

We are pleased you have made the decision to visit The Spine Institute at Rocky Mountain Associates in Orthopedic Medicine. We ensure that you will enjoy our friendly staff as well as our outstanding doctors.

Enclosed is the required paperwork for your first visit to RMA Ortho The Spine Institute. We are giving you the opportunity to fill this packet out at home, and simply bring it with you to your scheduled appointment time. We ask that you bring all the necessary information regarding your insurance policy. Please bring your insurance cards and a photo ID with you to your appointment, regardless of who we are to bill. In the instance of an auto accident or a workers compensation claim, please be sure to have your claim number, date of injury, and the address and phone number of your carrier and adjustor available. The patient, not the doctor, is responsible for this information. Without this information, we will be unable to see you for your appointment.

The following forms are enclosed and to be filled out in full:

History and Physical: You may attach a copy of prescriptions or surgeries if you do not have room on this form.

Patient Information: Please be sure to list your primary and secondary insurance (if applicable), as well as the date of birth of the policyholder.

Privacy Practices: HIPPA regulations.

Pain Control Consent: Our office prescription policy.

Patient Waiver Agreement: Not required if your insurance is Medicare only. We are not allowed to request a referral on a new patient.

PHI Authorization: Release of records.

Pain Questionnaire: Relates to the injury or pain that we are seeing you for.

Please bring the following to your appointment:

- Insurance cards or Auto/Worker's Comp information
- Any X-rays or MRI films and reports
- Any related medical records
- Completed paperwork

Patient Information

Today's Date ___ / ___ / ___

Please Print

Have you been seen by any doctor in our practice before? Yes ___ No ___

Which doctor referred you to this office today? _____

Patient _____ M ___ F ___ Age ___ Date of Birth _____
Legal last name first M.I.

Mailing Address _____
Street City State Zip code

Phone () _____ Cell () _____ Business phone () _____

Your email address: _____

Employed by _____ Occupation _____

Soc Sec # _____ Marital Status: M S D W spouse _____ Bus. Phone _____

Race _____ Preferred Language _____

Person Responsible for Payment (If patient, write "self;" if student, write parent's name and address)

Name _____ Relationship to Patient _____
Last First M.I.

Address _____
Street City State Zip code

Phone () _____ Cell () _____ Business phone () _____

Soc Sec # _____ Occupation _____ Employer _____

Employer's Address _____

Person to Notify in Case of Emergency (Other than person listed above)

Name _____ Relationship _____ Phone () _____

Insurance Information (please present most recent insurance card at time of check in)

Work Comp _____ Have you notified your employer? Y ___ N ___
Claim Number: _____ Date of Injury ___ / ___ / ___

Auto Injury _____ Claim Number: _____ Date of Injury: ___ / ___ / ___

Auto and W.C.: Adjustor/case manager's name & phone _____
Billing Address _____

→ **Primary Insurance** _____ **Policy holder's name & DOB** _____
(circle) PPO HMO OTHER Policy # _____ Group _____ Phone () _____
Address _____

→ **Secondary Insurance** _____ **Policy holder's name & DOB** _____
(circle) PPO HMO OTHER Policy # _____ Group _____ Phone () _____
Address _____

Briefly describe how this accident/injury occurred _____

_____ Date of Injury ___ / ___ / ___
Attorney involved: Name _____ Phone () _____
Address _____ (OVER)

Authorization for Treatment, Financial Agreement and Disclosures

A. CONDITIONS OF TREATMENT

1. Authorization for Care: The undersigned, knowing the patient is suffering from a condition requiring health care, diagnosis and medical treatment, does hereby voluntarily agree to such routine services, diagnostic procedures and other health care services, to such medical treatment, x-ray treatment, and injection which may be administered or performed on the patient under general or special instructions of Dr. _____, his assistants or his designees.

