ROCKY MOUNTAIN
BRAIN & SPINE
INSTITUTE

9218 Kimmer drive, Suite 107 Lone Tree, CO 80124 Phone (303) 471-4690 Fax (303) 471-4697

New Patient Medical History - Please complete this form prior to your first appointment

Legal Name: Robert Hanbury Means Prefer to be called: Bob
Date of Birth: 01/06/71 Age: 48 Gender: M SSN: 593-10-3416
Home Address: 30623 Sun Creek City: Evergren State: CO Zip: 80439
Home Phone: _____ Cell Phone: (720) 934-1245 Work Phone: _____
Email Address: robet@robertmeans.com
Employed: X Unemployed: _____ Student: _____ Retired: _____
Employer: Self Occupation: IT
Employer Address: Home office City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relation: _____ Phone: 911

How did you hear about our practice? Anthem website

♦ Insurance Information ♦

What type of claim is this? X Health Insurance ___ Work Comp ____Auto ____ Self-Pay
Primary Insurance Company: Anthem
Policy Holder's Name: Robert Means Date of Birth: ____/____/____
SSN:___-____-_____ Policy Holder's Empolyer: _____
Member ID or Claim #: VAB005M83567 Group #: _____
Effective Date or Date of Injury: 02 / 01 / 19 Phone: _____
Claims Address: _____ City: _____ State: _____ Zip: _____
Adjuster Name: _____ Adjuster Phone: _____

Secondary Insurance Company: _____
Policy Holder's Name: _____ Date of Birth: ____/____/____
SSN:___-____-_____ Policy Holder's Empolyer: _____
Member ID or Claim #: _____ Group #: _____
Effective Date or Date of Injury: ____/____/____ Phone: _____
Claims Address: _____ City: _____ State: _____ Zip: _____
Adjuster Name: _____ Adjuster Phone: _____

Signature: _____ Date 02 / 11 / 19

Guarantor (Person responsible to pay the bill):
- ☒ Self
- ○ Other: _____

♦ Please briefly state in the box below the reason for your visit ♦

♦ Other Physicians and Specialists ♦

List below your other physicians (i.e., Primary Care, Pain physician, Orthopedics, Psychiatry, etc)

Name of Provider: Randy Sclar Office Name: Arapahoe Peak Office #: (303) 679-8500

Name of Provider: _____ Office Name: _____ Office #: _____

♦ Referring Physician ♦

List below who referred you to our practice

Name of Provider: Randy Sclar Office Name: Arapahoe Peak Office #: (303) 679-8500

♦ Past Medical History ♦

Condition / Disease	*Year Began*	*Condition / Disease*	*Year Began*
❑ Hypertension		Other(s):	
❑ High Cholesterol			
❑ Hypothyroidism (low thyroid)			
❑ COPD, Emphysema or Asthma			
❑ Diabetes			
❑ Depression or Anxiety			
❑ Anticoagulation			
❑ Neck/ Low Back Pain (Please circle)	2016		

♦ Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures ♦

Operation / Hospitalization / Injury	*Month / Yr*	*Operation / Hospitalization / Injury*	*Month / Yr*
02.29.16 L3/L4 Left side Laminectomy,		Foraminotomy and Discectomy	
03.07.16 L4/L5 Left side Laminectomy,		Foraminotomy and Discectomy	
07.21.16 L4/L5 left side Re exploration of 03.07.16 surgery			

♦ Medication or Food Allergies or Intolerances ♦

List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)

Medication / Food	*Reaction*	*Medication / Food*	*Reaction*

♦ Medications, Vitamins and Herbal Supplements ♦

Medication	*Strength*	*Number of pills taken & frequency*	*Medication*	*Strength*	*Number of pills taken & frequency*
Example: *Tylenol*	*500 mg*	*1 - twice daily*			
Hydrocodone	10/325	1 - twice daily			

♦ Social, Educational and Work History ♦

Marital Status: d	Age of children, if any: 14 & 16	
Race: white	Religion:	
Highest Level of Education: BSBA	Completed at which institution / school: Western Carolinea Univ	
What type of exercises do you perform, duration & frequency? walking, hiking, firewod, 15hrs/wk		
In what type of residence do you live (i.e., house, assisted living, nursing home)? house		
What are your hobbies? mountaineering, mountainbiking - outside anything		
Do you drink alcohol? No	What type of alcohol?	No. of drinks per week?
Are you a current smoker? No	If you smoke, how many packs per day?	
Are you a former smoker? NO	If so, what year did you quit?	No. of years you smoked?
On average, how much did you smoke per day?		
Are you sexually active: Yes / No	Do you have sex with: Men / Women / Both	How many partners have you had during the past 12 months? 2
Are you concerned that you may have been exposed to HIV? Yes / No		

