

BOULDER
NEUROSURGICAL & SPINE
ASSOCIATES

Boulder · Longmont · Lafayette · Louisville · Brighton
· Denver Metro ·

CHART #: _____
FOR OFFICE USE ONLY

NEW PATIENT VISIT

LAST NAME: _____ FIRST: _____ MI: _____

MAILING ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

PHYSICAL ADDRESS (IF DIFFERENT THAN MAILING) : _____
CITY: _____ ST: _____ ZIP: _____

HOME PHONE:(_____) _____ WORK PHONE:(_____) _____ EXT:____ MOBILE:(_____) _____

PERMISSION TO USE MOBILE PHONE (INITIAL): _____

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 PHARMACY (INCLUDE CROSS STREETS): _____
CITY: _____ ST: _____ ZIP: _____

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: _____

PRINT NAME: _____

Boulder Neurosurgical & Spine Associates

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 (FULL NAME): _____

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 (FULL NAME) : _____ 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: _____

PRINT NAME: _____

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PATIENT STATEMENT OF INJURY/ACCIDENT/CONDITION DETAILS

THIS INFORMATION IS FOR YOUR INSURANCE COMPANY. CLAIMS MAY NOT BE PAID IF INFORMATION IS NOT ACCURATE.

PATIENT NAME: _____
LAST FIRST MI

DATE OF BIRTH: _____/_____/_____
MONTH DAY YEAR

FULL TIME STUDENT NO YES IF YES, NAME OF SCHOOL: _____

PRIMARY INSURANCE COMPANY: _____ ID#: _____

OTHER INSURANCE? NO YES

IF YES, PLEASE EXPLAIN: _____

DETAILS OF THE ACCIDENT:

AUTO ACCIDENT WORK INJURY RECREATIONAL ACCIDENT HOME ACCIDENT OTHER ACCIDENT

MY CONDITION IS NOT AN INJURY

DATE OF INJURY: _____/_____/_____
MONTH DAY YEAR

WHERE DID THIS OCCUR? _____

DETAILS OF CONDITION OR INJURY:

AUTHORIZATION: I HEREBY AUTHORIZE **BOULDER NEUROSURGICAL ASSOCIATES** TO FURNISH THIS INFORMATION TO MY INSURANCE CARRIERS CONCERNING MY INJURY/ACCIDENT/CONDITION.

PATIENT/GUARANTOR SIGNATURE: _____ DATE: _____

PRINT NAME: _____

THIS FORM IS TO BE SENT WITH THE FIRST VISIT INSURANCE CLAIM FORM.

Boulder Neurosurgical & Spine Associates

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 No Show Policy: A \$50 charge will be assessed if a patient fails to show up to their appointment without 24 hour notification.

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:** _____

PRINT NAME: _____

Boulder Neurosurgical & Spine 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.

Signature of Patient or Patient's Representative

Print Name

Date

Boulder Neurosurgical & Spine Associates

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 _____

SIGNATURE: _____ DATE: _____

PRINT NAME: _____

Boulder Neurosurgical & Spine Associates

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 HAVE YOU HAD 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: _____

SIGNATURE: _____ DATE: _____

PRINT NAME: _____

Boulder Neurosurgical & Spine Associates

LAST NAME: _____ FIRST NAME: _____ MI: _____ AGE: _____

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
- NOSEBLEEDS
- 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
- CANCER

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

SIGNATURE: _____ DATE: _____

PRINT NAME: _____