

## Welcome and Thank You for your Visit with Colorado Pain Experts!

Your completed intake paperwork helps our providers get to know you and your medical history. We rely on its accuracy and completeness to provide you with the best care possible. Please take your time and inquire at our front desk or call **970-473-7900** if you have any questions or are unsure how to complete any section of this form.

### Patient Information

Today's Date: \_\_\_\_\_

Your Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female

Street Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Physical Address Same as Mailing? Yes  No

If not, please list mailing address: \_\_\_\_\_

Occupation: \_\_\_\_\_ City: \_\_\_\_\_

Preferred Phone: \_\_\_\_\_  Home  Mobile  Work

Secondary Phone: \_\_\_\_\_  Home  Mobile  Work

Email: \_\_\_\_\_ Driver's License # \_\_\_\_\_ State: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Widowed  Other: \_\_\_\_\_

Race  American Indian or Alaskan Native  Asian or Pacific Islander  Black  White  Refuse to Report

Ethnicity  Hispanic  Non-Hispanic  Refuse to Report

Primary Language  English  Spanish  Other \_\_\_\_\_

### Preferred Pharmacy

Pharmacy Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## Primary Insurance Plan

Payer (e.g. BC/BS): \_\_\_\_\_ Plan: \_\_\_\_\_

Policy/I.D. Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

### Complete this box if you are Not the policy holder for your primary insurance

Insurance Policy Holder:  Self  Spouse  Child  Other: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Policy Holder Gender:  Female  Male

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

## Secondary Insurance Plan (if any)

Payer (e.g. BC/BS): \_\_\_\_\_ Plan: \_\_\_\_\_

Policy/I.D. Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

### Complete this box if you are Not the policy holder for your primary insurance

Insurance Policy Holder:  Self  Spouse  Child  Other: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Policy Holder Gender:  Female  Male

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

## Workers Compensation Claim Information

Complete this section only if your visit today is related to a Workers Compensation claim.

Workers Comp Company: \_\_\_\_\_

Agent Name: \_\_\_\_\_ State of Injury: \_\_\_\_\_

Phone number: \_\_\_\_\_ Fax number: \_\_\_\_\_

Claim Number: \_\_\_\_\_ Date of initial injury: \_\_\_\_\_

## Injury Claim

Is your pain the result of a motor vehicle accident or other accident, which occurred within the last two years, and was caused by the fault or negligent of another?  yes  no

Have you hired an attorney for purposes of making any claims arising from that accident?  yes  no

If yes to either question, you will be asked to complete two additional forms.

I certify that the above information is accurate, complete and true. I give my consent for Colorado Pain Experts to retrieve and review my medication history. I understand that this will become part of my medical record.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Clinical Information

Your Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Lbs: \_\_\_\_\_

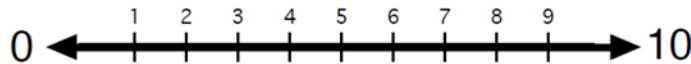
### Referral

Were you referred to our clinic by another physician? If so, whom? \_\_\_\_\_

If not, how did you hear about us?  TV  Radio  Insurance  Company  Family  Friend  PCP

Facebook  Twitter  YouTube  Other Website: \_\_\_\_\_

### Pain Description



Use the pain scale described below to rate your pain for the questions below:

- 0 – Pain-free
- 1 – Very minor annoyance, occasional minor twinges
- 2 – Minor annoyance, occasional strong twinges
- 3 – Annoying enough to be distracting
- 4 – Can be ignored if you are really involved in your work/task, but still distracting
- 5 – Cannot be ignored for more than 30 minutes
- 6 – Cannot be ignored for any length of time, but you can still go to work and participate in social activities
- 7 – Makes it difficult to concentrate, interferes with sleep, but you can still function with effort
- 8 – Physical activity is severely limited. You can read and talk with effort. Nausea and dizziness caused by pain.
- 9 – Unable to speak, crying out or moaning uncontrollably, near delirium
- 10 – Unconscious, pain makes you pass out

\_\_\_\_\_ What number on the pain scale (0-10) best describes your pain **right now**?

