COLORADO CENTER FOR SPINE MEDICINE

4820 Riverbend Rd. 2nd Floor Boulder CO 80301

#303-444-2955 Fax# 303-889-5103

NAME_____

ADDRESS: _____ **CITY**_____ST_____ ZIP_____

HOME PHONE (____)_____ **WORK PHONE** (____) _____ **MOBILE** (____) _____

DATE OF BIRTH _____ **AGE**_____ **SEX M or F HEIGHT**_____ **WEIGHT** _____

SOCIAL SECURITY #: _____ **EMAIL ADDRESS**_____

WHO REFERRED YOU TO OUR OFFICE? _____

PRIMARY CARE DOCTOR(S): _____

YOUR EMPLOYER: _____ **OCCUPATION:** _____

EMERGENCY CONTACT

NAME:_____ RELATIONSHIP:_____

ADDRESS: _____ CITY _____ ST_____ ZIP_____

HOME PHONE (____)_____ MOBILE (____)_____

PRIMARY INSURANCE:_____ID#_____

ADDRESS OF COMPANY:_____CITY:_____

STATE:_____ ZIP:_____TELEPHONE:(_____)_____

SECONDARY INSURANCE

INSURED'S NAME:_____RELATIONSHIP_____

NAME OF INSURANCE COMPANY:_____ID#_____

ADDRESS OF INSURANCE COMPANY:_____CITY:_____

STATE:_____ZIP:_____TELEPHONE:(_____)_____

RELEASE OF MEDICAL INFORMATION TO OTHER CARE PROVIDERS

Often times it may be necessary for CCSM to share medical information with other physicians or health care providers who may be currently involved in your treatment. This allows the doctors to cross reference important medical information to provide you the best care possible. Your doctor can only share your medical records with other care providers when you release him/her to do so. By completing your signature below, you understand all of the above and allow this office to share medical information necessary for your treatment.

SIGNATURE:_____ **DATE:**_____

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NAME:_____ **AGE:** _____

DESCRIBE THE REASON FOR TODAY'S VISIT:

_____

_____

CURRENT PROBLEM IS THE RESULT OF AN ACCIDENT: ☐NO ☐YES

ONSET OF SYMPTOMS OR INJURY: _____/_____/_____
MONTH DAY YEAR

HOW LONG DO YOU HAVE THIS CONDITION? _____YEARS_____MONTHS

HAVE YOU HAD THE FOLLOWING TREATMENTS FOR YOUR CONDITION? (CHECK ALL THAT APPLY)

☐BRACING ☐MASSAGE ☐PHYSICAL THERAPY ☐CHIROPRACTIC MANIPULATIONS

☐SPINAL INJECTIONS ☐ALTERNATIVE MEDICINE THERAPIES ☐NONE ☐OTHER_____

SURGERIES AND MEDICAL PROBLEMS

_____
_____
_____
_____
_____
_____
_____

PREFERRED PHARMACY_____ **CITY/CROSS STREETS** _____

MEDICATIONS THAT YOU ARE CURRENTLY TAKING:	**DOSE**	**TIMES/ DAY**

DO YOU HAVE ANY DRUG ALLERGIES? ☐NO ☐YES IF YES, PLEASE LIST_____

_____

ARE THERE ANY MEDICAL CONDITIONS THAT RUN IN YOUR FAMILY? ☐NO ☐YES IF YES, PLEASE DESCRIBE:_____

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NAME:_____ **AGE:** _____

PLEASE CIRCLE THE NUMBER THAT BEST INDICATES THE LEVEL OF YOUR **CURRENT PAIN**

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 SEVERE PAIN

IF YOU ARE EXPERIENCING NECK, LOW BACK, ARM OR LEG PAIN, PLEASE ANSWER THE FOLLOWING:

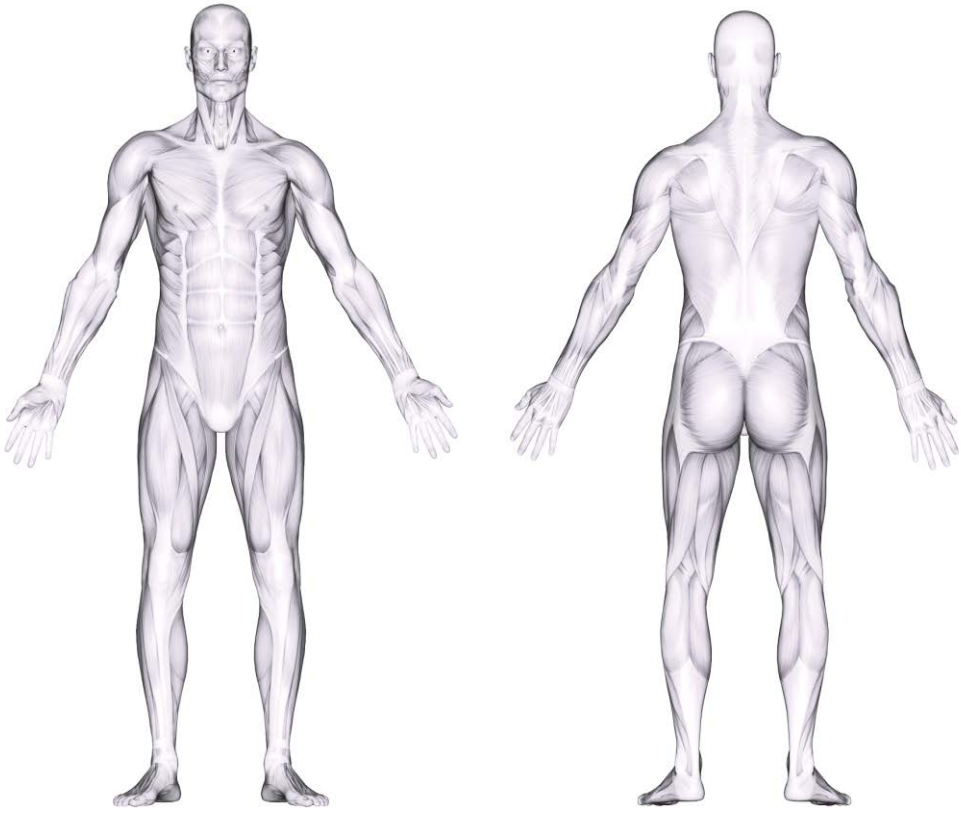
What percentage of your pain is in the NECK or LOW BACK? _____%

What percentage of your pain is in the ARM or LEG? _____%
Total must equal 100%

ARE YOU EXPERIENCING THE FOLLOWING SYMPTOMS?
☐WEAKNESS IN YOUR ARMS ☐LEGS ☐ARMS ☐LEFT ☐RIGHT
☐DIFFICULTIES WITH BOWEL AND/ OR BLADDER

IF YOU ARE EXPERIENCING NECK, LOW BACK, ARM 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**
//////////	/\/\/\/\	+++++++	oooooo



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NAME:_____

SOCIAL HISTORY Do you live alone? Yes or No

ARE YOU: Married Divorced Widowed Separated Single Partner (PLEASE CIRCLE ONE)

DO YOU HAVE CHILDREN? ☐NO ☐I HAVE _____CHILDREN

☐**I HAVE SMOKED** _____**PACK(S) PER DAY FOR** _____**YEARS** ☐**I NEVER SMOKED** ☐**QUIT** ___**YEARS AGO**
☐**I DO NOT DRINK ALCOHOL** ☐**I DRINK ONLY SOCIALLY** ☐**I DRINK DAILY. IF CHECKED, HOW MUCH?**_____

ARE YOU AT RISK FOR HIV/AIDS? (BLOOD TRANSFUSIONS, DRUG USE, ETC.)? IF YES, PLEASE EXPLAIN_____

REVIEW OF THE SYSTEMS (PLEASE CHECK CONDITIONS THAT YOU CURRENTLY HAVE)

1. GENERAL
☐RECENT FEVER/ CHILLS
☐RECENT WEIGHT LOSS
☐RECENT WEIGHT GAIN
☐SLEEP PROBLEMS

2. EYES
☐EYE INFECTIONS
☐EYE INJURIES
☐CATARACTS
☐GLAUCOMA

3. EAR, NOSE, THROAT AND MOUTH
☐WEAR HEARING AIDS
☐HEARING LOSS
☐EAR PAIN
☐EAR INFECTIONS
☐RINGING IN THE EARS
☐RT ☐LT
☐BALANCE DISTURBANCE
☐NOSEBLEEDS
☐INABILITY TO SMELL

4. PSYCHOLOGICAL
☐ANXIETY
☐DEPRESSION
☐CLAUSTROPHOBIA
☐TROUBLE CONCENTRATING

5. ENDOCRINE
☐DIABETES
☐THYROID DISEASE

6. MUSCULOSCELETAL
☐BACK PAIN
☐LEG PAIN
☐RT ☐LT
☐LEG WEAKNESS
☐RT ☐LT
☐NECK PAIN
☐ARM PAIN
☐RT ☐LT
☐ARM WEAKNESS
☐RT ☐LT
☐ARTHRITIS

