Neurology of the Rockies, L.L.C.

Crown Point Healthcare Plaza
9235 Crown Crest Blvd., #200
Parker, CO 80138

Limelight Healthcare Center
4350 Limelight Ave., #250
Castle Rock, CO 80109

Dry Creek Medical Campus
125 Inverness Dr. East, #330
Englewood, CO 80112

Phone (303) 840-5051 Fax (303) 840-5058

Appointment Date:_____ Check In_____ Provider:_____

Please make sure to bring the following (not all may apply to your visit):

___ Completed Paperwork (Must be completed prior to arrival or your appointment may be rescheduled)
___ Insurance Card(s), Prescription card and Photo ID
___ Co-Pay if required (We prefer Credit, Debit, or Cash.)
___ If your Insurance plan has a deductible that has not been met at the time of your appointment, you will be expected to pay a portion of that at the time of check-in.
___ Reports AND Discs for Imaging (i.e., MRI, CT, EEG and PET scans) and lab work if applicable.

___ If your insurance is ***AARP Medicare Complete Secure Horizons or an HMO product,*** a referral from your primary care provider is required. This is the patients' responsibility to obtain. If seen without this, patient will be responsible for payment.

******There are many plans within each insurance company. It is impossible to know if we are contracted with all plans. We highly encourage patients to call their insurance ahead of time to verify if we are in network. If you have any questions about this process, please call our office.

If you have any questions or concerns, please feel free to call us at 303-840-5051.

Thank you

Neurology of the Rockies, L.L.C.

Patient Demographic

Date: _____

Full Name: _____

Address: _____

City:_____ State:_____ Zip Code:_____

Home Phone:_____

Cell Phone:_____

Email:_____

Date of birth: _____ Age: _____

Marital Status:_____ Gender: __ Female __Male

Occupation: _____

Height_____ Weight_____

Please circle: Right or Left Handed

Preferred Pharmacy Name, Address, and Phone number:

_____

Emergency/Alternate Contact:_____

Relationship to you:_____

Primary Insurance _____Policy/Member ID # _____

Group # _____ Subscriber Name_____

Relationship _____ SS# _____Subscriber's Date of Birth _____

Secondary Insurance _____ Policy # _____

Group # _____ Policy Holder Name_____

Relationship _____ SS# _____ Subscriber's Date of Birth _____

Are you being treated related to a WORKER'S COMP INJURY? Please circle YES OR NO

Are you being treated related to a MOTOR VEHICLE ACCIDENT OR LEGAL PROCEEDING?

Please circle YES OR NO

Primary Care Physician _____ Phone_____

Address_____Fax_____

Referring Physician: _____ Phone_____

Address_____Fax_____

RELEASE OF MEDICAL RECORDS

I hereby authorize the release of my medical records to myself and any physicians listed below:

_____

Initial

Consent to Disclose Personal Health Information

May we leave a voice mail message about your health on any phone number you listed above _____ Yes _____ No

List names and relationship of those you authorize us to discuss your medical care with:

_____

Patient or patient representative signature **Date**

Medical / Health History: Please attach additional sheets of history if needed to include all prior medical, surgical history and current medication list.

History of your present illness/reason for your visit with the office

_____
_____
_____
_____
_____

Current medications you are taking - Include Dosage and Times.

_____
_____
_____
_____
_____
_____
_____
_____

List other medications previously tried for your neurologic problem

_____
_____

Are you allergic to any medications?

____ No ____ Yes If yes, Please list all drug allergies
_____
_____

Past medical history; List any current or past medical conditions, injuries, operations, hospitalizations.

_____
_____
_____
_____

_____ _____

Patient or patient representative signature **Date**

Past Medical Procedures or Imaging

Please note the procedures you have had completed in the last 3 years and the name of the facility:

MRI_____

CT (CAT) SCAN_____

SLEEP STUDY _____

EEG_____

EMG (Nerve Conduction Study) _____

LAB WORK_____

Family History **Please select and specify which family member was diagnosed with the following illness**

Migraine_____ Stroke _____ Parkinson's Disease_____

Seizure _____ Other _____

Social History

Employment_____ Years of education_____

Prior Tobacco Use YES NO Current Tobacco Use YES NO If yes, how much & how long_____

Alcohol drinks per week _____ Caffeinated drinks per week_____

Recreational drug use YES NO If yes, what & how long: _____

REVIEW OF SYMPTOMS: Have you had any of the following?

Chills		Cough		Easy Bruising	
Fever		Shortness of Breath		Excessive Bleeding	
Blurred Vision		Nausea		Temperature Intolerances	
Eye Pain		Gastrointestinal Problems		Excessive Sweating	
Ear Pain		Vomiting		Anxiety	
Diminished Hearing		Urinary Incontinence		Depression	
Ringing in ears		Frequent Urination		Sleep Disturbance	
Dizziness		Back Pain		Suicidal Thoughts	
Chest pain		Muscle Aches			
Palpitations					

Other symptoms you may want to mention or expand upon:

_____

_____ _____

Patient or patient representative signature **Date**

OFFICE POLICIES

OFFICE HOURS:
Our Office is open Monday through Friday 8AM-4:00PM. (Phone hours are Mon-Friday 8:30AM-3:30PM) We are **Closed** for lunch between 12-1PM (We will not be available by phone during that time)

PARKER LOCATION:
We are NOT IN PARKER ADVENTIST HOSPITAL or the attached buildings. We are located next to Black Eyed Pea in a 2 story building. The name of our building is **Crown Point Healthcare Plaza** which is printed at the top of the building.

CASTLE ROCK LOCATION:
We are NOT IN CASTLE ROCK ADVENTIST HOSPITAL or the attached buildings. We are located in the **Limelight Health Care Center** on Limelight Ave in Suite 250. We are directly across from the Emergency Ambulance Bay in a two-story building.

ENGLEWOOD LOCATION:
We are in the **Dry Creek Medical Campus.** We are on the southeast corner of Dry Creek and Inverness Drive East.

OUR FINANCIAL/INSURANCE POLICY:
It is your responsibility to know your insurance plan and your benefits. We will bill your insurance company as a courtesy if you provide us with all the necessary information. Please understand the agreement of the insurance carrier to pay for medical care is a contract between you and the carrier. There may be limitations and exclusions to coverage. The patient financial responsibility is set by the insurance company.

All co-pays and deductibles are due prior to treatment. If your deductible has not been met at the time of your appointment we will collect a portion.
Our collectable portion for New patient appointments with deductibles is $250.00
Our collectable portion for EMG/Nerve Conduction Study patients with deductibles varies from $200 to $600 depending on how many extremities.

_____Initial

PRESCRIPTION REFILL POLICY
Please call your pharmacy for medication refills. Prescriptions refills are authorized only during normal business hours, and Fridays from 8:30 a.m. to 12:00 p.m. Prescriptions will **not** be filled after hours or on the weekends or holidays. We require 24-48 hours for prescription refill authorizations. **Please notify your pharmacy at least 5 business days before you are out of your medication.**

_____ Initial

By signing below, I understand and agree to this the Office Policies

_____ _____

Patient or patient representative signature **Date**

LATE ARRIVAL, CANCELLATION AND NO-SHOW POLICY

Our providers do their best to run on-time. We ask that you check-in 15 minutes early for all appointments so we can keep our providers on time for you and other patients. If you are ten or more minutes late, you may be rescheduled.

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours notice. Office appointments which are cancelled with less than 24 hours notification may be subject to a **$50.00** cancellation fee. EMG and BOTOX cancellations require 48 hours advance notice, without notification you may be subject to a **$75.00** cancellation fee. No show fees need to be paid prior to scheduling the next appointment.

Patients who do not show up for their appointment without a call to cancel or reschedule will be considered as **NO SHOW**. Patients who No-Show two (2) or more times in a 12 month period, may be dismissed from the practice thus they will be denied any future appointments. Patients may also be subject to **a $50.00 NO-SHOW FEE.**

The Cancellation and No-Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with your provider's approval.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no-show fees should be directed to the Billing Department.

Please sign to indicate that you have read, understand and agree to this Late Arrival, Cancellation and No-Show Policy.

_____	_____
Patient Name (Please Print)	**Date of Birth**
_____	_____
Signature of Patient or Patient Representative	**Date**

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION (HIPAA Consent)

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the physician and I am financially responsible for non covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. I acknowledge that I am responsible to pay all charges for all treatments administered by the physician(s). I understand that insurance may not pay for all charges and I understand that I am obligated to pay for all charges not paid by insurance. I also agree to pay reasonable attorney fees if my account is turned over to an attorney or collection agency.

Purpose of Consent: This notice is a summary of how your protected health information is used and disclosed and how you can obtain access to this information. Please see the front desk to review a full copy of our Privacy Practices. By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Uses and Disclosures of Health Information

We use health information about your treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of care that you receive. We may use or disclose identifiable health information about you without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. We may change our policies at anytime. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and in each examination room. You can also request a copy of our notice at anytime. For more information about our privacy practices, contact the office.

Neurology of the Rockies endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the <CORHIO> HIE, or cancel an opt-out choice, at any time.

Patient Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- Obtain a paper copy of the notice of privacy practices upon request
- Inspect and obtain a copy of your record as provided for in 45 CFR 164.524
- Amend your health record as provided in 45 CFR 164.528
- Obtain an accounting of disclosure of your health information as provided in 45 CFR 164.528
- Request communication of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information expect to the extent that action has already been taken
-

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

By signing below I state that I have had full opportunity to read and consider the contents of this consent form and Notice of Privacy Practices posted in the office. I understand that, by signing this consent, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

_____	_____	_____
Printed patient or patient representative name	**Signature**	**Date**