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.
Melissa Butler, PA-C

PATIENT DEMOGRAPHICS

First Name:	MI	Last Name:	Preferred Name:

Date of Birth:	Sex:	E-Mail Address:

Address:	City:	State:	Zip:

Home Phone:	Cell Phone:	Work Phone:

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

Referring Doctor	Primary Care Doctor

Please include first and last name, and phone if not a local doctor

PHARMACY

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

Reason for visit: ______________________________ Date Condition Started:_____________

REVIEW OF SYSTEMS (any problems you have experienced in the last 90 days)

(Please check 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

SOCIAL HISTORY

Are you a:

☐ **Never smoker**

☐ **Former smoker**
If so, date range: _______ - _______

☐ **Current smoker**
☐ **Tobacco** ☐ **Marijuana** ☐ **Vape**
Date started: _______________

How often did you have a drink containing alcohol in the past year?
☐Never
☐Monthly or less ☐Two to four times a month ☐Two to three times per week ☐Four or more times a week

How many drinks did you have on a typical day when you are drinking?
☐1 or 2 ☐3 or 4 ☐5 or 6 ☐7 to 9 ☐10 or more

How often did you have six or more drinks on one occasion in the past?
☐Never ☐Less than monthly ☐Monthly ☐Weekly ☐Daily or almost daily

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.
Melissa Butler, PA-C

Name: ______________________________________ **Date of Birth:**

Height: ______ft _______ In	Weight: _________lbs	☐Left Handed OR ☐Right Handed

MEDICATIONS, SUPPLEMENTS, OVER THE COUNTER MEDICATIONS*					
Name	Strength (mg etc)	Frequency (how often?)	Name	Strength (mg etc)	Frequency (how often?)

Are you allergic to any medications? ☐YES ☐NO If yes, which ones? ____

____

MEDICAL HEALTH CONDITIONS

☐Asthma	☐High Blood Pressure	☐Headaches/Migraines	☐Sleep Apnea
☐Epilepsy	☐High Cholesterol	☐Heart Disease	☐Traumatic Brain Injury
☐Diabetes	☐Thyroid Disease	☐Multiple Sclerosis	☐Cancer: _________________

☐Other Conditions: ____
____

MAJOR SURGERIES*	DATE

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.)

ADDITIONAL QUESTIONS

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? ☐YES ☐NO

Amelia Scott Barrett, M.D.
Daniel Kitei, D.O., M.A.
Katie Coerver, M.D., Ph.D.
Ro Elgavish, MD, Ph.D.
Melissa Butler, PA-C

Initial and Date each section

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, Melissa Butler, PA-C
- 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, Melissa Butler, PA-C 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.
- TCPA Acknowledgment - I authorize this office, its agents, and assignees to contact me by email, 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.
- I give permission for the office to access my external medication history.
- I give consent to receive virtual check in services (including patient initiated online encounters via the patient portal)

Initial Here		Date:	

FINANCIAL POLICY

- Rocky Mountain Neurology will bill my insurance provided all the necessary information is given to the clinic at the time of service. This includes a valid, current insurance card. If this is not available, I will be asked to pay all charges for the day's visit before I leave the office. Rocky Mountain Neurology will ask to see a copy of your insurance card every visit to ensure that we have all the proper billing data and that the insurance card is current.
- If my insurance company does not submit payment within 30 days, I understand that I will be responsible for all outstanding balances. I am aware that my insurance carrier, rather than my physician, may deny some services for the reason of "not being medically necessary" or "non-covered" services, therefore, I will become fully responsible for payment of these services.
- If I have asked for an estimate of the cost for my visit, this will be given as closely as possible. However, since Rocky Mountain Neurology will still bill insurance, this is to be considered only as an estimate and not an exact change quote. There is a possibility that you will receive a bill for additional balances after the insurance has fully processed the claim.
- My responsibility will be my co-pay (required at time of service), deductibles, coinsurance, or any other amount that my insurance deems my responsibility. I will also be responsible for services not covered under my policy, paperwork fees, testing, online encounters via the patient portal, no-show fees, and late cancellation fees.
- I understand and agree that I will be responsible for a late fee of $25 if my account should become over 60 days past due. In addition, should my account become delinquent and sent to a collection agency, I agree to pay an additional collection charge of 33% of the outstanding balance or a minimum of $40 (whichever is greater) to offset the collection agency fee's charged to Rocky Mountain Neurology. Should legal action be initiated by the collection agency, I agree to be 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.
- I understand that a fee of $50 may be charged if I do not show up for my appointment or cancel without a minimum of 24 hours' notice. A fee of $250 may be charged if I do not show up for my testing appointment or late cancel without a minimum of 24 hours' notice. The implementation of this policy is at the discretion of the office and circumstances are always considered.
- I understand that Rocky Mountain Neurology charges a fee of $25 per paperwork request. This includes FLMA, Short-term disability, Disability forms, plan of care, and letter requests. I understand that I am responsible for the fee for this paperwork.

