BOULDER
NEUROSURGICAL & SPINE
ASSOCIATES

New Patient Visit

Last Name:_____First:_____DOB: _____

Birth Date:_____/_____/_____Age:_____ Sex: ☐ M ☐ F ☐ Identify as: _____
Mo Day Year

Occupation:_____Race: _____

Mailing Address:_____City:_____St:_____Zip: _____

Physical Address:_____City:_____St:_____Zip: _____
(If Different Than Mailing)

Preferred Language: _____

Home Phone: (_____)_____Mobile Phone: (_____)_____

Work Phone: (_____)_____Ext:_____

Email Address: _____

Preferred Type Of Contact: ☐ Home Phone ☐ Mobile Phone ☐ Work Phone ☐ Email

Referring Physician/Primary Care Doctor To Our Office: _____

Primary Care Doctor(s): _____

Your Pharmacy (Include Cross Streets): _____

City:_____St:_____Zip: _____

Please List the Family Members Or Significant Others, if Any, Whom We May Contact About Your Medical Condition:

Emergency Only

Contact Name:_____Phone:_____☐

Contact Name:_____Phone:_____☐

Contact Name:_____Phone:_____☐

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PLEASE LIST CURRENT MEDICAL INSURANCE INFORMATION
PRIMARY INSURANCE: _____ ID# _____ GROUP#_____

Address of Company: _____

City: _____ State: _____ Zip:_____Phone:_(__)_____

Policy Holder's Name: _____ _____ _____

Telephone: (_____)_____ Cellphone: (_____)_____

Relationship: _____ Date of Birth: _____/_____/_____

Employer (Full name): _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (_____)_____ Ext: _____

SECONDARY INSURANCE

Policy Holder's Name: _____ _____ _____

Relationship: _____ Date of Birth: _____/_____/_____

Name of Insurance Company: _____ ID# _____ GROUP#_____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (_____)_____ Ext: _____

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

SIGNATURE: _____ **DATE:** _____

PRINTED NAME: _____

BOULDER
NEUROSURGICAL & SPINE
ASSOCIATES

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 Form Is To Be Sent With The First Visit Insurance Claim Form.

This Information Is For Your Insurance Company. Claims May Not Be Paid If Information Is Not Accurate.

Last Name:_____ First:_____ MI: _____

Birth Date:_____/_____/_____ Age:_____ Sex: ☐ M ☐ F ☐ Identify as: _____
Mo Day Year

Full Time Student? ☐ No ☐ Yes If Yes, Name Of School:_____

Accident Insurance:_____ Policy:_____

Adjuster Name:_____ Adjuster Phone Number: _____

Details Of The Accident:

☐ Auto Accident ☐ Work Injury ☐ Recreational Accident ☐ Home Accident ☐ Other Accident

Date of Accident_____/_____/_____
Mo Day Year

Where Did This Occur? Please Briefly Explain What Happened:

_____

_____

_____

BOULDER
NEUROSURGICAL & SPINE
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Surgical History

Last Name:_____ First:_____ DOB: _____

Describe The Reason For Today's Visit:_____

_____

Have You Had Any Previous Surgeries For This Condition? ☐No ☐ Yes, Which Level(s)? _____

Have You Had The Following Treatments For Your Condition? (Please Mark All That Apply And Provide Information On The Treatment Location And Physician)

	Location/Hospital	Physician
☐ Physical Therapy		
☐ Chiropractic Manipulations		
☐ Spinal Injections		
☐ Massage		
☐ Other		

☐ None

☐ Medications For This Condition _____

_____

_____

_____

Previous Surgeries And/Or Hospitalizations (Include Complications If Any)	Date (MM/YYYY)	Location/Hospital

BOULDER
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Medical & Social History

Last Name:_____ First Name:_____ DOB: _____

- ☐ I Have Smoked_____Pack(s) Per Day For_____Years
- ☐ I Quit_____Years Ago
- ☐ I Have Never Smoked
- ☐ I Consume_____Drinks Daily.
- ☐ I Drink Only Socially
- ☐ I Do Not Drink Alcohol

Are You At Risk For HIV/AIDS or Hepatitis? (Blood Transfusions, Drug Use, etc.)? ☐ No ☐ Yes

