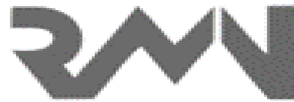
ROCKY MOUNTAIN NEUROLOGY



Amelia Scott Barrett, M.D.
Daniel Kitei, D.O., M.A.
Katie Coerver, M.D., Ph.D.
Ro Elgavish, MD, Ph.D.

PATIENT DEMOGRAPHICS

First Name:	MI	Last Name:	Preferred Name:

Date of Birth:	Sex:	SSN:	E-Mail Address:

Address:	City:	State:	Zip:

Home Phone:	Cell Phone:	Work Phone:	Employer:

Preferred Phone Number:	□ Home	□ Cell	□ Work	Marital Status:	Race/Ethnicity:
Ok to leave detailed message:	□ Home	□ Cell	□ Work		

Referring Physician:	**Primary Care Physician:**

Please provide first **and** last name. If they are not a local doctor, please provide phone and fax

IN CASE OF EMERGENCY

Name:	Address:	Relationship:	Phone

PRIVACY

WHO CAN WE SHARE YOUR MEDICAL INFORMATION WITH? (Family members, etc. - Please give **full names**.
(Please provide a contact phone number if they are different than your emergency contact above)

Please provide documentation if Power of Attorney applies

PHARMACY

Name:	Address (or major cross streets and city)	Phone no:

PATIENT RESPONSIBILITIES

- I hereby authorize assignment of benefits to be paid directly to Amelia Barrett MD, Daniel Kitei D.O., Katie Coerver M.D., PhD and Ro Elgavish M.D., PhD
- I understand that it is my sole responsibility to check with my insurance company regarding coverage & cost for any procedures and/or office visits. I am responsible for obtaining all referrals and insurance authorizations.
- I authorize Amelia Barrett MD, Daniel Kitei D.O., Katie Coerver M.D., PhD, Ro Elgavish M.D., PhD to provide protected health information to my insurance company for billing purposes.
- I understand that regardless of any insurance coverage or other potential co-guarantor or responsible party, I am accepting full financial responsibility for payment of all charges for services provided to me, my spouse, or dependents by this practice. The services provided include office visits, procedures (electromyography/nerve conduction studies or EMG/NCS, electroencephalogram or EEG, neurobehavioral testing and Botolium toxin or Botox injections) and online encounters via the patient portal. I agree that if my employer, insurance carrier or plan sponsor denies payment to all or any portion of my claim, I will be financially responsible for all outstanding charges. I agree to pay a late fee of $25 if my account should become over 60 days past due. In addition, should my account become delinquent and assigned to a collection agency, I agree to pay an additional collection charge of 33% of the outstanding balance or a minimum of $40.00 (whichever is greater) to offset in part the collection agency's fee charged to this practice. Should legal action be initiated by the collection agency, I agree to pay a collection charge of 50% of the outstanding balance as well as all costs and reasonable attorney fees incurred in such collection efforts by this office or our assignee.
- TCPA Acknowledgment - I authorize this office, its agents, and assignees to contact me by telephone, text/SMS, and/or via an automated dialing system with live or recorded voice in connection with any of my accounts with this office and at any telephone number I have provided as of this date or in the future.
- A fee of $50.00 may be assessed if I do not show up for a follow-up appointment or if I cancel without 24 hours' notice. A fee of $150 may be charged if I do not show up for a testing appointment. The implementation of this policy is at the discretion of the office and circumstances are always considered.
- I give permission for the office to access my external medication history.
- I acknowledge review of HIPAA notice and have received a copy if I requested it.
- I give consent to receive virtual check in services (including patient initiated online encounters via the patient portal)

____ ___________
PATIENT or POWER OF ATTORNEY/GUARDIAN SIGNATURE DATE

If signed by a Legal Guardian or Power of Attorney

Legal Guardian/POA Name: _____________________________ Relationship to patient: _____________________
*By providing your signature above, you attest that you have the legal right to sign for the patient.

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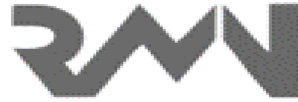

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NAME:____ **DATE OF BIRTH:** ______/_____/_______

Which symptoms are you being seen for today? _________________________

Height: ____ft _____ In | Weight: _______lbs

***USE BACK OF PAGE IF NEEDED**

MEDICATIONS*							
Name	Strength (mg etc)	Frequency (how often?)	Condition this medication is for	Name	Strength (mg etc)	Frequency (how often?)	Condition this medication is for

Are you allergic to any medications? YES NO Is yes, which ones? ______________________________

ADDITIONAL MEDICAL CONDITIONS*	
MAJOR SURGERIES*	**DATE (IF APPLICABLE)**

FAMILY HISTORY	
Father: □ Alive □ Deceased □ Unknown	Medical Conditions:
Mother: □ Alive □ Deceased □ Unknown	Medical Conditions:
Are there any other medical conditions that run in your family?	

(Examples of medical conditions we are looking for: diabetes, hypertension, heart disease, stroke, mental illness, cancer etc.)

REVIEW OF SYSTEMS

(Please circle all that apply)

General: weight loss, weight gain, fevers
ENT: sinus infections, ear pain/fullness, dizziness, ringing in ears
Eyes: blurry vision, double vision, loss of vision
Psychiatric: sadness/depression, anxiety, hallucinations
Respiratory: shortness of breath, wheezing, cough
Genitourinary: frequent urination, impotence, painful urination
Cardiovascular: heart palpitations, passing out/blackouts, poor circulation
Skin: rashes, birthmarks, skin growths
Gastrointestinal: burning in stomach, constipation, diarrhea
Musculoskeletal: weakness, joint pain, joint swelling
Neurologic: headache, difficulty swallowing, tingling/burning, neck/back pain, slurred speech, tremors, memory problems, balance problems, muscle cramps, numbness

ADDITIONAL QUESTIONS

(Please circle)

Do you have an Advanced Directive? YES NO
If so, have you assigned a decision maker? YES NO
Have you received a flu shot? YES NO MM/YY: _______
Have you received the pneumonia shot? YES NO MM/YY: _______
Have you fallen in the past year? YES NO
If yes, how many times did you fall? ______
Did you need medical treatment? ______
Is your appointment today regarding a work or auto related injury? YES NO
WORK or AUTO What was the date of Injury? __________

SOCIAL HISTORY

Are you a:
[ ] **Current smoker**
If so, how much?____________
Date started: _______________
[ ] **Former smoker**
If so, date range: ______ - _______
[ ] **Never smoker**

Do you drink alcohol?
[ ] **Yes**
If so, how often? ___________
[ ] **No**

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