Welcome to our practice. Our first priority is you, our patient.

Eric R. Jamrich, M.D., Orthopaedic Surgeon
John R. Barker, M.D., Orthopaedic Surgeon
Chad J. Prusmack, M.D., Neurosurgeon
Michael W. Madsen, M.D., Orthopaedic Surgeon

We specialize in the care of people with spinal disorders. Our primary office is located in Lone Tree, Colorado. We also see patients in Aurora, Lakewood, Hugo and Englewood, Colorado. We are enclosing a map for your convenience.

Enclosed are forms you will need to complete and bring with you to your appointment. These forms will become an important part of your medical record in our office and will greatly aid your physician in your health care.

Please bring all x-rays, MRI scans, CT scans or myelograms, and all previous medical records that pertain to your spine, as these will assist the doctor in performing a more complete exam.

Your doctor must have the x-ray films or disc. Reports only will not be sufficient. All records and films brought or sent to our office will become part of your permanent file and will be used to assist in your treatment. At any time you may sign out your films, MRI’s or CT’s and take them with you.

PLEASE NOTE: It is imperative that you bring ALL of your x-rays with you, including any that were done at outside facilities, or have them returned to us in time for your appointment.

**You must bring your current insurance CARD, not an electronic facsimile, or we will need to reschedule your appointment.

Your appointment is scheduled on _________________________ at _________
at the office indicated below.

We will call you the day before to confirm your appointment. If you do not receive a call, please call our receptionists at 303-225-8120 to confirm your appointment.

☐ Our Lone Tree office is located adjacent to Sky Ridge Medical Center in the Aspen Building. The address is 10103 RidgeGate Parkway, Suite 306, Lone Tree 80124

☐ Our Aurora office is located on Potomac Street across from The Medical Center of Aurora. The address is 1444 South Potomac Street, Suite 170, Aurora 80012

☐ Our Lakewood office is located at OrthoColorado Hospital. The address is 11700 West 2nd Place, Suite 210, Medical Plaza 2, Lakewood 80228

☐ Our Hugo office is located at Lincoln Community Hospital. The address is 111 6th Street, Hugo 80821

☐ Our Englewood office is located at 99 Inverness Drive East, Suite 100, Englewood, CO 80112

10103 RidgeGate Parkway • Suite 306 • Lone Tree, CO 80124
Phone 303/225-8120 • Fax 303/225-8130
www.spineclinic.com
Financial Arrangements and Insurance

We are committed to providing you with the best possible care. If you have health insurance, we will help you receive your maximum allowable benefits. In order to achieve this, we need your assistance and understanding of our payment policy. Please always bring your current insurance card with you to all appointments. We will collect your co-payment at the time of service. If you cannot pay your co-pay at the time of service, your appointment will need to be rescheduled.

We participate with Medicare. We accept Medicare assignment and will bill Medicare for you. If you have supplemental insurance please bring that information with you to your appointment. You may be responsible for a portion of your charges such as Medicare deductible and co-insurance.

If you belong to an insurance which requires a referral from your primary care physician, please bring the referral with you to your appointment. We must have a current referral before you can be seen. If you do not bring a current referral with you to your appointment, your appointment will have to be rescheduled.

If you are being treated for a work-related injury, injuries occurring from an automobile accident, or a third party liability (for example, injured on the property of another person), we must have approval from your adjuster prior to seeing you. We will also need the following information: name of your insurance carrier, their address and phone number, your adjuster's name, your claim number and the date of your injury/accident.

If your claim is denied by workmen's compensation, auto insurance or third party liability, you will be responsible for the entire bill for services. If the automobile insurance fails to pay 100 percent of the billed charges, you will be held responsible for any amount the insurance does not cover.

Returned checks and balances older than 30 days are subject to additional collection fees. You will be assessed a $25.00 fee on any returned checks, in addition to collection and legal fees (13-21-109 C.R.S.). Charges may also be made for broken appointments and appointments cancelled without 24 hours advance notice.

If payments are not paid as agreed and your account is placed for collection, you agree to pay all reasonable costs of collection, including but not limited to attorney fees, court costs and interest at 18% per annum from the date of service.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of "U.C.R." which is defined as "usual, customary and reasonable" fees for this region. Thus, our fees are considered usual, customary and reasonable by most companies.
This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as health care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

**DISABILITY/FMLA FORMS** - Our charge for filling out disability forms is: **First form:** No charge. **Subsequent forms:** $25.00 per form. All charges for completing disability forms must be paid in advance.