\_\_\_\_\_ What number on the pain scale (0-10) best describes your **worst pain**?

\_\_\_\_\_ What number on the pain scale (0-10) best describes your **least pain**?

\_\_\_\_\_ What number on the pain scale (0-10) best describes your average pain over the **last month**?

Where is your worst area of pain located? \_\_\_\_\_

Does this pain radiate? If so, where? \_\_\_\_\_

Please list any additional areas of pain: \_\_\_\_\_

**Onset of Symptoms**

Approximately when did this pain begin? \_\_\_\_\_

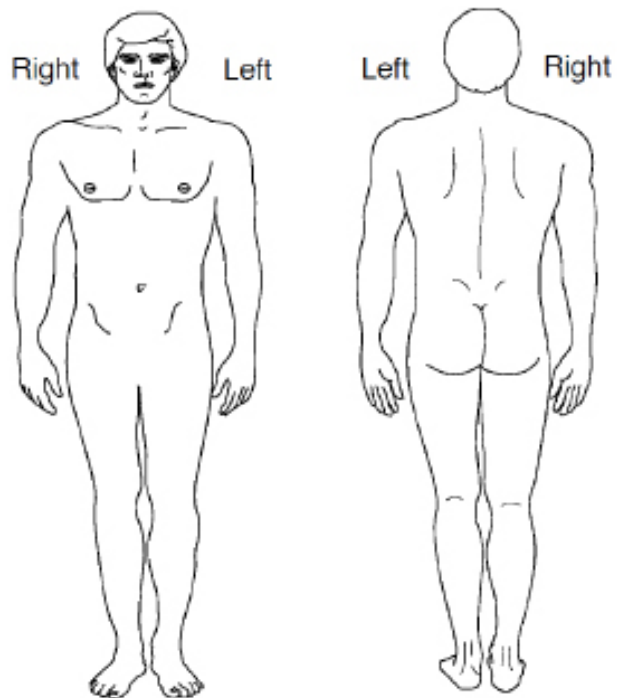
What caused your current pain episode? \_\_\_\_\_

How did your current pain episode begin?  Gradually  Suddenly

Since your pain began, how has it changed?  Decreased  Increased  Stayed the same

Use this diagram to indicate the location and type of your pain. Mark the drawing with the following letters that best describe your symptoms:

- “N” = numbness
- “S” = stabbing
- “B” = burning
- “P” = pins and needles
- “A” = aching



**Pain Description - Check all of the following that describe of your pain:**

- |                                      |                                     |   |  |
|--------------------------------------|-------------------------------------|---|--|
| <input type="checkbox"/> Aching      | <input type="checkbox"/> Numbness   | <input type="checkbox"/> Spasming       | <input type="checkbox"/> Throbbing               |
| <input type="checkbox"/> Cramping    | <input type="checkbox"/> Shock-like | <input type="checkbox"/> Squeezing      | <input type="checkbox"/> Tingling/Pins & Needles |
| <input type="checkbox"/> Dull        | <input type="checkbox"/> Shooting   | <input type="checkbox"/> Stabbing/Sharp | <input type="checkbox"/> Tiring/Exhausting       |
| <input type="checkbox"/> Hot/Burning |                                     |   |  |

**Pain Frequency**

What word best describes the frequency of your pain?  Constant  Intermittent

When is your pain at its worst?  Mornings  During the day  Evenings  Middle of the night

**Mark all of the following activities that are adversely/negatively affected by your pain**

- Enjoyment of Life
- Normal Work
- Sleep
- General Activity
- Recreational Activities
- Walking
- Mood
- Relationship with people
- Other: \_\_\_\_\_
- My goal is to resume normal activities

**In the past three months have you developed any new:**

- Balance Problems
- Bladder incontinence
- Bowel incontinence
- Chills
- Difficulty Walking
- Fevers
- Nausea
- Vomiting
- Numbness/Tingling- Where? \_\_\_\_\_
- Other: \_\_\_\_\_

