



Cliff Gronseth, M.D.
John Tobey, M.D.
Michelle Pepper, M.D.
Marshall Emig, M.D.
Vaheed Sevvom, PA-C

Phone: (303) 494-7773
Fax: (303) 494-1104

Boulder Office
5387 Manhattan Circle #200
Boulder, CO 80303

www.spinewest.com

Centennial Office
6825 S. Galena Street #314
Centennial, CO 80112

NEW PATIENT CHECKLIST

APPOINTMENT DATE & CHECK IN TIME: _____

LOCATION: _____

Note:

Please be aware that Spine West utilizes space at Sky Ridge Medical Center and Yampa Valley Medical Center, but we are a **separate practice**. We do **NOT** always have access to medical records and films. Please be sure to obtain any pertinent information prior to the appointment and call us if you have any questions.

- **Please bring to the appointment:**
 - Completed & Signed **Spine West Forms** (available at www.spinewest.com)
 - Financial Policy
 - Consent for Use & Disclosure of Health Information
 - Patient Information
 - Medical History Form
 - Insurance Card
 - X-rays, MRIs, or other films pertaining to your injury

- For Injection and EMG (Nerve Testing) instructions and information please go to our website www.spinewest.com.

We look forward to meeting you.

The Staff at Spine West



FINANCIAL POLICY

Patient Name: _____ D.O.B.: _____

I understand and acknowledge that my insurance coverage is a contract between me and my insurance company and that I am personally responsible for all medical expenses incurred during evaluation and treatment by the providers at Spine West, PLLC. I understand that as a courtesy my primary insurance will be billed; however, it is my responsibility to follow up on delinquent claims. If I am a member of a PPO or an HMO I am required to make my co-pay and co-insurance payments in a timely fashion, and I am responsible for keeping my primary care physician referrals current.

CREDIT/DEBIT CARD ON FILE

It is the policy of Spine West, PLLC to retain on file a credit/debit card number for all active patients. **This information is kept strictly confidential** and will only be used for payment of fees to Spine West, PLLC.

Spine West will submit claims to your insurance company following your visit. Once the billing office receives final payment and/or disposition from your insurance carrier the office will bill your credit/debit card on file for any amounts not paid by your insurance carrier that are considered patient responsibility. Examples of these amounts may be unpaid co-pays, co-insurance and deductibles. In many cases you will have already received an EOB (Explanation of Benefits) from your insurance company showing the unpaid amounts. This will in no way compromise your ability to question your insurance carrier's determination of payment.

Please familiarize yourself with our **No-Show/Cancellation Policy** as this \$50 fee would be charged to your payment card on file.

If your balance due exceeds \$250.00 Spine West, PLLC will call to inform you of the amount to be charged to your credit/debit card.

Authorization: *I authorize Spine West to charge my payment card for the balance of fees not paid by my insurance carrier. I understand that if the amount is greater than \$250.00 I will be called and informed of the amount charged to my credit/debit card.*

Name of Cardholder (print) _____ (circle one) VISA M/C DISCOVER (circle one) DEBIT CREDIT HSA

Card Number _____ - _____ - _____ - _____ Expiration Date _____

Signature of Cardholder _____ Date _____ verified

CANCELLATION/ NO-SHOW POLICY

You must notify Spine West no later than 12 noon the business day prior to your appointment to change or cancel your appointment. If notification comes in less time your account will be assessed a \$50 cancellation fee. No notification of cancelling or rescheduling your appointment will cause a \$50 no-show fee to be added to your account.

LAST MINUTE CANCELLATIONS AND NO-SHOWS PREVENT OTHERS FROM GETTING TIMELY SERVICE. THANK YOU FOR YOUR UNDERSTANDING.

I have read and understand the *Cancellation/No-Show Policy* for Spine West. I understand there will be a \$50 fee added to my account for any appointments not cancelled or rescheduled by 12 noon the business day prior to my appointment as well as any appointments no-showed. I understand my payment card on file will be used to collect said charges.

Signature of Patient/Responsible party: _____ Date: _____

New Patient Intake Form

Patient Name: _____
(last name) (first name) (initial)

How do you wish to be addressed? _____

Date of Birth _____ Sex: Male Female Marital Status: Single Married
 Divorced Widowed
 Significant Other

Email: _____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone #: _____ Cell phone #: _____ Work phone #: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

How did you hear about Spine West? _____

Per Federal law, please completely fill out the following:

Primary Insurance Company: _____

Name of Insured if other than patient: _____ Relationship: _____

Insurance ID # _____ Group# _____

Work Comp or Auto Claims Work Comp Auto

Claim # _____ Date of Injury: _____

Adjustor/Case Manager: _____ Phone #: _____ Fax#: _____

For Spine West to be compliant with current federal health record requirements, please respond to the following questions. Thank you.

