THE STEADMAN CLINIC

Peter Millett, MD
Shoulder, Elbow & Knee Specialist
Sports Medicine
970-479-5871: Tel
970-479-5861: Fax

CLINICAL CASE AND MRI REVIEW

Dr. Peter Millett welcomes your *Clinical Case and MRI Review* for a fee of $150. After Dr. Millett has reviewed all of the information regarding your case, he will email or call you directly with the results.

To initiate a *Clinical Case and MRI Review* with Dr. Millett, please follow the instructions below to prepare a package to be mailed to our office:

- Print out and complete the Patient Consent Form and Clinical History Form
- Gather ALL imaging on a disk (X-Ray, MRI, CT-SCAN)
- Gather and send ALL radiology reports and interpretations of the image studies
- Include check or complete the payment authorization form in this packet

*****We recommend patients gather and mail their own materials in order to avoid delays and shipping errors from image centers and/or clinics.*****

Once all forms are complete, imaging has been gathered, and payment has been rendered, please mail the package to our Practice Director, Amy Manske as follows:

The Steadman Clinic
181 West Meadow Drive Suite 400
Vail, CO 81657
Attn: Amy Manske

Please direct any questions regarding this process to Amy Manske at 970-479-5871.

We look forward to the opportunity to help you!

Dr. Millett and Team

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Clinical Case and MRI Review Patient Consent Form

Consent for Clinical Case and MRI Review &
Authorization for the Release of Medical Information

Patient Information

Name: _____
Address: _____
_____
_____
Date of Birth: _____
Home Phone: _____

☐ I am 18 years or older. ☐ I am under the care of a physician

Because there is not an opportunity for a physical examination, this Clinical Case and MRI Review differs from diagnostic services typically provided by a physician. Without the benefit of examining you in person and observing your physical condition, Dr. Millett may not be aware of facts or information that could influence or be critical to his opinion. By requesting this service, you acknowledge that you are aware of this limitation and agree to assume the risk of this limitation.

Please read the following and indicate agreement to each paragraph by checking the "I agree" box below that paragraph:

I understand that the Clinical Case and MRI Review that I will receive from Dr. Millett is preliminary and limited because it does not have information typically obtained through a physical examination. The absence of a physical examination could affect Dr. Millett's ability to diagnose my condition or injury. This Clinical Case and MRI Review is not intended to replace a full medical evaluation or an in-person visit with a physician. I agree to solely assume the risks of the limitations associated with this review and understand that no warranty or guarantee is made to me concerning a specific result or cure of my condition or injury. I have read and agree to be bound by these conditions.

☐ Yes, I agree ☐ No, I do not agree

I have received the Notice of Privacy Practices of The Steadman Clinic and understand the explanation of how they may use and disclose confidential health information that identifies me. I consent to let The Steadman Clinic use and disclose health information about my Clinical Case and MRI Review. I can revoke my consent in writing at any time except to the extent that The Steadman Clinic has already relied on my consent.

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☐ Yes, I agree ☐ No, I do not agree

Authorization to Release Medical Information

If you would like us to share information with your physician, you must authorize us to do so by providing your physician's name and address and then signing below.

I hereby authorize The Steadman Clinic to release my Clinical Case and MRI Review report to the physician identified below.

☐ Yes, I would like you to send a copy of the online medical second opinion evaluation to:

Physician Name: _____
Address: _____
_____
_____

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Authorization for Clinical Case and MRI Review

I understand that if I do not sign the below authorization, Dr. Peter Millett will not be able to provide me with a Clinical Case and MRI Review. I also understand that any disclosure that The Steadman Clinic makes to a third party, such as the physician identified above, may or may not be protected by privacy laws.

This authorization is subject to revocation at any time, except to the extent that action has been taken thereon, and this authorization will expire one year from the date of authorization written below.

_____	_____	_____/_____/____
Signature of Patient**	Printed Name	Date Signed

**If other than patient's signature, a copy of legal papers verifying authority (e.g., Power of Attorney, Legal Guardian) must accompany the authorization when presented. The form must be signed, dated, witnessed by two people, and notarized when possible.

Exception: parent is signing for patient under 18.

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Payment Authorization Form

We accept both checks and credit cards for an 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.

Sign and complete this form to authorize The Steadman Clinic to make a one time debit to your cred card listed below. By signing this form, you give us permission to debit your account for the amount indicated on or after the indicated date. This is permission for a single 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 for **$150**. This
(Full Name)

payment is for an MRI review with Dr. Millett of The Steadman Clinic.

Billing Address _____
City, State, Zip _____
Phone Number _____
Email _____

Account Type (circle): Visa Mastercard AMEX Discover

Card Holder 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 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.

THE STEADMAN CLINIC
AND
STEADMAN PHILIPPON RESEARCH INSTITUTE

Acknowledgement of Notice of Privacy

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.]

Nondiscrimination

The Steadman Clinic complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

This information available in Spanish upon request. Solicite la versión en español de esta información.

181 W. Meadow Dr. Suite Number 400 Vail, CO 81657 (970) 476-1100 Fax (970) 479-5835
360 Peak One Drive Suite 340 P.O. Box 4815 Frisco, CO 80443 (970) 668-6760 Fax (970) 668-6761

www.thesteadmanclinic.com

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:_____