**I Have Not Recently Developed Any Of The Above Conditions**

**Diagnostic Tests and Imaging**

- MRI of the \_\_\_\_\_ Date: \_\_\_\_\_ Facility: \_\_\_\_\_
- X-ray of the \_\_\_\_\_ Date: \_\_\_\_\_ Facility: \_\_\_\_\_
- CT scan of the \_\_\_\_\_ Date: \_\_\_\_\_ Facility: \_\_\_\_\_
- EMG/NCV study of the \_\_\_\_\_ Date: \_\_\_\_\_ Facility: \_\_\_\_\_
- Ultrasound of the \_\_\_\_\_ Date: \_\_\_\_\_ Facility: \_\_\_\_\_
- Other diagnostic testing: \_\_\_\_\_

**I Have Not Had Any Diagnostic Tests Performed For My Current Pain Complaints**

**Pain Treatment History**

Mark all of the following pain treatments you have undergone prior to today's visit:

- Chiropractic
- Physical Therapy
- Psychological Therapy
- Podiatrist Treatment
- Discogram – (circle all levels that apply) Cervical / Thoracic / Lumbar
- Epidural Steroid Injection – (circle all levels that apply) Cervical / Thoracic / Lumbar
- Joint Injection – Joint(s) \_\_\_\_\_
- Medial Branch Blocks or Facet Injections – (circle all levels that apply) Cervical / Thoracic / Lumbar
- Nerve Blocks – Area/Nerve(s) \_\_\_\_\_
- Radiofrequency Ablation – (circle all levels that apply) Cervical / Thoracic / Lumbar
- Spinal Column Stimulator – (circle one) Trial Only / Permanent Implant
- Spine Surgery
- Trigger Point Injection – Where? \_\_\_\_\_
- Vertebroplasty / Kyphoplasty – Level(s) \_\_\_\_\_
- Other: \_\_\_\_\_

**I Have Not Had Any Prior Treatments For My Current Pain Complaints**

## Anesthesia History

Have you ever had anesthesia (sedation for a surgical procedure)?  Yes  No

If so, have you ever had any adverse reaction to anesthesia?  Yes  No

Which type of anesthesia did you react adversely to? Please check all that apply.

- Local anesthesia     Epidural     General anesthesia     IV Sedation

Do you have a family history of adverse reactions to anesthesia? If so, to which of the following?

- Local anesthesia     Epidural     General anesthesia     IV Sedation

## Past Surgical History

Please indicate any surgical procedures you have had done in the past, including the date, type, and any pertinent details.

### Abdominal Surgery

- Gallbladder removal \_\_\_\_\_  
 Appendectomy \_\_\_\_\_  
 Other \_\_\_\_\_

### Female Surgeries

- Caesarean section \_\_\_\_\_  
 Hysterectomy \_\_\_\_\_  
 Laparoscopy \_\_\_\_\_  
 Ovarian \_\_\_\_\_  
 Other \_\_\_\_\_

### Heart Surgery

- Valve replacement \_\_\_\_\_  
 Aneurysm repair \_\_\_\_\_  
 Other \_\_\_\_\_

### Joint Surgery

- Shoulder \_\_\_\_\_  
 Hip \_\_\_\_\_  
 Knee \_\_\_\_\_

### Spine / Back Surgery

- Discectomy (levels) \_\_\_\_\_  
 Laminectomy \_\_\_\_\_  
 Spinal fusion (levels) \_\_\_\_\_

### Other Common Surgeries

- Hemorrhoid surgery \_\_\_\_\_  
 Hernia repair \_\_\_\_\_  
 Thyroidectomy \_\_\_\_\_  
 Tonsillectomy \_\_\_\_\_  
 Vascular surgery \_\_\_\_\_

Please list any other surgeries and dates (attach an additional sheet if necessary): \_\_\_\_\_

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

I Have Never Had Any Surgical Procedures Done

## Current Medications

Are you taking a prescribed **blood-thinner** medication?  Yes  No If yes, please check which one:

- Aggrenox     Coumadin     Effient     Eliquis     Lovenox     Plavix     Pleta     Pradaxa  
 Ticlid     Warfarin     Xarelto     Other \_\_\_\_\_

Please list ALL medications you are currently taking. Attach an additional sheet, if required.

