

OROFACIAL PAIN ASSOCIATES

Of Colorado Springs

PATIENT INFORMATION

LAST NAME _____ FIRST NAME _____ (MI) _____ DOB _____

ADDRESS _____ GENDER _____

CITY, STATE, ZIP _____ EMAIL _____

PRIMARY PHONE _____ SECONDARY PHONE _____

S.S. # _____ MARITAL STATUS _____

EMERGENCY CONTACT #1 _____ RELATION _____ PHONE _____

EMERGENCY CONTACT #2 _____ RELATION _____ PHONE _____

MEDICAL INSURANCE INFORMATION

PRIMARY INSURANCE

OROFACIAL PAIN ASSOCIATES OF COLORADO SPRINGS IS NOT IN NETWORK WITH ANY INSURANCE COMPANIES. WE WILL BILL YOUR MEDICAL INSURANCE AS A COURTESY TO YOU. WE CANNOT GUARANTEE REIMBURSEMENT OR APPLICATION OF PAYMENT TO YOUR DEDUCTIBLE. PLEASE DO NOT PROVIDE MEDICAID, MEDICARE OR MEDICARE SUPPLEMENT INFORMATION AS WE CANNOT SUBMIT CLAIMS TO THOSE INSURANCE CARRIERS.

INSURANCE NAME _____ SUBSCRIBER NAME _____

SUBSCRIBER I.D. # _____ GROUP # _____ SUBSCRIBER DOB _____

PATIENT RELATIONSHIP TO SUBSCRIBER _____ MALE ___ FEMALE ___

INSURANCE ADDRESS _____ CITY, STATE, ZIP _____

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I CONSENT TO TREATMENT AND AUTHORIZE OROFACIAL PAIN ASSOCIATES OF COLORADO SPRINGS TO RELEASE TO ANY INSURANCE COMPANY OR GOVERNMENT AGENCY ANY AND ALL INFORMATION NECESSARY TO PROCESS CLAIMS. I UNDERSTAND THAT OROFACIAL PAIN ASSOCIATES OF COLORADO SPRINGS IS NOT IN NETWORK WITH ANY INSURANCE COMPANIES, ANY AND ALL CLAIMS ARE SUBMITTED AS COURTESY TO ME. OROFACIAL PAIN ASSOCIATES OF COLORADO SPRINGS CANNOT GUARANTEE REIMBURSEMENT OR APPLICATION OF PAYMENT TO MY INSURANCE DEDUCTIBLE. I UNDERSTAND THAT CHARGES NOT COVERED BY MY INSURANCE CARRIER ARE MY RESPONSIBILITY. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

PLEASE PROVIDE THE NAMES OF YOUR MEDICAL PROVIDERS (IF ANY):

REFERRING PHYSICIAN/DENTIST _____ PHONE _____

MAY WE SPEAK TO THE PROVIDERS LISTED REGARDING YOUR CONDITION? YES ___ NO ___

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SOCIAL HISTORY

CAFFEINE USE YES ___ NO ___

ALCOHOL USE YES ___ NO ___

TOBACCO USE YES ___ NO ___ DID YOU QUIT SMOKING? YES ___ NO ___ WHEN? _____

ARE YOU CURRENTLY UNDER UNUSUAL STRESS? YES ___ NO ___

HAVE YOU EXPERINCED A RECENT LIFESTYLE CHANGE? YES ___ NO ___

REVIEW OF SYSTEMS

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING? PLEASE MARK ALL THAT APPLY.

GENERAL

- Fever
- Weight changes
- Night sweats

EYES, EARS, NOSE & THROAT

- Visual changes
- Trouble hearing
- Ear ringing
- Nose bleeds
- Hoarseness
- Sinus problems
- Dry mouth

CARDIOVASCULAR

- High blood pressure
- Heart disease
- Heart murmur
- Palpitations
- High cholesterol

PULMONARY

- Shortness of breath
- Asthma
- Tuberculosis

GASTROINTESTINAL

- Trouble swallowing
- Indigestion/heartburn
- Ulcers
- Constipation
- Diarrhea

GENITOURINARY

- Nursing
- Hysterectomy
- Sexual dysfunction
- Bladder problems
- Kidney disease

DERMATOLOGIC

- Skin problem
- Malignant melanoma
- Other skin cancer form

HEMATOLOGIC

- Easy bruising
- Anemia
- B12 deficiency
- Cancer

RHEUMATOLOGIC

- Muscle pain/swelling
- Joint pain/swelling
- Back or neck pain

ENDOCRINE

- Thyroid problems
- Diabetes

PSYCHOLOGIC

- Stress
- Depression
- Anxiety
- Eating problem
- Suicidal

NEUROLOGIC

- Headaches
- Seizures/convulsion
- Numbness sensation
- Weakness
- Tremors
- Concussion/whiplash
- Trouble sleeping
- Trouble walking
- Speech difficulty
- Dizziness
- Motion sickness
- Double vision
- History of stroke
- Confusion
- Memory problems

PLEASE ADD ANY ADDITIONAL INFORMATION THAT YOU FEEL IS RELEVANT:

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Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
TOTALS				

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the **most appropriate number** for each situation:

- 0 = would **never** doze
- 1 = **slight chance** of dozing
- 2 = **moderate chance** of dozing
- 3 = **high chance** of dozing

It is important that you answer each question as best you can.