Initial Here		Date:	

HIPPA ACKNOWLEDGEMENT

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out.

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day to day healthcare/dental care operations of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA.

I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Initial Here		Date:	

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.
Melissa Butler, PA-C

EMERGENCY CONTACTS / HIPPA RELEASE

Name	Phone Number	Relationship	Can share medical information
			☐YES ☐NO
			☐YES ☐NO

Telemedicine Informed Consent

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

Initial Each Line:

_____ I understand that telehealth involves the communication of my medical information in an electronic or technology-assisted format.
_____ I accept that I authorize Dr. Barrett, Dr. Kitei, Dr. Coerver, Dr. Elgavish, or Melissa Butler to use telehealth for my diagnosis and treatment.
_____ I accept that I need access to a mobile device and a good internet connection in order to have an efficient telemedicine appointment. (laptop/computer or tablet for Dr. Elgavish)
_____ I understand that I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this office.
_____ I understand that telehealth services can only be provided to patients, including myself, who are residing in the state of Colorado at the time of this service.
_____ I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s), Medicare, or Medicaid, and it is my responsibility to check with my insurance plan to determine coverage. I understand that I can be charged any additional fees that my insurance does not cover.
_____ I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to: *It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures. Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network. • Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.*
_____ I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.
_____ I agree that the healthcare provider is not responsible for breaches of confidentiality caused by me or by an independent third party.
_____ I agree that information exchanged during my telehealth visit will be maintained by the doctor, other healthcare providers, and healthcare facilities involved in my care.
_____ I agree that I will verify to my healthcare provider my identity and current location in connection with the telehealth services.
_____ I understand and agree that a medical evaluation via telehealth may limit my healthcare provider’s ability to fully diagnose a condition or disease. As the patient, I agree to accept responsibility for following my healthcare provider’s recommendations —including further diagnostic testing, such as lab testing, or an in-office visit if needed.
_____ I understand that my healthcare provider may choose to forward my information to an authorized third party or communicate clinical information to me through email. Therefore, I have informed the healthcare provider if there is any information I do not wish to be transmitted through electronic communications.
_____ I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical care is provided.
_____ By signing below, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit.
_____ I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the existing emergency 911 services in my community.

I certify that I have read and understand this and all above agreements with the opportunity to have questions answered to my satisfaction. For electronic communication between Dr. Barrett, Dr. Kitei, Dr. Coerver, Dr. Elgavish, Melissa Butler, Rocky Mountain Neurology staff

Print Patient Name:____

Patients, Parents, Guardian signature____Date_____________________________

Name and Relationship to Patient (if patient is unable to sign):____

My most reliable contact information for telehealth communication:

Phone number: ___________________________Text ☐YES ☐NO

Email: ____

10103 RIDGE GATE PARKWAY, STE 125 (Aspen Bldg) • LONE TREE, CO 80124 • PHONE (303) 790-8899 • FAX (303) 790-2810
www.RockyMountainNeurology.com
RMN@MDOFFICEMAIL.COM