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

## Allergies

Do you have any known drug allergies?  Yes  No

If so, please list all medications you are allergic to:

<b>Medication Name:</b>	<b>Allergic Reaction Type:</b>
_____	_____
_____	_____
_____	_____
_____	_____

Please check if you are allergic to  Iodine or  Tape    Are you allergic to shellfish?  Yes  No

**\*Are you allergic to latex?**  Yes  No    \*If yes, you will be asked to complete a separate questionnaire

## Family History

Mark all appropriate diagnoses as they pertain to your biological **MOTHER AND FATHER** only.

	Arthritis	Cancer	Diabetes	Headaches	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Problems	Liver Problems	Osteoporosis	Rheumatoid Arthritis	Seizures	Stroke
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other medical problems: \_\_\_\_\_

I Have No Significant Family Medical History

I Am Adopted (No Medical History Available)

## Social History

Are you capable of becoming pregnant?  Yes  No

If so, are you currently pregnant?  Yes  No

Highest level of education obtained:  Grammar school  High School  College  Post-graduate

Alcohol Use:  Current Alcoholism  Daily Limited Alcohol Use  History of Alcoholism  
 Never Drinks Alcohol  Social Alcohol Use

Tobacco Use:  Current Tobacco  Former Tobacco User  Never Used Tobacco

Drug Use:  Denies Any Illegal Drug Use  Currently Using Illegal Drugs (Which: \_\_\_\_\_ )

Currently Using Someone Else's Prescription Medications

Formerly Used Illegal Drugs (not currently using) (Which: \_\_\_\_\_ )

Have you ever abused narcotic or prescription medications?  Yes  No (Which: \_\_\_\_\_ )

Have you ever been discharged (fired) from a pain management practice in the past?

If so, please explain here: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



## Past Medical History

Mark the following conditions/diseases that you have been treated for in the past:

### General Medical

- Cancer – Type \_\_\_\_\_
- Diabetes – Type \_\_\_\_\_
- HIV / AIDS

### Head/Eyes/Ears/Nose/Throat

- Glaucoma
- Headaches
- Head Injury
- Hyperthyroidism
- Hypothyroidism
- Migraines

### Cardiovascular / Hematologic

- Anemia
- Bleeding Disorders
- Coronary Artery Disease
- Heart Attack
- High Blood Pressure
- High Cholesterol
- Mitral Valve Prolapse
- Murmur
- Pacemaker/Defibrillator
- Phlebitis
- Poor Circulation
- Stroke

### Respiratory

- Asthma
- Bronchitis
- Emphysema / COPD
- Pneumonia
- Tuberculosis
- Valley Fever

### Gastrointestinal

- Bowel Incontinence
- Acid Reflux (GERD)
- Gastrointestinal Bleeding
- Constipation

### Musculoskeletal

- Amputation
- Bursitis
- Carpal Tunnel Syndrome
- Chronic Low Back Pain
- Chronic Neck Pain
- Chronic Joint Pain
- Fibromyalgia
- Joint Injury
- Osteoarthritis
- Osteoporosis
- Phantom Limb Pain
- Rheumatoid arthritis
- Tennis Elbow
- Vertebral Compression Fracture

### Genitourinary/Nephrology

- Bladder Infection(s)
- Dialysis
- Kidney Infection(s)
- Kidney Stones
- Urinary Incontinence

### Hepatic

- Hepatitis A  
active / inactive / unsure)
- Hepatitis B  
(active / inactive / unsure)
- Hepatitis C  
(active / inactive / unsure)

### Neuropsychological

- Alcohol Abuse
- Alzheimer Disease
- Bipolar Disorder
- Depression
- Epilepsy
- Prescription Drug Abuse
  
- Multiple Sclerosis
- Paralysis
- Peripheral Neuropathy
- Schizophrenia
- Seizures
- Reflex Sympathetic Dystrophy/CRPS
- Other Diagnosed Conditions

Who and (approximately when) was the last provider to prescribe you pain medications or other controlled substances?

