175	180	186	191	196	202	207	213	218	224	229	235	240	246	251	256	262	267	273	278	284	289	295
63	107	113	118	124	130	135	141	146	152	158	163	169	175	180	186	191	197	203	208	214	220	225	231	237	242	248	254	259	265	270	278	282	287	293	299	304
64	110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204	209	215	221	227	232	238	244	250	256	262	267	273	279	285	291	296	302	308	314
65	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210	216	222	228	234	240	246	252	258	264	270	276	282	288	294	300	306	312	318	324
66	118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216	223	229	235	241	247	253	260	266	272	278	284	291	297	303	309	315	322	328	334
67	121	127	134	140	146	153	159	166	172	178	185	191	198	204	211	217	223	230	236	242	249	255	261	268	274	280	287	293	299	306	312	319	325	331	338	344
68	125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230	236	243	249	256	262	269	276	282	289	295	302	308	315	322	328	335	341	348	354
69	128	135	142	149	155	162	169	176	182	189	196	203	209	216	223	230	236	243	250	257	263	270	277	284	291	297	304	311	318	324	331	338	345	351	358	365
70	132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	243	250	257	264	271	278	285	292	299	306	313	320	327	334	341	348	355	362	369	376
71	136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250	257	265	272	279	286	293	301	308	315	322	329	338	343	351	358	365	372	379	386
72	140	147	154	162	169	177	184	191	199	206	213	221	228	235	242	250	258	265	272	279	287	294	302	309	316	324	331	338	346	353	361	368	375	383	390	397
73	144	151	159	166	174	182	189	197	204	212	219	227	235	242	250	257	265	272	280	288	295	302	310	318	325	333	340	348	355	363	371	378	386	393	401	408
74	148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272	280	287	295	303	311	319	326	334	342	350	358	365	373	381	389	396	404	412	420
75	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279	287	295	303	311	319	327	335	343	351	359	367	375	383	391	399	407	415	423	431
76	156	164	172	180	189	197	205	213	221	230	238	246	254	263	271	279	287	295	304	312	320	328	336	344	353	361	369	377	385	394	402	410	418	426	435	443

Source: Adapted from *Clinical Guidelines on the Identification, Evaluation and Treatment of Overweight and Obesity in Adults: The Evidence Report.*

YELLOWSTONE SPORTS MEDICINE
Notice of Privacy Practices
HIPPA: HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

TREATMENT: Your Protected Health Information (PHI) may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health care professionals who may provide treatment or who may be consulted by staff members.

PAYMENT: Your Protected Health Information (PHI) may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

HEALTH CARE OPERATIONS: Your Protected Health Information (PHI) may be used as necessary to support the day-to-day activities and management of Yellowstone Sports Medicine. For example, information on the services you received may be used to support budgeting and financial reporting and for activities to evaluate and promote quality.

LAW ENFORCEMENT: Your Protected Health Information (PHI) may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

PUBLIC HEALTH REPORTING: Your Protected Health Information (PHI) may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

WORKERS COMPENSATION: Your Protected Health Information (PHI) will be released to Workers' Compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

LAWSUITS AND DISPUTES: Your Protected Health Information (PHI) may be disclosed in response to a court or administrative order in a lawsuit or dispute. Subject to all legal requirements we may also disclose your Protected Health Information (PHI) about you in response to a subpoena.

ADDITIONAL USES OF PERSONAL HEALTH INFORMATION

APPOINTMENT REMINDERS: Your Protected Health Information (PHI) will be used by our staff to provide you with appointment reminders.

INFORMATION ABOUT TREATMENTS: Your Protected Health Information (PHI) may be used to send you information that you may find of interest on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Other uses and disclosures of your Protected Health Information (PHI) require your WRITTEN authorization. Disclosure of your Personal Health Information (PHI) or its use for any purpose other than those listed above requires your specific WRITTEN authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a WRITTEN revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

INDIVIDUAL PATIENT RIGHTS

You have certain rights under the federal privacy standards. These include:

1) THE RIGHT TO receive a printed copy of this notice.
2) THE RIGHT TO request restrictions on the use and disclosure of your Protected Health Information (PHI).
3) THE RIGHT TO inspect and obtain a copy of your Protected Health Information (PHI).
4) THE RIGHT TO amend or submit corrections to your Protected Health Information (PHI).
5) THE RIGHT TO receive an accounting of how and to whom your Protected Health Information (PHI) has been disclosed.
6) THE RIGHT TO receive confidential communications concerning your medical condition and treatment.

YELLOWSTONE SPORTS MEDICINE DUTIES

As required by federal law, Yellowstone Sports Medicine will maintain this privacy of your Protected Health Information (PHI) and will provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to revise Privacy Practices
As permitted by federal law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. We will provide you with a revised notice at your next office visit or upon request. This revised policies and practices will be applied to all Protected Health Information (PHI) we maintain.

REQUESTS TO INSPECT PERSONAL HEALTH INFORMATION (PHI)

A patient may inspect or obtain a copy of the Protected Health Information (PHI) that we maintain. As permitted by federal regulation, all requests to inspect or obtain a copy of Protected Health Information (PHI) must be submitted in WRITING. A form to request access to your Protected Health Information (PHI) may be obtained from a receptionist or our privacy officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request. A decision to grant the patient or the patient's personal representative permission to inspect or obtain a copy of the Protected Health Information (PHI) will be made within 30 (THIRTY) DAYS of the date on which the request is submitted.

COMPLAINTS

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Compliance Officer
Yellowstone Sports Medicine
720 Lindsay Lane, Suite B
Cody, Wyoming 82414
(307) 578-1953

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person
The name and address of the person you can contact for further information concerning our privacy practices is:

Carlene Heeg, Privacy Officer
Yellowstone Sports Medicine
720 Lindsay Lane, Suite B
Cody, Wyoming 82414
(307) 578-1949

This notice is effective on or after April 14, 2003
Date Updated: September 16, 2011