BOULDER
NEUROSURGICAL & SPINE
ASSOCIATES

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

CHART #:____________________
FOR OFFICE USE ONLY

NEW PATIENT VISIT BACK

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): _____ **PREFERRED LANGUAGE:** ______________

BIRTH DATE:___/___/____ **AGE:**___ **SEX:** ☐ M ☐F **HGT:**____ **WGT:**____ **RACE:**_______ **ETHNICITY:**________
MO DAY YEAR

SOCIAL SECURITY NO.:______________________ **EMAIL ADDRESS:**______________________________

MAY WE USE YOUR EMAIL FOR COMMUNICATION? ☐ NO ☐YES

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):____

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 (<u>NOT LIVING WITH YOU</u>)

NAME:____________________________________ **RELATIONSHIP:**__________________

ADDRESS:______________________________ **CITY:**____________ **ST:**______ **ZIP:**________

TELEPHONE#:_(_____)______________________ **MOBILE:_(____)**______________________

I hereby acknowledge that I have been provided BNA's Notice of Privacy Practices and understand that I may, at any time, request to receive the full Notice of Privacy Practices from BNA, 4743 Arapahoe Ave, Suite 202, Boulder, CO 80303, 303-938-5700.

SIGNATURE:______________________________________ **DATE:**________________

PRINT NAME:___________________________ **RELATIONSHIP:**________________________

CHART #:____________________
FOR OFFICE USE ONLY

Boulder Neurosurgical & Spine Associates

PLEASE LIST CURRENT MEDICAL INSURANCE INFORMATION

PRIMARY INSURANCE:______________________________ ID#______________ GROUP#____________

ADDRESS OF COMPANY:____

CITY:____________________ STATE:___________ ZIP:__________ TELEPHONE:_(_____)____________

POLICY HOLDER'S NAME:________________________ ____________________ ____
LAST FIRST MI

TELEPHONE:(_______)____________________ MOBILE TELEPHONE:(______)____________________

RELATIONSHIP:__________________ DATE OF BIRTH:_____/______/_____ SOCIAL SEC#:______________
MONTH DAY YEAR

EMPLOYER (FULL NAME):____

ADDRESS:____

CITY:________________________________ STATE:__________ ZIP:______________

TELEPHONE: _(______)____________________ EXT.:__________

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: ____

CHART #:______________________
FOR OFFICE USE ONLY

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

2. EYES
- ☐ WEAR GLASSES

3. EAR, NOSE, THROAT AND MOUTH
- ☐ HEARING LOSS

4. RESPIRATORY
- ☐ ASTHMA
- ☐ EMPHYSEMA

5. CARDIOVASCULAR
- ☐ HEART DISEASE
- ☐ CHEST PAIN, ANGINA
- ☐ SHORTNESS OF BREATH
- ☐ HIGH BLOOD PRESSURE
- ☐ IRREGULAR PULSE
- ☐ HEART MURMUR

6. GASTROINTESTINAL
- ☐ BLOOD IN YOUR VOMIT

7. GENITOURINARY
- ☐ BLOOD IN URINE

9. NEUROLOGICAL
- ☐ HEADACHE
- ☐ DIZZINESS/ VERTIGO
- ☐ SEIZURES
- ☐ DIFFICULTY WITH SPEECH
- ☐ DOUBLE/ BLURRED VISION
- ☐ FACE WEAKNESS
- ☐ FACIAL PAIN

10. PSYCHOLOGICAL
- ☐ DEPRESSION

11. MUSCULOSCELETAL
- ☐ BACK PAIN
- ☐ LEG PAIN ☐ **RT** ☐ **LT**
- ☐ LEG WEAKNESS ☐ **RT** ☐ **LT**
- ☐ NECK PAIN
- ☐ ARM PAIN ☐ **RT** ☐ **LT**
- ☐ ARM WEAKNESS ☐ **RT** ☐ **LT**
- ☐ ARTHRITIS

12. BLOOD AND LYMPH
- ☐ BLEEDING TENDENCIES

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

____

CHART #: ____________________
FOR OFFICE USE ONLY

Boulder Neurosurgical & Spine Associates

LAST NAME: ____________________ **FIRST NAME:** ____________________ **MI:** ____ **AGE:** ____

DESCRIBE THE REASON FOR TODAY'S VISIT: ____________________

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/OR HOSPITALIZATIONS	YEAR	SURGERY COMPLICATIONS

PLEASE REQUEST AN ADDITIONAL SHEET IF NECESSARY

OTHER MEDICAL CONDITIONS (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: ____________________

CHART #:________________________
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PATIENT STATEMENT OF INJURY/ACCIDENT/CONDITION DETAILS

ARE YOU HERE AS A RESULT OF AN INJURY OR ACCIDENT? ☐ NO ☐YES IF YES, PLEASE COMPLETE BELOW:

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

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

WHERE DID THIS OCCUR?______________________________

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.