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## Review of Symptoms

Mark the following symptoms that you currently suffer from. Note: Diagnosed conditions/diseases should be noted under Past Medical History, above.

**Constitutional:**

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Excessive Sweating      | <input type="checkbox"/> Chills                  | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Easy Bruising |
| <input type="checkbox"/> Insomnia                | <input type="checkbox"/> Excessive Thirst        | <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Fevers        |
| <input type="checkbox"/> Unexplained Weight Gain | <input type="checkbox"/> Low Sex Drive           | <input type="checkbox"/> Night Sweats        |  |
|  | <input type="checkbox"/> Unexplained Weight Loss | <input type="checkbox"/> Weakness            |  |

**Eyes:**

- Recent Visual Changes

**Ears/Nose/Throat/Neck:**

- |                                     |   |  |   |
|-------------------------------------|---|--|---|
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Dental Problems        | <input type="checkbox"/> Earaches            | <input type="checkbox"/> Hearing Problems |
|                                     | <input type="checkbox"/> Recurrent Sore Throats | <input type="checkbox"/> Ringing in the Ears | <input type="checkbox"/> Sinus Problems   |

**Cardiovascular:**

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Fainting                         | <input type="checkbox"/> Bleeding Disorder   | <input type="checkbox"/> Chest Pain           | <input type="checkbox"/> Deep Vein Thrombosis |
| <input type="checkbox"/> Shortness of Breath During Sleep | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Irregular Heartbeat  | <input type="checkbox"/> Lightheadedness      |
|   |  | <input type="checkbox"/> Swelling in the Feet |   |

**Respiratory:**

- |   |                                |  |   |
|---|--------------------------------|--|---|
| <input type="checkbox"/> Shortness of Breath on Exertion/Effort | <input type="checkbox"/> Cough | <input type="checkbox"/> Wheezing                    | <input type="checkbox"/> Pulmonary Embolism |
|   |                                | <input type="checkbox"/> Shortness of Breath at Rest |   |

**Gastrointestinal:**

- |  |   |  |                                       |
|--|---|--|---------------------------------------|
| <input type="checkbox"/> Coffee Ground Appearance in Vomit | <input type="checkbox"/> Abdominal Cramps | <input type="checkbox"/> Acid Reflux           | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Hernia                            | <input type="checkbox"/> Vomiting         | <input type="checkbox"/> Dark and Tarry Stools | <input type="checkbox"/> Diarrhea     |

**Musculoskeletal:**

- |   |  |                                     |  |
|---|--|-------------------------------------|--|
| <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Back Pain     | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Joint Stiffness |
|   | <input type="checkbox"/> Muscle Spasms | <input type="checkbox"/> Neck Pain  |  |

**Genitourinary/Nephrology:**

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Decreased Urine Flow/Frequency/Volume |  |
|   | <input type="checkbox"/> Flank Pain     | <input type="checkbox"/> Painful Urination                     | <input type="checkbox"/> Pelvic Pressure |

**Neurological:**

- |   |   |                                    |                                    |
|---|---|------------------------------------|------------------------------------|
| <input type="checkbox"/> Instability When Walking | <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Headaches |
|   | <input type="checkbox"/> Numbness/Tingling      | <input type="checkbox"/> Seizures  |                                    |

**Psychiatric:**

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Suicidal Thoughts | <input type="checkbox"/> Depressed Mood    | <input type="checkbox"/> Feeling Anxious | <input type="checkbox"/> Stress Problems |
|  | <input type="checkbox"/> Suicidal Planning |  |  |



## Medical History and Consent for Treatment

I certify that the above information is accurate, complete, and true.