Person Medical History, Conditions and/or Concerns That You Believe To Be Relevant To Our Office):

Family Medical History, Conditions and/or Concerns That You Believe To Be Relevant To Our Office):

Review of the Systems (Please Check Conditions That You Currently Have)

General
- ☐ General Weight Loss
- ☐ Recent Fever/Chills

Eyes
- ☐ Contacts
- ☐ Wear Glasses

Ear/Nose/Throat/Mouth
- ☐ Hearing Loss

Psychological
- ☐ Addiction
- ☐ Anxiety
- ☐ Bipolar
- ☐ Depression

Respiratory
- ☐ Asthma
- ☐ Emphysema

Genitourinary
- ☐ Blood In Urine

Blood and Lymph
- ☐ Bleeding Tendencies

Cardiovascular
- ☐ Chest Pain, Angina
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Irregular Pulse
- ☐ Shortness of Breath

Neurological
- ☐ Difficulty With Speech
- ☐ Dizziness / Vertigo
- ☐ Double / Blurred Vision
- ☐ Face Weakness
- ☐ Facial Pain
- ☐ Headache
- ☐ Seizures

Musculoskeletal
- ☐ Arm Pain ☐ L ☐ R
- ☐ Arm Weakness ☐ L ☐ R
- ☐ Arthritis
- ☐ Back Pain
- ☐ Leg Pain ☐ L ☐ R
- ☐ Leg Weakness ☐ L ☐ R
- ☐ Neck Pain

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Medication History

Last Name:_____ First Name:_____ DOB: _____

Prescription Medications That You Are Currently Taking	Dose	Times/ Day

Please List Any Blood Thinners (Aspirin, Advil, Warfarin, Etc)

_____

Please List Any Herbal Supplements (includes CBD, Cannabis)

_____

Do You Have Any Allergies? ☐ No ☐ Yes

If Yes, Please Indicate Below

☐ Drug: _____ _____ _____ _____

_____ _____ _____ _____

☐ IV Dye ☐ Latex ☐ Adhesives ☐ Food: _____

☐ Other (Please Indicate Below)

_____

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Visual Analog Pain Scale

Please Circle The Number That Best Describes Your Pain **On Average In The Last 7 Days**

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

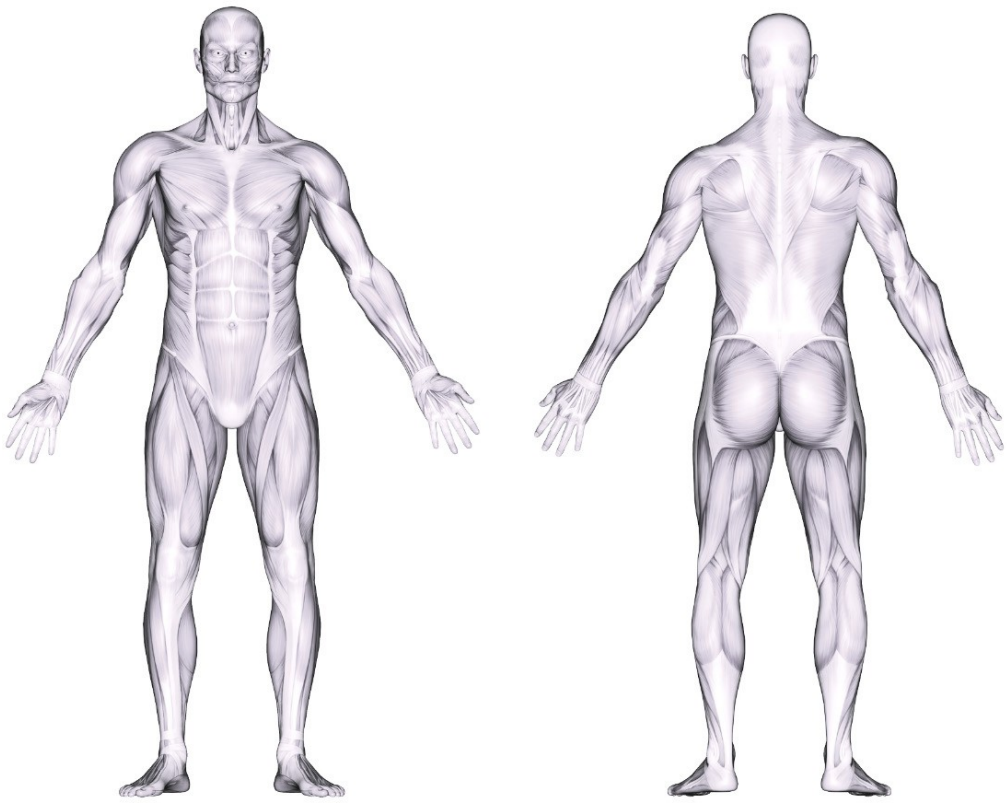
Are You Experiencing The Following Symptoms:

☐ Weakness In Your Legs ☐ Left ☐ Right ☐ Difficulties With Bowel And/ Or Bladder

☐ Weakness In Your Arms ☐ Left ☐ Right

If You Are Experiencing Low Back, Neck, Leg Or Arm 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
//////////////////////	/\/\/\/\/\/\/\/\/\	++++++++++++++++++	oooooooooooooooooo



Printed Name:_____ DOB:_____ Date: _____

BOULDER
NEUROSURGICAL & SPINE
ASSOCIATES

SF-12 Health Survey Questionnaire

Name: _____ DOB:_____ Date:_____

☐ 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 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 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 ☐ Not at all

April 2021

BOULDER
NEUROSURGICAL & SPINE
ASSOCIATES

Oswestry Disability Index (OWI) Questionnaire

THIS QUESTIONNAIRE IS FOR BACK PAIN PATIENTS ONLY

Name:_____ Date: _____ DOB: _____

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

1. Pain Intensity	2. Personal Care (Washing, Dressing, Etc.)
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.	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	**4. Walking**
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.	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	**6. Standing**
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.	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	**8. Sex Life (if applicable)**
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.	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	**10. Traveling**
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.	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 traveling except to receive treatment.

BOULDER
NEUROSURGICAL & SPINE
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Neck Disability Index (NDI) Questionnaire

THIS QUESTIONNAIRE IS FOR NECK PAIN PATIENTS ONLY

Name:_____ Date: _____ DOB: _____

☐ 3 Weeks	☐ 6 Weeks	☐ 3 Months	☐ 6 Months
☐ 12 Months	☐ 24 Months	☐ Other	

Instructions: Could you please complete this questionnaire. It is designed to give us information as to how your neck (or arm) 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. Please do not erase or cover mistake with correction fluid or tape. Line through mistake once, intial and date correction

1. Pain Intensity	2. Personal Care (Washing, Dressing, Etc.)
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.	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	**4. Reading**
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.	0 ☐ I can read as much as I want with no neck pain. 1 ☐ I can read as much as I want with slight neck pain. 2 ☐ I can read as much as I want with moderate neck pain. 3 ☐ I cannot read as much as I want because of moderate neck pain. 4 ☐ I can hardly read at all because of severe neck pain. 5 ☐ I cannot read at all.
5. Headaches	**6. Concentration**
0 ☐ I have no headaches at all. 1 ☐ I have slight headaches which come infrequently. 2 ☐ I have moderate headaches which come infrequently. 3 ☐ I have moderate headaches which come frequently. 4 ☐ I have severe headaches which come frequently. 5 ☐ I have headaches almost all the time.	0 ☐ I can concentrate fully when I want with no difficulty. 1 ☐ I can concentrate fully when I want with slight difficulty. 2 ☐ I have a fair degree of difficulty in concentrating when I want. 3 ☐ I have a lot of difficulty in concentrating when I want. 4 ☐ I have a great deal of difficulty in concentrating when I want. 5 ☐ I cannot concentrate at all.
7. Work	**8. Driving**
0 ☐ I can do as much work as I want. 1 ☐ I can only do my usual work, but no more. 2 ☐ I can do most of my usual work, but no more. 3 ☐ I cannot do my usual work. 4 ☐ I can hardly do any work at all. 5 ☐ I cannot do any work at all.	0 ☐ I can drive my car without any neck pain. 1 ☐ I can drive my car as long as I want with slight neck pain. 2 ☐ I can drive my car as long as I want with moderate neck pain. 3 ☐ I cannot drive my car as long as I want because of neck pain. 4 ☐ I can hardly drive at all because of severe neck pain. 5 ☐ I cannot drive my car at all.
9. Sleeping	**10. Recreation**
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.	0 ☐ I can engage in all my recreating activities with no neck pain at all. 1 ☐ I can engage in all my recreating activities with some neck pain. 2 ☐ I am able to engage in most, but not all of my usual recreation activities because of neck pain. 3 ☐ I am able to engage in a few of my usual recreation activities because of neck pain. 4 ☐ I can hardly do any recreation activities because of neck pain. 5 ☐ I cannot do any recreation activities at all.

