COLORADO INSTITUTE FOR
NEUROMUSCULAR AND NEUROLOGICAL
DISORDERS

Pierre Pavot, DO
Board-certified Neurology, Electrodiagnostic Medicine

New Patient Forms Packet

This packet contains forms to be completed by all new CINND patients

Note that several of the forms in this packet require a signature by the patient or other responsible party. Please be sure to sign and date all required items.

Please help us stay on schedule by having all forms completed prior to your visit.

Colorado Institute for Neuromuscular and Neurological Disorders

Checklist for New Patients

Please bring the items below to your appointment. **We cannot see you without them.**

☐ Insurance card(s) and a photo ID to confirm your identity.

☐ Method of payment for any applicable charges. We accept credit cards (Visa or MasterCard only), debit cards or cash. **Checks are not accepted.**

☐ The New Patient Forms Packet – available at www.longmontneurology.com – must be completed **prior** to the time of your appointment.

If you have any prior diagnostic test results (MRI, EEG, EMG, labs, etc.) or prior records that are applicable to your appointment, and they were **completed outside of Longmont United Hospital**, please bring them to your appointment or arrange for them to be forwarded to the office prior to the date of your visit. For radiographic studies such as MRI, CT or X-ray that were **performed at a facility other than Longmont United Hospital or Health Images**, please bring any written reports that you have.

Patients being evaluated for memory loss or other cognitive problems should have a reliable family member or caregiver attend their appointment to provide necessary medical information.

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 $75.00 fee. An appointment for the day after the office is closed would need to be cancelled by 12:00 noon the last working day before the office is closed. For example: A Monday appointment would need to be cancelled by 12:00 noon Friday prior to the Monday appointment.

X_____ _____

Responsible Party Date

COLORADO INSTITUTE FOR NEUROMUSCULAR AND NEUROLOGICAL DISORDERS
PATIENT INFORMATION FORM

TODAY'S DATE _____

PATIENT'S NAME AND ADDRESS

LAST _____ **FIRST** _____ **M.I.** _____

ADDRESS _____ **CITY** _____ **STATE** ___ **ZIP**_____

HOME PHONE _____ **CELL** _____ **PREFERRED #** HOME / CELL

DATE OF BIRTH _____ **AGE**_____ **SEX** _____

MARITAL STATUS _____

EMPLOYER

_____ (NAME)

(STREET ADDRESS) (CITY/ST/ZIP)

OCCUPATION _____ **WORK PHONE** _____

MAY WE CONTACT YOU AT WORK (CIRCLE ONE)? Y N

PARENT/GUARDIAN/SPOUSE

LAST _____ **FIRST** _____ **M.I.** _____

ADDRESS _____ **CITY** _____ **STATE** ___ **ZIP**_____

HOME PHONE _____ **CELL** _____

DATE OF BIRTH _____ **AGE** _____ **SEX** _____

MARITAL STATUS _____

RELATIONSHIP TO PATIENT _____

PRIMARY MEDICAL INSURANCE

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

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

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

SECONDARY MEDICAL INSURANCE

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

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

(Policy Holder Name) (ID#) (**POLICY HOLDER** Date of Birth)

EMERGENCY CONTACT INFORMATION

(Name) (Phone) (Relationship)

AGREEMENT TO PAY FOR TREATMENT

I, the responsible party, hereby 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 when that treatment is not considered to be a covered service by the primary 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 to 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 of 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 also 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.

Name: _____

Primary Care Physician: _____

Date: ___/___/____

Pierre V. Pavot, D.O.
Colorado Institute For Neuromuscular
and Neurological Disorders
600 S. Airport Rd., Bldg. B, Ste. E
Longmont, CO 80503

		Number of pills you take at each time of the day				
Drug Name	Strength	Morning	Noon	Evening	Bedtime	Prescriber
1)						
2)						
3)						
4)						
5)						
6)						
7)						
8)						
9)						
10)						
11)						
12)						
13)						
14)						
15)						

Colorado Institute for Neuromuscular and Neurological Disorders
Initial Visit Questionnaire

Patient name: _____ Date of birth: _____

Referred by: _____

CHIEF COMPLAINT Please describe in your own words the reason for your appointment.

_____

_____

Which hand do you write with? __ Right __ Left

PAST MEDICAL HISTORY List all current and prior medical problems, including any problems that are controlled with your current medications.

_____

_____

PAST SURGICAL HISTORY List all current and prior surgical procedures.

_____

_____

FAMILY HISTORY List any significant medical problems of your closest relatives – grandparents, parents, siblings, children.