I authorize Colorado Pain Experts, LLC and any associates, assistants, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness. I give my consent for Colorado Pain Experts, LLC to retrieve and review my medication history. I understand that this will become part of my medical record.

I acknowledge that I have had the opportunity to review Colorado Pain Experts, LLC Notice of Privacy Practices, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

I authorize Colorado Pain Experts, LLC to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, and any physician(s) I may be referred to. I also authorize Colorado Pain Experts, LLC to release any information required in obtaining procedure authorization or the processing of any insurance claims.

I understand that Colorado Pain Experts, LLC will not release my Protected Health Information to any other party (including family) without my completing a written "Patient Authorization for Use and Disclosure of Protected Health Information" form, available at its facility and on its website.

I understand that data collected during assessment or treatment may be utilized for research and teaching purposes and all identifying demographic PHI will remain confidential.

In the event that I am asked to provide a urine, oral swab and/or blood sample, **I voluntarily seek laboratory services and hereby consent to provide a urine and/or blood sample as requested.** I have the right to refuse specific tests but understand this may impact my pain management treatment. This agreement can be revoked by me at any time with written notification and is valid until revoked. I hereby assign to the Laboratory my right to the insurance benefits that may be payable to me for services provided, arising from any policy of insurance, self-insured health plan, Medicare or Medicaid in my name or in my behalf. I further authorize payment of benefits directly to the Laboratory. I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance. I also acknowledge that the Laboratory may be an out-of-network provider with my insurer. Payment in full is expected 30 days of being notified of any balance due. Please note that in the event that you fail to make payment when due, this account will be referred to a collection agency for collections. In that event, the contingency fee assessed by the collection agency will be added to the principal and interest due. You will be additionally liable for attorney fees. Both collection agency fees and attorney fees will increase the balance you owe.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_



**Colorado Pain Experts, LLC believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.**

1. **PAYMENT** - is expected at the time of your visit. (This includes Copayments, Deductibles, Coinsurance, Missed Appointments, Procedure Prepayment; unpaid balance after insurance has paid their portion, Past Due, etc.). If you are unable to make a full payment Colorado Pain Experts, LLC reserves the right to reschedule your appointment for a later time when you are able to make your full payment, (any payment due or owed at time of service). If a prepayment is made for any services and a refund is due after insurance processes, any outstanding balance on your account will be deducted before issuing your refund. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit. We do ask for a copy of an ID card or license and insurance cards.

2. **INSURANCE** - We are participating providers with several insurance plans. We will file all of these insurance claims. A list of these insurance plans is available upon request. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment for your insurer, we will refund any overpayment to you.

If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for you are due at the time of service. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Be sure to check with your insurer's member benefits department about services and physicians before your appointment. Many web sites have erroneous information and are not a guarantee of coverage. You are responsible for obtaining a properly dated referral, prior authorization if required by your insurer and responsible for payment if your claim rejects for the lack of one.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.

Colorado Pain Experts, LLC only has a specific amount of time to submit a claim to your insurance carrier. If your coverage/ insurance company changes and we bill your old carrier we may miss the time limit to process the claim. In this case the claim becomes your responsibility for payment, so please notify us immediately if your coverage changes so that we can accurately submit the claims.

3. **TOXICOLOGY LAB** - In the event that I am asked to provide a urine and/or blood sample, I voluntarily seek laboratory services and hereby consent to provide a urine and/or blood sample as requested. I have the right to refuse specific tests but understand this may impact treatment. This agreement can be revoked by me at any time with written notification and is valid until revoked. I hereby assign to the Laboratory my right to the insurance benefits that may be payable to me for services provided, arising from any policy of insurance, self-insured health plan, Medicare or Medicaid in my name or in my behalf. I further authorize payment of benefits directly to the Laboratory. I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance. I also acknowledge that the Laboratory may be an out-of-network provider with my insurer. Payment in full is expected within 30 days of being notified of any balance due.