B. INSURANCE POLICY

1. We will be happy to bill your insurance company if you will supply us with the appropriate information. Please keep us informed of any changes to your insurance information.
2. If your insurance requires a referral to see a specialist, please make sure that your primary doctor gets that information to us before your appointment.
3. We participate in a number of HMO/PPO organizations. Please check with us or your insurance company to see if we are a participating provider before scheduling your appointment.
4. In the case of divorce, the parent bringing the child in for treatment will be responsible for payment. We will file any insurance claims for you, provided we have received the appropriate information from you.

C. Payment Policy

1. Payment is due and payable at the time of each service.
2. We accept cash, checks, Visa and Master Card.
3. All co-pays are due at the time of service.
4. If there is no payment or notice from your insurance company within 45 days of the date of service, the balance will become your responsibility.
5. Our fees are generally considered to fall within the acceptable range by most companies and, therefore, are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage of usual, customary and reasonable fees for the region. Thus, our fees are considered usual, customary and reasonable by most companies.
6. Not all services are a covered benefit in all contracts. Some insurance companies may select certain services they will not cover.

D. Statements

1. A statement of fees is sent to you regularly. Our office relies on you for settling your account. You are ultimately responsible for all fees relating to your care. Your health policy is an agreement between you and your health insurance carrier. If you need to make special arrangement for payment, please contact our billing office.
2. As a last step in collecting overdue accounts, we do participate with a collection service agency. Any account with no payments or contact from the patient within 45 days of the day of service will be turned over to this company.

E. Medicare

1. We do accept assignment on your Medicare charges. Medicare pays our office directly.
2. You will receive a statement each month to let you know the status of your account.
3. We will be happy to bill a secondary insurance company if you will supply us with the appropriate information.

RELEASE OF INFORMATION

I hereby authorize direct payment of medical benefits to Rocky Mountain Radiology Center, LLC. My signature below also authorizes this office to release medical information to assist with any outstanding balances on my account. This will be considered a life time signature for all Medicare patients.

Patient Signature _____ Date _____

HISTORY AND PHYSICAL (Please complete carefully and completely)

TODAY'S DATE _____

NAME _____ AGE _____ BIRTH DATE _____
HEIGHT _____ WEIGHT _____
REFERRING PHYSICIAN _____

REVIEW OF SYMPTOMS (Circle any of these symptoms you may have had within the past year)

GENERAL: Poor appetite, weight change HEART: Chest pain, heart pounding, swollen ankles/hands
HEAD: Headaches ABDOMEN: Nausea, vomiting, change in bowel habits,
EYES: Blurred or double vision blood in stool, recurrent indigestion, abdomen pain
THROAT: Chronic sore throats, difficulty swallowing GU: Frequent urination, pain or burning with urination
MOUTH: Loose or false teeth, dental problems
LUNGS: Shortness of breath, chronic cough

****HAVE YOU EVER RECEIVED A BLOOD TRANSFUSION? YES NO**

PAST MEDICAL HISTORY: (Circle if you have ever had any of the following)

Anemia	Epilepsy/Seizures	Lung Disease/COPD	Diabetes Adult/Child
Anxiety/Depression	Fibromyalgia	Multiple Sclerosis	Insulin Dependent
Arthritis	Hard of Hearing	Nervous Breakdown	Emphysema
Blood Clots in Legs/Lungs	Heart Disease	Pneumonia	Jaundice
Bowel Disease	Hernia-Hiatal/Other	Polio	Kidney Disease
Breast Cysts or Lumps	Hepatitis	Poor Vision	Liver Disease
Bleeding Disorder	High Blood Pressure	Rheumatic Fever	Tuberculosis
Chronic Bronchitis	High Cholesterol/Triglycerides	Skin Disease	Ulcers
Dizziness	HIV	Thyroid Problem	MRSA
Sleep Apnea	Cancer	Other _____	

CARDIAC HISTORY

Have you ever been treated for a heart problem? YES/NO

Name and Number of Cardiologist _____ Last visit/EKG _____

FAMILY HISTORY

Maternal or Paternal

Blood Disease	_____	_____
Heart Attack/Disease	_____	_____
Cancer	_____	_____
Diabetes	_____	_____
Tuberculosis	_____	_____
Problems with Anesthesia	_____	_____
Lung Disease	_____	_____
Birth Defects	_____	_____
Liver Disease	_____	_____
Kidney Disease	_____	_____