CHART #:____________________
FOR OFFICE USE ONLY

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, voicemail or sent via email?

YES____________ NO ____________

SIGNATURE:______________________________________ **DATE:**____________________

PRINT NAME: ______________________________________

CHART #:______________________
FOR OFFICE USE ONLY

Boulder Neurosurgical & Spine Associates

LAST NAME:______________________ **FIRST NAME:** ______________________ **MI:** _____ **AGE:** _____

PLEASE CIRCLE THE NUMBER THAT BEST DESCRIBES YOUR PAIN **ON AVERAGE IN THE LAST 7 DAYS**

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**

ARE YOU EXPERIENCING THE FOLLOWING SYMPTOMS:

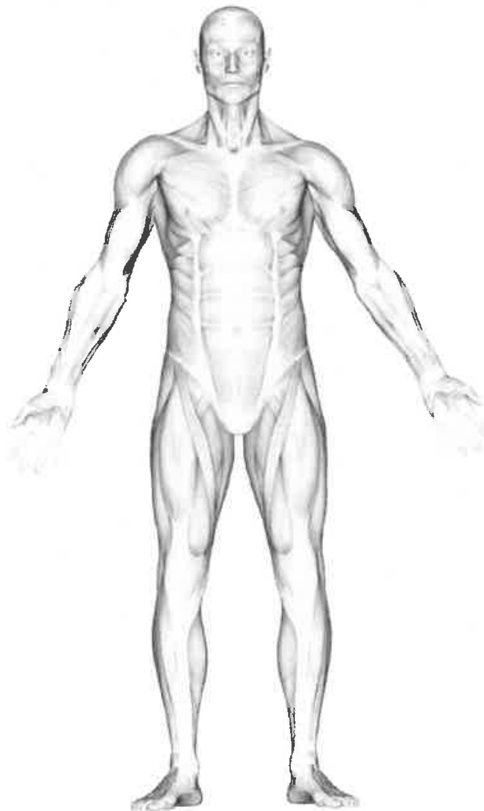
☐ WEAKNESS IN YOUR LEGS ☐ LEFT ☐ RIGHT

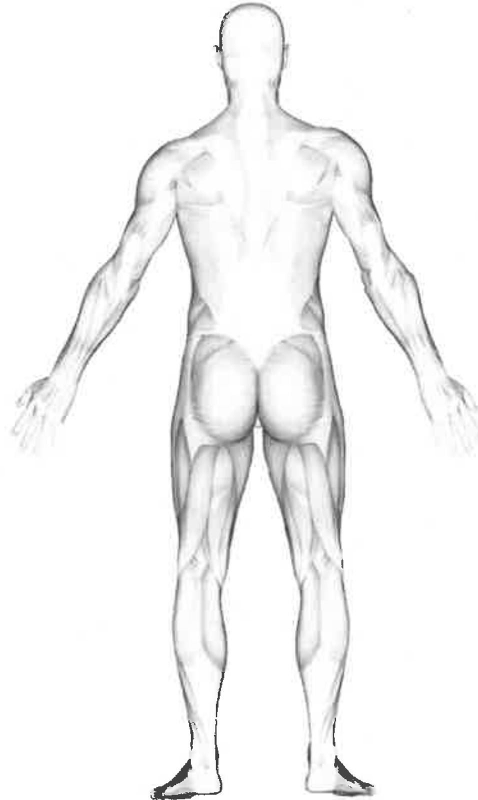
☐ DIFFICULTIES WITH BOWEL AND/ OR BLADDER

IF YOU ARE EXPERIENCING LOW BACK OR LEG 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.

SHOOTING-STABBING	**BURNING / ACHING**	**PINS & NEEDLES**	**NUMBNESS**
//////////	ΛΛΛΛΛΛ	+++++++	oooooo





SIGNATURE:______________________ **DATE:**______________________

PRINT NAME: ______________________

Oswestry Disability Index (OWI) Questionnaire

☐ Preoperative	☐ 6 Week Follow-Up	☐ 3 Month Follow-Up	☐ 6 Month Follow-Up
☐ 1 Year Follow-Up	☐ 2 Year Follow-Up	☐ Unscheduled	

INSTRUCTIONS: Could you please complete this questionnaire. It is designed to give us information as to how your back (or leg) trouble has affected your ability to manage in everyday life. Please answer **every section**. Mark **one box only** in each section that most closely describes you today.

