Boulder Valley Neurology, PC

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 _____ First Name _____ Middle Initial _____

Address _____ City_____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

SS# _____ Date of Birth _____ Sex _____

Marital Status _____ Email _____

Employers Name _____ Phone _____

Employer Address _____ City _____ State _____ Zip _____

INSURANCE INFORMATION

Primary Insurance

Insurance Name _____ Policy # _____ Phone _____

Name of Insured _____ Relationship _____

SS# _____ Date of Birth _____

Employers Name _____ Phone _____

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 to treat the patient identified above. I acknowledge that I am responsible to pay all charges for all treatments administered by the physician to the patient. 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.

Signature of Patient / Authorized Person _____ Date _____

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.

Signature of Patient / Authorized Person _____ 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, PC, for medical benefits.

Signature of Person Responsible for Account/Patient _____

Date _____

Printed Name _____

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183 South Taylor Avenue, Suite 160
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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 before 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 _____ Phone_____

Name _____ 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 _____

PATIENT NAME_____

PATIENT/GUARDIAN SIGNATURE_____

DATE _____

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Medical History

Patient Name _____ Birth Date _____ Age _____

Address _____City/State _____ Zip _____

Phone Home _____ Work Phone _____ **Left** or **Right** Handed? _____

Occupation _____ Height _____ Weight _____

Chief Complaint

In your own words, please describe the problem(s) for which you are being referred

_____
_____
_____
_____
_____
_____

Past and Current Medical Conditions	**Approximate Date**

Surgeries	**Approximate Date**

Current Medications	**Dosage**	**Frequency**	**Reason**

Have you ever been told that you need to take medicine before medical or dental procedures? Yes _____ No _____

Drug Allergies _____

Other Allergies (e.g. latex, iodine, adhesives) _____

Family Medical Problems:

Family Member	Medical Problem
Mother	
Father	
Sister(s)	
Brother(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.**_____

Do you have any of the following conditions regularly/currently/within the past 2 months? Please mark all that apply:

General
___ Recent Weight Change ___ Fever/Chills ___Fatigue ___ General Weakness ___ Elevated Cholesterol
___ Central Line/Catheter ___ Metal Implants ___ Change in Appetite ___ Trouble Walking

Skin
___ Rashes/Sores ____ Itching

Eyes
___ Eye Pain ___ Double Vision ___ Cataracts ___ Loss of Vision ___ Glaucoma ___ Droopy Eyelids
___ Color Blindness

Ears
___ Changes in Hearing ___ Buzzing/Ringing in Ears ___ Spinning/Vertigo ___ Hard of Hearing

Blood/Hematologic
___ Easy Bruising/Bleeding ___ Blood Clots ___ Past Transfusions ___ Anemia

Immunologic/Infections
___ AIDS ___ Hepatitis ___ Susceptible to Infection ___ Enlarged Lymph Nodes

Lung/Respiratory
___ Asthma ___ Emphysema ___ Tuberculosis ___ Shortness of Breath ___ Cough ___ Sore Throat
___ Trouble Swallowing ___ Other Lung Condition

Heart/Cardiovascular
___ Chest Pains ___ Heart Condition ___ Rheumatic Fever ___ High Blood Pressure ___ Palpatations
___Artificial Heart Valve ___ Mitral Valve Prolapse ___Pacemaker ___Irregular Heartbeat

Musculoskeletal
___ Muscle or Joint Pains ___ Muscle Stiffness ___Arthritis ___ Back Pain ___ Neck Pain

Gastrointestinal
___ Constipation ___ Nausea/Vomiting ___ Abdominal Pain ___ Trouble Chewing or Swallowing
___ Diarrhea ___ Ulcers ___Blood in Stools ___ Dark or Tarry Stools

Genitourinary
___ Urinary Urgency ___Urinary Hesitancy ___ Urinary Incontinence ___Pain/Burn with Urination
___ Kidney Stones ___ Urinary Infection ___Erectile Dysfunction ___Trouble Reaching Orgasm
___ Menstrual troubles

Neurologic
___ Blackouts ___ Seizures ___ Paralysis ___ Numbness/Tingling ___Tremors ___ Stroke/TIA's
___ Lack of Coordination ___ Slow or Stiff Movements ___ Headaches

Endocrine
___ Intolerance to Heat ___ Intolerance to Cold ___ Thyroid Disease ___ Diabetes

Psychiatry
___ Anxiety ___ Memory Loss/Poor Concentration ___ Hallucinations ___ Thoughts of Suicide ___ Depression
___ Trouble Sleeping ___ Loss of Interest in Hobbies

List Name, Phone, and Address of Emergency Contact:

_____

_____

_____

_____

Relationship _____

I certify the above information is accurate and correct.

Information on this form given by: _____

Signature _____

Relationship to Patient _____ Date _____

_____ _____
Physician Signature Date