♦ Family Health History ♦

Please list below the health history of your blood (genetic) first degree relatives

Relative	*Living or Deceased*	*Current age or age at death*	*Cause of Death*	*Health Problems*
Father:	Living	86		Diabetes type II
Mother:				
Brother(s):				
Sister(s):				

♦ Review of Systems ♦

Please review the following symptoms and circle those items that are a problem for you

Vision problems	Wheezing	Lumps in breast	Frequent Urination	Excessive hunger
Hearing problems	Asthma / COPD	Breast discharge	Incontinence	Excessive thirst
Sinus trouble	Emphysema	Trouble swallowing	Blood in Urine	Headaches
Hay fever	Bronchitis	Nausea	History of STD's	Fatigue
Nosebleeds	TB exposure	Vomiting	Anemia	Neck Pain
Sore throat	Chest pain	Abdominal pain	Easy bruising	Back Pain
Hoarseness	Chest discomfort	Hepatitis / Jaundice	Pain in legs	Seizures / Tremor
Lumps in neck	Shortness of breath	Gallstones	Joint pain / stiffness	Weakness
Tooth problems	High blood pressure	Diarrhea	Blood clot	Numbness/tingling
Cough	Diabetes	Constipation	Weight loss / gain	Anxiety/Depression
Coughing blood	High cholesterol	Blood in stool	Heat/cold intolerance	Difficulty sleeping

❑ ***Place an "X" in the box to the left if you have none of the above.***

♦ Disease Prevention and Health Maintenance ♦ *Please list below the most recent dates of your vaccines and health screening tests*					
	Month/Yr		***Month/Yr***		***Month/Yr***
Flu Vaccine		Mammogram		Eye Exam	
Pneumonia Vaccine		Pap Smear		Heart Catheterization	
Tetanus Vaccine		Colonoscopy		Endoscopy (EGD)	
Hepatitis B Vaccine		Bone Density		Heart Stress Test	
Shingles Vaccine		EKG		Ab Aneurysm Screen	
Gardasil Vaccine		Chest X-Ray		HIV Test	

THE INFORMATION PROVIDED ON THIS FORM IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

Signature: _____ **DATE:** 02 / 11 /19

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Patient Name: (Last, First): Means, Robert
Date of Birth: 01 / 06 / 71

Consent of Medical Treatment

1) **CONSENT FOR HEALTH CARE SERVICES**. I authorize physician(s), physician assistants(s), and/ or designees to administer any treatment as may be necessary or advisable in my diagnosis and treatment at Rocky Mountain Brain & Spine Institute practices. This authorization includes, but is not limited to: medical services, diagnostic procedures, diagnostic imaging, intravenous therapy, medications, injections, laboratory services, and other services or procedures, which my physician or provider considers necessary. My health care provider(s) will discuss with me the risks, benefits and alternatives to recommended treatments. I understand that health care services may be rendered by students, interns or residents under supervision. I understand that Rocky Mountain Brain & Spine Institute may release copies of my medical records to other physicians, practitioners and healthcare providers or facilities for treatment and other purposes, as permitted by law. I acknowledge that no promises or guarantees have been made to me regarding treatment of services rendered in/ by the practice. I acknowledge that no promises or guarantees have been made to me regarding outcome from recommendations or treatment by Rocky Mountain Brain & Spine Institute.

2) **NON-ROCKY MOUNTAIN BRAIN & SPINE INSTITUTE PROFESSIONALS/ FACILITIES**. I understand that I may receive services from professionals or facilities who provide care to me or are involved in my care/ treatment who are not employees or agents of Rocky Mountain Brain & Spine Institute. These professionals may include other physicians/providers requested by my physician to participate in my care as well as radiology, pathology, neuromonitoring technicians and neuromonitoring readers, and laboratory services. As a result, I understand that I may receive bills for these services that are separate from the bills I receive from Rocky Mountain Brain & Spine Institute. **I understand that, in some cases, these non- Rocky Mountain Brain & Spine Institute professionals or facilities may not be participating providers or facilities under my insurance plan. I understand it is my responsibility to verify whether professionals/facilities providing my care are participating providers/ facilities under my insurance, and that I may be responsible for any out of network costs incurred due to non-participation.**

3) **MEDICARE AND/OR MEDICAID CERTIFICATION.** I certify that the information given to me in applying for payment under the Medicare and/or Medicaid programs is correct, and I authorize the release of all information needed to act on this request. I request that payment of authorized benefits be made to the practice of my behalf for the charges for which the practice is authorized to bill in connection with these health care services.