7. NEUROLOGICAL
☐HEADACHE
☐LOSS OF CONSCIOUSNESS
☐DIZZINESS/ VERTIGO
☐SEIZURES
☐DIFFICULTY WITH SPEECH
☐DOUBLE/ BLURRED VISION
☐PARALYSIS
☐FACE WEAKNESS

8. BLOOD AND LYMPH
☐ANEMIA
☐HEMOPHILIA
☐BLEEDING TENDENCIES
☐SWOLLEN GLANDS OR LYMPH NODES
☐IMMUNOLOGIC DISORDERS

9. CARDIOVASCULAR
☐HEART DISEASE
☐CHEST PAIN, ANGINA
☐SHORTNESS OF BREATH
☐DATE OF LAST EKG_____
☐HIGH BLOOD PRESSURE
☐LOW BLOOD PRESSURE
☐IRREGULAR PULSE
☐HEART MURMUR
☐HIGH CHOLESTEROL
☐LEG SWELLING

10. RESPIRATORY
☐ASTHMA
☐EMPHYSEMA
☐BRONCHITIS
☐PNEUMONIA
☐LUNG CANCER

11. GASTROINTESTINAL
☐LIVER DISEASE
☐JAUNDICE
☐ULCERS OR GASTRITIS
☐COLON, LIVER OR STOMACH CANCER
☐BLOOD IN YOUR VOMIT

12. GENITOURINARY
☐BLOOD IN URINE
☐DIFFICULTY URINATING
☐INCONTINENCE
☐KIDNEY STONES
☐PROSTATE CANCER
☐UTERINE/ CERVICAL CANCER

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The following policy applies to all providers of Colorado Center for Spine Medicine, LLC.

Our Policy of Payment

Insurance

• Your insurance policy is a contract between you and your insurance company. We are not a party in that contract. We are **not** contracted with **Medicaid**.

• We will file your insurance claim two times, if necessary. If it is denied, it will be your responsibility to follow up with your insurance company to resolve the claim.

• Not all services are a covered benefit in all insurance contracts. *All charges are your responsibility whether your insurance company pays or not.*

• **Co-pays must be paid at the time of your appointment.** *If you are unable to pay your co-pay you may reschedule your appointment.* Any returned or cancelled checks will be subject to a **$50.00 cancellation fee**. Cancellations must be made 24 hours in advance or a **$50.00 no show office visit fee & $150.00 no show injection fee** will be charged.

• Accounts become past due 30 days after your insurance pays. Statements are sent out weekly and the balance is due within 10 days of receipt. We reserve the right to send the account to a collection agency if the balance is not paid in full 45 days after your insurance pays its portion.

• In the event of your non-payment, you agree to pay, whether or not legal proceedings are instituted, a reasonable *collection agency fee* which shall be 35% of the principal balance for any debt incurred hereunder and to pay all reasonable costs of collection including but not limited to *court costs, attorney fees and interest* as a result of your default.

Cash Patients

• All cash patients must pay the cash fee at the time of service or be rescheduled for a later date.

Payment Options

We accept cash, check, money order, Visa, MasterCard, Discover or American Express for payment.

I hereby acknowledge that I have read, understand, and agree to the terms of this document relating to insurance coverage and payment of my bill.

Patient Name (printed): _____

Patient or Representative Signature: _____ Date: _____

Relationship of Representative: _____

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Name of patient: _____ Date of birth _____

I hereby acknowledge that I am aware of the Notice of Privacy Practices (HIPPA) for CCSM and that a copy is available for my records.

So that the physician(s) and/or office staff may address privacy issues, please indicate with whom we may discuss your routine and/or emergent care and treatment:

Spouse: _____

Family Member(s): _____

Guardian: _____

Other: _____

Please initial below if you do not want physicians or staff to discuss medical care and treatment with anyone other than healthcare providers/representatives. _____

Please note that if there is question in regards to diversion, abuse, or misuse of medications, as dictated by Federal and Colorado State Laws, we must cooperate fully with Legal Authorities and Regulatory Agencies.

Patient or Representative Signature: _____ Date:_____

Relationship of Representative: _____

FOR OFFICE USE ONLY

Documentation of Good Faith Effort to obtain patient's acknowledgement that they were made aware of the provider's Notice of Privacy Practices and could obtain a copy of the document.

The patient presented to the office on _____ and was made aware of the Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgement of his/her of the Notice. However, such acknowledgement was not obtained because (please circle below):

Patient refused to sign

Patient was unable to sign or initial because:_____

Other Reason:_____

Signature of employee completing form: _____ Date: _____