Situation	Chance of Dozing (0-3)
Sitting and reading _____	
Watching TV _____	
Sitting, inactive in a public place (e.g. a theatre or a meeting) _____	
As a passenger in a car for an hour without a break _____	
Lying down to rest in the afternoon when circumstances permit _____	
Sitting and talking to someone _____	
Sitting quietly after a lunch without alcohol _____	
In a car, while stopped for a few minutes in the traffic _____	

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ACCIDENT INFORMATION

IS YOUR VISIT TODAY THE RESULT OF AN ACCIDENT? YES ___ NO ___

IF YES, PLEASE FILL OUT THE REST OF THIS PAGE, IF NO CONTINUE TO THE NEXT PAGE.

DATE OF INJURY _____

ARE YOU CURRENTLY INVOLVED IN A LAWSUIT FOR THIS INCIDENT? YES ___ NO ___

ATTORNEY NAME _____

ATTORNEY ADDRESS _____

ATTORNEY PHONE NUMBER _____

ATTORNEY FAX NUMBER _____

ARE YOU USING A 3RD PARTY LIEN? YES ___ NO ___ WHO? _____

WORKERS COMP INFORMATION

WORKERS COMP INURANCE _____

WORKERS COMP CONTACT _____

WORKERS COMP PHONE _____

WORKERS COMP FAX _____

WORKERS COMP CLAIM # _____

WHO IS YOUR EMPLOYER FOR THIS CLAIM? _____

AUTO INSURANCE INFORMATION

AUTO INURANCE _____

AUTO INURANCE CONTACT _____

AUTO INURANCE PHONE _____

AUTO INURANCE FAX _____

AUTO INURANCE CLAIM # _____

HOW MUCH MED PAY IS LEFT? **REQUIRED** _____

IF YOU ARE USING MED PAY, WE REQUIRED A \$245 DEPOSIT. THIS WILL USED TO PAY FOR YOUR LAST APPOINTMENT IF YOUR MED PAY BECOMES EXHAUSTED DURING THE DURATION OF YOUR TREATMENT. IF YOUR MEDPAY DOES NOT BECOME EXHAUSETED, THE FULL AMOUNT WILL BE REFUNDED AT THE END OF TREATMENT.

CC # _____ EXP _____ CVC _____

PATIENT NAME _____ SIGNATURE _____ DATE _____

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PATIENT PREFERENCE FOR DISCLOSURE OF PERSONAL MEDICAL INFORMATION

THE HIPAA PRIVACY LAW GIVES INDIVIDUALS THE RIGHT TO REQUEST RESTRICTION ON USES AND DISCLOSURES OF THEIR PROTECTED HEALTH INFORMATION (PHI). THE INDIVIDUAL IS ALSO PROVIDED THE RIGHT TO REQUEST THE RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS OR THAT COMMUNICATION OF PHI BE MADE BY ALTERNATIVE MEANS.

PLEASE READ AND MARK THOSE FORMS OF COMMUNICATIONS LISTED BELOW THAT YOU PERSONALLY APPROVE FOR DISCLOSURE AND DISCUSSION OF PROTECTED HEALTH INFORMATION.

COMMUNICATION WITH PERSON(S) OTHER THAN THE PATIENT:

IS THERE POWER OF ATTORNEY? YES ___ NO ___ IF YES, PLEASE PROVIDE US WITH A COPY.

MAY WE DISCUSS YOUR CONDITION WITH ANYBODY ELSE? YES ___ NO ___ IF YES, PLEASE LIST THEIR NAMES.

NAME: _____ RELATIONSHIP _____ PHONE _____

NAME: _____ RELATIONSHIP _____ PHONE _____

NAME: _____ RELATIONSHIP _____ PHONE _____

PATIENT CONTACT INFORMATION

HOME PHONE

MAY WE LEAVE A MESSAGE ABOUT YOUR APPOINTMENT? YES ___ NO ___
MAY WE LEAVE A MESSAGE ABOUT YOUR CONDITION? YES ___ NO ___

CELL PHONE

MAY WE LEAVE A MESSAGE ABOUT YOUR APPOINTMENT? YES ___ NO ___
MAY WE LEAVE A MESSAGE ABOUT YOUR CONDITION? YES ___ NO ___

