PERFORMANCE
INJURY CARE & SPORTS MEDICINE

Out of State Patient Packet Introduction

Appointment:

- Please understand that Dr. Steele receives referrals from all over the United States and abroad, all from patients suffering from chronic pain.
- Dr. Steele books out about 12-14 weeks on average for multiple day appointments.
- Due to Dr. Steeles complicated schedule, **NO** telemedicine appointments will be scheduled before meeting with Dr. Steele in person.

Standard Two-Day Appointments:

- **Day One** is an evaluation day. To review your history, imaging, perform diagnostic ultrasound and develop a plan of care. Pretreatment may be performed if Dr. Steele deems it necessary.
- **Day Two** is procedure day. This appointment is anywhere from 1-2 hours in length. **A driver is required** if you are prescribed a sedative prior to the procedure.
- Departure from Helena is recommended for the day following your procedure to allow for recovery time before travel and to update the clinic on your pain/symptoms.

Procedures:

- The regenerative procedures are an out-of-pocket expense as most insurance companies deem them experimental or elective. We will try and provide you with an estimate of your out-of-pocket cost **AFTER** your plan of care has been established on day one.
- Procedure costs range anywhere from $1,200.00 - $5,500.00 depending upon the type of procedure and its overall complexity.

Complex Cases:

- Please understand that not all cases are a one visit and done kind of fix. Many complex cases have had numerous treatments and even surgeries performed to try and resolve the pain with little to no success. We strive to identify and resolve the complications left from other treatments, as well as determine the original problem. This approach has helped many patients improve overall function and experience a decrease in pain.

Phillip M. Steele, MD, RMSK
3150 N. Montana Ave, Suite A Helena, MT 59602
Tel: 406-422-5817 Fax: 406-422-5928
www.helenasportsmed.com

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Consultation and Treatment Program

We appreciate your interest in our clinic and the treatment options provide by Dr. Steele. To allow Dr. Steele to provide you with the most comprehensive care, we need to know a few things about your injury and what treatments options have been explored. The more we understand about your injury, symptoms, and pain patterns, the more likely we can create an appropriate treatment plan to resolve your pain. We understand that you may have already received diagnoses for your pain, but it is our job to question everything, as prior treatments may have focused on where the pain is located but not where the pain is being referred from. We pride ourselves on looking at injuries from a systemic approach focusing on correcting imbalances to decrease your pain and improve function within the whole system.

To help facilitate your visit, we need the following filled out along with the items listed below from you **BEFORE** scheduling an appointment:

Out-of-State Checklist

- Letter that outlines the possible cause for your pain, what treatments that have been explored, along with a date of injury if applicable
- Current Imaging such as MRI, CT or X-rays related to the injury – **please mail imaging discs to our location above**
- Copy of Driver's License
- Copy of Insurance Card(s)
- Referral Letter from Physician – outlining the reason for the referral
- Any office notes and imaging/injection reports from referring physician office

Please fax or email documentation back as soon as possible in order to ensure that Dr. Steele has appropriate time to review all records and imaging prior to scheduling.

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Airport

Helena Regional Airport
2850 Mercer Loop
Helena, MT 59602
www.helenaairport.com
2.9 miles from the office

Bozeman Yellowstone Airport
850 Gallatin Field Rd
Belgrade, MT 59714
https://bozemanairport.com
91.2 miles from the office

Missoula
5225 US Highway 10 W
Missoula, MT 59808
https://flymissoula.com
120.19 miles from the office

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PERFORMANCE
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Hotels Near Our Office

Residence Inn by Marriott
2500 E Custer Ave
Helena, MT 59602
406-443-8010
1.4 miles from the office

Holiday Inn Express & Suites Helena
3170 N. Sanders St
Helena, MT 59602
406-442-7500
0.5 miles from the office

Home2suites
3325 N. Sanders St
Helena, MT 59602
406-502-2222
0.9 miles from the office

Downtown Hotels

Best Western Premier Helena
835 Great Northern Blvd
Helena, MT 59601
2.1 miles from the office

DoubleTree by Hilton Helena Downtown
22 N. Last Chance Gulch
Helena, MT 59601
406-443-2200
2.5 miles from the office

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Bed and Breakfast

Bed and Breakfast
Oddfellow Inn & Farm
2245 Head Ln
Helena, MT 59602
406-587-1304
4.7 miles from the office

The Carolina
309 N Ewing St,
Helena, MT 59601
406- 422-0418
8 miles from the office

The Sanders-Helena's Bed and Breakfast
328 N Ewing St,
Helena, MT 59601
406-442-3309
8 miles from the office

Barrister Bed & Breakfast
416 N Ewing St
Helena, MT 59601
406-443-7330
7 miles from the office

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Helena, MT 59602
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F: 406-422-5928
helenasportsmed.com

Today's Date _____

Revised Date _____

Referred by _____

Patient Information

Last Name	First Name	Middle Name	Nickname	Social Security No.

Mailing Address	City	State	Zip	Home Phone

Physical Address (if different from above)	Cell Phone

Age	Date of Birth	☐ Male ☐ Female	Marital Status ☐ S ☐ M ☐ D ☐ W	Occupation	Work Phone / Ext

Employer (company / firm name)	Pharmacy	Email

Preferred Language	Ethnicity: ☐ White/Caucasion ☐ Hispanic/Latino ☐ Black/African American ☐ Native American ☐ Asian/Pacific Islander ☐ Other

Primary Insurance Information

Insurance Company Information	Policy ID No.	Group No.

#1 Policy Holder Name:	Date of Birth	Relationship to Patient

Address (if different from patient)	Home / Cell Phone

Employer	Occupation	Social Security Number

Secondary Insurance Information

Insurance Company Information	Policy ID No.	Group No.

#2 Policy Holder Name:	Date of Birth	Relationship to Patient

Address (if different from patient)	Home / Cell Phone

Employer	Occupation	Social Security Number

Emergency Contacts

Name	Phone	Relationship

Name	Phone	Relationship

Responsible Party (if patient is a minor child)

Last Name	First Name	Relationship to Patient	Date of Birth

Mailing Address	Social Security Number

Employer (if applicable)	Work Phone	Home / Cell Phone

Past Medical History

Medical Systems: Please check any of the following medical problems that you have now or have had in the past.

CARDIOVASCULAR
- ❑ High Blood Pressure
- ❑ Heart Attack
- ❑ Palpitations
- ❑ Irregular Heartbeat
- ❑ Heart Murmur
- ❑ Heart Valve Disorder
- ❑ Angina (chest pain)
- ❑ Rheumatic Fever
- ❑ Pacemaker
- ❑ Vascular Disease
- ❑ Other _____

RESPIRATORY
- ❑ Asthma
- ❑ Emphysema
- ❑ COPD
- ❑ Chronic Bronchitis
- ❑ Pneumonia
- ❑ Sleep Apnea
- ❑ Tuberculosis
- ❑ Chronic Cough
- ❑ Require Supplemental Oxygen
- ❑ Other _____

ABDOMINAL
- ❑ Ulcer
- ❑ Polyps
- ❑ Hiatal Hernia
- ❑ Gallstones
- ❑ Kidney Stones
- ❑ Liver Failure
- ❑ Kidney Failure
- ❑ Pancreatic
- ❑ Yellow Jaundice
- ❑ IBS
- ❑ Chrohns Inflammatory
- ❑ Bladder Incontinence
- ❑ Bowel Incontinence
- ❑ Other _____

MENTAL
- ❑ Depression
- ❑ Bipolar
- ❑ Anxiety
- ❑ Other _____

NERVE / JOINT
- ❑ Arthritis
- ❑ Lupus
- ❑ Glaucoma
- ❑ Paralysis
- ❑ Stroke
- ❑ Pain Syndrome
- ❑ Migraines
- ❑ Severe Headaches
- ❑ Seizures
- ❑ Chronic Neck Pain
- ❑ Vision Loss
- ❑ Hearing Loss
- ❑ Nerve Damage
- ❑ Neuropathy
- ❑ T-M Joint Problems (jaw)
- ❑ Other _____

BLOOD
- ❑ Bleeding Difficulties
- ❑ Clotting
- ❑ Anemia
- ❑ Leukemia
- ❑ Lymphoma
- ❑ Sickle Cell
- ❑ Prior Blood Transfusion
- ❑ Blood Clots
  - ❑ in legs
  - ❑ in lungs
- ❑ Hepatitis
  - ❑ A
  - ❑ B
  - ❑ C
- ❑ HIV
- ❑ Other _____

METABOLIC
- ❑ Diabetes
- ❑ Thyroid
- ❑ Osteoporosis
- ❑ Osteopenia
- ❑ Metabolic Syndrome
- ❑ Cushing's
- ❑ Gout / Pseudogout
- ❑ High Cholesterol
- ❑ Other _____

MISCELLANEOUS
- ❑ Alcoholism
- ❑ Chemical Dependency
- ❑ Sexually Transmitted Disease
- ❑ Cancer (specify)

Medications

Medication	Dosage	Medication	Dosage

Allergies to Medication

❑ Penicillin ❑ Iodine ❑ Sulfa ❑ Aspirin ❑ Keflex / Ancef ❑ Anti-inflammatory ❑ Novocaine Other: _____

Allergic to Latex? ❑ Yes ❑ No **Food Allergies?** (Bananas, eggs, shellfish, kiwi) Other: _____

Previous Operations List any previous surgery including dates if known.

Type of Surgery	Date	Type of Surgery	Date

Family Medical History Check boxes next to illnesses that have occurred in a blood-related family member.

- ❑ None
- ❑ Addiction
- ❑ Asthma
- ❑ Back Pain
- ❑ Birth Defects
- ❑ Bleeding Tendency
- ❑ Cancer
- ❑ Diabetes
- ❑ Headaches
- ❑ Other _____
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mental Illness
- ❑ Metabolic Disorder
- ❑ Neuropathy
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Pulmonary Disorder
- ❑ Rheumatoid Disorder
- ❑ Sleep Apnea
- ❑ Stroke
- ❑ Tremor
- ❑ Tuberculosis
- ❑ Vascular Disease

Social History / Habits

❑ TOBACCO	❑ Cigar ❑ Pipe ❑ Cigarettes ❑ Chew	Amount per Day _____	If Stopped, When _____
❑ ALCOHOL	❑ Beer/Ale ❑ Wine ❑ Whiskey	Amount per Day _____	If Stopped, When _____
❑ OTHER	❑ Marijuana ❑ Other Illegal Drugs	Amount per Day _____	If Stopped, When _____

Review of Symptoms If you are experiencing any of these symptoms please check boxes.

- ❑ None
- ❑ Change in Speech
- ❑ Chest Pain
- ❑ Chills
- ❑ Chronic Cough
- ❑ Excessive Thirst
- ❑ Fainting Spells
- ❑ Fever
- ❑ Frequent Urination
- ❑ Hives
- ❑ Hot Joints
- ❑ Joint Aches
- ❑ Loss of Appetite
- ❑ Loss of Weight
- ❑ Nausea
- ❑ Night Sweats
- ❑ Rapid or Irregular Heartbeat
- ❑ Rashes
- ❑ Shortness of Breath
- ❑ Sleeping Disorder
- ❑ Sweats
- ❑ Swollen Ankles
- ❑ Upset Stomach
- ❑ Vomiting
- ❑ Weight Gain
- ❑ _____
- ❑ _____
- ❑ _____

PERFORMANCE
INJURY CARE & SPORTS MEDICINE

Medical Appointment Cancellation/No Show/Late Policy

Thank you for trusting your medical care to Performance Injury Care & Sports Medicine, Inc., (PICSM). We set aside enough time with your practitioner to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible. Please give us at least 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Effective July 1, 2018 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24-hour notice or shows up 10 minutes past your scheduled time will be considered a **NO SHOW**.
- **NO SHOW** appointments will have a fee of **$50.00** applied to your account.
- Any established patient who No Shows or fails to cancel/reschedule/late for an appointment without a 24-hour notice for the **second** time will be charged a **$75.00** fee.
- If a **third** **NO SHOW** or cancellation/reschedule with no 24-hour notice should occur, the patient may be dismissed from Performance Injury Care and Sports Medicine.
- Any new patient who fails to show for their initial visit may not be rescheduled. You may be assessed a **$50.00** no show fee, which must be paid in full before rescheduling.
- The fee is charged to the patient, not the insurance company, and is due at the time of next visit. This will be a 12-month rolling period.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our office at (406)422-5817 as we may waive the No Show Fee. As a courtesy we send reminders, in the form of email, texts and phone calls. Our office is open Monday-Friday 8am-5pm.

I have read and understand the Medical Appointment Cancellation/No Show Policy/late and agree to its terms.

Signature (Parent/Legal Guardian) _____ Relationship to Patient _____

Print Name _____ Date _____

Revised 3/2022 cks

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ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

Federal Law requires all physician offices to have a signed privacy statement on file for every patient. To legally provide care, we must have a signed Acknowledgement of Privacy Practices on file. This law is intended to protect the privacy of your medical information.

Performance Injury Care & Sports Medicine, Inc. complies with all Federal Civil Rights Laws and does not and shall not discriminate on the basis of race, color, religion (creed), gender, gender expression, age, national origin (ancestry), disability, marital status, sexual orientation, or military status, in any of its activities or operations.

(initial) _____I agree that telephone messages regarding my appointments, prescriptions renewals, lab results and other protected health information pertinent to my care may be left for me on voicemail systems at the numbers provided to Performance Injury Care & Sports Medicine.

(initial) _____I have acknowledged that I am aware of the Performance Injury Care & Sports Medicine, Inc. Notice of Privacy Practices and that I can receive a copy if I wish to do so.

_____

Printed Name of Patient Date of Birth

_____

Signature of Patient or Patient Representative Date Signed

_____

Relationship to Patient – Parent, Guardian, Power of Attorney

_____

Clinic Witness Date Signed

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