

**BOULDER  
NEUROSURGICAL  
ASSOCIATES**

Innovating the treatment of spine and brain disorders

**NEW PATIENT VISIT**

LAST NAME: \_\_\_\_\_ FIRST: \_\_\_\_\_ MI: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ST \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE:(\_\_\_\_\_) \_\_\_\_\_ WORK PHONE:(\_\_\_\_\_) \_\_\_\_\_ EXT:\_\_\_\_ MOBILE:(\_\_\_\_\_) \_\_\_\_\_

DATE OF BIRTH:\_\_\_\_/\_\_\_\_/\_\_\_\_ AGE:\_\_\_\_ SEX:  MALE  FEMALE HEIGHT:\_\_\_\_ WEIGHT:\_\_\_\_  
MONTH DAY YEAR

SOCIAL SECURITY NO.: \_\_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_

HAVE YOU BEEN SEEN BY A BOULDER NEUROSURGICAL PHYSICIAN BEFORE?  NO  YES

IF "YES" WHEN AND WHO: \_\_\_\_\_

WHO REFERRED YOU TO OUR OFFICE?: \_\_\_\_\_

PRIMARY CARE DOCTOR(S): \_\_\_\_\_

HAVE YOU SEEN ANOTHER DOCTOR OR HEALTH CARE PROVIDER FOR THIS CONDITION?  NO  YES

IF YES, NAME OF DOCTOR OR HEALTH CARE PROVIDER: \_\_\_\_\_

YOUR EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

EMPLOYED  RETIRED  DISABLED DUE TO CURRENT CONDITION  DISABLED DUE TO OTHER REASONS

MARITAL STATUS:  SINGLE  MARRIED  DIVORCED  WIDOWED

**EMERGENCY CONTACT (NOT LIVING WITH YOU)**

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

TELEPHONE#: (\_\_\_\_\_) \_\_\_\_\_ MOBILE: (\_\_\_\_\_) \_\_\_\_\_

**RELEASE OF MEDICAL INFORMATION TO OTHER CARE PROVIDERS**

Often times it may be necessary for BNA to share medical information with other physicians or health care providers who may be currently involved in your treatment. This allows the doctors to cross reference important medical information to provide you the best care possible. Your doctor can only share your medical records with other care providers when you release him/her to do so. By completing your signature below, you understand all of the above and allow this office to share medical information necessary for your treatment.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**PLEASE LIST CURRENT MEDICAL INSURANCE INFORMATION**

POLICY HOLDER'S NAME: \_\_\_\_\_  
LAST FIRST MI

ADDRESS: \_\_\_\_\_ APT#: \_\_\_\_\_ CITY: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

TELEPHONE: (\_\_\_\_\_) \_\_\_\_\_ MOBILE TELEPHONE: (\_\_\_\_\_) \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ SOCIAL SEC#: \_\_\_\_\_  
MONTH DAY YEAR

EMPLOYER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

TELEPHONE: (\_\_\_\_\_) \_\_\_\_\_ EXT.: \_\_\_\_\_

**PRIMARY INSURANCE:** \_\_\_\_\_ ID# \_\_\_\_\_ GROUP# \_\_\_\_\_

ADDRESS OF COMPANY: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ TELEPHONE: (\_\_\_\_\_) \_\_\_\_\_

**SECONDARY INSURANCE**

POLICY HOLDER'S NAME: \_\_\_\_\_  
LAST FIRST MI

RELATIONSHIP: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ SOCIAL SEC#: \_\_\_\_\_  
MONTH DAY YEAR

NAME OF INSURANCE COMPANY: \_\_\_\_\_ ID# \_\_\_\_\_ GROUP# \_\_\_\_\_

ADDRESS OF INSURANCE COMPANY: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ TELEPHONE: (\_\_\_\_\_) \_\_\_\_\_

**PERSON RESPONSIBLE FOR ACCOUNT**

MYSELF

OTHER LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ APT#: \_\_\_\_\_ CITY: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

TELEPHONE: (\_\_\_\_\_) \_\_\_\_\_ MOBILE: (\_\_\_\_\_) \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ WORK PHONE#: (\_\_\_\_\_) \_\_\_\_\_ EXT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ SUITE#: \_\_\_\_\_ CITY: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ DRIVERS LICENSE#: \_\_\_\_\_ STATE: \_\_\_\_\_

**AUTHORIZATION:** I HEREBY AUTHORIZE BOULDER NEUROSURGICAL ASSOCIATES TO FURNISH INFORMATION TO MY INSURANCE CARRIERS CONCERNING MY INJURY/ACCIDENT/CONDITION, AND I HEREBY IRREVOCABLY ASSIGN TO BOULDER NEUROSURGICAL ASSOCIATES ALL PAYMENTS FOR MEDICAL SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE COVERED BY MY INSURANCE.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



## Patient Financial Policy

1. I understand it is my responsibility to provide all referral forms, referral numbers and insurance cards needed to process my claim at the time of service.
2. All visits not covered by your insurance policy are to be paid at the time of service. It is the patient's responsibility to understand his/her insurance benefits.
3. All accounts, which are 90 days past the date of service, may be sent to collections, unless prior arrangements have been made.
4. I understand it is my responsibility to notify this office of any insurance changes.

Patient Payment Policy: Patients who are covered under an insurance plan are responsible for all co-pays, deductibles, and co-insurance amounts. Co-pays will be collected at the time of service. Once insurance has been filed and an explanation of benefits received, any amount indicated as patient responsibility will be billed to the patient or responsible party.

Returned Check Policy: All returned checks will be issued a \$25.00 fee to be billed to the patient. If a patient writes one insufficient fund check, the patient may clear their account by paying the \$25.00 service fee, in addition to the account balance, and may keep their check writing privileges. If the patient writes a second insufficient fund check, the account must be cleared and the service fee of \$25.00 paid, but check writing privileges will be revoked. The account would then be deemed "CASH ONLY".

Collection Agency Policy: Once insurance is billed and services have been processed, any patient balance is expected from the patient within the 30 days, unless other arrangements have been made. If the patient does not make payment on their account within 30 days, the account may be turned over to an outside collections agency. At which time additional fees may be incurred.

I have read and understand the above information

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Boulder Neurosurgical Associates, PLLC**  
**Notice of Health Information Privacy Practices**  
**Effective Date of this Notice: April 1, 2003**

**THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED WITHIN THIS ORGANIZATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE READ THIS CAREFULLY.**

Boulder Neurosurgical Associates (BNA) is required by law to maintain the privacy of your personal/medical information and to provide you with this notice of its privacy policies.

**Uses and Disclosures:**

**Treatment:** BNA may use your information to provide or coordinate your care. We may disclose all or any of your medical information to any of our physicians, other consulting or referring physicians, nurses or nurse practitioners, physician assistants, and other employees who have legitimate need for such information.

**Payment:** We may release your information to determine coverage by an insurer for our services, billing, and claims processing. The information may be released to an insurance company, third party payer or other organization involved in the payment of your bill. This information may include copies or excerpts of your medical information that is necessary to receive payment.

**Routine Operations:** We may use and disclose your information during routine operation of the practice. An example of routine operations would be to contact you to remind you of an appointment or to disclose information to transcriptionists, attorneys or consultants working for our practice. These entities are called "Business Associates". Our practice requires our Business Associates to treat your information in the same manner that we do.

**Research:** Under certain circumstances, we may use and disclose your information within approved clinical research studies. Most clinical research studies require specific patient consent; however, there may be some cases where a review of your information without patient contact may be conducted by the researchers.

**Regulatory Agencies:** We may disclose your information to state, local or federal agencies authorized by law to conduct inspections, audits, or investigations of the practice.

**Law Enforcement/Litigation:** We may disclose your information for valid law enforcement purposes as required by law or in response to a court order or subpoena.

**Public Health:** We may disclose your information to public health authorities as authorized by law and related to the prevention or control of certain diseases.

**Workers' Compensation:** We may release your information to Workers' Compensation agencies in the event your illness or injury may be related to your work.

**Military/Veterans:** If you are a member of the armed forces or a veteran, we may release your information as required by military command authorities.

**As Otherwise Required:** We may disclose your information in any situation in which such disclosure is required by law (for example, child or domestic abuse).

**Prohibited Uses:** We will not disclose your information to persons outside the practice for purposes other than treatment, payment or healthcare operations without your authorization in writing. If you provide such an authorization to us, you may revoke it in writing at anytime in the future and we will honor that request.

**Your Rights Related to Your Health Information:** Although all records concerning your treatment at BNA are the property of BNA, you have certain rights concerning this information as follows:

**Right to Confidentiality:** You have the right to receive confidential communication of your health information by alternative means or at alternative locations.

**Right to Inspect and Copy:** You generally have the right to inspect and receive a copy of your health information from BNA, unless, the information is restricted by law or your physician. You will need to make payment for copies of any records we provide.

**Right to Amend:** You have the right to request an amendment or correction to your health information. If we agree that information is appropriate, we will include that information in your health information.

**Right to Accounting:** You have the right to obtain a record of disclosures that we make of your health information for other than treatment, payment or routine operations of the practice.

**Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of your health information. We will abide by these requests to the extent that we are able.

**Right to Revoke Authorization:** You have the right to revoke your prior authorization to release your health information except to the extent action was taken in reliance of your original authorization.

Changes to this notice: BNA will abide by the terms of this Notice currently in effect. However, BNA reserves to change the terms of the Notice at any time. Any new notice provisions will be effective for all health information from the time that the changes are effective within BNA.