SOCIAL HISTORY

Do you smoke cigarettes?	YES/NO
Packs/Day	_____
Have you ever smoked cigarettes?	YES/NO
When did you stop?	_____
Do you chew tobacco?	YES/NO
Do you use "street" drugs?	YES/NO
Do you drink alcohol daily?	YES/NO
Have you ever taken Cortisone?	YES/NO
Any problems with Anesthesia?	YES/NO
Are you LEFT or RIGHT handed?	(circle one)
History of drug or alcohol abuse?	YES/NO
Do you use medical marijuana?	YES/NO

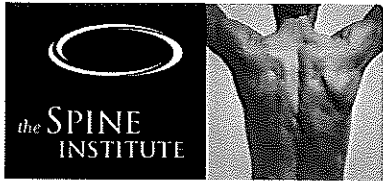
LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING OR HAVE TAKEN OVER THE PAST YEAR.

Name/Strength/Frequency

LIST ALL KNOWN ALLERGIES/REACTION

LIST ALL MAJOR OPERATIONS, INJURIES, OR CRONIC ILLNESSES

DATE	TYPE OF OPERATION, INJURY OR ILLNESS
_____	_____
_____	_____
_____	_____
_____	_____



Kenneth A. Pettine, MD
E. Jeffery Donner, MD
Michael P. Grant, MD
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D.J. Browne, PA-C

Informed Consent on the Use of Pain Control with Opioid Medications

Informed consent:

I, _____, have been informed and clearly understand the following issues regarding the treatment of pain with opioids (i.e. Morphine or Morphine-like drugs).

1. **I understand an office visit every 6-8 weeks is required** for management of the medications and refills of the pain medication prescribed and will be given on a weekly basis. Failure to attend office visits will result in slow tapering and ultimate discontinuation of all opioid medications.
2. **I understand I must designate a sole pharmacy** in which to have all medications filled, and provide the doctor's office with the pharmacy phone number. Pharmacy "hopping" is not tolerated.
3. **I understand medications used will be prescribed by a single physician.** I am aware that "doctor shopping" is an unacceptable behavior. The same physician will be managing the possible side effects during use of opioids. This physician will be the only one to decide when and how opioid dosage may be increased. If the physician decides to discontinue the use of the opioids, the physician will follow me through this tapering off period and I will agree to recommendations made by the physician.
4. **I understand the use of the medication is not to completely eliminate pain.** Rather, the medication is used to significantly reduce pain so that I will be able to perform many activities of daily living as well as social activities. It is hoped that the use of these medications will improve the quality of life but it is **unexpected that pain relief will be complete.**
5. **I understand I must report significant side effects of each of the opioid medications.** For example: over-sedation, nausea, vomiting, constipation, confusion, euphoria (high feelings) and dysphoria (down feelings). Other side effects which may be related to narcotic use also include dizziness; sweating; respiratory depression (difficulty breathing); gastrointestinal upset; quick, sudden jerky movements of the arms or legs; headaches; weakness; tremor; seizure; dreams; musculature rigidity; transient hallucinations; disorientation; visual disturbances; insomnia; dry mouth; diarrhea; stomach cramps; taste alteration; flushing of the face; chills; increased or decreased heart rate; increased or decreased blood pressure; difficulty with urination; itching; skin rashes; and swelling of the skin.
6. **I understand that the use of this medication may result in physical dependence.** This condition is common to many drugs including steroids, blood pressure medications, anti-anxiety medications and anti-seizure medications, as well as opioids. Physical addiction poses no problem to me as long as I avoid abrupt discontinuation of the drug. Medication can be safely discontinued after 2 or 3 weeks of slow tapering.
7. **I understand that psychological addiction is a possible risk of the use of opioid medications.** This has been shown to be an infrequent occurrence in patients who have been diagnosed with an organic disease causing chronic pain. Psychological addiction is recognized when the individual abuses the drug to obtain mental numbness or euphoria, when the patient shows a drug craving behavior or engages in "doctor shopping", when the drug is quickly escalated without correlation with pain relief and when the patient shows a manipulative attitude toward the physician in order to obtain the drug. If I exhibit such behavior, the drug will be tapered; I will not be a candidate for continued opioid usage.