If you have any questions about the above information or are uncertain regarding your insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

I have read and understand the financial policy of Eric R. Jamrich, M.D., John R. Barker, M.D., Chad J. Prusmack, M.D. and Michael W. Madsen, M.D. and agree to abide by the policy as stated.

________________________________________________________________________

Signature of Patient or Person with Authority to Sign for Patient

________________________________________________________________________

Date

This contract will be governed by and construed and enforced in keeping with the laws of the State of Colorado. Venue for any action to enforce the terms and conditions of this contract will be in Douglas County, Colorado.
NARCOTIC PAIN MEDICATION CONTRACT

Patient Name (please print): ______________________________________________________

Physician Name: _________________________________________________________________

The purpose of this agreement is to prevent a misunderstanding about how narcotic prescriptions (medicines) are distributed by the physician to the patient in this office. This document will help both the patient and the doctor comply with the law regarding controlled pharmaceuticals.

Use of narcotic pain medication can produce dangerous side effects and potentially cause addiction if used for extended periods of time. Narcotic pain medications are used in this office for treatment of acute or short-term pain such as the pain experienced after an injury. The amount of narcotics taken for any condition will be limited in order to prevent the body from building up a tolerance to the medications.

It is important to remember that other techniques may be used in place of narcotics for symptom control such as ice/heat, massage, deep breathing and relaxation techniques, and over-the-counter medications such as Extra Strength Tylenol, etc. You should check with your physician or his medical assistant prior to starting any over-the-counter medications.

After 90 days alternative sources will be recommended by the physician (return to primary care doctor, pain management, physiatrist evaluation, etc.).

If any side effects from the prescriptions occur, the patient should notify the medical assistant at the Rocky Mountain Spine Clinic at 303-225-8120. Medication refill requests must be called in before 4:00 PM Monday-Thursday and before 12:00 noon Friday. Prescription refills will not be issued after these hours or on the weekends by the on-call physician. Allow 48 hours for processing refill requests.

Medication will be provided post surgery up to 90 days.

This office will not permanently take over medications if a patient is enrolled in a pain management program.

If you are receiving pain medications from multiple doctors, we will discontinue prescribing pain medications for you and dismiss you from our practice.

(continued)
NARCOTIC PAIN MEDICATION CONTRACT

I will use any and all prescription medications that are issued to me in accordance with the specific dosing regimen, without deviation, escalation or significant disparity from my provider's directions. Violation of this agreement shall constitute grounds for termination of the patient/provider relationship and subsequent discharge from our practice immediately.

I will not use any illegal substances, including marijuana, cocaine, etc., while under this agreement.

I will not trade with or sell my medicines to anyone.

I will not attempt to obtain any controlled medications, including opioid pain medication, controlled stimulants or any anti-anxiety medicines from any other physician without consent of my prescribing physician.

I will safeguard my medicines from loss or theft. Lost or stolen medicines WILL NOT be replaced.

I will turn in all unused medicine if a prescription is changed.

I authorize the doctor and my pharmacy to cooperate fully with any city, state or Federal law enforcement agency including the State Board of Pharmacy, State Board of Medical Examiners and the Drug Enforcement Administration (DEA) in the investigation of any possible misuse, sale or other diversion of my pain medicine.

I authorize my doctor to provide a copy of this agreement to my pharmacy if requested. I agree to waive any applicable right of privacy or confidentiality with respect to these authorizations.

Patient's signature indicates that the patient understands and agrees to this policy.

Patient Signature: __________________________________ Date: __________________
ROCKY MOUNTAIN SPINE CLINIC, P.C.

Eric R. Jamrich, M.D.     John R. Barker, M.D.     Chad J. Prusmack, M.D.     Michael W. Madsen, M.D.

Name___________________________ Last   First   Middle Initial   Birthdate___________________________

Address__________________________ Apt. #   City________________ State_________ Zip__________

Home Phone ( )___________________ Work Phone ( )_________________ Cell Phone ( )________________

E-mail Address____________________ Preferred method of contact: □ Phone □ E-mail □ Text

Gender □ Male □ Female  Marital Status □ Single □ Married □ Widowed □ Divorced

Employer__________________________ Occupation__________________________

Employer's Address_________________ City________________ State_________ Zip__________

Employment Status □ Full-Time □ Part-Time □ Retired □ On Leave □ Other

In case of emergency contact__________________________ Relationship__________________________

Home Phone ( )___________________ Work Phone ( )_________________ Cell Phone ( )________________

REFERRING PHYSICIAN / COMPLETE NAME AND ADDRESS:

__________________________________________________________________________________________

PCP (if different from Referring Physician) COMPLETE NAME AND ADDRESS

__________________________________________________________________________________________

Pharmacy__________________________ Phone__________________________

INSURANCE INFORMATION ~ We will need a copy of your insurance card(s).