1. Pain Intensity

0 ☐ I have no pain at the moment.
1 ☐ The pain is very mild at the moment.
2 ☐ The pain is moderate at the moment.
3 ☐ The pain is fairly severe at the moment.
4 ☐ The pain is very severe at the moment.
5 ☐ The pain is the worst imaginable at the moment.

2. Personal Care (Washing, Dressing, Etc.)

0 ☐ I can look after myself normally without causing extra pain.
1 ☐ I can look after myself normally, but it is very painful.
2 ☐ It is painful to look after myself and I am slow and careful.
3 ☐ I need some help, but manage most of my personal care.
4 ☐ I need help everyday in most aspects of self-care.
5 ☐ I do not get dressed, I wash with difficulty and stay in bed.

3. Lifting

0 ☐ I can lift heavy weights without extra pain.
1 ☐ I can lift heavy weights, but it gives extra pain.
2 ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
3 ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
4 ☐ I can lift only very light weights.
5 ☐ I cannot lift or carry anything at all.

4. Walking

0 ☐ Pain does not prevent me walking any distance.
1 ☐ Pain prevents me walking more than 1 mile.
2 ☐ Pain prevents me walking more than ½ of a mile
3 ☐ Pain prevents me walking more than 100 yards.
4 ☐ I can only walk using a stick or crutches.
5 ☐ I am in bed most of the time and have to crawl to the toilet.

5. Sitting

0 ☐ I can sit in any chair as long as I like.
1 ☐ I can sit in my favorite chair as long as I like.
2 ☐ Pain prevents me from sitting for more than 1 hour.
3 ☐ Pain prevents me from sitting for more than ½ an hour.
4 ☐ Pain prevents me from sitting for more than 10 minutes.
5 ☐ Pain prevents me from sitting at all.

6. Standing

0 ☐ I can stand as long as I want without extra pain.
1 ☐ I can stand as long as I want but it gives me extra pain.
2 ☐ Pain prevents me from standing more than 1 hour.
3 ☐ Pain prevents me from standing more than ½ an hour.
4 ☐ Pain prevents me from standing more than 10 minutes.
5 ☐ Pain prevents me from standing at all.

7. Sleeping

0 ☐ My sleep is never disturbed by pain.
1 ☐ My sleep is occasionally disturbed by pain.
2 ☐ Because of pain I have less than 6 hours sleep.
3 ☐ Because of pain I have less than 4 hours sleep.
4 ☐ Because of pain I have less than 2 hours sleep.
5 ☐ Pain prevents me from sleeping at all.

8. Sex Life (if applicable)

0 ☐ My sex life is normal and causes no extra pain.
1 ☐ My sex life is normal but causes some extra pain.
2 ☐ My sex life is normal but is very painful.
3 ☐ My sex life is severely restricted by pain.
4 ☐ My sex life is nearly absent because of pain.
5 ☐ Pain prevents any sex life at all.

9. Social Life

0 ☐ My social life is normal and causes me no extra pain.
1 ☐ My social life is normal but increases the degree of pain.
2 ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. sport, etc.
3 ☐ Pain has restricted my social life is normal and I do not go out as often.
4 ☐ Pain has restricted my social life to my home.
5 ☐ I have no social life because of pain.

10. Traveling

0 ☐ I can travel anywhere without pain.
1 ☐ I can travel anywhere but it gives me extra pain.
2 ☐ Pain is bad, but I manage journeys over two hours.
3 ☐ Pain restricts me to journeys of less than one hour.
4 ☐ Pain restricts me to short necessary journeys under 30 minutes.
5 ☐ Pain prevents me from travelling except to receive treatment.

Please do not erase or cover mistake with correction fluid or tape. Line through the mistake once, initial and date next the correction.

Subject Initials: ______________________ Date: ______________________

SF-12 Health Survey Questionnaire

☐ Preoperative	☐ 6 Week Follow-Up	☐ 3 Month Follow-Up	☐ 6 Month Follow-Up
☐ 1 Year Follow-Up	☐ 2 Year Follow-Up	☐ Unscheduled	

INSTRUCTIONS: This questionnaire asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Please answer every question by marking one box. If you are unsure about how to answer, please give the best answer you can.

1. **In general**, would you say your health is:

☐ Excellent	☐ Very Good	☐ Good	☐ Fair	☐ Poor

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, Limited A Lot	Yes, Limited A Little	No, Not Limited At All
2. **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling or playing golf	☐	☐	☐
3. Climbing **several** flights of stairs	☐	☐	☐

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	Yes	No
4. **Accomplished less** than you would like	☐	☐
5. Were **limited** in the kind of work or other activities	☐	☐

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	Yes	No
6. **Accomplished less** than you would like	☐	☐
7. Were **limited** in the kind of work or other activities	☐	☐

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

☐ Not at all	☐ A little bit	☐ Moderately	☐ Quite a bit	☐ Extremely

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks –

	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
9. Have you felt calm and peaceful?	☐	☐	☐	☐	☐	☐
10. Did you have a lot of energy?	☐	☐	☐	☐	☐	☐
11. Have you felt downhearted and blue?	☐	☐	☐	☐	☐	☐

12. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

☐ All of the time	☐ Most of the time	☐ A Good bit of the time	☐ Some of the time	☐ A little of the time	☐ None of the time

Subject Initials: ____________________ Date: ____________________

CHART #:________________
FOR OFFICE USE ONLY

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: ________________________________

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how Boulder Neurosurgical & Spine Associates may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Name of Patient (print): ______________________________

Date of Birth: ______________

I. My Authorization

I authorize ______________ to use or disclose the following health information:

- ❑ All of my health information
- ❑ My health information relating to the following treatment or condition:

  ____
- ❑ My health information covering the period of healthcare from ________ (Start Date) to ________ (End Date).
- ❑ Other:______________________________

The above party may disclose this health information to the following recipient:

Name/Organization: ______________________________

Phone: ______________ Fax: ______________ Email: ______________

The purpose of this authorization is (check all that apply):

- ❑ At my request
- ❑ To authorize the using or disclosing party to communicate with me for marketing purposes when they receive payment from a third party to do so.
- ❑ To authorize the using or disclosing party to sell my health information. I understand that the seller will receive compensation for my health information and will stop any future sales if I revoke this authorization.
- ❑ Other: ______________________________

  ____

This authorization ends:

☐ On (Date): ______________ ☐ When I am no longer a patient of the practice.

☐ When the following event occurs: ______________________________

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards. I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization. I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: ______________________ Date: __________

If the patient is a minor or unable to sign please complete the following:

- ❑ Patient is a minor: _____ years of age
- ❑ Patient is unable to sign because: ______________________

Authorized Representative Signature: ______________________ Date: __________

Print Name of Representative: ______________________

Authority of representative to sign on behalf of patient:

☐ Parent ☐ Legal Guardian ☐ Court Order ☐ Other: ______________________

III. Additional Consent for Certain Conditions

This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released.

☐ I consent ☐ I do not consent

Signature of Patient or Authorized Representative: ______________________

Date: __________ Time: __________

IV. Additional Consent for HIV/AIDS

This medical record may contain information concerning HIV testing and/or AIDS diagnosis or treatment. Separate consent must be given to have this information released.

☐ I consent ☐ I do not consent

Signature of Patient or Authorized Representative: ______________________

Date: __________ Time: __________

V. Notice of Privacy Practices

The signature below indicates that I have been provided with a copy of the Notice of Privacy Practices for the authorized party listed above and have read and understood its content.

Signature of Patient or Authorized Representative: ______________________

Date: __________ Time: __________

Boulder Neurosurgical & Spine Associates | Notice of Privacy Practices

Effective 03/06/2020

Your Information. Your Rights. Our Responsibilities.
This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights
When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. You can get an electronic or paper copy of your medical record:

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information. We may charge a reasonable, cost-based fee.

ASK US TO CORRECT YOUR MEDICAL RECORD

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days

REQUEST CONFIDENTIAL COMMUNICATIONS

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

ASK US TO LIMIT WHAT WE USE OR SHARE

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

GET A LIST OF THOSE WITH WHOM WE'VE SHARED INFORMATION

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

GET A COPY OF THIS PRIVACY NOTICE

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

CHOOSE SOMEONE TO ACT FOR YOU

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

FILE A COMPLAINT IF YOU FEEL YOUR RIGHTS ARE VIOLATED

- You can complain if you feel we have violated your rights by contacting us at 303-938-5700.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints
- We will not retaliate against you for filing a complaint.

Your Choices
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

HOW DO WE TYPICALLY USE OR SHARE YOUR HEALTH INFORMATION?

We typically use or share your health information in the following ways:

TREAT YOU

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

RUN OUR ORGANIZATION

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

BILL FOR YOUR SERVICES

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

HELP WITH PUBLIC HEALTH AND SAFETY ISSUES

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

DO RESEARCH

We can use or share your information for health research.

COMPLY WITH THE LAW

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

RESPOND TO ORGAN AND TISSUE DONATION REQUESTS

We can share health information about you with organ procurement organizations.

WORK WITH A MEDICAL EXAMINER OR FUNERAL DIRECTOR

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

ADDRESS WORKERS' COMPENSATION, LAW ENFORCEMENT, AND OTHER GOVERNMENT REQUESTS

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

RESPOND TO LAWSUITS AND LEGAL ACTIONS

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

FOR MORE INFORMATION SEE:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.