Race :

- American Indian or Alaska Native
- Asian
- Black or African American
- Caucasian
- Hispanic
- Native Hawaiian
- Other Pacific Islander
- Other _____
- Prefer not to answer

Ethnicity

- Hispanic/Latino
- Not Hispanic/Latino
- Prefer not to answer

Preferred Language:

- English
- Spanish
- Indian (includes Hindi & Tamil)
- Russian
- Other _____
- Prefer not to answer

I understand and acknowledge that my insurance coverage is a contract between me and my insurance company and that I am personally responsible for all medical expenses incurred during evaluation and treatment by the providers at Spine West, PLLC.

I understand that as a courtesy my primary insurance will be billed; however, it is my responsibility to follow up on delinquent claims. If I am a member of a PPO or an HMO I am required to make my co-pay and co-insurance payments in a timely fashion, and I am responsible for keeping my primary care physician referrals current.

I authorize Spine West, PLLC to release any medical information to my insurance carrier, PCP's and therapists. I assign all benefits from said claims to Spine West, PLLC. I further agree that a photocopy of this agreement shall be as valid as the original. Should my injury be work related, I also authorize release of any medical information related to that injury to my employer or their representative.

Patient or responsible party: _____ Date: _____

New Patient Intake Form

Do you have...

- Fevers or chills (unexplained) Yes No
 Weight loss (unexplained) Yes No
 Incontinence (leak urine or stool) Yes No
 Numbness in arms or legs Yes No
 Weakness in arms or legs Yes No
 Sleep problems Yes No
 Do you have an attorney for this issue? Yes No
 How long can you sit? _____
 How long can you stand? _____
 How far can you walk? _____
 What can you NOT do because of this problem?

OTHER MEDICAL PROBLEMS:

Do you have or have you ever had in the past any of the following medical problems?

- | | |
|---|---|
| <input type="checkbox"/> Eye problems | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Anemia/bleeding problems | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Pulmonary problems | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Nerve problems |
| <input type="checkbox"/> Aspirin sensitivity | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Bipolar Disorder |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Thyroid problems | Other: _____ |

Are you currently experiencing any of the following conditions?

- | | |
|--|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Sore throat | <input type="checkbox"/> Joint swelling |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Balance problems |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Feeling "down" |

ANY PAST: Name type and date (month/yr), if known.

SURGERIES: _____

CAR ACCIDENTS: _____

WORK INJURIES: _____

SOCIAL HISTORY: Do you currently ...

- Smoke? Yes, How much? _____ No
 Drink alcohol? Yes, How much? _____ No
 Drink caffeine: Yes, How much? _____ No
 Use recreational drugs: Yes, What kind? _____ No

Marital status: S M D W SO

Do you have any children: Yes - Ages: _____ No

Who lives with you? _____

List your hobbies? _____

What do you do for exercise, and how often do you exercise?

Highest level of education:

WORK HISTORY:

Which of the following best describes you currently?

- Currently working:
 Occupation: _____
 Employer: _____
 How long working there? _____
 Any current work restrictions? _____
 Past Jobs: _____

- Not working because of this problem:
 Date last worked? _____
 How long working there until your injury? _____

- Not working due to another health problem:
 Describe _____
 Unemployed Student Homemaker
 Retired: When _____ Occupation _____

AVERAGE DAILY STRESS LEVEL:

- None Mild Moderate Extreme

FAMILY HISTORY:

Have any of your parents (or close relatives) had...

- Neck or back problems
 Other muscle or bone or nerve problems
 Bleeding problems
 Cancer - Describe: _____
 Disability from work
 Diabetes
 Other _____

MEDICATION ALLERGIES: Attach additional sheets if necessary.

DRUG	REACTION

CURRENT MEDICATIONS, vitamins, herbs

List every thing you take daily or as needed.

Attach additional sheets if necessary.

NAME	DOSE	FREQUENCY

PHARMACY (Name and Phone):

List any other concerns you have: _____

What do you hope we can accomplish in today's visit? _____

Provider Initials: _____

New Patient Intake Form

CONSENT FOR USE, DISCLOSURE & RELEASE OF HEALTH INFORMATION

SECTION A – PATIENT GIVING CONSENT

Name: _____ D.O.B: _____

Telephone: _____ Social Security Number: _____

SECTION B – TO THE PATIENT

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: 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.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we obtain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting this office.

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.

I, _____, have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that by signing this Consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

SECTION C – CONSENT TO RELEASE

I give my permission for Cliff Gronseth, MD, John Tobey, MD, Michelle Pepper, MD and Vaheed Sevvom, PA-C to discuss any of my medical information with:

(Other than Physicians or Insurance companies as listed above)

Name(s): _____ Relation: _____

Address: _____

Phone Number(s): _____

I understand that I must provide written change to the office Cliff Gronseth, MD, John Tobey, MD, Michelle Pepper, MD and Vaheed Sevvom, PA-C to change/delete this information.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient _____