WELCOME TO COLORADO SPINE THERAPY, LLC

PATIENT INFORMATION DATE OF INTAKE:

NAME: _____ GENDER: _____

PHONE (C): _____ (H): _____ (W): _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

BIRTHDATE: _____ EMAIL ADDRESS: _____

EMPLOYER: _____

MARITAL STATUS: _____ PARTNER'S NAME: _____

PARTNER'S EMPLOYER: _____ PARTNER'S PHONE: _____

REFERRING PHYSICIAN: _____ DIAGNOSIS: _____

FAMILY PHYSICIAN: _____ DATE OF INJURY: _____

EMERGENCY CONTACT NAME: _____ PH: _____

HOW DID YOU HEAR ABOUT OUR CLINIC? _____

IS YOUR CASE IN LITIGATION: ☐ YES ☐ NO

INSURANCE INFORMATION:

CLAIMS SHOULD BE FILED UNDER: (PLEASE CHECK ONE)

☐ HEALTH INSURANCE ☐ AUTO INSURANCE ☐ WORKMAN'S COMP INSURANCE ☐ PRIVATE PAY

IF BILLING HEALTH INSURANCE PLEASE FILL OUT THIS SECTION:

PRIMARY HEALTH INSURANCE CARRIER: _____

MEMBER ID: _____ GROUP # _____

INSURANCE PHONE NUMBER: _____

SECONDARY HEALTH INSURANCE CARRIER: _____

MEMBER ID: _____ GROUP # _____

INSURANCE PHONE NUMBER: _____

IF BILLING AUTO OR WORKMAN'S COMP INSURANCE PLEASE FILL OUT THIS SECTION:

AUTO/WORKMAN'S COMP INSURANCE CARRIER: _____

ADJUSTER: _____ PH: _____

SSN OF HOLDER: _____ DATE OF CLAIM: _____

CLAIM #: _____

EMPLOYER INSURING CLAIM: _____

PERSON RESPONSIBLE FOR ACCOUNT: _____ PHONE: _____

NOTICE OF PATIENT INFORMATION PRACTICES

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

Colorado Spine Therapy, LLC's Legal Duty

Colorado Spine Therapy, LLC is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Colorado Spine Therapy, LLC uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Colorado Spine Therapy, LLC may use your personal health information to contact you to provide appointment reminders, newsletters, or information about treatment alternatives or other health related benefits that could be of interest to you.

Colorado Spine Therapy, LLC may also use or disclose your personal information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law. In any other situation, Colorado Spine Therapy, LLC's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Colorado Spine Therapy, LLC may change its policy at any time. When changes are made, a new Notice of Patient Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Patient Information Practices at any time.

PATIENT INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Colorado Spine Therapy, LLC will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERN AND COMPLAINTS

If you are concerned that Colorado Spine Therapy, LLC may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Colorado Spine Therapy's health information practices or if you have a complaint, please contact the following person:

Stefan van Duursen, 1385 S Colorado Blvd, Building A, Suite 620, Denver, CO 80222

I HAVE READ AND UNDERSTAND ALL OF THE POLICIES PERTAINING TO PATIENT INFORMATION PRACTICES AND I AUTHORIZE COLORADO SPINE THERAPY, LLC TO RENDER THE APPROPRIATE PHYSICAL THERAPY TREATMENT ACCORDING TO REASONABLE AND CUSTOMARY PHYSICAL THERAPY PRACTICE.

Patient/Parent or Guardian's Name (Please Print) Date

Patient/Parent or Guardian's Signature Date

PATIENT RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS:

I hereby authorize Colorado Spine Therapy, LLC to release to my insurance company or its representatives, and other health care professionals working on my medical case, my information including the diagnosis and the records of my treatment or examination rendered to me during the period of such medical care.

I also authorize and request my insurance company to pay directly to the above named physical therapy clinic the amount due for services rendered. I understand that it is my responsibility to call my insurance company to verify coverage for physical therapy through my policy, and agree to pay any copays, deductibles, and any other portions that my insurance company will not pay. **If I cancel my appointment with less than 24 hours notice I will be charged and agree to pay for the visit.** If no payment is made, my account will be placed with a collection agency for the amount due as well as any collection fees.

I have read and fully understand Colorado Spine Therapy's Notice of Patient Information Practices. I understand that Colorado Spine Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to designate individuals to whom my information can be released. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Colorado Spine Therapy, LLC will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosures of my personal health information for purposes as noted in Colorado Spine Therapy's Notice of Patient Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____

Patient/Parent or Guardian's Name (Please Print) Date

_____

Patient/Parent or Guardian's Signature Date

We at Colorado Spine Therapy, LLC wish to provide you with the best in Physical Therapy care. The following are policies that you need to read and comply with so that we can serve you better.

CANCELLATION POLICY

We have a 24-hour cancellation or "no show" policy. If you wish to cancel your appointment, please do so 24 hours in advance or you will be charged a **$75 cancellation fee**. The reason for the 24-hour advance notice is to enable us to offer your appointment time to a patient that we were previously unable to schedule.

COPAYS AND BILLING FEES

Copays and deductible payments are due at the time of service.

SUPPLIES

All supplies must be paid for at the time of purchase.

HEALTHCARE PARTICIPANTS ONLY

INSURANCE VERIFICATION

It is our policy to verify your coverage when you schedule an appointment, but we cannot guarantee its validity, correctness, or ensure that the carrier will pay. You are responsible for any outstanding monies owed. If you have any questions at any time, please do not hesitate to call us at **303-691-3733**.

I have read and understood the above information.

Patient/Parent or Guardian's Signature Date

COLORADO
SPINE
THERAPY, LLC

Colorado Spine Therapy, LLC

Credit Card Payment Authorization

Our Merchant's card payment software (www.worldpay.com) allows for the secure storage of credit card information, through tokenization, for future payments associated with **Colorado Spine Therapy**. You authorize charges to your credit card by Colorado Spine Therapy as payment for all products, services, fees and charges under your account with **Colorado Spine Therapy**. A receipt for each payment will be provided to you and the charge will appear on your credit card statement.

Colorado Spine Therapy's Information
Address: 1385 S. Colorado Blvd., A-620, Denver, CO 80222
Phone #: 303-691-3733
Email: stephwcst@gmail.com

Card:

☐ Visa ☐ MasterCard ☐ Discover

I understand that this authorization will remain in effect until I cancel it verbally or in writing.

I acknowledge that the origination of credit card transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card.

NAME:

SIGNATURE Date