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Signature of Patient or Patient's Representative

Print Name

Date

**MEDICAL INFORMATION DISTRIBUTION/RELEASE**

I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

\_\_\_\_\_  
\_\_\_\_\_

II. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

III. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

\_\_\_\_\_  
\_\_\_\_\_

IV. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL":

YES \_\_\_\_\_ NO \_\_\_\_\_

V. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home phone number:

( ) \_\_\_\_\_

\* I am fully aware that a cell phone is not a secure and private line.

\*\* I am fully aware my health information can be transmitted by facsimile (fax), mail or the internet.

VI. Can confidential messages (i.e., appointment reminders) be left on your home answering machine or voicemail?

YES \_\_\_\_\_ NO \_\_\_\_\_

PATIENT NAME \_\_\_\_\_

PATIENT/GUARDIAN SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_ AGE: \_\_\_\_\_

DESCRIBE THE REASON FOR TODAY'S VISIT: \_\_\_\_\_  
\_\_\_\_\_

CURRENT PROBLEM IS THE RESULT OF AN ACCIDENT:  NO  YES

IF "YES"  AUTO ACCIDENT  WORK INJURY  RECREATIONAL ACCIDENT  HOME ACCIDENT

ONSET OF SYMPTOMS OR INJURY : \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MONTH DAY YEAR

HOW LONG DO YOU HAVE THIS CONDITION? \_\_\_\_\_ YEARS \_\_\_\_\_ MONTHS

HAVE YOU HAD THE FOLLOWING TREATMENTS FOR YOUR CONDITION? (MARK ALL THAT APPLY)

- BRACING  MASSAGE  PHYSICAL THERAPY  CHIROPRACTIC MANIPULATIONS
- SPINAL INJECTIONS  TRACTION THERAPY  SPINAL CORD STIMULATOR
- MORPHINE PUMP  ALTERNATIVE MEDICINE THERAPIES  NONE  N/A

HAVE YOU HAD ANY PREVIOUS SURGERIES FOR THIS CONDITION?  NO  YES IF YES, WHICH LEVEL? \_\_\_\_\_

OTHER SURGERIES AND HOSPITALIZATIONS	YEAR	SURGERY COMPLICATIONS
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE REQUEST AN ADDITIONAL SHEET IF NECESSARY

HAVE YOU EVER HAD GENERAL ANESTHESIA?  NO  YES  
PLEASE DESCRIBE HERE IF YOU HAD ANY PROBLEMS WITH GENERAL ANESTHESIA? \_\_\_\_\_  
\_\_\_\_\_

OTHER MEDICAL PROBLEMS IN THE PAST (NOT INCLUDED ABOVE) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PLEASE REQUEST AN ADDITIONAL SHEET IF NECESSARY

MEDICATIONS THAT YOU ARE CURRENTLY TAKING:	DOSE	TIMES/ DAY
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE LIST ANY BLOOD THINNERS (ASPIRIN, ADVIL, WARFARIN, ETC) AND HERBAL SUPPLEMENTS. PLEASE REQUEST AN ADDITIONAL SHEET IF NECESSARY

DO YOU HAVE ANY DRUG, IV DYE, LATEX OR FOOD ALLERGIES?  NO  YES IF YES, PLEASE LIST \_\_\_\_\_  
\_\_\_\_\_

ARE THERE ANY MEDICAL CONDITIONS THAT RUN IN YOUR FAMILY?  NO  YES IF YES, PLEASE DESCRIBE: \_\_\_\_\_  
\_\_\_\_\_

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_

**SOCIAL HISTORY**

DO YOU LIVE ALONE?  NO  YES

DO YOU HAVE CHILDREN?  NO  I HAVE \_\_\_\_\_ CHILDREN

I HAVE SMOKED \_\_\_\_\_ PACK(S) PER DAY FOR \_\_\_\_\_ YEARS  I NEVER SMOKED  QUIT \_\_\_\_\_ YEARS AGO

I DO NOT DRINK ALCOHOL  I DRINK ONLY SOCIALLY  I DRINK DAILY. IF CHECKED, HOW MUCH? \_\_\_\_\_

ARE YOU AT RISK FOR HIV/AIDS? (BLOOD TRANSFUSIONS, DRUG USE, ETC.)? IF YES, PLEASE EXPLAIN \_\_\_\_\_

**REVIEW OF THE SYSTEMS** (PLEASE CHECK CONDITIONS THAT YOU CURRENTLY HAVE)

**1. GENERAL**

- RECENT FEVER/ CHILLS
- RECENT WEIGHT LOSS
- RECENT WEIGHT GAIN
- SLEEP PROBLEMS

**2. EYES**

- WEAR GLASSES
- EYE INFECTIONS
- EYE INJURIES
- CATARACTS
- GLAUCOMA

**3. EAR, NOSE, THROAT AND MOUTH**

- WEAR HEARING AIDS
- HEARING LOSS
- EAR PAIN
- EAR INFECTIONS
- RINGING IN THE EARS  
 RT  LT
- BALANCE DISTURBANCE
- VERTIGO/ SPINNING
- NOSEBLEDS
- INABILITY TO SMELL
- RINGING IN THE EARS

