Pain Consultants of the Rockies & Pain Treatment Center of Wyoming

** Please answer *all* questions in the packet. Mark with N/A if it does not apply to you**

Patient Information				
REFERRING PROVIDER & PHONE NUMBER:			PRIMARY CARE PROVIDER:	
First Name:	Last Name:		MI	Date of Birth:
Address:	City:		State:	Zip:
Primary Phone:	Home:	Work:		Cell:
Other Name(s) Used:		E-Mail Address:		
Gender: ◯ Female ◯ Male	Social Security Number:		Driver's License Number:	
Marital Status:	Preferred Contact:	Employer's Name:		Are you Disabled? (Y or N)

Insurance Information		
Please make sure you provide us with a legible copy of the front and back of your insurance card(s). If you do not provide us with legible copies of your insurance card(s) you will be responsible for any balance on the account.		
Primary Insurance Name:	**Primary Insurance Policy Number:**	
Policy Holder's Name:	**Policy Holders DOB:**	**Relationship:**
Secondary Insurance Name:	**Secondary Insurance Policy Number:**	
Policy Holder's Name:	**Policy Holders DOB:**	**Relationship:**

If this is an accident related injury, please fill out the information below. All information must be completed to properly file your claim. If you do not fill out all information below, you will be responsible for any balance on your account.

◯ **Workers Compensation** ◯ **Auto Accident** ◯ **Other Accident (Home-owners, etc.)**

Adjuster's Name:	Adjusters Phone Number:	Adjusters Fax Number:
Have you notified your employer:? ◯ Yes ◯ No	Case Number: (mandatory)	Date of Injury: (mandatory)

Consent

I/We do hereby consent to and authorize the performance of all treatments and medical services deemed advisable by the physicians and staff of the Pain Consultants of the Rockies, PC and Paint Treatment Center of Wyoming, LLC to me or to the above-named person whom I am the legal guardian of. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical services for regardless of insurance coverage. I furthermore agree to pay legal interest, collection expenses, and attorneys' fees incurred to collect any amount I may owe. I also hereby authorize Pain Consultants of the Rockies, PC and Paint Treatment Center of Wyoming, LLC to release information requested by insurance company and/or its representatives. I fully understand this agreement and consent will continue until cancelled by me in writing.

NEW PATIENT DEPOSIT:

There is a $50 new patient refundable deposit that must be paid before making your initial appointment. This deposit will be made by

_____ _____

SIGNATURE OF PATIENT DATE

_____ _____

SIGNATURE OF PARENT OR GUARDIAN DATE

INSURANCE

Please read the following as it has important information regarding your account with us. If your insurance company is not listed below, please call us to make sure we accept payment from your insurance. Please note, our office is **NOT** Tricare or Colorado Medicaid participants.

Our clinic participates with:

- Blue Cross/Blue Shield
- BestLife
- UPREHS
- Veterans Administration
- Veterans Choice Program
- Medicare
- Wyoming Medicaid
- Wyoming Worker's Compensation
- Arizona, Montana, Nebraska, and Colorado Workers Compensation

It is your responsibility to have your current insurance card with you at time of service. You are responsible for deductibles that are not yet met, co-payments, costs share and/or denied benefits. **If you do not have insurance, you are responsible for payment at time of service. There will be no exceptions.** For your convenience we do accept money orders, cashier checks, personal checks (no post-dated checks will be accepted), Visa, MasterCard, Discover, debit cards, and cash.

As with any insurance, there are "usual and customary" fees. This is the amount that your insurance allows for office visits, procedures, etc…. Please understand this is an agreement between your insurance and yourself when you enrolled with their company. In most cases, the doctor's fees are above the "usual and customary" rate which insurance companies choose to pay. **Our office cannot and will not allow the insurance company to set the amount that we charge for services.** Please be aware that you may receive a bill for physician fees and facility fees for any procedure done at Pain Treatment Center of Wyoming.

MEDICAID

For Wyoming Medicaid (Title 19) there is a "cap limit" of 12 office visits per year. This limit includes visits to all doctors including the Emergency Room. As a courtesy to you, we will write one letter to Medicaid to ask that the cap limits be waived for our office only. If there is not a response from Medicaid, all medical bills are your responsibility and payment will be expected at the time of service. **NOTE** You must bring your current coupon or other proof of coverage to each visit; we cannot see you without it. If you have a co-payment, it must be paid at the time of service. There are o exceptions. If you do not pay your co-pay, you will not be seen and will have to reschedule your appointment.

WORKERS' COMPENSATION

We do not accept any out of state Workers' Compensation except from Colorado, Montana, Nebraska, and Arizona. This is subject to change at any time without notice.

TRICARE

As our office in not a member of the TriCare Network. We will bill TriCare as an "out-of-network" provider, meaning any amount not paid by TriCare will be your responsibility.

COPAYMENTS

There are several commercial insurance companies whose plans have copayments. This is an agreement between you and your insurance company and are not conditions determined by this office. These co-payments are due at the time of service. There are no exceptions. If you do not have your co-payment, you will not be seen by the provider and you will have to reschedule your appointment.

DELINQUENT ACCOUNTS

After your insurance had paid, the remaining balance on the account, if any, will become your responsibility. If the balance is $300 or greater, you will be asked to meet with one of our Billing Specialist. The scheduling of future appointments is contingent up on the results of this meeting. Unpaid accounts will be referred to an outside source for collections. Any unpaid balances, including bankruptcy, may lead to your dismissal from this clinic.

_____ _____

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SELF PAY

PLEASE REAS AND INITIAL EACH ITEM AND SIGN BELOW

I _____ (PATIENT NAME), understands that as a self-pay patient:

_____ I will be responsible for all charges related to the services provided to me by Pain Consultants of the Rockies, PC., Pain Treatment Center of Wyoming, LLC., and providers.

_____ The charges presented to me are due in full on the day of service, unless arrangements have been made with the billing department prior to my schedule appointment.

_____ If I am on a Payment Plan and fail to make a payment for more than two (2) consecutive scheduled payments then the Self-Pay Discount will be forfeited and the patient will be obligated and required to pay the full charges.

_____ These charges are solely in relation to professional services provided by the provider, and or other services that are performed in the office.

_____ I will receive a provider's discount on office visits.

_____ I will be given a discounted price to receive a procedure, and that amount will be due before the procedure is performed.

_____ I will have to pay any fees to the clinic for a returned check. I will not be allowed to write another check to the clinic. I will have to by cash, credit card, or money order for any appointment thereafter.

_____ The amount due may fluctuate depending on how long the provider spends with me and if any labs were performed.

_____ Once I have received health insurance, I must call and provide that information to the billing department. If I do not provide the clinic with the health insurance information, I **CANNOT** send the health insurance company any claims for reimbursement. I understand this is **INSURANCE FRAUD**.

_____ Once I provide the health insurance information to the clinic, I will be responsible for my deductible, copay, and coinsurance. I will not be considered self-pay and my health insurance will be billed for any and all claims form the effective date and all future appointments.

_____ Once I received health insurance, I cannot choose to become self-pay again. I can only become self-pay when my health insurance terminates and I do not have any other form of health insurance.

By signing below, I am indicating that I have read and understand the above policies with Pain Consultants of the Rockies, PC., and Pain Treatment Center of Wyoming, LLC.

_____ _____

SIGNATURE OF PATIENT DATE

_____ _____

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NOTICE OF PRIVACY PRACTICES & ACKNOWLEDGEMENT

This is a description of how your health information may be used and disclosed and how you can gain access to this information.

PLEASE READ THIS CAREFULLY.

Each time you visit our office or treatment center, a record of this visit is made. This records is referred to as your "medical record". Your medical record contains your health information including symptoms, examination findings, lab or x-ray results, diagnoses, treatment, and plans for your care.

Our facilities have polices in place requiring our staff to maintain the privacy of your health information. These polices may be changed, but our staff must stay abreast of these changes and continue to abide by them.

USES AND DISCLOSURES

Your health information will be disclosed:

- To healthcare professionals providing, coordinating and/or managing your health care or related services and
- To insurance agencies or third party payers for the purpose or reimbursement for services rendered.

Disclosures of your health information may be made:

- When required by federal, state, or local law and
- In matters of public health and safety.

