Colorado Institute for Neuromuscular and Neurological Disorders

PATIENT INFORMATION FORM

Todays Date*:**____ ***Patient #__________________________

****

PATIENT'S NAME

(LAST)_____________________________**(FIRST)**__________________________________**(M.I)**____

ADDRESS__________________________________**CITY**__________________**STATE**_____**ZIP**______

HOME PHONE_______________________________**CELL**____________________________________

DATE OF BIRTH____________________**AGE**_______________**SEX**___________

SOCIAL SECURITY #___________________________________**MARITAL STATUS**_________________

EMPLOYER____

(NAME) (ADDRESS) (CITY/ST/ZIP)

OCCUPATION____________________________**Work Phone**______________________**MAY WE CONTACT YOU AT WORK? Y N**

PARENT/GUARDIAN/SPOUSE

(LAST)__________________________________**(FIRST)**____**(M.I.)**__________

ADDRESS__________________________________**CITY**__________________**STATE**_____**ZIP**______

HOME PHONE_______________________________**CELL**____________________________________

DATE OF BIRTH____________________**AGE**_______________**SEX**___________

SOCIAL SECURITY #___________________________________**MARITAL STATUS**_________________

PRIMARY MEDICAL INSURANCE **Date of Accident/Injury** ____

____

(Primary Insurance Company Name) (ID#) (Group#)

____

(Address) (City/State/Zip) (Phone)

____

(Policy Holder Name) (ID#) (INSURED Date of Birth)

WORKERS COMPENSATION (If applicable) **Date of Injury:**______________________________

____

(Insurance Company Name) (Claim #) (Adjuster Name and Phone)

Has and Incident Report been filed with your employer? _______________

SECONDARY MEDICAL INSURANCE

____

(Primary Insurance Company Name) (ID#) (Group#)

____

(Address) (City/State/Zip) (Phone)

____

(Policy Holder Name) (ID#) (Date of Birth)

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EMERGENCY CONTACT INFORMATION

____
(Name) (Phone) (Relationship)

____
(Address) (City) (State) (Zip)

AGREEMENT TO PAY FOR TREATMENT

I, the responsible party, herby agree to pay all charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization with which this office has a contractual agreement, I agree to pay all applicable co-payments, co-insurance and deductibles, which arise during the course of treatment for the patient. The responsible party also agrees to pay for treatment rendered to the patient, which is not considered to be a covered service by my insurer and/or a third party insurer or other payor.

X____
RESPONSIBLE PARTY DATE

RELEASE AND STATEMENT TO PERMIT PAYMENT OF PRIVATE INSURANCE BENEFITS TO THE PROVIDER

I, the undersigned responsible party hereby authorize this office/its employees to release and disclose all or any part of the patient's medical records to any entity which is, or may be liable, for all or part of the provider charges.
I, authorize the release and disclosure of any and all of my or my child's medical records to any other entity, including, but not limited to specialty physicians, hospitals, or other health care providers which may be of assistance in the opinion of this office, in providing treatment of the patient.
I, authorize the release of records necessary to assist in the reimbursement of benefits to which I may be entitled.
I, authorize this office and/or its employees to release, via fax machine, medical records which are needed in order to provide the patient with the most appropriate medical care.
I, authorize and request that payment of any third party or insurance company benefits be made directly to this office for any services furnished to the patient. The signature furnished below shall suffice for all insurance forms on a continuing basis.

X____
RESPONSIBLE PARTY DATE

NOTICE OF PRIVACY PRACTICES

I, the undersigned have received a copy and understand the Privacy Practices of the Colorado Institute for Neuromuscular and Neurological Disorders.

X____
RESPONSIBLE PARTY DATE

Colorado Institute for Neuromuscular and Neurological Disorders may disclose my health care information to:

NAME:____ RELATIONSHIP_____________________________

This authorization is effective from ___________________________ to _________________________________ and includes only personal health information pertaining to Colorado Institute for Neuromuscular and Neurological Disorders and its providers.

X____
RESPONSIBLE PARTY DATE

- **Patients with Health Plans, please present your insurance ID Card to the receptionist after completing this form.**
- **Some contract Health Plans (HMO, PPO, IPA, etc) require a co-payment at the time of service – Please have this ready.**

Colorado Institute for Neuromuscular and Neurological Disorders

ADDENDUM TO PATIENT INFORMATION FORM

PATIENT'S NAME:

(LAST)________________________________(FIRST)____________________________________(M.I)____

CINND policy regarding phone calls:

Charges may be applied for telephone calls to CINND by patients or their family member or representatives that result in over 5 minutes of consultation with either providers or staff members. Charges will be applied in strict accordance with standards set forth in established coding guidelines. Such guidelines and a fee schedule for telephone calls are available for review and will be provided if requested.

CINND policy regarding late cancellations:

Any patient that does not give at least 24 hours notice of an appointment cancellation or any patient that does not show for their scheduled appointment or any patient that is 10 minutes or more late for their appointment will be charged a $50.00 fee. An appointment for the day after the office is closed would need to be cancelled by 12 noon the last working day before the office is closed. For example: A Monday appointment would need to be cancelled by 12 noon Friday prior to the Monday appointment.

X ____

RESPONSIBLE PARTY DATE