Patient Name: _____ **DOB:** _____

Please list your current primary care physician and any other specialists you are currently seeing.

Primary Care Physician:

Name: _____

Practice: _____

Phone: _____ Fax: _____

Specialists:

Name: _____

Specialty: _____

Practice: _____

Phone: _____ Fax: _____

Name: _____

Specialty: _____

Practice: _____

Phone: _____ Fax: _____

Name: _____

Specialty: _____

Practice: _____

Phone: _____ Fax: _____

South Denver Physicians PLLC
New neurology patient form

Full Name: _____ Gender: Male_____ Female_____
Address: _____ Date of Birth: _____ Age: _____
City, State, Zip: _____ SS#: _____
Telephone Number (H): _____ Marital Status: M____S____D____W____
(C): _____
E-mail: _____
Preferred way of reaching you: Home____ Cell____ Email_____ OK to leave messages? Yes___ No_____
Race: _____ Ethnicity: _____ or Decline: _____ Preferred Language: _____
Emergency Contact Name: _____ Number: _____
Emergency Contact Relationship to Patient: _____
OK to contact your emergency contact about your medical care? Yes___ No___
Name of Primary Insurance: _____
Policy #: _____ Group #: _____
Subscriber Name: _____ Relationship to patient __self__spouse __parent
Subscriber Address: _____
Subscriber SS#: _____ Subscriber D.O.B: _____
Name of Secondary Insurance: _____
Policy #: _____ Group #: _____
Subscriber Name: _____ Relationship to patient __self__spouse __parent
Subscriber Address: _____
Subscriber SS#: _____ Subscriber D.O.B: _____

(Please be sure to bring your current insurance card and driver's license to your appointment)

Primary Care Physicians Name: _____ **Phone:** _____
Reason for today's visit

_____

Allergies

Are you allergic to penicillin or any other drugs? Please check no if none. □ Yes □ No If Yes, Please list:

1. Name of Drug _____ What reaction? _____
2. Name of Drug _____ What reaction? _____
3. Name of Drug _____ What reaction? _____

Are you taking any medications? □ None If yes, please list:

1. Name _____ Dose _____ How many times a day? _____
2. Name _____ Dose _____ How many times a day? _____
3. Name _____ Dose _____ How many times a day? _____
4. Name _____ Dose _____ How many times a day? _____
5. Name _____ Dose _____ How many times a day? _____
6. Name _____ Dose _____ How many times a day? _____
7. Name _____ Dose _____ How many times a day? _____
8. Name _____ Dose _____ How many times a day? _____
9. Name _____ Dose _____ How many times a day? _____
10. Name _____ Dose _____ How many times a day? _____
11. Name _____ Dose _____ How many times a day? _____

Which of the following conditions are you currently being treated for or have you been treated for in the past? (please check)

□ Arrhythmia □ Murmur □ Angina/ heart stents □ Clots in legs/arms □ High Cholesterol
□ High blood pressure □ Heart attack □ Congestive Heart Failure
□ Asthma/COPD □ Lung Clots □ Sleep Apnea □ Osteoporosis
□ Cirrhosis □ Hepatitis □ Irritable Bowels □ Crohn's Disease □ Heartburn (reflux)
□ Gastric Ulcers □ Kidney Stones □ Urinary Tract Infections □ Fibromyalgia □ Arthritis
□ Chronic Pain (Where?) _____ □ Any Cancer (what kind?) _____
□ Diabetes □ Thyroid Problems (□ High or □ Low)
□ Stroke □ Dementia □ Migraine □ Multiple Sclerosis □ Parkinson's □ Neuropathy□ Seizures
□ Meningitis □ TIA/ mini-strokes □ Head Injury □ Lupus
□ Cataract □ Glaucoma □ Anemia or blood problems □ Depression □ Anxiety

List any serious illnesses, injuries, operations and hospitalizations:

Please specify illness, injury, operations and hospitalizations.