_____

_____

SOCIAL HISTORY

Marital status: _____
Do you live alone? __ Yes __ No If not, whom do you live with? _____
If you have children, how many? _____

Last grade you completed in school: _____
Occupation: _____

Do you currently drink alcohol? __ Yes __ No

If **yes**:

How much do you drink per day? __ less than 2 drinks __ more than 2 drinks
If more than 2 drinks per day, how much do you drink? _____

If **no:**

Have you ever drunk more than 2 drinks per day? __ Yes __ No
If you have, when did you start drinking less than 2 drinks per day? _____
and how much did you drink before then? _____

Do you currently smoke tobacco? __ Yes __ No

If **yes**:

How much do you smoke per day? _____
How long have you been smoking? _____

If **no**:

Have you ever been a smoker? __ Yes __ No
If so:
How much did you smoke? _____
How long were you a smoker? _____
When did you quit? _____

Do you use street/illegal/recreational drugs? __ Yes __ No

If **yes**, which drugs do you currently use? _____

If **no**, have you ever used street/illegal/recreational drugs? __ Yes __ No
If so, which drugs did you use and when is the last time you used them?

_____

ALLERGIES Please list any allergies to medications or other substances. Indicate the reaction caused (rash, itching etc.).

_____

_____

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Review of Systems

Please place a checkmark next to any of the following symptoms you have experienced **in the LAST MONTH**.

General
____ Night sweats
____ Fevers
____ Rash
____ Bleeding disorder
____ Weight changes
Loss / Gain (circle one)
____ HIV infection of AIDS
____ Psychiatric diseases
____ Fatigue

Head and Neck
____ Double vision
____ Blurred vision
____ Ear pain
____ Hearing loss
____ Dizziness
____ Ringing in ears
____ Sinus problems
____ Snoring
____ Excessive sleepiness
____ Facial pain
____ Pain with chewing
____ Lumps in the neck
____ Neck pain

Respiratory System
____ Cough
____ Regurgitation
____ Shortness of breath
____ Wheezing

Neurologic
____ Headaches
____ Head injury
____ Numbness (or tingling)
____ Seizures
____ Strokes
____ Balance problems
____ Weakness

Musculoskeletal
____ Joint pain or swelling
____ Muscle pain

Endocrine
____ Diabetes
____ Heat/cold intolerance
____ Thyroid imbalance
____ Menstrual disorders

Gastrointestinal
____ Difficulty swallowing
____ Diarrhea
____ Vomiting
____ Constipation
____ Bloody stools
____ Heartburn
____ Ulcers

Cardiovascular
____ Hypertension
____ Palpitations
____ Chest pain
____ Swelling (legs or arms)

Urologic
____ Difficulty in urination
____ Frequent urination
____ Blood in the urine
____ Prostate problems

Other
_____
_____
_____

Patient name (please print) _____

Patient signature _____

Physician signature _____

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Colorado Institute for Neuromuscular and Neurological Disorders (CINND) is required to maintain the privacy of your health information and to provide you with a notice of its legal duties and privacy practices. CINND will not use or disclose your health information except as described in this Notice. This Notice applies to all of the medical records generated by the CINND, as well as records we receive from other providers.

USES AND DISCLOSURES REQUIRING YOUR CONSENT: With your consent, CINND may use and disclose your health information for the following purposes.

TREATMENT: CINND may use your health information in the provision and coordination of your healthcare. We may disclose all or any portion of your medical record information to your attending physician, consulting physician(s), nurses, technicians, medical students, and other health care providers who have a legitimate need for such information in your care and treatment. Different departments may share health information about you in order to coordinate specific services, such as prescriptions, lab work and x-rays. CINND also may disclose your health information to people outside CINND who may be involved in your medical care after you leave CINND, such as family members, clergy and others used to provide services that are part of your care. Other ways we may use or disclose your health information for purposes related to treatment are:

- **Treatment Alternatives:** To tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- **Appointment Reminders:** To contact you as a reminder that you have an appointment for treatment or medical care at CINND.

PAYMENT: CINND may release health information about you for the purposes of determining coverage, billing, claims management, medical data processing, and reimbursement. The information may be released to an insurance company, third party payer or other entity (or their authorized representatives) involved in the payment of your medical bill and may include copies or excerpts of your medical record, which are necessary for payment of your account. For example, a bill sent to a third party payer may include information that identifies you, your diagnosis, and the procedures and supplies used. We may also provide payment information to other care providers who have been involved in your care, e.g., an ambulance company.

ROUTINE HEALTHCARE OPERATIONS: CINND may use and disclose your health information during routine healthcare operations, including quality assurance, utilization review, medical review, internal auditing, accreditation, certification, licensing or credentialing activities of CINND, medical research and educational purposes. CINND may engage outside companies to carry out certain aspects of routine healthcare operations. These entities are called the "business associates" of the CINND. CINND may need to disclose your health information to the business associates to allow them to perform their duties. The business associates will, in turn, use and disclose your health information as they conduct business on the CINND's behalf. Examples of business associates, include, but are not limited to, a copy service used by CINND to copy medical records, consultants, accountants, lawyers, medical transcriptionists and third-party billing companies. CINND requires the business associate to protect the confidentiality of your health information.

USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION: CINND may not disclose your health information to persons outside of CINND for purposes other than treatment, payment or healthcare operations without your authorization. In addition, CINND may not use or disclose psychotherapy notes written by your mental health provider, if any, without your authorization, even for treatment, payment or healthcare operations. You have the right to revoke any authorization you have previously given by submitting a written statement of revocation to CINND.

USES AND DISCLOSURES TO WHICH YOU MAY OBJECT:

FAMILY/FRIENDS: CINND may disclose your health information to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friends of your condition and that you are in the Hospital. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. If you have any objection to the use and disclosure of your health information in this manner, please tell us.

USES AND DISCLOSURES THAT ARE REQUIRED OR PERMITTED WITHOUT CONSENT OR AUTHORIZATION RESEARCH: Under certain circumstances CINND may use and disclose your health information to approved clinical research studies. While most clinical research studies require specific patient consent, there are some instances where a retrospective record review with no patient contact may be conducted by such researchers. For example, the research project may involve comparing the health and recovery of patients who received one medication for their medical condition to those who received a different medication for that same condition.

REGULATORY AGENCIES: CINND may disclose your health information to government and certain private health oversight agencies, e.g., the Department of Public Health and Environment, the Joint Commission on Accreditation of Healthcare Organizations or the Board of Medical Examiners, for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations and inspections. These activities are necessary to monitor compliance with the requirements of government programs.

LAW ENFORCEMENT/LITIGATION: CINND may disclose your health information for law enforcement purposes as required by law or in response to a court order.

PUBLIC HEALTH: As required by law, CINND may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability. For example, CINND is required to report the existence of a communicable disease, such as acquired immune deficiency syndrome ("AIDS"), to the Department of Public Health and Environment to protect the health and well-being of the general public.

WORKERS' COMPENSATION: CINND may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

MILITARY/VETERANS: CINND may disclose your health information as required by military command authorities, if you are a member of the armed forces.

AS OTHERWISE REQUIRED BY LAW: CINND will disclose your health information in any situation in which such disclosure is required by law (e.g., child abuse, domestic abuse).

YOUR RIGHTS RELATED TO YOUR HEALTH INFORMATION: Although all records concerning your treatment obtained at CINND are the property CINND, you have the following rights concerning your health information:

RIGHT TO CONFIDENTIAL COMMUNICATIONS: You have the right to receive confidential communications of your health information by alternative means or at alternative locations. For example, you may request CINND only contact you at work or by mail.

RIGHT TO INSPECT AND COPY: You generally have the right to inspect and copy your health information, except as restricted by your physician or by law.

RIGHT TO AMEND: You have the right to request an amendment or correction to your health information. If we agree that an amendment or correction is appropriate, we will ensure that the amendment or correction is attached to your medical record.

RIGHT TO AN ACCOUNTING: You have the right to obtain a statement of the disclosures that have been made of your health information other than by your authorization, other than to you and other than for the purpose of treatment, payment or routine operational purposes.

RIGHT TO REQUEST RESTRICTIONS: You have the right to request restrictions on certain uses and disclosures of your health information. If we are able to agree to your request, we will abide by the restrictions.

RIGHT TO RECEIVE COPY OF THIS NOTICE: You have the right to receive a paper copy of this Notice, upon request, if this Notice has been provided to you electronically.

RIGHT TO REVOKE CONSENT OR AUTHORIZATION: You have the right to revoke your consent or authorization to use or disclose your health information, except to the extent that action has already been taken in reliance on your consent or authorization.

FOR MORE INFORMATION REGARDING HOW TO EXERCISE THESE RIGHTS: If have questions or would like more information regarding any of the rights listed above, please contact:

Pierre V. Pavot, D.O.
Colorado Institute of Neuromuscular and Neurological Disorders
600 S. Airport Road, Bldg B Suite E
Longmont, CO 80503
720-491-3322

IF YOU BELIEVE THAT YOUR RIGHTS HAVE BEEN VIOLATED: You may file a complaint with CINND or with the Secretary of the Department of Health and Human Services. To initiate a complaint with CINND, please call 720-491-3322. All complaints must be submitted in writing. There will be no retaliation for a complaint.

CHANGES TO THIS NOTICE: CINND will abide by the terms of the Notice currently in effect. CINND reserves the right to change the terms of this Notice at any time. Any new notice provisions will be effective for all protected health information that it maintains. CINND will mail any revised Notice to the address indicated on the General Admission Agreement, or Patient Information Forms, or such other address you may provide to us from time to time.

NOTICE EFFECTIVE DATE: The effective date of this Notice is January 1, 2006.

_____

Patient Signature Date