

CLINICAL CASE AND MRI REVIEW

Dr. Peter Millett welcomes your *Clinical Case and MRI Review* for a fee of \$250. After Dr. Millett has reviewed all of the information regarding your case, he will email or call you directly with the results.

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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
- Please email a copy of your insurance card (front and back) to Dr. Millett's Surgical Coordinator, Amanda Rakow: arakow@thesteadmanclinic.com. This will aide in expediting the scheduling process if you decide to pursue further treatment with Dr. Millett after your image review.

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

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Once all forms are complete, imaging has been gathered, and payment has been rendered, please mail the package to our Surgical Coordinator, Amanda Rakow as follows:

The Steadman Clinic
181 West Meadow Drive Suite 400
Vail, CO 81657
Attn: Amanda Rakow

Please direct any questions regarding this process to Amanda Rakow at 970-479-5879.

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We look forward to the opportunity to help you!
Dr. Millett and Team

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: _____
Preferred Phone: _____
Email Address: _____

- 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.

- Yes, I agree No, I do not agree

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, 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.

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 \$250.

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

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Sign and complete this form to authorize The Steadman Clinic to make a one time debit to your credit 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.

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I _____ authorize The Steadman Clinic to charge my credit card for **\$250**. 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 _____

CCV/CVV Code (three-digit security number on the back of Visa®, Mastercard®, and Discover® and four-digit code on the front of American Express®) _____

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.

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 GENERAL None Recent weight change Chills Fever Weakness/Fatigue
 Other _____

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: _____