8. **I understand tolerance is also a condition which can occur with use of opioid medications.** It is defined as a need for higher opioid dose to maintain the same pain control. Usually, tolerance to sedation, euphoria, nausea and vomiting occurs more commonly than tolerance to pain relief. This condition may be controlled by switching to a different opioid medication. Tolerance can also be managed by adding a second, different drug to the opioid management. If tolerance to opioids becomes unmanageable, the opioid will be tapered and discontinued.
9. **I understand that if I develop drowsiness, sedation or dizziness I may not drive motor vehicles or operate machinery that can jeopardize my life or other people's lives.**
10. **I understand the use of the medication is designed and prescribed only for me.** I will never distribute it to others.
11. **I understand I am responsible for contacting the physician if at any time during the use of the opioid medications drowsiness or other major side effects develop.** The phone number to contact is 970-669-8881.
12. **I understand that I may not stop taking the opioid medications abruptly.** If this happens, withdrawal symptoms usually occur 24-48 hours after the last dose. An individual may experience yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot or cold flashes, "goose flesh", abdominal cramps and diarrhea. The withdrawal symptoms are self-limited, but could be life-threatening. It may last a few days. In order to avoid the withdrawal symptoms, I am informed that **I must contact the physician's office 48 hours prior to needing a new prescription and that no refills will be done on Fridays, after office hours or on the weekends.**
13. **I understand that I may not take other drugs such as tranquilizers, sedatives or antihistamines without first consulting with the physician.** I may not use alcohol. The combination of the above drugs, alcohol and opioids may produce profound sedation, respiratory depression, blood pressure drop or death.
14. **I understand I must follow the physician's directions and not increase the opioid dose on my own.** Drug overdose can cause severe sedation, respiratory depression and possible death.
15. **I understand I must take the medication as prescribed by the physician.** Medications should be taken whole, and are not to be broken, chewed or crushed. Possible risk would be rapid absorption of the medication causing anxiety or death.
16. **I understand that if I am a female I should notify the physician if I am pregnant or am at possible risk of becoming pregnant.** Children born when the mother is on opioid maintenance therapy will likely be physically dependent on the opioid at birth.
17. **I understand if there is any evidence of drug hoarding, acquisition of drugs from other physicians, uncontrolled dose escalation or other aberrant behavior, this would be followed by tapering and discontinuation of opioid maintenance therapy and possible discharge from the physician's practice.**

Signature of Patient _____ Date _____

Pharmacy: _____ Telephone #: _____



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PATIENT WAIVER AGREEMENT

When my Primary Care Physician referred me to this office, I understand he/she received an authorization number from my insurance company via phone, fax or mail; copies of which should have been mailed to this office and myself. If at the time of visit, I do not have a copy of the referral form and this office has not yet received authorization, I release I have the following options:

- 1) I can call my insurance company to obtain the authorization number
- 2) I can reschedule the appointment and bring a copy of the referral form issued by my insurance company. If my insurance company did not send me an official form, I must provide this office with the:

-authorization number -start date -end date -number of visits

- 3) I can keep this appointment today, without either of the above, and I understand that my insurance company WILL NOT PAY for the charges occurred at this visit today.

**ALSO IF NO REFERRAL IS REQUIRED, I UNDERSTAND
THAT I AM RESPONSIBLE FOR ALL PAYMENT/BALANCE OF TODAY'S VISIT.**

Printed name of patient/enrollee

Date of service

Signature of patient or authorized representative

This form is not applicable to and cannot be used for Medicare + Choice (Medicare HMO) members

3810 N Grant Avenue
Loveland, Co 80538

(970) 669-8881
Fax (970) 669-4200

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

By signing below I authorize RMA Ortho/Spine Institute to disclose my Protected Health Information to the person or persons listed below:

NAME

PHONE NUMBER

I understand that once the information is released it may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations.

