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

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 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.

THE STEADMAN CLINIC

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

☐ 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: _____
_____
_____

THE STEADMAN CLINIC

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

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.

THE STEADMAN CLINIC

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

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 _____
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.