Injury Care Associates

www.injurycareco.com

Patient Information

Patient Name/*Nombre del paciente*: _____ SSN: _____

Date of Birth/ *Fecha de nacimento*: _____ Date/ Fecha: _____ ☐ Male/ *Varon* ☐ Female/ *Hembra*

Phone/*Telefono*: _____ Email: _____

Street Address/ *Direccion*: _____ Unit/ *Unidad*: _____

City/*Ciudad*: _____ State/*Estado*: _____ Zip Code/*Codigo Postal*: _____

Employer/*Empleador*: _____ Occupation/*Oficio*: _____

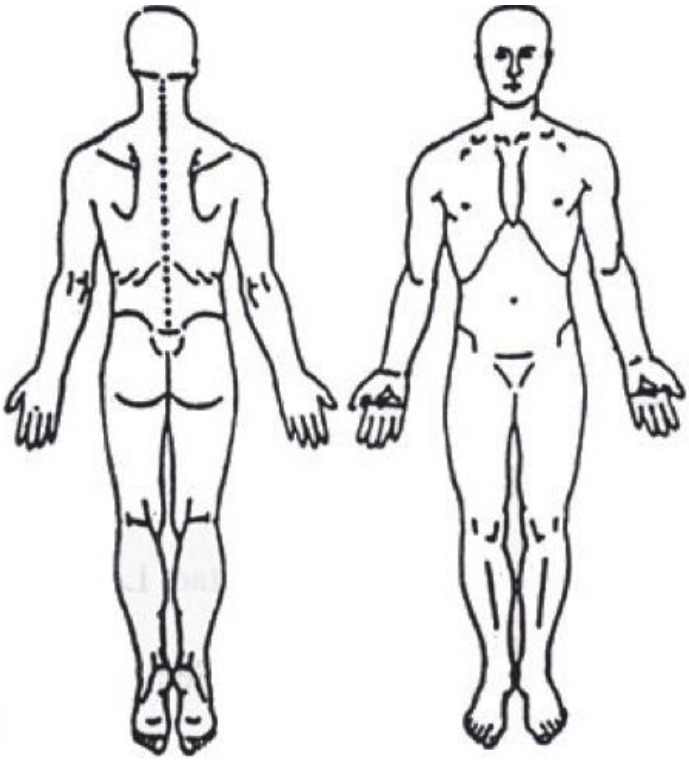
Employer Contact/*Contacto de trabajo*: _____ Employer Phone/*Numero de trabajo*: _____

Employer Address/*Direccion de trabajo*: _____

City/*Ciudad*: _____ State/*Estado*: _____ Zip Code/*Codigo Postal*: _____

Emergency Contact/*Contacto de Emergencia*: _____ Phone/*Telefono*: _____

Please note the location of your injuries on the diagram →
Por favor indique la ubicacion de sus lesiones en el diagrama



Side/ *Lado*: ☐ Right/ *Derecho* ☐ Left/ *Izquierdo* ☐ Both/ *Ambos*

Date of accident/ *Fecha del accidente*: _____

Time of accident/ *Hora del accidente*: _____

Where did the injury occur/ *Donde ocurrio la herida*? _____

_____

_____

How did you get hurt/ *Como se lesionó*? _____

_____

_____

_____

For Office Use Only/ *Sólo para uso de oficina*

BP _____ / _____ Pulse _____ O2 _____ RR _____ Temp _____ Height _____ Weight _____

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Patient Name: _____ Date of Birth: _____ Date: _____

Consent to Receive Treatment

I hereby voluntarily request and consent to the rendering of medical services by Injury Care Associates, LLC, including its affiliate practices, employees and other service providers affiliated with Injury Care Associates. I consent to the rendering of procedures and/or ancillary services, which may be administered or performed by the clinic's employees under the general or specific instruction of my physician or his or her designees. I acknowledge that no guarantees have been implied or made to me as to the results of my treatment or the outcome of services rendered by Injury Care Associates.

Furthermore, all information provided to Injury Care Associates and its medical providers and staff is accurate and up-to-date to the best of my knowledge. I authorize Injury Care Associates to provide services on my behalf using any and all information available to them.