I understand that I may revoke this authorization at any time by notifying, in writing, RMA Ortho/Spine Institute. However, a revocation will not affect any actions taken by RMA Ortho/Spine Institute prior to the receipt of the revocation.

How may we contact you regarding your PHI?

Home phone: _____

May we leave a detailed message? _____

Work phone: _____

Cell phone: _____

SIGNATURE

DATE

NECK OSWESTRY INDEX

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your everyday activities. In the event that two or more of the statements in a category may relate to you, please mark the one answer that most accurately describes your problem. Please answer based upon your average pain over the past two weeks **without pain medication.**

SECTION 1—Pain Intensity

- 0 I have no pain at the moment.
- 1 The pain is mild at the moment.
- 2 The pain is moderate and comes and goes.
- 3 The pain is moderate and does not vary much.
- 4 The pain is severe but comes and goes.
- 5 The pain is severe and does not vary much.

SECTION 2—Personal Care (Washing, Dressing etc.)

- 0 I can look after myself without extra pain.
- 1 I can look after myself but it causes extra pain.
- 2 It is painful to look after myself and I am slow and careful.
- 3 I need some help, but manage most of my personal care.
- 4 I need help every day in most aspect of self-care.
- 5 I do not get dressed, wash with difficulty, and stay in bed.

SECTION 3—Lifting

- 0 I can lift heavy weights without extra pain.
- 1 I can lift heavy weights, but it causes extra pain.
- 2 Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently placed for example, on a table.
- 3 Pain prevents me from lifting heavy weights but I can lift light to medium weights if they are conveniently placed.
- 4 I can lift very light weights.
- 5 I cannot lift or carry anything at all.

SECTION 4—Reading

- 0 I can read as much as I want with no pain in my neck.
- 1 I can read as much as I want with slight pain in my neck.
- 2 I can read as much as I want with moderate pain in my neck.
- 3 I cannot read as much as I want because of moderate pain in my neck.
- 4 I cannot read as much as I want because of severe pain in my neck.
- 5 I cannot read at all.

SECTION 5—Headache

- 0 I have no headaches at all.
- 1 I have slight headaches that come infrequently.
- 2 I have moderate headaches that come infrequently.
- 3 I have moderate headaches that come frequently.
- 4 I have severe headaches that come frequently.
- 5 I have headaches almost all of the time.

SECTION 6—Concentration.

- 0 I can concentrate fully with no difficulty.
- 1 I can concentrate fully with slight difficulty.
- 2 I have a fair degree of difficulty in concentrating
- 3 I have a lot of difficulty in concentrating.
- 4 I have a great deal of difficulty in concentrating.
- 5 I cannot fully concentrate at all.

SECTION 7—Work

- 0 I can do as much work as I want to.
- 1 I can do my usual work but no more.
- 2 I can do most of my usual work but no more.
- 3 I cannot do my usual work.
- 4 I can hardly do work at all.
- 5 I cannot do any work.

SECTION 8—Driving

- 0 I can drive my car without neck pain.
- 1 I can drive my car as long as I want with slight neck pain.
- 2 I can drive my car as long as I want with moderate neck pain.
- 3 I cannot drive my car as long as I want because of moderate neck pain.
- 4 I can hardly drive my car at all because of severe neck pain.
- 5 I cannot drive my car at all.

SECTION 9—Sleeping

- 0 I have no trouble sleeping.
- 1 My sleep is slightly disturbed (less than 1 hour sleepless).
- 2 My sleep is mildly disturbed (1-2 hours sleepless).
- 3 My sleep is moderately disturbed (2-3 hours sleepless).
- 4 My sleep is greatly disturbed (3-5 hours sleepless).
- 5 My sleep is completely disturbed (5-7 hours sleepless).