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Patient Name: (Last, First): Means, Robert
Date of Birth: 01/06/71

4) **FINANCIAL AGREEMENT.** I understand that there is no guarantee of reimbursement or payment from any insurance company or other payor. I acknowledge full financial responsibility for, and agree to pay, all charges of the practice and or physicians rendering services not otherwise paid by my health insurance or other payor. Estimated patient responsibility is due at the time of service. Any remaining charges are due and payable upon receipt of the bill. I understand the practice may request and use data from third parties such as credit reporting agencies in order to verify demographic data or evaluate financial options. If payment is not made within 90 days after receipt of the bill, a delinquent charge or interest at the maximum legal rate may be added. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I acknowledge and understand that nay refund that I may be owed will first be applied to any outstanding balance, and the remainder will be forwarded to the address on file with the practice. **I consent to be contacted by regular mail, by e-mail or by telephone (including a cell phone number) regarding any matter related to my account by the practice or any entity to which the practice assigns my account. I also consent to the use of any updated or additional contact information that I may provide by the practice or any entity to which the practice assigns my account, as well as to the use of technology including auto-dialing and/or prerecorded messages in contacting me.**

5) **PREAUTHORIZATION REQUIREMENTS.** I understand that it is my sole responsibility to verify all pre-authorizations are in place and to comply with all requirements of nay insurance plan upon which I am relying for coverage of the practice's and physicians' charges. I also understand that my insurance may require an office visit referral from my primary care physician to see a specialist. It is my responsibility to contact my primary care physician and acquire the necessary referral prior to my scheduled appointment. If a referral is not obtained prior to my appointment, I may be financially responsible for the charges incurred during the visit.

6) **ASSIGMENT FOR DIRECT PAYMENT.** I authorize and direct hta payment of any insurance or healthcare benefits otherwise payable to me for health care services or goods be made directly to the practice and my physicians/ providers. I understand that I am financially responsible to the practice or my physician/ providers for charges not covered or paid pursuant to this authorization.

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Patient Name: (Last, First): Means, Robert
Date of Birth: 01 / 06 / 71

7) **ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES.** I acknowledge that Rocky Mountain Brain & Spine Institute has offered me a copy of its Notice of Privacy Practices. I understand this acknowledgement in no way affects the care I shall receive at the practice.

By checking one of the circles below, I acknowledge:

- ⊗ **I have been offered or accepted a copy of the Notice of Privacy Practices**
- ○ **I declined a copy of the Notice of Privacy Practices**

Practice Representative Comments: _____

I ACKNOWLEDGE I HAVE READ THIS FORM AND UNDERSTAND ITS CONTENTS AND HAVE RECEIVED A COPY HEREOF. I FURTHER ACKNOWLEGE THAT I AM THE PATIENT, OR PERSON DULY AUTHORIZED EITHER BY THE PATIENT OR OTHERWISE, TO SIGN THIS AGREEMENT, CONSENT TO, AND ACCEPT ITS TERMS.

[signature]	02.11.19	15:28
SIGNATURE OF PATIENT OR LEGALLY RESPONSIBLE PERSON NAME (PRINT)	DATE	TIME

RELATIONSHIP/ REASON WHY PATIENT IS UNABLE TO SIGN

30623 Sun Creek Drive, Evergreen, CO 80439

ADDRESS OF PATIENT

HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

1. Authorization

I authorize Rocky Mountain Brain & Spine Institute (healthcare provider) to use and disclose the protected health information described below to _____ (individual seeking the information).

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. ☐ _____ to _____.

OR

b. ☒ all past, present, and future periods.

3. Extent of Authorization

a. ☒ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. □ I authorize the release of my complete health record with the exception of the following information:

□ Mental health records

□ Communicable diseases (including HIV and AIDS)

□ Alcohol/drug abuse treatment

□ Other (please specify): _____

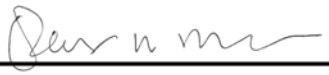
4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.



Signature of patient or personal representative

Robert Means

Printed name of patient or personal representative and his or her relationship to patient

02.11.19

Date