Primary Insurance

Group #__________________________ ID #__________________________ Policy Holder □ Self □ Spouse □ Parent/Guardian

Address (Street/City/State)__________________________ Employer__________________________

Secondary Insurance

Group #__________________________ ID #__________________________ Policy Holder □ Self □ Spouse □ Parent/Guardian

Address (Street/City/State)__________________________ Employer__________________________

INSURED RESPONSIBLE PARTY INFORMATION – If other than self

Name__________________________ Relationship__________________________ Birthdate________________ SSN________________

Address (if different from patient)__________________________

Home Phone ( )___________________ Work Phone ( )_________________ Employer__________________________

ACCIDENT INFORMATION

Is this a □ Work Comp or □ Motor Vehicle Accident? □ Yes □ No  If YES, on what date did the injury occur? ________________

Work Comp / Motor Vehicle Claim Number__________________________

Adjuster's Name__________________________

Phone Number ( )___________________ Fax Number ( )____________________

I authorize that payment of any insurance benefits for health care services be made directly to Rocky Mountain Spine Clinic, P.C.

NOTE: If patient is a minor under the age of 18 years, these forms must be signed by parent or legal guardian. They cannot be signed by a minor.

Signature of Patient, Parent or Legal Guardian__________________________ Date__________________________
What symptoms are you having?

How long ago did your symptoms begin?

How did your symptoms begin? (Circle one): Injury Accidental Began slowly over time Began suddenly

Do your symptoms limit you?


Is the pain constant, or does it come and go?

Does the pain radiate into your arms or legs?

Is the pain worse at night?

Do you have any weakness or numbness in your arms or legs?

Have you lost control of bowel or bladder function?

How long can you sit? stand?

How far can you walk?

What, if anything, makes the pain better?

What makes your pain worse?

Using the symbols below, please draw your pain on the diagrams below:

Circle your pain level on a scale of 1 to 10, with 10 being unbearable or the worst imaginable pain.

(no pain) 1 2 3 4 5 6 7 8 9 10 (extreme pain)
NAME ________________________________

DOMINANT HAND: □ Right □ Left

Tell us about any previous treatments and/or tests you have had.

Who first treated you for this problem?__________________________________________

What treatments did you have?___________________________________________________

__________________________________________________________

Did this include any surgery on your neck or back? If so, what and when:__________________________

Have you had physical therapy?__________ If so, did it help?__________________________

Explain:________________________________________________________

Do you do any special exercises for your neck or back?______________________________

Have you had any of the following tests regarding your back or neck within the last year?

□ X-rays □ MRI □ CT Scan □ EMG/nerve conduction studies

Have you had any injections for your problem?_______ If so, please describe:________________________

What do you hope to accomplish today?

__________________________________________________________

__________________________________________________________

__________________________________________________________

PAST MEDICAL HISTORY: (List all current medical problems)

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________
ROCKY MOUNTAIN SPINE CLINIC, PC.
HEALTH HISTORY FORM

NAME_________________________________________ Date of Birth_________________________ Today’s Date______________

List all medications you are currently taking:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Times/Day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DRUG ALLERGIES: ___________________________________________________________

<table>
<thead>
<tr>
<th>REACTION:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

FOOD ALLERGIES: ___________________________________________________________

<table>
<thead>
<tr>
<th>REACTION:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

ENVIRONMENTAL ALLERGIES: _________________________________________________

Have you recently experienced fever/chills, weight gain, weight loss, chest pain or shortness of breath? (Circle)

PAST SURGICAL HISTORY ~ Please list all surgeries you have had, the year, and any complications.