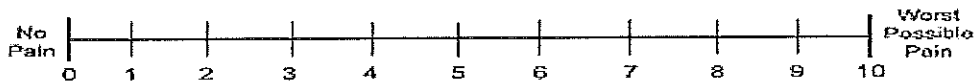
SECTION 10—Recreation

- 0 I am able to engage in all recreational activities with no pain.
- 1 I am able to engage in all recreational activities with slight pain.
- 2 I am able to engage in most, but not all, recreational activities because of pain.
- 3 I am able to engage in a few of my usual recreational activities because of pain.
- 4 I can hardly do any recreational activities because of pain.
- 5 I cannot do any recreational activities.

Signature: _____
 Print Name: _____

DOB: / / . Date: _____ Score %: _____

RATE YOUR PAIN ON THE SCALE OF 1-10 AND PLACE A NUMBER IN EACH OF THE BLANK SPACES:



NECK PAIN _____ ARM (LEFT) _____ SHOULDER (LEFT) _____
 HEADACHE _____ ARM (RIGHT) _____ SHOULDER (RIGHT) _____

IF YOU ARE POST-OP: (Please Circle)

1. Overall were you satisfied with your surgery? YES NO
2. Returned to work after surgery? YES NO
3. If given the chance would you do the same surgery again for the same outcome? YES NO Retired? YES NO

Pre-Op 6 Wks. 3 Mon. 6 Mon. 1 Year 2 Year

NAME _____

DATE _____

PATIENT QUESTIONNAIRE FOR NECK PAIN, HEADACHE, SHOULDER AND ARM PAIN

CHIEF COMPLAINT (CIRCLE ALL THAT APPLY): HEADACHE, NECK PAIN, SHOULDER/ARM PAIN, OTHER (DESCRIBE). LIST IN ORDER OF SEVERITY:

1) _____
2) _____

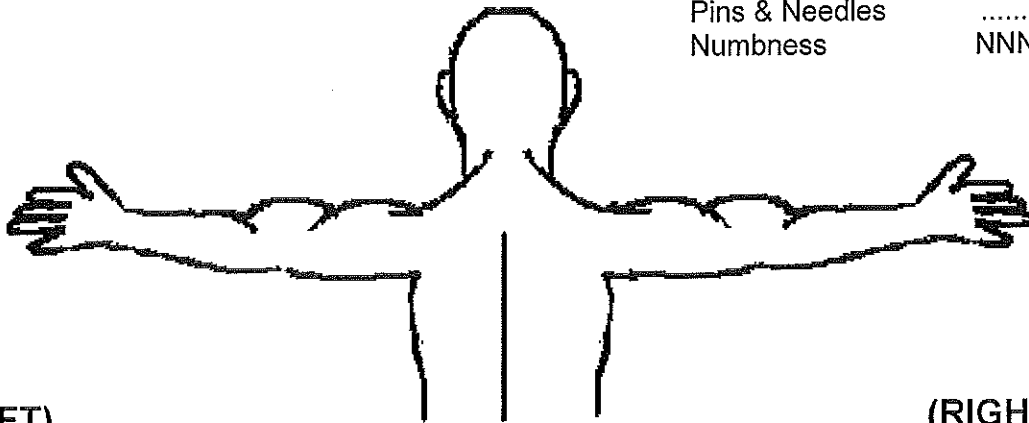
IS YOUR OVERALL PROBLEM: GETTING BETTER, GETTING WORSE, OR STAYING THE SAME

HOW DID YOUR PAIN BEGIN: UNKNOWN, AUTO ACCIDENT, TRAUMA, OR OTHER CAUSE (DESCRIBE)

