

Thomas M. Rampy, M.D., Ph.D. 183 South Taylor Avenue, Suite 160 Louisville, Colorado 80027

Office: 303.926.1015

PATIENT REGISTRATION

Patient Last Name	Fii	rst Name		N	Iiddle Initial	
Address	Cit	ty		State	Zip	
Home Phone	Work Phone _			Cell Phone _		
SS#	Date of Birth			Sex		
Marital Status	Email					
Employers Name						
Employer Address		City		State	Zip	
	INSURAN	NCE INI	FORMATIO	N		
Primary Insurance						
Insurance Name						
Name of Insured					<u>-</u>	
SS#						
Employers Name						
Employer Address		City		State	Zip	
Secondary Insurance						
Insurance Name	Policy # _			Phone		
Name of Insured			Relationship			
SS#	Date of Birth					
Employers Name		Phone				
Employer Address		City		State	Zip	
Referring Physician Name			Phone			
PCP Name			Phone			
Emergency Contact			Phone			
I hereby authorize Dr. Thomas Rampy administered by the physician to the parall charges not paid by insurance. I also	tient. I understand that insu	rance may	not pay for all cl	narges and I under	stand that I am obligated to page	
Signature of Patient / Authorized Person	n			Date		
Assignment and Release: I hereby authorize the ph						l
Signature of Patient / Authorized Person	n			Date		



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Financial Policies and Information

Our commitment is to provide the very best care to our patients while recognizing the need to limit services to only those that are necessary for each patient. To meet this commitment, we recognize the need for a definite understanding and agreement concerning our patient's health care and financial arrangements for that medical care. Your clear understanding of our financial policies is important to our professional relationship. Please contact our billing office regarding any questions about our fees, financial policies, or your insurance coverage and your responsibilities.

Professional fees: Our fees for medical services are comparable to other similarly trained physicians in the community and reflect the complexity of your specific needs, the physician time dedicated to your care, the specialized nature of the doctor's training and education, supplies, and support costs associated with providing and coordinating your care.

Patient Payments/Balances: Co-payment, deductibles, and services not covered by your insurance plan or outstanding balances are due at the time of your appointment. Payment may be made by: cash, checks, Visa, MasterCard, or Discover. A 3.75% service fee will be applied to all credit card payments (payments made in office, mailed in, and over phone).

Insurance Payments: We participate in assignment of payment with **specific** insurance plans in the area. When the correct insurance information is provided, we will submit your claims as a courtesy to you, our patient. Your insurance coverage is a contract between you and your insurance plan – it is your responsibility to verify Dr. Rampy participates with your specific insurance plan prior to your visit. If it is determined by your insurance that Dr. Rampy is out of network with your insurance, you will be responsible for the charges. You are responsible for unpaid balances left on your account regardless of the amount your insurance coverage.

Additional Fees:

Missed appointments: Please keep in mind that the appointment you have scheduled has been set aside specifically for you. To assist patients with access to our physician, we will charge a fee of \$50.00 for any appointment not canceled by 12pm the prior business day.

Administrative Fees: The completion of disability forms, attending physician statements, and other supplemental insurance forms requires additional staff and time. An annual fee of \$50.00 will be collected at your first visit of every year. (This fee does NOT cover paperwork pertaining to legal matters).

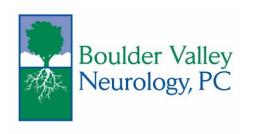
Collection Agencies: If it becomes necessary to place your account with a third party collection agency due to your non- payment, the account of the person responsible will be turned over to collections, and the patient will be dismissed from our practice.

Bounced Checks: A \$50.00 charge will be applied for each check returned by the bank.

Your signature on this page constitutes an agreement to this policy.

I have read and agree to the above policies and authorize payment directly to Boulder Valley Neurology,

rC, for medical benefits.	
Signature of Person Responsible for Account/Patient	
Date	
Printed Name	_
	Revised 03/2025

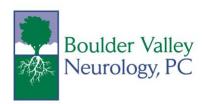


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Fax 303.926.1032

Notice of Privacy Practices: Acknowledgement of Notice

I acknowledge receipt of the Notice of Privacy Practices for Boulder Valley Neurology, PC.
Patient Signature
Printed Name
Date
ADDITIONAL POLICIES OF BOULDER VALLEY NEUROLOGY, PC
Appointment Policies
Patient Initials:
Our office requires you to contact us by 12pm on the business day prior to your scheduled appointment to cancel/reschedule it. If you fail to notify our office that you will be unable to keep your appointment, a \$50.00 fee will be charged.
If you are more than 15 minutes late for your scheduled appointment time, at the discretion of Dr. Rampy, your appointment may be rescheduled.
While we will do our best, our office is not obligated to give courtesy appointment reminder calls. Please make sure that you document when your appointment dates and times are. The \$50.00 no show fee will not be waived because we were unable to remind you of your appointment.
Prescription Refill Policies
Patient Initials:
Our office requires 48 hours for prescription refills. Prescription refills are authorized during business hours, Monday – Thursday from 8:30am to 4:00pm, and Friday from 8:30am to 12:00pm.
Prescriptions will not be filled after hours or on the weekends. Please allow enough time and notify us before you run out of your medication.