4. **COLLECTION** - If you have an outstanding balance over 120 days old and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency and/or an attorney, which may result in reporting to credit bureaus and/or legal action. Colorado Pain Experts, LLC reserves the right to refuse treatment to patients with outstanding balances over 120 days old. You agree to pay Colorado Pain Experts, LLC for any expenses we incur to collect on your account, including attorney fees, collection fees, and contingent fees to collection agencies that can be more than 35% of the delinquent balance. Contingency fees will be added and assigned to the collection agency

immediately upon our referral of your account to the collection agency of our choice. You agree that in order for us to service your account or to collect any amounts you may owe, we may contact you by phone at any number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded voice messages and/or use of an automatic dialing device.

5. **RETURNED CHECKS** - will incur a \$40.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the \$40 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments or overturned chargebacks on your credit card constitute a breach of payment and are subject to the \$40 service fee and collections action. All bad checks written to this office are subject to collections and will be prosecuted in Weld County.

6. **ACCOUNTING PRINCIPALS** - Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

7. **FORMS AND CONSULTS FEES** - Completing insurance forms, copying medical records, etc... requires office staff time and time away from patient care for our doctors. We require pre-payment for completing forms, copying medical records, notarizing, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication. On occasion, our staff may be asked to provide a deposition and/or other testimony or actions concerning your care. There is a separate fee schedule for such activity. The fees for such activity are to be paid by the patient regardless of the party requesting the activity.

8. **CANCELLATIONS OR MISSED APPOINTMENTS** - If you do not cancel your appointment at least 24 hours before, or if you no-show, we will assess you a \$25 missed appointment fee. If you do not cancel your procedure with at least 24 hours' notice, you will be assessed a \$150.00 missed procedure fee. Any missed visits may result in discharge from the practice.

9. **RESPONSIBILITY FOR PAYMENT** - I understand that I, personally, am financially responsible to Colorado Pain Experts, LLC care for charges not covered by the assignment of insurance benefits.

10. **ASSIGNMENT OF INSURANCE BENEFITS** - I hereby assign, transfer, and set over directly to Colorado Pain Experts, LLC sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said practice. I authorize Colorado Pain Experts, LLC to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Colorado Pain Experts, LLC. I authorize Colorado Pain Experts, LLC to release all medical information requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

11. **RELEASE OF INFORMATION** - I hereby authorize and direct Colorado Pain Experts, LLC to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

**I have read and understand the practice's financial policy of Colorado Pain Experts, LLC and I agree to be bound by its terms. I understand that I am financially responsible for ALL services I receive from Colorado Pain Experts, LLC. I hereby assign all medical and surgical benefits and authorize my insurance carrier (s) to issue payment directly to Colorado Pain Experts, LLC. This financial policy is binding upon you, your estate, executors and/or administrators, if applicable.**

**I also understand and agree that such terms may be amended by the practice from time to time.**

**Signature of Patient (or Guarantor, if applicable)** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Please print the name of the patient** \_\_\_\_\_



## Patient Authorization for Use and Disclosure of Protected Health Information

Colorado Pain Experts, LLC will not disclose your medical records (protected health information) to any party without your signed consent, except as stipulated in our Notice of Privacy Practices. This form authorizes Colorado Pain Experts, LLC to release your medical records to parties indicated.

### Colorado Pain Experts takes your privacy seriously!

Your Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

#### Authorized Parties

By signing below, I authorize Colorado Pain Experts, LLC its agents and employees ("Provider"), to use and / or disclose any and all of my protected health information of any kind and description to the following party or parties ("Recipients"):

Party	Relationship
_____	_____
_____	_____
_____	_____

#### Authorization to Disclose Protected Health Information Including HIV & AIDS Related Information

I understand that neither Provider nor Recipient may condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization. In addition, I understand that Recipient may re-disclose the Records and that the Records may no longer be protected by the Federal privacy regulations.

I acknowledge and agree that the protected health information authorized to be disclosed under this Authorization may include records for drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV-related diseases and communicable disease-related information.

With respect to any communicable disease-related information protected by State confidentiality rules and disclosed under this Authorization, Recipient is prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by applicable law.