DISCLOSURE OF YOUR HEALTH INFORMATION FOR ANY OTHER PURPOSE WILL REQUIRE YOUR WRITTEN, SIGNED AUTHORIZATION.

YOUR RIGHTS

Your health care provider usually must let you see your medical record or give you a copy upon your request. This right is called the right to access your medical record.

- A hospital generally must give you access to your medical no later than 10 days after they receive it.
- Physicians generally must respond in a reasonable time, but no later than 30 days.
- Your health care provider is allowed to charge you a fee for copying your record. They can also charge you the actual cost for postage if you have the copy mailed to you.
- Request a restriction on some disclosures of your health information. However, if our facilities are unable to agree to said restriction, you will be notified of the reason.
- Inspect and obtain a copy of your medical record unless restricted by Federal law. There may be a copying fee attached.
- Request amendment of your medical record.

ACKNOWLEDGEMENT

I hereby acknowledge receipt of my copy of this Notice of Privacy Practiced from Pain Consultants of the Rockies, PC and/or Pain Treatment Center of Wyoming, LLC.

_____ _____

SIGNATURE OF PATIENT DATE

_____ _____

SIGNATURE OF PARENT OR GUARDIAN DATE

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I, the undersigned, authorize Pain Consultants of the Rockies, PC and/or Pain Treatment Center of Wyoming, LLC, to release or receive my health information as noted below:

PATIENT INFORMATION:

FULL NAME: _____ OTHER NAMES USED: _____

DATE OF BIRTH: _______________ ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ PHONE: _____

RELEASE INFORMATION: ☐ TO ☐ FROM SECTION MUST BE FILLED OUT COMPLETELY FOR REQUEST TO BE PROCESSED

NAME|FACILITY: Pain Consultants of the Rockies ATTENTION: Medical Records

ADDRESS: 4136 Laramie Street, Suite A PHONE: (307) 633-8100

CITY: CHEYENNE STATE: WY ZIP: 82001 FAX: (307) 633-8108

RELEASE INFORMATION: ☐ TO ☐ FROM

NAME|FACILITY: _____ ATTENTION: _____

ADDRESS: _____ PHONE: _____

CITY: _____ STATE: _____ ZIP: _____ FAX: _____

REASON FOR REQUEST: _____

INFORMATION TO BE DISCLOSED: I authorize the release of the following health information:

☐ All of my health information that the provider ha, including information to any medical history, mental or physical condition and any treatment received.

☐ Only the following records or types of health information: _____

_____

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information _____ (Patient or Legal Representative Initials).

TERM: I understand that this Authorization will remain in effect:

☐ From the of this Authorization until the _____ day of _____, 20_____.

☐ Until the Provider fulfills this request.

☐ Until the follow even occurs _____.

I understand that:

- I may refuse to sign this authorization and that it is strictly voluntary.
- I can request a copy of this form after I sign and date it.
- Physicians generally must respond in a reasonable time, but no later than 30 days.

_____ _____

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_____ _____

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPPA), in order for your healthcare provider or staff of Pain Consultants of the Rockies, PC and Pain Treatment Center of Wyoming, LLC to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

PLEASE INITIAL

_____ I do not authorize Pain Consultants of the Rockies, PC and Pain Treatment Center of Wyoming, LLC to release any or all information concerning my medical care to any individual except as set for above.

_____ I do authorize Pain Consultants of the Rockies, PC and Pain Treatment Center of Wyoming, LLC to verbally release any or all information concerning my medical care to the following individuals:

_____ _____

Name Relationship to Patient

_____ _____

Name Relationship to Patient

_____ _____

SIGNATURE OF PATIENT DATE

_____ _____

SIGNATURE OF PARENT OR GUARDIAN DATE

Voicemail Authorization

I hereby authorize the staff members of Pain Consultants of the Rockies, PC and Pain Treatment Center of Wyoming, LLC to leave voicemail messages for me at my telephone number(s) of record or at any telephone number I may indicate in any message I leave. I understand messages left by staff members could contain information which may be confidential in nature. At no time should any employees leave in detail message about your care and/or results.

_____ _____

SIGNATURE OF PATIENT DATE

_____ _____

SIGNATURE OF PARENT OR GUARDIAN DATE