1. When _____ Where _____ What for? _____
2. When _____ Where _____ What for? _____
3. When _____ Where _____ What for? _____
4. When _____ Where _____ What for? _____
5. When _____ Where _____ What for? _____

Family History:

Please use the space below to list all of your immediate family. Please list serious illnesses or diseases, especially any neurological disorders

Relationship	Major Diseases they have/had (seizures, cancer, diabetes, stroke, heart attack etc)		
Mother			
Father			
Brother(s)			
Sister(s)			
Son(s)			
Daughter(s)			

Social and Preventative History:

Do you currently smoke or chew tobacco? □ Yes □ No If no, have you in the past? □ Yes □ No
How many packs per day? _____
Do you drink alcohol, beer, or wine? □ Yes □ No If no, have you in the past? □ Yes □ No
How many times per week? _____ How many drinks per occasion? _____
Do you currently drink coffee and/or tea? □ Yes □ No If yes, how many cups per day? _____
Do you exercise? □ Yes □ No If yes, how often? _____
Do you currently use any street drugs? □ Yes □ No If no, have you in the past? □ Yes □ No
If yes, name them ? _____

By signing below, I certify that to the best of my knowledge all of the above information is complete and accurate.

_____ _____
Printed Name of Patient/Legal Representative If Legal Representative, relationship to Patient

_____ _____
Signature of Patient/Legal Representative Date

South Denver Physicians PLLC
Phone: 720-441-4410 Fax: 1-888-474-7158

Patient's Name_____ DOB_____

1. Private insurance authorization for assignment of benefits and release of information
I hereby authorize and direct payment of my medical benefits to South Denver Physicians PLLC, for any services furnished to me by the physicians. I authorize the physician to release any information, including diagnosis and the records of any treatment or examinations rendered to me or my child during the period of such medical services to third party payers and/or health practitioners. In the event that my health plan determines service to be "not covered", I will be responsible for the complete charge. I agree to be responsible for payment of all unpaid services rendered on my behalf or my dependants, including any fees for collection services needed.

_____ Initials

2. Payment
I hereby assume responsibility to pay the costs of all services provided to me by South Denver Physicians PLLC and its physicians

_____ Initials

3. Authorization of Payments
I understand that South Denver Physicians PLLC will assist me in submitting my claim to the insurance carrier. I hereby authorize payment directly to South Denver Physicians PLLC and its physician(s) of medical benefits, otherwise payable to me, for the services provided. I understand that I am financially responsible for my health insurance deductibles, coinsurance (co-pays) and non-covered services.

_____ Initials

4. Medicare Lifetime signatures on File
I request that payment of authorized Medicare benefits be made to South Denver Physicians PLLC for any services furnished to me by the physicians. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid services and its agents any information that is needed to determine these benefits or the benefits payable for related services.

_____ Initials

5. Medigap Authorization for Assignment of Benefits and Releases of Information
I request that payment of authorized Medigap benefits to be made to South Denver Physicians PLLC for any services furnished to me by the provider of service. I authorize any holder of medical information about me to release to the Medigap Insurer any information needed to determine these benefits payable for related services.

_____ Initials

6. Acknowledgement of our Privacy Practices
I hereby acknowledge that I have received and understand South Denver Physicians PLLC "Notice of Privacy Practices"

_____ Initials

7. Consent to treat
I consent to treatment by South Denver Physicians PLLC physicians.

_____ Initials

_____ _____
Printed Name of Patient/Legal Representative | If Legal Representative, relationship to Patient

_____ _____
Signature of Patient/Legal Representative | Date

South Denver Physicians PLLC
Phone: 720-441-4410 Fax: 1-888-474-7158

Patient's Name_____ DOB_____

How can we reach you?

South Denver Physicians PLLC, at times, may need to contact you about test results, appointments, referrals or billing/ Insurance. By filling out the information below, we will be better able to serve you. In an effort to protect your privacy and follow federal guidelines, we have developed a policy on leaving medical care messages, unless we have permission to do so:

- ☐ We will NOT leave messages with anyone except the patient or legal guardian
- ☐ We will NOT leave messages on voicemail or answering machines
- ☐ We will not send emails/faxes

Please read below and carefully consider who, if anyone, you want to have access to your medical/account information.

I, _____ give my permission South Denver Physicians PLLC staff/physicians to leave phone messages regarding my medical care/ account information to:

Name _____ Relationship_____

Name _____ Relationship_____

Name _____ Relationship_____

Is it ok to leave messages on your voicemail regarding your appointment date and time? ☐ Yes or ☐ No

I fully understand that this consent will remain valid until revoked in writing by me.

_____ _____
Printed Name of Patient/Legal Representative | If Legal Representative, relationship to Patient

_____ _____
Signature of Patient/Legal Representative | Date

South Denver Physicians PLLC
Phone: 720-441-4410 Fax: 1-888-474-7158

Patient's Name_____ DOB_____

South Denver Physicians PLLC is staffed by licensed Colorado physicians.