Further, with respect to any drug and alcohol abuse treatment information disclosed under this Authorization, this information has been disclosed from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit the recipient of this information from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.



## Authorized Parties

I acknowledge that I have had the opportunity to review Colorado Pain Experts, LLC Notice of Privacy Practices, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

I understand I have the right to refuse to sign this authorization and that I do not have to sign this authorization to receive treatment at Colorado Pain Experts, LLC. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Health Insurance Portability and Accountability Act (HIPAA). I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer whose address is listed below:

### Privacy Officer

Colorado Pain Experts, LLC  
7251 W. 20<sup>th</sup> Street, Unit K Greeley, CO 80634

## Expiration

This Authorization will remain effective until the expiration date specified below or, if no date is set forth below, for one-year following the date of this signing, at which time this Authorization will expire. A photocopy of this Authorization will be considered effective and valid as the original.

Date authorization expires (if any): \_\_\_\_\_

## Signature

Signature of Patient or Legal Guardian \_\_\_\_\_ Today's Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

## AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO COLORADO PAIN EXPERTS

\*Patients Name: \_\_\_\_\_ \* Date of Birth: \_\_\_\_\_

\*I hereby authorize \_\_\_\_\_

\* Phone: \_\_\_\_\_ \* Fax: \_\_\_\_\_

or it's agent(s) to disclose my health information as described in this authorization to Colorado Pain Experts  
Office 970-473-7900 Fax 970-473-7901

**\*Choose Physicians Location**

\_\_\_ Greeley: 7251 W 20th Street, Unit K Greeley, CO 80634

\_\_\_ Loveland: 1647 E 18th Street Loveland, CO 80538

**\*The health information is being disclosed for the following purpose: (check appropriate box):**

Change of Insurance or Physician  Continuation of Care

**\*Health information to be disclosed: (check appropriate box)**

2 years prior from last date seen by the healthcare provider  The following health information (be specific):

\*I understand I may revoke this Authorization at any time by sending written notice of my revocation to CPE's health information management department. I understand that my revocation will not be effective to the extent the healthcare provider has taken action in reliance on this Authorization. Unless revoked sooner, this Authorization will expire on the following date, event, or condition. If no date, event, or condition is written, this authorization will expire 1 year from the date signed. A photocopy of this Authorization will expire 1 year from the date signed. A photocopy of this Authorization will be considered effective and valid as the original.

*\*I understand that the health information authorized to be disclosed under this Authorization may include information regarding drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV-related diseases and communicable disease-related information.*

\*I understand that CPE may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that the Recipient may redisclose the records and that the records may no longer be protected by Federal privacy regulations.

**\*I have read this Authorization and I acknowledge that I am familiar with and fully understand its terms and conditions.**

X \_\_\_\_\_

Signature of Patient / Parent / Guardian or Authorized Representative

\_\_\_\_\_

Date

(Guardian or Authorized Representative must attach documentation of such status.)

\_\_\_\_\_  
Printed name of Authorized Representative and Telephone Number

\_\_\_\_\_  
Relationship / Capacity to





## Patient Health Questionnaire (PHQ-2)

**Patient Name:** \_\_\_\_\_ **Date of Visit:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At All	2-3 Days	4-5 Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
Column Totals		+ _____	+ _____	
Add Totals Together	_____			

<b>FOR PROVIDERS ONLY</b>
PATIENT RESULT: <input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE <input type="checkbox"/> PATIENT DECLINED SCREENING <input type="checkbox"/> PATIENT HAS A CURRENT DIAGNOSIS AND CARE PLAN _____ <input type="checkbox"/> PATIENT GIVEN PHQ-9 ON _____ RESULT _____
<b>FOLLOW-UP:</b> <input type="checkbox"/> 1-2 WEEKS <input type="checkbox"/> 2-3 WEEKS <input type="checkbox"/> 3-4 WEEKS <input type="checkbox"/> NO F/UP NEEDED
RESULT NOTES:
SIGNATURE: