DENVER Neurological Clinic

DATE:_____

Full Name: _____ Date of birth: _____ Age:_____

Address: _____ Marital Status: _____Gender: M F

City: _____State:_____Zip:____ Occupation: _____

Cell Phone: _____Home: _____ Last 4 of SSN: _____ Handedness: R L

Email: _____ May we send email/text reminders? Y N

Preferred pharmacy name, address and phone: _____

Emergency Contact name and phone:_____

Primary Care Physician name and phone: _____

Referring Physician name and phone: _____

Primary Insurance: _____Policy #/Subscriber ID:_____

Group #_____Policy Holder name:_____

Relationship:_____SS#_____Date of birth:_____

Secondary Insurance: _____Policy #/Subscriber ID:_____

Group #_____Policy Holder name:_____

Relationship:_____SS#_____Date of birth:_____

If this is a work comp or motor vehicle accident you MUST provide the following:

Company's name, Adjustor's name, phone #, Fax #, Claim #, Date of Injury and if Med Pay is set up.

RELEASE OF MEDICAL RECORDS

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

_____

CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION:

May we leave a voice mail message about your health on ANY number you listed above? Yes: _____No: _____

List whom we may discuss your health care, appointments, prescription information, etc., with and their relationship to you.

Name: _____

_____ _____

SIGNATURE **DATE**

MEDICAL/HEALTH HISTORY

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

_____

_____

_____

_____

_____

Current medications you are taking – Include dosages and times.

_____

_____

_____

_____

_____

List all medications that you have <u>previously</u> tried for your neurologic problem.

_____

_____

_____

_____

Are you allergic to ANY medications?

Yes No If yes, please list._____

Past medical history. Please list any current or past medical conditions, surgeries, injuries, hospitalizations.

_____

_____

_____

_____

_____ _____

Patient Name Date

Past Medical Procedures or Imaging

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

MRI_____

CT 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_____Seizure_____

Parkinson's Disease_____Other_____

Social History

Employment_____Years of Education_____

Prior tobacco use YES NO Current tobacco use YES NO If yes, how much and how long?_____

Alcohol drinks per week_____Caffeinated drinks per week_____

Recreational drug use YES NO If yes, what and how long? _____

REVIEW OF SYMPTOMS: Have you had any of the following: Please circle

Chills	Fever	Blurred Vision	Eye pain	Ear pain
Cough	Shortness of Breath	Diminished hearing	Ringing in ears	Dizziness
Chest Pain	Palpitations	Gastrointestinal issues	Nausea	Vomiting
Urinary Incontinence	Frequent urination	Back pain	Muscle aches	Leg cramps
Anxiety	Suicidal thoughts	Sleep Disturbance	Excessive sweating	Depression
Migraines	Headaches			

_____ _____

Name **Date**

DENVER Neurological Clinic

Office Information and Policies

OFFICE HOURS:
Our office is open Monday through Thursday 8 AM-4:30 PM; Friday 8 AM – 3:30 PM. We are closed for lunch between 12:30-1, at which time our phones will be turned off.

We see patients in two locations: Our Porter location is 950 E. Harvard Ave. Suite 570 Denver, CO 80210 Our phone is 303-715-9024. Our fax is 303-715-5020.

Our Lone Tree location is located at 9980 Park Meadows Dr. #100 Lone Tree, CO 80124
Phone is 720-481-2665 Fax is 720-481-3242

FINANCIAL/INSURANCE POLICY:
It is the patient responsibility to know what your insurance plan is and what your benefits include. You must bring your insurance card to every visit for verification. As a courtesy to our patients, we will bill your insurance company directly as long as you have provided us with all the necessary information to do so. 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 portion is set by the insurance company. It is ultimately your responsibility to see that your bill is paid in full.
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. All refunds are returned 30 days after final insurance coverage EOB information has been received by our office.
New patient appointment deductibles are $250.00. Botox injections may be a deductible of $1300.00. Any nerve conduction/EMG study patient deductibles range between $250.00 - $600.00.
_____Initial

INSURANCE REFERRALS: (Medicare complete, Tricare, etc.)
Many insurance companies require a referral to a specialist prior to a appointment. It is the patient responsibility to ensure this referral is obtained prior to all scheduled appointments. Failure to obtain a referral PRIOR to your appointment will require payment in full at time of service, or your appointment will be rescheduled. Please contact your PCP to obtain your referrals.
_____Initial

PRESCRIPTION REFILL POLICY:
Please call your pharmacy for medication refills. Prescription refills are authorized ONLY during normal business hours. We will not refill medications during the weekend or holidays. Please allow 48 hours for refill authorizations.
_____Initial

I understand and agree to these policies.

_____ _____ _____
Patient or patient representative **Signature** **Date**

DENVER
Neurological Clinic

ADDITIONAL OFFICE POLICIES

Name: _____ Date of birth: _____

Our providers do their best to be on time. We ask that you check-in 15 minutes early for all appointments so we may complete any paperwork, collect co-pays and answer questions. If you are more than 15 minutes late, you may be rescheduled for your appointment.

NO SHOW POLICY: Patients who do not show up for their appointment without a call to cancel or rescheduled will be considered a No-show. Patients who no show 2 or more times in a 12 month period may be dismissed from the practice. Patients understand that they will be charged **$50.00 fee for an appointment no show and $100 for an injection/procedure no show.**

CANCELLATIONS: We understand that situations arise in which you must cancel your appointment. We request you provide us with at least 24 hours notice of any cancellation, therefore allowing other patients to be seen during your time slot.

The fee's are the sole responsibility of the patient and must be paid in full before the next appointment is scheduled.

ASSIGNMENT: I request that payment of authorized insurance, Medicare and/or Medicaid benefits be made payable to Denver Neurological Clinic Professional, LLC on my behalf for services furnished to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. In the event that my account is turned over to a collection agency, I agree to pay all reasonable costs of collection and understand that I may o longer be a patient at this office.

RETURNED CHECKS:
I understand and agree to pay a returned check charge of $35.00 for each check that is returned for any reason. I agree to pay the amount of the check plus the service charge within 30 days of receipt of notification.

With my signature I agree that I have read and agree to the above statements.

_____ _____

Signature Date

_____

Printed Name

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 a 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 any time. Before we make 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 any time. For more information about our privacy practices, contact the practice administrator.

Denver Neurological Clinic Professional, LLC 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 CFR164.524
- 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 except 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 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.

_____ _____ _____

Patient or patient representative name Signature Date