THE STEADMAN CLINIC
STEADMAN PHILIPPON RESEARCH INSTITUTE

Peter Millett, MD, MSc

Shoulder, Elbow, Knee Surgeon &
Sports Medicine Specialist

*181 W Meadow Drive, Suite 400 * Vail, Colorado 81657*
Office Phone: 970-479-5871
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Dr. Millett Film Review & Payment Form

Thank you for contacting Dr. Millett

Dr. Millett welcomes your MRI review for a fee of **$150**.
Once Dr. Millett completes the MRI review, he or a member of his team will call you directly with the results. In order to have an MRI Review with Dr. Millett you will need to:

- Print out and complete the **Film Review, Payment & Initial Evaluation Form**
- Gather ***ALL* imaging on a disk (X-Ray, MRI, CT-SCAN)**
- Gather ***ALL* reports of images, procedures & consultations**

Once all forms are complete and imaging has been gathered, please mail to Dr. Millett's Practice Manager, Susan Sabido at:

Susan Sabido
181 W Meadow Drive, Suite 400
Vail, Colorado 81657

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WE RECOMMEND PATIENTS GATHER AND MAIL ALL MATERIALS TO AVOID DELAY/MISS-SHIPPING FROM IMAGE CENTERS/CLINICS

Payment Authorization Form

We accept both **checks** and **credit cards** for MRI review payment.

For those writing a check, please make the check payable to ***The Steadman Clinic*** for the amount of ***$150***

If you are paying by credit card, please complete the information below.

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ign and complete this form to authorize **The Steadman Clinic** to make a one time debit to your credit card listed below. By signing is form you give us permission to debit your account for the amount indicated on or after the indicated date. This is permission for a ngle transaction only, and does not provide authorization for any additional unrelated debits or credits to your account.

I _____ authorize **The Steadman Clinic** to charge my credit card

(full name)

account indicated below for ___**$150**___. This payment is for **a MRI review with Dr. Millett at The Steadman Clinic.**

(amount) (description)

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Cardholder Name _____

Account Number _____

Expiration Date _____

SIGNATURE _____ DATE _____

I authorize The Steadman Clinic to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only, and is valid for one time use only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

[redacted]

Name of Patient *(please print)* ..... Date of Birth .....

I hereby acknowledge that I received the Steadman Clinic´s Notice of Privacy Practices.

Signature of patient or patient representative ..... Date .....

Documentation of Good Faith Efforts
To obtain patient´s acknowledgement that they received provider´s Notice of Privacy Practices

(For use when acknowledgement cannot be obtained from the patient.)

The patient presented to the office/hospital on ..... and was provided with a copy of Covered Entity´s Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- ☐ Patient refused to sign
- ☐ Patient was unable to sign or initial because: .....
- ☐ The patient had a medical emergency, and an attempt to obtain the acknowledgement will be made at the next available opportunity
- ☐ Other reason (describe below): .....

Signature of Employee Completing Form ..... Date .....

[Note: Providers are required to make good faith efforts to obtain acknowledgement that each patient has received their Notice of Privacy Practices. Should the individual refuse to acknowledge receipt of provider´s Notice of Privacy Practices, the provider should document the "Good Faith Efforts" taken to obtain such acknowledgement. The regulation does not specify how those "Good Faith Efforts" should be documented.
This example form is meant to serve as an example of one way that a provider could satisfy this requirement.]

INITIAL EVALUATION FORM

Peter J. Millett, M.D., M.Sc.
Shoulder, Knee, Elbow Surgery / Sports Medicine
The Steadman Clinic

NAME: _____

Age: _____ **Today's Date:**_____

Date of Birth: _____

Height: _____ **Weight:** _____

Who referred you to us?
If yes, please give name / address of the person/physician:

_____

Occupation? _____

Where is your problem? (please circle)

Shoulder Knee Elbow

Neck Back Other

Which side(s)? Right / Left / Both

Dominant Arm? Right / Left

Problem(s) (please check all that apply):

- Pain
- Weakness
- Instability / giving way / dislocation?
- Stiffness?
- Swelling?
- Other _____

How did you injure yourself?

- No injury
- Sports (which sport?)_____
- Motor vehicle accident
- Work / job –

Is there a workers comp claim? Yes / No

Sports level: none / recreational / college / professional

Date of injury?_____

How long have you had symptoms?
_____ Days _____ Mos. _____ Yrs.

Please briefly describe the injury:

_____

_____

Diagnosis (if you know or have been told)?

_____

Previous treatments (other than surgery)?
(medications, physical therapy, injections, bracing)

_____

_____

Previous surgery for this problem (include dates)

_____

_____

How severe is the pain? ***(0 = none, 10 = severe pain)***

At rest? 0 1 2 3 4 5 6 7 8 9 10

At its worst? 0 1 2 3 4 5 6 7 8 9 10

Do you have pain at night? Yes / No

Does it waken you from sleep? Yes / No

Are you currently working? Yes / No / Retired

☐ Normal job? ☐ Limited duty?

What makes your problem better?

_____

What makes your problem worse?

_____

Please describe your current limitations?

_____

Have you had any previous imaging studies?

X-rays	No / Yes	date:_____
MRI	No / Yes	date:_____
CAT scan	No / Yes	date:_____

PAST MEDICAL HISTORY:

- ❑ High blood pressure _____
- ❑ Heart problems _____
- ❑ History of Heart attack_____
- ❑ Stroke _____
- ❑ Seizures _____
- ❑ Asthma _____
- ❑ Gastritis _____
- ❑ Kidney disease _____
- ❑ History of Cancer _____
- ❑ Osteoporosis _____
- ❑ History of blood clot/embolus_____
- ❑ Blood clotting disorder_____
- ❑ Diabetes _____
- ❑ History of skin infections_____MRSA_____
- ❑ Other _____

_____

MEDICATIONS: (please list all medications you are currently taking)

_____

_____

_____

ALLERGIES:

Are you allergic to Latex ❑ Yes ❑ No

Allergies to Medications? ❑ None _____

SOCIAL HISTORY:

Marital Status: _____

Residency: _____

Alcohol use: ❑ Daily ❑ Socially ❑ Never Tobacco use: ❑ Yes ❑ No

FAMILY HISTORY: (please list diseases that run in your family)

_____

Family history of blood clots _____ Bleeding disorders_____

REVIEW OF SYSTEMS:

1. CONSTITUTIONAL ❑ None ❑ Recent weight change ❑ Chills ❑ Fever ❑ Weakness/Fatigue
   GENERAL ❑ _____

2. EYES ❑ None ❑ Vision change ❑ Glasses/Contacts ❑ Cataracts ❑ Glaucoma
   ❑ Other_____

3. EARS, NOSE, THROAT ❑ None ❑ Loss of hearing ❑ Ear ache or infection ❑ Ringing in ear ❑ Hoarseness
   ❑ Other_____

4. CARDIOVASCULAR ❑ None ❑ Chest Pain ❑ Swelling in legs ❑ Shortness in breath ❑ Palpitations
   ❑ Other_____

5. RESPIRATORY ❑ None ❑ Shortness of breath ❑ Wheezing/Asthma ❑ Frequent Cough
   ❑ Other_____

6. GASTROINTESTINAL ❑ None ❑ Heartburn ❑ Acid Reflex ❑ Nausea or vomiting ❑ Abdominal Pain
   ❑ Other_____

7. MUSCULOSKELETAL ❑ None ❑ Arthritis / joint stiffness ❑ Muscle aches ❑ Swelling of joints
   ❑ Other_____

8. SKIN ❑ None ❑ Rash ❑ Ulcers ❑ Abnormal scars ❑ Sores
   ❑ Other_____

9. NEUROLOGICAL ❑ None ❑ Headaches ❑ Fainting/blackouts ❑ Numbness, tingling, loss of sensation in any part of body ❑ Dizziness
   ❑ Other_____

10. PSYCHIATRIC ❑ None ❑ Depression ❑ Nervousness ❑ Anxiety ❑ Mood Swing
    ❑ Other_____

11. ENDOCRINE ❑ None ❑ Excessive thirst or hunger ❑ Hot/cold intolerance ❑ Hot Flashes
    ❑ Other_____

12. HEMATOLOGICAL ❑ None ❑ Easy Bruising ❑ Easy Bleeding ❑ Anemia
    ❑ Other_____

Signature:_____ Date:_____

Name:_____