



**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 \_\_\_\_\_

## **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:**

**New Patient Scheduling Deposit Fee:** We collect a \$100.00 deposit upon scheduling a new patient appointment to hold your appointment date and time. Upon check-in, we will apply \$50.00 to the administrative fee (described below), and any remaining credit balance to your copay for that visit. If you have an additional credit balance (after the administrative fee and copay), it will be applied to additional amounts due (ie deductible) stemming from your new patient appointment. If you fail to arrive for your appointment or do not cancel your appointment per our policy, you will not be refunded.

**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** \_\_\_\_\_



Boulder Valley  
Neurology, PC

Thomas M. Rampy, M.D., Ph.D.  
183 South Taylor Avenue, Suite 160  
Louisville, CO 80027  
Office: 303.926.1015  
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 \_\_\_\_\_

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### 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.



## **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**



### 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):

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- 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.

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- 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 \_\_\_\_\_



### **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**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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#### **Surgeries**

#### **Approximate Date**

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\_\_\_\_\_

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#### **Current Medications**

#### **Dosage**

#### **Frequency**

#### **Reason**

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\_\_\_\_\_

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.** \_\_\_\_\_

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**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