WHEN DID YOUR PAIN BEGIN: DATE _____

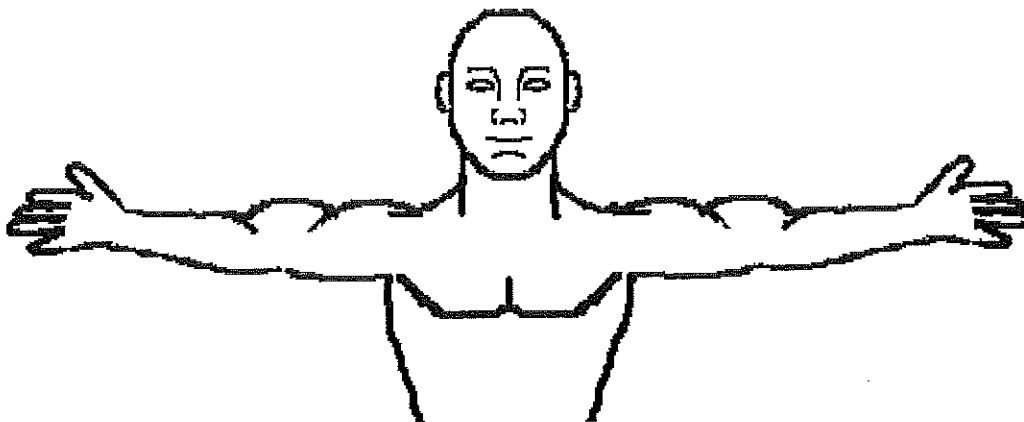
WHERE DO YOU HAVE PAIN (MARK ON THE PICTURES WITH SYMBOLS):

Burning	XXXX
Aching	WWW
Stabbing	////
Pins & Needles
Numbness	NNNN



(LEFT)

(RIGHT)



(RIGHT)

ANTERIOR VIEW

(LEFT)

WHAT IS THE CURRENT DIAGNOSIS OF YOUR HEADACHE/NECK PAIN (CIRCLE ALL THAT APPLY):
CERVICAL STRAIN, MIGRAINE, HERNIATED DISC, SHOULDER PROBLEM, NO DIAGNOSIS,
OTHER: _____

WHAT MAKES YOUR PAIN BETTER: _____
WHAT MAKES YOUR PAIN WORSE: _____

IS YOUR PAIN WORSE ON THE: LEFT RIGHT BOTH

TYPICALLY, HOW SEVERE IS YOUR PAIN, RATE YOUR PAIN ON THE SCALE OF 1-10 AND PLACE A
NUMBER IN EACH OF THE BLANK SPACES:

NO 0 1 2 3 4 5 6 7 8 9 10 WORST PAIN I
PAIN _____ CAN IMAGINE

HEADACHE _____ ARM (LEFT) _____ SHOULDER (LEFT) _____
NECK PAIN _____ ARM (RIGHT) _____ SHOULDER (RIGHT) _____

ARE YOUR SYMPTOMS SEVERE ENOUGH THAT YOU WOULD CONSIDER SURGERY: YES NO

PATIENT WITH HEADACHES, COMPLETE THE FOLLOWING:

DOES YOUR HEAD THROB OR POUND: YES NO
DO YOU FEEL A HEADACHE "COMING ON" OR EXPERIENCE AN "AURA" (WARNING SIGNS): YES NO

DO YOU HAVE ANY OTHER SYMPTOMS ACCOMPANYING YOUR HEADACHE (CIRCLE ALL THAT APPLY)
NUMBNESS, TINGLING, DIZZINESS, VISUAL PROBLEMS, NAUSEA, VOMITING,
OTHER: _____

HOW OFTEN DO YOU HAVE HEADACHES: _____/WEEK HOW LONG DOES IT LAST: _____ HOURS

PREVIOUS TREATMENT:

1) PHYSICAL THERAPY:	YES	NO	LENGTH OF TREATMENT: _____
DID THIS HELP:	YES	NO	WHERE: _____
2) CHIROPRACTIC:	YES	NO	LENGTH OF TREATMENT: _____
DID THIS HELP:	YES	NO	WHERE: _____
3) MASSAGE:	YES	NO	LENGTH OF TREATMENT: _____
DID THIS HELP:	YES	NO	WHERE: _____
4) OTHER TREATMENT:	YES	NO	LENGTH OF TREATMENT: _____
DESCRIBE TREATMENT:	_____		
DID THIS HELP:	YES	NO	WHERE: _____

LIST ALL MEDICINES USED FOR NECK PAIN OR HEADACHES:
OVER THE COUNTER: _____
PRESCRIBED: _____

LIST PREVIOUS MEDICAL DOCTORS SEEN FOR NECK PAIN OR HEADACHES:

IMAGING STUDIES PERFORMED:

			DATE	WHERE
PLAIN X-RAYS	YES	NO	_____	_____
CT SCAN	YES	NO	_____	_____
MRI SCAN	YES	NO	_____	_____
MYELOGRAM	YES	NO	_____	_____
INJECTIONS	YES	NO	_____	_____
DISCOGRAMS	YES	NO	_____	_____
OTHER	YES	NO	_____	_____

IF OTHER, DESCRIBE: _____

IF YOUR PROBLEM WAS CAUSED BY A WORK INJURY, COMPLETE SECTION C.
IF YOUR PROBLEM WAS CAUSED BY AN AUTO ACCIDENT, COMPLETE SECTION D.

SECTION C: (WORK INJURY)

DATE AND TIME OF INJURY: _____
DESCRIBE YOUR INJURY IN DETAIL: _____

HOW LONG WERE YOU EMPLOYED BEFORE YOUR WORK INJURY: _____

ANY HISTORY OF PREVIOUS SYMPTOMS OR INJURIES: YES NO
IF YES, PLEASE EXPLAIN: _____

ANY HISTORY OF PREVIOUS MISSED WORK DUE TO INJURY: YES NO

ARE YOU WORKING NOW: YES NO

WHEN WAS THE LAST TIME YOU WORKED FULL TIME: _____ PART TIME: _____

DO YOU HAVE ANY CURRENT WORK RESTRICTIONS: YES NO
IF YES PLEASE EXPLAIN: _____

DETAIL YOUR JOB DESCRIPTION: _____

TOTAL TIME LOST FROM WORK: _____

SECTION D: (AUTO ACCIDENT INJURY)

ARE YOU WORKING NOW: YES NO

WHEN WAS THE LAST TIME YOU WORKED FULL TIME: _____ PART TIME: _____
TOTAL TIME LOST FROM WORK: _____

DATE AND TIME OF ACCIDENT: _____

LOCATION OF ACCIDENT: _____

MAKE AND MODEL OF CAR: _____ AMOUNT OF DAMAGE: _____

OTHER PASSENGERS IN YOUR CAR INJURED: _____

YOUR POSITION IN CAR: _____ SEAT BELT WORN: YES NO

HOW ACCIDENT OCCURRED: _____

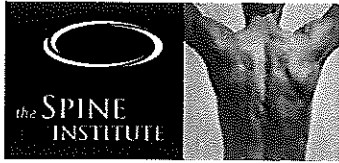
INITIAL TREATMENT AT: _____

TRANSPORTED BY: AMBULANCE or PRIVATE VEHICLE

WERE X-RAYS TAKEN YES NO
IF YES, WHICH ONES: _____

TYPE OF TREATMENT: _____

LOCATION AND TYPE OF PAIN: _____



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PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacies and I have been provided an opportunity to review it.

Name _____ Birthday _____

Signature _____ Date _____

3810 N Grant Avenue
Loveland, Co 80538

(970) 669-8881
Fax (970) 669-4200

5285 McWhinney Blvd. Ste 145
Loveland, Co 80538

(970)669-8881
Fax (970) 669-4200

NOTICE OF PRIVACY PRACTICES

**Rocky Mountain Associates
3810 N. Grant Ave.
Loveland, CO 80538**

This notice takes effect on _____ and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that are now in effect.

We have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notices effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performances of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

NOTICE OF PRIVACY PRACTICES

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facilities' directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification: Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief: Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising: We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances: Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official correctional institute under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information for public health or legal authorities charged with preventing or controlling disease, injury, or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to tract products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

NOTICE OF PRIVACY PRACTICES

Victims of Abuse, Neglect or Domestic Violence: We may disclose medical information to appropriate authorities if we reasonably believe that you are possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

4. YOUR INDIVIDUAL RIGHTS

You have a Right to:

1. Look at or get copies of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you \$_____ for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change your medical information. We may deny your request if we did not create the information you want changes or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the Privacy Officer at your office.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.