<table>
<thead>
<tr>
<th>Surgery</th>
<th>Year</th>
<th>Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Have you ever had any problems with anesthesia?  □ Yes  □ No  If yes, explain:______________________________________________

FAMILY HISTORY
Do your parents, grandparents, siblings or your children have any of the following?  If yes, please explain:

<table>
<thead>
<tr>
<th>Condition</th>
<th>□ Yes</th>
<th>□ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High blood pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arthritis</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SOCIAL HISTORY

<table>
<thead>
<tr>
<th>Question</th>
<th>□ Yes</th>
<th>□ No</th>
<th>#________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you live alone?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have children?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you exercise?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What types of exercises do you do?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you currently smoke?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you quit smoking?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you chew tobacco?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you drink alcohol?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of substance abuse?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marijuana use?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How many packs per day ______ for how long___________

When did you quit:___________________________

How much:___________________________

How much / how often:___________________________

Explain:_________________________________________
ROCKY MOUNTAIN SPINE CLINIC, P.C.

NAME:__________________________________________

REVIEW OF SYSTEMS

Are you currently having or have you had problems with: Describe all YES responses

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ears, Nose, Throat</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lungs/Breathing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Digestion/Ulcers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bowel movements</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bladder problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart problems / Chest pain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(including rheumatic fever)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High blood pressure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High cholesterol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bleeding problems / Blood clots</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balance problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numbness / Tingling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blackouts / Fainting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological problems / Depression</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AIDS / Hepatitis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arthritis / Rheumatoid</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polio</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Patient’s Signature:___________________________ Date:___________________________

Physician’s Initials:_________________________ Date:___________________________
<table>
<thead>
<tr>
<th>DATE</th>
<th>AGE</th>
<th>HEIGHT</th>
<th>WEIGHT</th>
<th>B/P</th>
<th>PULSE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Please do not write above this line)

**PATIENT'S NAME:**

**AGE:**

**BIRTHDATE:**

**JOB TITLE:**

**JOB DESCRIPTION:**

**COMPLETE NAME & ADDRESS OF REFERRAL SOURCE (Physician/Friend/Agency, etc.):**

---

**ROCKY MOUNTAIN SPINE CLINIC, P.C.**

ERIC R. JAMRICH, M.D.  JOHN R. BARKER, M.D.  CHAD J. PRUSMACK, M.D.

MICHAEL W. MADSEN, M.D.
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 THIS NOTICE CAREFULLY.

Rocky Mountain Spine Clinic, P.C. is required to maintain the privacy of your health information and to provide you with a notice of its legal duties and privacy practices. Rocky Mountain Spine Clinic 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 Rocky Mountain Spine Clinic as well as records we receive from other providers.

USES AND DISCLOSURES REQUIRING YOUR CONSENT:
With your consent, Rocky Mountain Spine Clinic may use and disclose your health information for the following purposes:

Treatment:
Rocky Mountain Spine Clinic 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. Rocky Mountain Spine Clinic also may disclose your health information to people outside Rocky Mountain Spine Clinic, 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 Rocky Mountain Spine Clinic.

Payment:
Rocky Mountain Spine Clinic 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 on 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:
Rocky Mountain Spine Clinic 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 Rocky Mountain Spine Clinic, medical research and educational purposes. Rocky Mountain Spine Clinic may engage outside companies to carry out certain aspects of routine healthcare operations. These entities are called the “business associates” of Rocky Mountain Spine Clinic. Rocky Mountain Spine Clinic 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 or behalf of Rocky Mountain Spine Clinic. Examples of business associates include, but are not limited to, a copy service used by Rocky Mountain Spine Clinic to copy medical records, consultants, accountants, lawyers, medical transcriptionists and third-party billing companies. Rocky Mountain Spine Clinic requires the business associates to protect the confidentiality of your health information.
USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION:
Rocky Mountain Spine Clinic may not disclose your health information to persons outside of Rocky Mountain Spine Clinic for purposes other than treatment, payment or healthcare operations without your authorization. In addition Rocky Mountain Spine Clinic 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 Rocky Mountain Spine Clinic.

RIGHT TO RECEIVE A 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 TO 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 and authorization.

FOR MORE INFORMATION REGARDING HOW TO EXERCISE THESE RIGHTS:
If you have questions or would like more information regarding any of the rights listed above, please call 303-225-8120.

IF YOU BELIEVE THAT YOUR RIGHTS HAVE BEEN VIOLATED:
If you believe that your rights have been violated, you may file a complaint with Rocky Mountain Spine Clinic or with the Secretary of the Department of Health and Human Services. To file a complaint with Rocky Mountain Spine Clinic please contact Rocky Mountain Spine Clinic at 303-225-8120. All complaints must be submitted in writing. There will be no retaliation for filing a complaint.

CHANGES TO THIS NOTICE:
Rocky Mountain Spine Clinic will abide by the terms of the Notice currently in effect. Rocky Mountain Spine Clinic 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. Rocky Mountain Spine Clinic will mail any revised Notice to the address indicated on the Patient Information forms or such other address you may provide to us from time to time.