Effective Date: 4/1/2021

BOULDER
NEUROSURGICAL & SPINE
ASSOCIATES

Notice of Privacy Practices

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 records:

- You can ask to see or get an electronic or paper copy of your medical health record and other health information
- 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 we describe blow, 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

Effective Date: 4/1/2021

BOULDER
NEUROSURGICAL & SPINE
ASSOCIATES

Notice of Privacy Practices

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 any injury asks another doctor about your overall health condition

Run our organization
We can use 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.

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 worker's compensation, law enforcement, and other government requests
We can use of 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, natonal security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in a response to a court or administrative order, or in response to a subpoena.

Our Uses and Disclosures
We are required by law to maintain the privacy and security of your protected health information.
We will let you know prompty 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.

March 2021

BOULDER
NEUROSURGICAL & SPINE
ASSOCIATES

Prescription Refill Policy

This agreement is important to you for a safe and controlled treatment plan. Pain medications have high potential for abuse and can be dangerous if used in the wrong way. You need to understand the risks that come from the use of pain medications. Please read and make sure you understand each statement below. Below are the rules for refills, health risks, and rationale for stopping your pain control treatment.

BNA providers may prescribe post-operative pain medications, including opioids. We DO NOT manage non-surgical or chronic pain. We only manage pain after surgery and it will NOT exceed 90 days. We DO NOT prescribe pain medications outside of the immediate post-operative period. The duration you may be prescribed pain medication is dependent on the type of surgery you will have/had and is at the provider's discretion. If you require long-term pain medication(s), we can refer you to an appropriate Pain Management clinic/provider. BNA providers follow protocols recommended by the Colorado Board of Medicine and the DEA. The following are guidelines for all BNA providers, subject to provider discretion:

- Prescriptions will not be refilled on Saturdays, Sundays, Holidays, or after Business Hours.
- Prescription phone-in/pick-up is permitted Monday-Friday, 8am-5pm.
- A minimum of 2 business days are required to process prescription(s) renewal(s) and/or pick-up requests. Patients are responsible for knowing when medication(s) need to be refilled.
- Walk-in refill prescription requests are NOT permitted - patients must call the office first or have a scheduled clinical appointment.
- Patients will not leave their medications where children can find them, where they can be stolen, or where others can take them. Any medications lost, stolen or mistakenly destroyed will not be replaced by new prescriptions under any circumstances.
- If a different medication is requested early, old prescriptions or unused pills must be taken to the pharmacy where you are filling the new prescription and turned over to the pharmacist.
- Medications prescribed are for the patient ONLY. Sharing, selling, trading or misuse is illegal and grounds for prosecution or termination as a patient of BNA.
- Pain medication should be taken as directed with the goal to reduce use as part of the treatment plan.
- Patients will avoid alcohol or street drugs while taking the pain medications. Patients are responsible for any overdose or withdrawal from improper use.
- The use of pain medications can make patients less alert. Patients should never drive a car, operate heavy machinery, stand in high places or do anything to harm others while under the influence of pain medicines.
- Pain medications can be addictive. This means the body will require more pain medications, making it very difficult to stop taking the medications.
- Too much pain medication or mixing medicines can cause health problems, including overdose, addiction and/or death. Potential things that can go wrong with too much medication use include, but are not limited to: overdose, slower reflexes, addiction, nausea, constipation, depression, vomiting, confusion, trouble breathing, and death.
- If you have a pain contract with a pain management physician, you must disclose this information to your BNA provider. Failure to do so is can violate your pain management contract.