**4. PSYCHOLOGICAL**

- ANXIETY
- DEPRESSION
- CLAUSTROPHOBIA
- TROUBLE CONCENTRATING

**5. ENDOCRINE**

- DIABETES
- THYROID DISEASE

**6. MUSCULOSCELETAL**

- BACK PAIN
- LEG PAIN  
 RT  LT
- LEG WEAKNESS  
 RT  LT
- NECK PAIN
- ARM PAIN  
 RT  LT
- ARM WEAKNESS  
 RT  LT
- ARTHRITIS

**7. NEUROLOGICAL**

- HEADACHE
- LOSS OF CONSCIOUSNESS
- DIZZINESS/ VERTIGO
- POOR BALANCE/ FREQUENT FALLING
- SEIZURES
- DIFFICULTY WITH SPEECH
- DOUBLE/ BLURRED VISION
- PARALYSIS
- FACE WEAKNESS
- FACIAL PAIN
- FACIAL SPASM

**8. BLOOD AND LYMPH**

- ANEMIA
- HEMOPHILIA
- BLEEDING TENDENCIES
- SWOLLEN GLANDS OR LYMPHNODES
- BLOOD TRANSFUSIONS  
IF YES, WHEN?
- IMMUNOLOGIC DISORDERS

**9. CARDIOVASCULAR**

- HEART DISEASE
- CHEST PAIN, ANGINA
- SHORTNESS OF BREATH
- DATE OF LAST EKG \_\_\_\_\_
- HIGH BLOOD PRESSURE
- LOW BLOOD PRESSURE
- IRREGULAR PULSE
- HEART MURMUR
- HIGH CHOLESTEROL
- LEG SWELLING

**10. RESPIRATORY**

- ASTHMA
- EMPHYSEMA
- BRONCHITIS
- PNEUMONIA
- LUNG CANCER
- DATE OF LAST CHEST X-RAY \_\_\_\_\_

**11. GASTROINTESTINAL**

- LIVER DISEASE
- JAUNDICE
- ULCERS OR GASTRITIS
- COLON, LIVER OR STOMACH CANCER
- BLOOD IN YOUR VOMIT

**12. GENITOURINARY**

- BLOOD IN URINE
- DIFFICULTY URINATING
- INCONTINENCE
- KIDNEY STONES
- PROSTATE CANCER
- UTERINE/ CERVICAL CANCER

PLEASE LIST ANY OTHER CONDITIONS/CONCERNS NOT MENTIONED ABOVE THAT YOU BELIEVE WOULD BE RELEVANT TO YOUR OFFICE VISIT \_\_\_\_\_

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_ AGE: \_\_\_\_\_

PLEASE CIRCLE THE NUMBER THAT BEST INDICATES THE LEVEL OF YOUR CURRENT PAIN

LOW BACK PAIN	NO PAIN	0	1	2	3	4	5	6	7	8	9	10	SEVERE PAIN
LEG PAIN	NO PAIN	0	1	2	3	4	5	6	7	8	9	10	SEVERE PAIN
NECK PAIN	NO PAIN	0	1	2	3	4	5	6	7	8	9	10	SEVERE PAIN
ARM PAIN	NO PAIN	0	1	2	3	4	5	6	7	8	9	10	SEVERE PAIN
OTHER PAIN (_____)	NO PAIN	0	1	2	3	4	5	6	7	8	9	10	SEVERE PAIN

ARE YOU EXPERIENCING THE FOLLOWING SYMPTOMS:

- WEAKNESS IN YOUR ARMS    LEGS    ARMS    LEFT    RIGHT  
 DIFFICULTIES WITH BOWEL AND/ OR BLADDER

IF YOU ARE EXPERIENCING NECK, LOW BACK, ARM, LEG OR OTHER PAIN, PLEASE ANSWER THE FOLLOWING:

PLEASE MARK THESE DRAWINGS ACCORDING TO WHERE YOU HURT USING THE KEY BELOW TO ILLUSTRATE THE CHARACTER OF YOUR PAIN. MARK A CIRCLED "X" IN THE ONE PLACE YOUR PAIN IS MOST SEVERE.

<b>SHOOTING-STABBING</b> //////////	<b>BURNING / ACHING</b> ~~~~~	<b>PINS &amp; NEEDLES</b> +++++++	<b>NUMBNESS</b> 000000
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