CONSENT TO COMMUNICATE MEDICAL RESULTS:
OKAY to leave message/results at home: ☐ Yes ☐ No Phone #:__________________________
OKAY to leave message/results at work: ☐ Yes ☐ No Phone #:__________________________
OKAY to leave message/results on cell: ☐ Yes ☐ No Phone #:__________________________

Persons with whom Rocky Mountain Spine Clinic may discuss my medical condition, test results, billing issues and/or schedule appointments are named below:

SPOUSE ☐ Yes ☐ No

NAME ___________________________________________ RELATIONSHIP _______________________________________

NAME ___________________________________________ RELATIONSHIP _______________________________________

PATIENT’S PRINTED NAME: __________________________________________________________

PATIENT’S SIGNATURE: ___________________________ DATE: __________________________

NOTICE EFFECTIVE DATE: The effective date of this Notice is April 15, 2008
NEW PATIENT CHECKLIST

Please use this checklist to ensure that you have all the necessary paperwork and records for your first visit.

If you have any questions, please give our office a call at 303-225-8120.

☐ Previous MRI, CT scans, discograms and x-rays pertaining to complaint

☐ Medical records and imaging reports from referring physician pertaining to complaint

☐ New patient paperwork completed

☐ Insurance card(s)

☐ Insurance referral (if necessary)

☐ Name, address and telephone number of referring physician

☐ Insurance co-payment
Your physician at Rocky Mountain Spine Clinic, P.C. will require an assistant surgeon during your surgical procedure. The purpose of this letter is to assist you in making an informed decision about your health insurance coverage for your surgical procedure.

You have the right to receive medical services from a non-participating provider in order to obtain health care, including from a surgical assistant. A non-participating medical provider is a person who may not be covered by your health insurance plan. According to the American College of Surgeons, the surgical assistant helps the surgeon carry out a safe operation with optimal results for the patient. These highly skilled practitioners are integral members of the operating room team.

Prior to the surgical assistant rendering services for your medical procedure, we ask that you take a moment to read carefully the statement below, and print and sign your name as authorization to provide surgical assistance:

I am aware that a surgical assistant will be involved in my care and I understand that this health care provider is not a participating provider in my health insurance coverage network. I am voluntarily choosing to obtain services from this surgical assistant. I am aware that I may be responsible for any additional costs resulting from my use of the surgical assistant. Please note that if you have out-of-network benefits under the terms of your health care plan, you may utilize those benefits to receive services from a non-participating provider.

______________________________
Signature of Patient, Parent, or Legal Guardian

______________________________
Printed Name of Patient, Parent, or Legal Guardian

We understand medical coverage and billing is not always simple to understand, but we can help. If you have a question regarding your payment obligations to the surgical assistant, please do not hesitate to contact our office at 303-225-8120, Option 7. If you are experiencing financial difficulties, please let us know so we can assist you in making payment arrangements. Thank you in advance for your assistance.
Driving Directions to Rocky Mountain Spine Clinic
10103 RidgeGate Pkwy. Suite 306, Lone Tree, CO 80124
Located in the Aspen Building at Sky Ridge Medical Center

From the North
Take I-25 south. Exit at Lincoln Avenue (Exit 193). Stay to the left (there are three lanes to the light; you will want to be in the far right lane) and go to the stoplight at Lincoln Avenue. Turn right (west) onto Lincoln and head one block to Park Meadows Blvd. Turn left (south) on Park Meadows Blvd. The hospital campus is on the left, 1/4 mile south of Lincoln Avenue. You may also use the RidgeGate Parkway exit (Exit 192), one mile south of the Lincoln Avenue exit, to enter the campus from the south.

From the South
If coming from the south on I-25, exit at RidgeGate Parkway (Exit 192) and follow signs to the hospital entrance.

From the East
If coming from the east on Lincoln Avenue, cross over the I-25 overpass to Park Meadows Blvd. Turn left (south) on Park Meadows Blvd.

From Denver International Airport
Exit airport terminal to Pena Blvd. Take Pena Blvd. 4 miles to E-470 south (Exit 6A). Travel south on E-470 for 27 miles. Take the I-25 exit. Head south for 1 mile and exit at Lincoln Avenue (exit 193). Turn right (west) onto Lincoln Avenue and head one block to Park Meadows Drive. Turn left (south) on Park Meadows Drive.