_____

Signature of Patient or Responsible Party

Authorization for the Use and Disclosure of Medical Information

For patients requesting employment related physical evaluations, drug or alcohol testing, other Occupational Health or Workers' Compensation services to be performed by Injury Care Associates, LLC or its affiliated practices. I authorize Injury Care Associates and its affiliated practices to use and disclose health information and results about me acquired in the course of my evaluation or testing to my employer or potential employer. The information to be used and disclosed may include medical records, treatment records, surgical records, diagnostic records, psychiatric and/or psychological records, information pertaining to past or current drug or alcohol use, or previous work related injuries. I also authorize Injury Care Associates to disclose any testing results that I have submitted to including; drug and alcohol testing, or other diagnostic testing. Information obtained throughout the course of my evaluation may also be reported to any authorized regulatory agencies including but not limited to: The Department of Transportation, the State of Colorado Division of Workers' Compensation, State of Colorado Department of Public Health or other government agencies as required by law.

For patients requesting medical services pertaining to injuries sustained in an automobile or other accident. I authorize Injury Care Associates, LLC and its affiliated practices to use and disclose any and all medical information gathered during my treatment to my legal representative or lien company responsible for care coordination or payment. The information to be used and disclosed may include medical records, treatment records, surgical records, diagnostic records, psychiatric and/or psychological records, information pertaining to past or current drug or alcohol use, or previous injuries. I also authorize Injury Care Associates to disclose any testing results that I have submitted to including drug and alcohol testing, or other diagnostic testing.

This Authorization for the Use and Disclosure of Medical Information is in addition to the HIPAA Notice of Privacy Practices for Injury Care Associates, LLC or its affiliated practices.

I have been provided with and read the Authorization for the Use and Disclosure of Medical Information and consent to allow Injury Care Associates, LLC and its affiliated practices to share my Protected Health Information (PHI) in accordance with the above terms.

_____

Signature of Patient or Responsible Party

HIPAA Disclosure

I have been provided with and read the HIPAA Notice of Privacy Practices for Injury Care Associates, LLC. I consent to allow my Protected Health Information (PHI) and other information collected by Injury Care Associates, LLC to be used in accordance with the HIPAA Notice of Privacy Practices I have been provided.

_____
Signature of Patient or Responsible Party

Appointment Policy

I understand that it is my responsibility to provide a minimum of 24-hours notice in the event I am not able to attend my scheduled appointments. I understand that my Workers' Compensation or Accident Injury insurance company will be notified in the event of canceled, rescheduled, or "no-show" appointments and may be billed for "no-show" appointments. I understand that failure to abide by the treatment schedule established by my medical team may increase my recovery time and negatively impact my recovery and treatment outcome. Non-compliance with the recommend treatment schedule may result in a discharge or transfer of care.

_____
Signature of Patient or Responsible Party

Financial Disclosure

I understand and acknowledge that my Workers' Compensation or Accident Injury insurance coverage is a contract between my insurance company, my employer or legal representation and me. I understand that I will be personally responsible for all medical expenses incurred outside of either the Workers' Compensation or Accident Injury system and that it is my responsibility to immediately notify Injury Care Associates, LLC of any change in my claim status including, but not limited to: changes in insurance, cancellation of payer agreement, denial of coverage, or claim settlement. It is my responsibility to notify Injury Care Associates, LLC of any change in my personal information that may result in the denial of claims such as changes in address, phone number, or treating providers. I authorize Injury Care Associates, LLC to release all medical information in its entirety to the party responsible for the processing and payment of my claims. I assign all benefits from the claims to Injury Care Associates, LLC. I agree that a photocopy of this agreement shall be as valid as the original.

_____
Signature of Patient or Responsible Party

Consent to Bill Responsible Party

I agree to allow Injury Care Associates, LLC to bill my employers' Workers' Compensation insurance company, employer, lien holder, or legal representation for services rendered. I authorize Injury Care Associates, LLC to disclose medical, billing, demographic, or other information to my insurance company or party responsible for payment as necessary to receive reimbursement for services rendered.

_____
Signature of Patient or Responsible Party

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We attempted to obtain written acknowledgement of the above listed policies, but acknowledgement could not be obtained because:

- □ Individual Refused to Sign
- □ Communication barriers prohibited obtaining the acknowledgment
- □ An emergency situation prevented us from obtaining acknowledgement
- □ Other (specify): _____

INJURY / ILLNESS REPORT
INFORME DE LESIONES / ENFERMEDADES

1. ☐ Right Handed/ *Diestro(derecho)* ☐ Left Handed/ *Zurdo (izquierdo)* ☐ Ambidextrous/ *Ambidextro*

2. Describe your injury or illness/ *Describa su lesión o enfermedad*: _____

_____

_____

3. What makes your pain better/¿Que mejora su dolor?

_____

4. What makes your pain worse/ ¿Que empeora su dolor?

_____

5. Have you received any treatment for this injury/ *¿Ha recibido algún tratamiento para esta lesión en el pasado*? ☐No ☐Yes
If yes, describe/ *Si es así, describa*

_____

_____

6. For this injury, have you had/ *Para esta lesión, ¿has tenido*:

☐ XRAY/ *radiografía* ☐ CT ☐ MRI ☐ Surgery/ *cirugía*

☐ Ultrasound/ *Ultrasonido* ☐ EMG, Nerve Test/ *EMG, Prueba de nervio*

7. Rate the severity of your pain by circling a number 0 – 10 on the scale below:

Califique la severidad de su dolor circulando del numbero 0-10 en las escala a continuacion:

No Pain / Sin Dolor **0 1 2 3 4 5 6 7 8 9 10** ***Worst Pain / Peor Dolor***

ALLERGIES TO MEDICATIONS
ALERGIAS A MEDICAMENTOS

List all ***known or suspected*** allergies to medication, food or environment:
Enumere todas las alergias conocidas o sospechadas a medicamentos, alimentos o medioambiente:

☐ No Known Drug Allergies *(Ninguna alergia conocida a medicamentos)*

☐ Allergies or Sensitivities. Please list *(Alergias o sensibilidades. Por favor indique)*

_____

_____

_____

CURRENT MEDICATIONS
MEDICAMENTOS ACTUALES

List any medications that you are currently taking, include vitamins and supplements:
Haga una lista de los medicamentos que está tomando actualmente, incluya vitaminas y suplementos:

☐ None *(Nada)*

Name *(Nombre)* Dose & Directions *(Dosis e indicaciones)* Reason *(Razón)*

_____

_____

_____

_____

SURGICAL AND HOSPITALIZATION HISTORY
HISTORIAL QUIRÚRGICO (CIRUJIAS) Y DE HOSPITALIZACIÓN

List any surgeries or hospitalizations you have had, include the year and reason:
Haga una lista de las cirugías u hospitalizaciones que haya tenido, incluya el año y la razón

☐ None *(Ninguna)*

_____

_____

_____

PAST MEDICAL HISTORY
HISTORIAL MÉDICO

List any medical conditions, illness or disease that you have ever been diagnosed with?
Indique cualquier condición médica o enfermedad con la que alguna vez haya sido diagnosticado?

☐None *(Ninguna)*

_____

_____

_____

FAMILY HISTORY
HISTORIA DE FAMILIA

List any significant family medical history we may need to be aware of
Indique cualquier historia médica familiar importante de la que necesitemos estar informados

☐None *(Ninguna)*

☐ Diabetes ☐ Heart Problems/ *Problemas Cardiacos* ☐ Blood Clots/ *Coágulos de sangre*
☐ Blood Pressure/ *Presión Sanguínea* ☐ Addiction/ *Adicción* ☐ Early death/ *Muerte temprana*
☐ Cancer, Type/ *Cáncer, Tipo*: _____

Other/ *Otro*: _____

SOCIAL HISTORY
HISTORIA SOCIAL

1. Highest level of education completed/ *Mayor Nivel de Educación Completado* **:**

☐ High School or GED/ *Bachillerato (preparatoria) o GED* ☐ College/ *Universidad* ☐ Advanced Degree/ *grado avanzado*

2. Marital Status/ *Estado civil*: ☐ Married/ *Casado* ☐ Single/ *Soltero* ☐ Widowed/ *Viudo*

3. Have you used, or do you currently use and of the following substances/ *¿Ha usado o usa actualmente y de las siguientes sustancias?*

Caffeine/ *Cafeína*: ☐No ☐Yes
Tobacco/ *Tabaco*: ☐No ☐Yes, packs per day/ paquetes por día _____
Alcohol: ☐No ☐Yes, number of drinks per week/ número de bebidas por semana _____
Marijuana: ☐No ☐Yes
Frequency/ Frecuencia? ☐Daily/ diariamente ☐Weekly/ semanal ☐Occasionally/ Ocasional

WORK HISTORY (IF INJURY IS WORK RELATED)
HISTORIAL DE TRABAJO (SI LA LESIÓN ESTÁ RELACIONADA CON EL TRABAJO)