As a patient of the South Denver Physicians PLLC, you have a right to:

- ☐ Know the identity, professional status and experience of those with whom you interact.
- ☐ Make choices regarding your healthcare professional.
- ☐ Receive considerate, professional, respectful and private care.
- ☐ Expect effective communication that maintains confidentiality.
- ☐ Expect your privacy to be respected to the fullest extent possible, and expect confidentiality of your medical records and communications.
- ☐ Expect that every professional with whom you interact will fully comply with HIPAA and other law or regulation pertaining to the delivery of healthcare.
- ☐ Receive complete and understandable information regarding your diagnosis, options, risks and alternatives.
- ☐ Refuse or withdraw your consent at any time and discontinue any treatment, drug or procedure.
- ☐ Be provided timely access to your medical records for review.
- ☐ Request an estimate of charges prior to receiving non-emergency care.
- ☐ Request an explanation of all billing charges and procedures, and expect a timely resolution of all billing concerns.
- ☐ Register a complaint or concern regarding your care with the Office Manager and to have those concerns addressed without fear of recrimination or penalty.

In certain circumstances, Federal or State laws or regulations may impose certain limitations on your ability to exercise any rights listed above.

As a patient, you have the responsibility to:

- ☐ Provide complete and accurate health information.
- ☐ Ask questions that are significant for your healthcare.
- ☐ Participate with your provider in the development and implementation of your plan of care.
- ☐ Take responsibility for refusing treatment, withdrawing consent, or failing to follow a plan of care.
- ☐ Report any worsening of your condition or unexpected reactions to medications promptly.
- ☐ Keep appointments, and follow our cancellation policy.

I have read and understand the foregoing and agree to adhere to South Denver Physicians PLLC's Patient Rights and Responsibilities.

_____ _____
Printed Name of Patient/Legal Representative If Legal Representative, relationship to Patient

_____ _____
Signature of Patient/Legal Representative Date

South Denver Physicians

Phone: (720) 441-4410

Fax: (888) 474-71-51

As of March 31, 2020 we will no longer be working with worker's compensation insurance companies directly.

I, _____, understand that if my visit is or will be related to worker's compensation I will pay for the visit(s) out-of-pocket as my regular health insurance will not cover it.

I understand that it will be my responsibility as a patient to submit the claims to my worker's compensation insurance on my own for reimbursement.

I understand that I need to let the office know before being seen by the doctor if I believe that my visit may be related to a worker's compensation claim.

_____ _____

Patient/Legal Representative Name (Printed) Date

_____

Patient/Legal Representative (Signature)

South Denver Physicians, PLLC

Phone: 720-441-4410 Fax: 1-888-474-7158

Welcome to South Denver Physicians. We are very glad to have you as a patient in our clinic. We strive to provide our patients with the best care possible. We have several rules we would like to make you aware of. If you have any questions or concerns about these rules, don't hesitate to ask the receptionist. We'll be happy to answer all your questions.

1. Our office is open Monday through Friday 9 a.m. to 5 p.m.
2. You many also call DispatchHealth. They will send an emergency care provider to your house on nights, weekends, and holidays. They are contracted with most major insurance companies including Medicare and Medicaid. For more information, please visit www.dispatchhealth.com.
   DispatchHealth Phone: (303) 500-1518
3. Always bring your photo ID, insurance information, and a list of your current medications to your appointment.
4. We have a 24-hour cancellation policy. All patients who miss their appointments or fail to cancel without a 24-hour notice will be charged a $50 cancellation fee.
5. Please be on time for your appointment. If you are more than 10 minutes late, you may be asked to reschedule.
6. All payments are due the day of your appointment.
7. Please call all of your medication refills in at least 5 days in advance to your local pharmacy.
8. We don't give refills of controlled substances (such as narcotic pain medication, anxiety and benzodiazepines, etc.) to new patients until medical records from your previous health care provider outlining the reason those medications were prescribed are brought by the patients to their appointment.
9. There is a 7-14 day turn around on all medical records requests or physician forms to fill out.
10. No forms will be filled out without an appointment. This includes disability forms.
11. Sometimes appointments take longer than they are scheduled for due to a variety of reasons. This may cause delays. We sincerely apologize if you have to wait for your appointment and will reschedule you if you are unable to wait. We appreciate your patience as we are trying to accommodate our patients' medical needs.

Once again, we are delighted that you have chosen South Denver Physicians, PLLC.

_____ _____

Printed Name of Patient/Legal Representative If Legal Representative, relationship to Patient

_____ _____

Signature of Patient/Legal Representative Date