Your signature below indicates understanding, agreement, and compliance with this policy. You acknowledge that failure to adhere to the policies listed above may result in cessation of therapy by your BNA providers. You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all of its terms.

Printed Name	Signature	Date

BOULDER
NEUROSURGICAL & SPINE
ASSOCIATES

Patient Financial Policy

- I understand it is my responsibility to bring a valid ID (i.e. Driver's License, Passport, Social Security Card) to every visit.

- I understand it is my responsibility to bring a current insurance card to every visit and to notify this office of any changes in my insurance.

- I understand that BNA highly encourages all patients to obtain a referral before being seen. A referral ensures that patients are seeing the correct provider type and is often required by insurance companies. I understand that if I choose not to get a referral, I will be 100% responsible for the bill, if my insurance company denies payment based on lack of referral.

- I understand that I am responsible for covering the cost of charges my insurance does not cover, for example, copays, deductibles and coinsurance.

- I understand self-pay patients will be given a 50% discount off of charges, if the charges are paid at the time of service. This discount does not apply for deductibles, copays or coinsurance.

- I understand that Medical bills can add up quickly and BNA is willing to set up a reasonable payment plan with me or provide me with other payment options.

- I understand it is my responsibility to cancel appointments, if necessary, with a minimum of 24 hours' notice. I will be charged a $50 no show fee unless I directly speak to someone to cancel.

- Once your insurance has processed your claim and BNA has done everything possible to ensure proper payment, you will receive a statement indicating what your insurance has set aside as your responsibility. BNA expects to receive payment within 30 days of sending you a statement. We understand insurance explanation of benefits and statements can be confusing, please don't hesitate to call the billing office, if you have questions. The billing office can be reached by dialing the main number and asking for billing.

I hereby acknowledge that I have read and understand the above information.

Printed Name: _____ Date of Birth: _____

Signature: _____ Date: _____

March 2021

BOULDER
NEUROSURGICAL & SPINE
ASSOCIATES

Financial Transparency Disclosure

Dear Patient,

The purpose of this letter is to advise you that, during the process of your care with Boulder Neurosurgical & Spine Associates (BNA), you may receive services from providers that do not participate and are not in network with your insurance plan. While we may request or order services for your benefit, we are not always aware of the insurance participation status of providers that may provide those services. BNA wants to be transparent and informational regarding out-of-network services it may deem necessary for your care. **Non-participating, out-of-network providers of healthcare services will bill you separately for your portion of financial responsibility for the services they provide and they are not part of BNA and MAY BE OUT-OF-NETWORK FOR YOU.**

Some examples of services that you may receive from non-participating providers are:

- Anesthesia
  BNA utilizes anesthesia for all of its surgical services. Anesthesia is utilized for patient comfort during surgery. All anesthesia services provided to BNA patients are provided by providers who are not part of BNA.

- Surgical Assisting
  BNA utilizes surgical assistants for all of its surgical services. The surgical assistant helps the surgeon carry out a safe operation with optimal results for the patient. These highly skilled practitioners are integral members of the operating room team. Occasionally surgical assisting services provided to BNA patients are provided by providers who are not part of BNA.

- Neuro-Monitoring
  BNA utilizes neuro-monitoring services for the majority of its surgical services. Neuro-monitoring is utilized to assess and provide feedback about the patient's nervous system during surgery. Neuro-monitoring is important for patient safety, while limiting the possibility of unnecessary complications. All neuro-monitoring services provided to BNA patients are provided by providers who are not part of BNA.

- Bracing
  BNA may require that you obtain a cervical or lumbar brace for your surgical recovery period. Braces are utilized to provide post-surgery skeletal stability and help reduce the possibility of re-injury during the healing process. All bracing services are provided to BNA patients are provided by providers who are not part of BNA.

- Laboratory
  BNA utilizes laboratory services prior to most of its surgical services. Laboratory services and tests are utilized to make sure that you are healthy enough for surgery. All laboratory services provided tor BNA patients are provided by providers who are not part of BNA.

We realize that medical coverage and billing is not always simple or easy to understand. We hope this disclosure helps better explain some of the intricacies.

Sincerely,
The Physicians and Staff at Boulder Neurosurgical & Spine Associates

I have read and understand the above information.

Signature: _____ Date: _____