1. Are you currently working/*¿Esta trabajando actualmente?* ☐ No ☐ Yes. If yes/ *Si es sí,*

☐ Full-time/ *Tiempo completo* ☐ Part-time/ *Medio tiempo* ☐ As Needed/ *Segun sea necesario*

2. Occupation/ *Ocupación*: _____ Years/ *Años*: _____

3. Name of Employer/ *Nombre de empleador*: _____ How Long/ *Cuanto tiempo*: _____

4. Are you employed anywhere else/ *Está empleado en otro lado*? ☐ No ☐ Yes. Where/ *Donde*: _____

5. Do you operate machinery or power tools/ *Maneja maquinaria o herramientas electricas*? ☐ No ☐ Yes

6. Have you ever suffered a work-related injury/ *alguna vez sufrio una lesion relacionada con el trabajo*? ☐ No ☐ Yes

If yes, please explain/ *En caso afirmativo, expliquielo porfavor:* _____

_____

7. Have you ever had an Impairment Rating/ *alguna vez ha tenio una calificación de impedimento*? ☐ No ☐ Yes

If yes, what is the rating/ *En caso afirmativo, cual es la calificación*? _____

8. Do you have any Permanent Restrictions/ *tiene alguna restricción permanente*? ☐ No ☐ Yes. If yes, list/ *Si sí, indique*:

_____

REVIEW OF SYSTEMS
REVISIÓN DE SISTEMAS

Are you currently experiencing any of the following?
¿Estás experimentando alguna de las siguientes situaciones?

1. Change in appetite, chills, fatigue, fever, sweats, unexplained weight loss or gain ..... ☐No ☐Yes
   Cambio en el apetito, escalofríos, fatiga, fiebre, sudores, pérdida o pérdida de peso inexplicable
2. Blurred or double vision, use of contact lenses, eye discharge or eye pain ..... ☐No ☐Yes
   Visión borrosa o doble, uso de lentes de contacto, secreción ocular o dolor ocular
3. Dizziness, ear pain, nasal congestion, nose discharge, sneezing or sore throat ..... ☐No ☐Yes
   Mareos, dolor de oídos, congestión nasal, secreción nasal, estornudos o dolor de garganta
4. Chest pain or pressure, fainting or irregular heart beat ..... ☐No ☐Yes
   Dolor o presión en el pecho, desmayo o latido irregular del corazón
5. Congestion, cough, shortness of breath or wheezing ..... ☐No ☐Yes
   Congestión, tos, dificultad para respirar o sibilancias
6. Abdominal pain, diarrhea, nausea, urinary or bowel changes or vomiting ..... ☐No ☐Yes
   Dolor abdominal, diarrea, náuseas, cambios urinarios o intestinales o vómitos
7. Discharge, frequent urination, night time urination or painful urination ..... ☐No ☐Yes
   Secreción, micción frecuente, micción nocturna o dolor al orinar
8. Joint pain, muscle pain or swelling ..... ☐No ☐Yes
   Dolor en las articulaciones, dolor muscular o hinchazón
9. Easy bruising, rash, redness or skin sores ..... ☐No ☐Yes
   Aparición fácil de hematomas, sarpullido, enrojecimiento o llagas en la piel
10. Headache, light headedness, numbness ..... ☐No ☐Yes
    Dolor de cabeza, mareo, entumecimiento
11. History of depression, on psychiatric medication alcoholism or drug abuse ..... ☐No ☐Yes
    Historia de depresión, sobre medicamento psiquiátrico, alcoholismo o abuso de drogas
12. Diabetes, hyper or hypothyroid, heat or cold intolerance ..... ☐No ☐Yes
    Diabetes, hiper o hipotiroidismo, intolerancia al calor o al frío
13. Frequent infections or swollen glands ..... ☐No ☐Yes
    Infecciones frecuentes o glándulas hinchadas
14. Hay fever, medication allergies or food allergies ..... ☐No ☐Yes
    Fiebre del heno, alergias a los medicamentos o alergias a los alimentos

Please explain any "yes" responses/ *Por favor explique cualquier respuesta "sí":*

All information provided is accurate and up-to-date to the best of my knowledge
Toda la información es precisa y actualizada según mi leal saber y entender.

_____ _____
Patient or responsible party signature/ firma del paciente o responsable Date/ Fecha