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For Our Patient's Information: An Explanation of Medical Insurance

Our commitment is to provide the very best care to our patients while recognizing the need to limit services to only those that are necessary for each patient. To meet this commitment, we recognize the need for a definite understanding and agreement concerning our patient's health care and financial arrangements for that medical care. Your clear understanding of our financial policies is important to our professional relationship. Please contact our billing office regarding any questions about our fees, financial policies, or your insurance coverage and your responsibilities.

Misunderstandings about medical insurance have become increasingly common since "managed care" revolutionized the medical insurance industry. At one time it was not unusual for insurance to cover 100% of the cost of services provided during a medical visit. However, this is rarely the case at the current time. The discussion that follows will help you evaluate your insurance coverage for treatment obtained through this office.

Your Insurance Contract

A claim from our office for all services provided to you (office visits, procedures, surgery, etc.) will be sent to your insurance company. The amount that your insurance pays to the physician (provider) as reimbursement for these services — **and the amount that must be paid by you** — is determined by the contractual agreement between you and your insurance company. That agreement most likely states that you, the insured, are responsible for several types of payments. These include:

• Copayment

Copayment is the amount that your insurance company requires you to pay to the physician at the time of the service (office visit). Depending on the type of service being rendered, you may be required to pay a copay with each visit.

• Deductible (per calendar year)

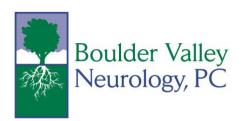
The deductible is the amount that your insurance requires **you to pay** for services rendered <u>before</u> the insurance company will begin paying for benefits.

• Co-Insurance (per calendar year)

After your deductible has been met, your insurance company will pay for all or part of the expenses according to your agreement with the insurance company. The amount that your insurance company pays will vary from 0% to 100%, with common options being 90% / 10% and 80% / 20%. This means that you (the patient) will be responsible for a percentage of the expenses (up to a maximum) beyond the deductible and your insurance company will be responsible for a percentage. The percentage amount is determined by your contract with your insurance company.

The terms under which insurance policies establish these limitations on reimbursement vary widely among policies and depend on your individual contract and plan benefits. We will contact your insurance company and verify your individual plan benefits (copay, deductible, co-insurance) and inform you of these benefits. We also encourage you to contact your insurance company to verify your plan benefits. Patients are financially responsible for any service received that is not a covered benefit of their insurance plan.

EFFECTIVE IMMEDIATELY:
IT IS OUR OFFICE POLICY TO COLLECT YOUR COPAY AND OUTSTANDING
ACCOUNT BALANCES



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PATIENT HIPAA QUESTIONNAIRE

I.	Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):					
II.	Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:					
Name	e Phone					
Name	e Phone					
III.	Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.					
IV.	Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL":					
	YES NO					
V.	Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results or other health care information if other than your home phone number: ()					
*	I am fully aware that a cell phone is not a secure and private line.					
**	I am fully aware my health information can be transmitted by facsimile (fax), mail or the internet.					
VI.	Can confidential messages (i.e., appointment reminders) be left on your home answering machine or voicemail?					
	YES NO					
PATI	IENT NAME					
PATI	IENT/GUARDIAN SIGNATURE					
DAT	Ti di					



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Medical History

Patient Name		Birth Date _		Age		
Address		City/State	Z	ip		
Phone Home	Work Phone	I	Left or Right Handed?			
Occupation		_ Height	Weight			
		Chief Compla	nint			
	In your own words, please describe the problem(s) for which you are being referred					
Past and Current M	edical Conditions		Approximate	e Date		
		_				
Surgeries		_	Approxim	nate Date		
Current Medication	S	Dosage	Frequency	Reason		

Have you ev	ver been told that you need to take medicine	e before medical or dental procedures? Yes	_No	
Drug Aller	Drug Allergies			
Other Allers	gies (e.g. latex, iodine, adhesives)			
Family Me	dical Problems:			
	Family Member	Medical Problem		
	Mother			
	Lothor			
	Cictor(c)			
	Prother(s)			
	Children			
Personal History: Your Marital Status Number of Children Ages: Spouses Occupation Highest Level of Education Degree(s) Do You Smoke? Yes No Quit Packs Per Day For How Long Do You Drink Alcohol? Yes No Quit Number of Drinks Per Week Do You Drink Coffee, Tea, or Caffeinated Soft Drinks? Yes No How much Do You Now or Have You in the Past Used Street Drugs? Yes No If Yes, List Please tell us about other medical conditions, not mentioned elsewhere on this form				
General		Satigue General Weakness Elevated Company Change in Appetite Trouble Walking		
Skin Rashes/	/Sores Itching			
Eyes Eye Pai Color B	n Double Vision Cataracts	Loss of Vision Glaucoma Droopy	y Eyelids	
Ears Change	es in Hearing Buzzing/Ringing in Ear	s Spinning/Vertigo Hard of Hearing		
Blood/Hem Easy B	ruising/Bleeding Blood Clots	Past Transfusions Anemia		
	gic/Infections Hepatitis Susceptible to Infecti	on Enlarged Lymph Nodes		
Lung/Respi Asthma Trouble	iratory Emphysema Tuberculosis Swallowing Other Lung Condition	Shortness of Breath Cough Sore	Throat	