PERFORMANCE
INJURY CARE & SPORTS MEDICINE
3150 N. Montana Ave, Suite A Helena, MT 59602
Tel: 406-422-5817 Fax: 406-422-5928
www.helenasportsmed.com

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 8-12 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 $1,175.00 - $5,100.00 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.

PERFORMANCE

INJURY CARE & SPORTS MEDICINE

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

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, EMG or X-rays related to the injury – please mail 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.

PERFORMANCE
INJURY CARE & SPORTS MEDICINE

3150 N. Montana Avenue, Ste A
Helena, MT 59602
P: 406-422-5817
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
- ☐ _____
- ☐ _____
- ☐ _____

INJURY INFORMATION SHEET

Patient Name: _____ Birthdate: _____ Date: _____

Part of Body Injured: _____ ☐ Right ☐ Left Referred By: _____

**This information must be completed in order for us to bill for services. If it is not complete, the patient will be responsible for full payment at the time they are treated.

WORKER'S COMPENSATION

EMPLOYER AT TIME OF INJURY: _____ Phone #: _____

Please explain how accident/injury occurred?

_____

_____

DATE OF INJURY: _____ LAST WORKED DATE: _____

WORK COMP INSURANCE CARRIER: _____

WORK COMP CARRIER ADDRESS: _____
STREET ADDRESS CITY STATE ZIP

CLAIMS EXAMINER: _____ PHONE #: _____
Text

CLAIM #: _____ FAX #: (if available) _____

AUTO ACCIDENT

POLICY HOLDER: _____

CLAIM #: _____ ACCIDENT DATE: _____

INSURANCE AGENCY: _____ PHONE # _____

AGENT: _____ FAX # (if available) _____

ADDRESS: _____
STREET ADDRESS CITY STATE ZIP

PAIN / INJURY INFORMATION

Date of Injury (if applicable): _____

PLEASE EXPLAIN HOW PAIN / INJURY BEGAN:

_____

_____

IMPORTANT INFORMATION (PLEASE READ and SIGN)

* *I consent to examination, treatment and procedures which may be performed during office visits including emergency treatment considered necessary by the physician and/or his designated providers.*
* *I authorize the release of any medical information necessary to determine benefits payable for insurance claims for services rendered and agree that all proceeds of insurance are assigned to this office where applicable.*
* *I understand that I am financially responsible for all charges whether or not paid by my insurance. If no insurance payment after 90 days the balance becomes my responsibility.*
* *I understand that should I default on payment of my account and collection agency services are required, all costs of collections up to 50% of the balance, including attorney/court costs will be added to the balance of my account.*

PATIENT OR GUARDIAN SIGNATURE: _____ DATE: _____

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 PICSM.
- Any new patient who fails to no 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 3/22 BR

PERFORMANCE

INJURY CARE & SPORTS MEDICINE

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

Federal Law requires all physician offices to have a signed privacy statement on file for every patient. In order to serve you we must have an existing Acknowledgement of Privacy Practices on file. This law is intended to protect the privacy of your medical records.

Performance Injury Care & Sports Medicine, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Thank you

(initial) _____I agree that telephone messages regarding my appointments, prescriptions renewals, lab results and other PHI may be left for me on voicemail systems at the numbers provided to you by me

(initial) _____I have been notified and/or received a copy of the Performance Injury Care & Sports Medicine Inc. Notice of Privacy Practices.

_____

(PRINT) 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

Performance Injury Care & Sports Medicine, Inc.
Notice of Privacy Practices

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

PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care providers for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example; A physician, nurse, or other member of your healthcare team will record information in your record to diagnose your condition and determine the best course of treatment for you. Or, your health information may be disclosed to another health care provider if that provider will be involved in your care and treatment.

Performance Injury Care & Sports Medicine will provide information to pharmacies in order to help prevent harmful drug interactions and as a precaution for drug overdoses. We will also provide your referring physician with copies of your records to assist them in treating you.

Payment. Your health information may be used or disclosed to request payment from your health plan, from other sources of coverage such as an automobile insurer, or workers compensation. For example; We will send a bill to your health insurance plan, which will include information that identifies you, your diagnosis, treatment received, and supplies used.

Health care operations. Your health information may be used or disclosed as necessary to support the day-to-day activities and management of Performance Injury Care & Sports Medicine, Inc. For example; Members of the medical staff and management may use information in your health record to assess the care and outcomes in our cases and the competence of the caregivers. We will use this information in an effort to continually improve the quality and effectiveness of the healthcare and services we provide.

Required by law. We may use and disclose your health information as required by federal, state, or local law. Any use or disclosure will comply with the law and will be limited to the requirements of the law.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law for purposes related to preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

Workers compensation. We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Correctional institution. Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Judicial and administrative proceedings. We may disclose your health information in the course of an administrative or judicial proceeding pursuant to a properly issued subpoena or discovery request.

Health oversight activities. We may disclose your health information to health agencies during the course of audits, investigations, licensing and other proceedings.

Public safety. We may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

Deceased person information. We may disclose your health information to coroners, medical examiners and funeral directors.

Notification and communication with family. We may disclose your health information to notify a family member, your personal representative or another person responsible for your care about your general condition or your treatment. If you are able to agree or object, we will give you the opportunity to object prior to making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgement in communicating with your family and others.

Appointment reminders. Your health information will be used by our staff to send you appointment reminders or to make reminder calls.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest.

Other uses and disclosures require your authorization. Disclosure of your health information 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.

Your Rights Regarding Your Health Information

You have certain rights regarding your health information. These include:

- The right to request restrictions on the use and disclosure of your protected health information. Your request must be made in writing. If we agree, we will comply to the extent we have not already relied on our legal right to use or disclose your health information.

- The right to receive confidential communications concerning your medical condition and treatment. Your request must be made in writing.

- The right to inspect and copy your protected health information. Your request must be made in writing. We reserve the right to charge a reasonable fee for copies.

- The right to amend your protected health information. You must submit a request to amend your health information in writing and give a reason for your request. We may deny your request to amend in certain instances, including if the request is not in writing or if you do not provide a reason for the request.

- The right to request an accounting of how and to whom your protected health information has been disclosed by us during a specified time period of up to six years, other than disclosures made for treatment, payment and health care operations, to family members or friends involved in your care, to you directly, pursuant to an authorization of you or your personal representative, or certain notification purposes.

- The right to receive a printed copy of this notice .

- The right to revoke your consent or authorization to use or disclose health information except to the extent that we have already taken action in reliance on the consent or authorization.

Performance Injury Care & Sports Medicine Inc.
Responsibilities under the Federal Privacy Standards

We are required by law to maintain the privacy of your protected health information and to 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.

We are required to train our personnel concerning privacy and confidentiality.

We are required to implement a sanction policy to discipline those who breach privacy/confidentiality or our policies with regard thereto.

We are required to mitigate (lessen the harm of) any breach of privacy/confidentiality.

RIGHT TO REVISE PRIVACY PRACTICES

As permitted by 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. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect
Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our Records Custodian or Privacy Officer.

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:

Privacy Officer
Performance Injury Care & Sports Medicine, Inc.
3150 N. Montana Avenue, Suite A
Helena, MT 59602

Or to:

United States Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Building
200 Independence Ave., S.W.
Washington, DC

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.

We will respond to your written complaint within 60 days of its receipt.

Contact Person

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

Privacy Officer
Performance Injury Care & Sports Medicine, Inc.
3150 N. Montana Avenue, Suite A
Helena, MT 59602
(406) 422-5817

Effective Date

This Notice is effective on or after 2-14-2003