WORK PHONE

MAY WE LEAVE A MESSAGE ABOUT YOUR APPOINTMENT? YES ___ NO ___
MAY WE LEAVE A MESSAGE ABOUT YOUR CONDITION? YES ___ NO ___

WRITTEN COMMUNICATION

MAY WE SEND MAIL TO YOUR HOME ADDRESS? YES ___ NO ___
MAY WE SEND MAIL TO YOUR EMAIL ADDRESS? YES ___ NO ___

MAY WE TEXT YOU ABOUT YOUR CONDITION? YES ___ NO ___
MAY WE TEXT YOU ABOUT YOUR APPOINTMENT? YES ___ NO ___

MAY WE EMAIL YOU ABOUT YOUR APPOINTMENT? YES ___ NO ___
MAY WE EMAIL YOU ABOUT YOUR CONDITION? YES ___ NO ___

I GRANT PERMISSION TO OROFACIAL PAIN ASSOCIATES, PLLC TO RELAY, LEAVE MESSAGE, FAX AND/OR EMAIL ME WITH DETAILED INFORMATION REGARDING MY PERSONAL HEALTH INFORMATION WITH THE PERSON(S) AND CONTACT NUMBER(S) AND INFORMATION LISTED ABOVE.

SIGNATURE _____ **DATE** _____

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PATIENT FINANCIAL POLICY

Thank you for choosing Orofacial Pain Associates of Colorado Springs as your health care provider. We are committed to building a successful provider-patient relationship with you and your family. Your clear understanding of our patient financial policy is important to our professional relationship. It is intended to describe our expectations regarding payments for the services we provide. Due to the current situation with the healthcare industry, we rely on payments from both health insurance companies and our patients in order to cover our expenses. **It is your responsibility to notify our office of any patient information changes.** Please read this policy carefully and feel free to ask any question regarding items that you do not fully understand.

Medication Refills: Please contact our office directly for prescription refills. **Prescription refills may take 3-5 days to process.** Routine refill requests may not be honored if the patient has not been evaluated by their provider in the past 3-6 months. However, urgent refill requests may be honored with the understanding that the patient must be evaluated by their provider before another refill is authorized.

Payment: Payment is due at the time of service, unless other arrangements have been made. We accept credit and debit card (Visa, Mastercard, American Express, Discover) check, and Care Credit. Cash payments cannot be accepted. All copayments, deductibles, and past due balances are due at the time of check in, prior to your visit, unless previous arrangements have been made. **A \$15 processing fee will be charged in addition to your copayment if not paid at the time of service or by the end of the next business day.**

Outstanding Balance Policy: It is our policy that all past due accounts be sent three statements. If payment is not made on the account, the account will be sent to an outside collection agency, or attorney, and possible discharge from the practice. In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections cost including (but not limited to) attorney fees and court costs. If you are over 18 and receiving treatment, you are ultimately responsible for payment of the service. **All outstanding balance needs to be paid in full prior to receiving new medical services unless previous arrangements have been made.**

PAYMENT IS DUE IN FULL WITHIN 30 DAYS UPON RECEIPT OF A STATEMENT. A \$20 BILLING CHARGE WILL BE APPLIED TO EACH OUTSTANDING STATEMENT.

Returned Checks: The fee for a returned check is \$35.00 payable by credit card. This will be applied to your account in addition to the insufficient funds amount. Please make immediate financial arrangements prior to your appointment, if there is a possibility of insufficient funds.

Insurance Claims: We are not in network with any insurance companies. Because of this, we require payment for all appointments at the time of the visit. We do not accept single case agreements. Insurance is a contract between you and your insurance company. We are not a party of this contract. We will bill your medical insurance company as a courtesy to you. We are contracted as a non-network provider with TRICARE only, and are required per our agreement to collect all patient's co-pays and co-insurances. **It is ultimately your responsibility to understand your insurance policy.**

Denied Claims: Our office will not be involved in disputes between you and your insurance company regarding uncovered charges, coordination of benefit issues, eligibility issues, pre-existing conditions or any other matter, which causes the claim to be denied. Should our claim be denied for any of these reasons or any other reason not listed here, the claim payment will become your responsibility.

Medicare/Medicaid: We are not Medicare or Medicaid providers. We are unable to bill supplemental insurance.

Self-Pay Accounts: Most of our patients are self pay only. We are not in network with any insurance companies.

Minors: The parent(s) or guardian(s) present in the office and signing this financial policy and/or the release to treat is the guarantor, and therefore responsible for full payments and billing statements.

Forms: There is a \$20 documentation fee for all forms or letters. The fee is intended to cover administrative costs required to complete these forms because the administrative services are not covered by health insurance plans.

Medical Records: We are dedicated to keeping your medical records confidential and therefore require written authorization for release of medical records. Request for medical records will be processed in 5-10 business days and will be subjected to a processing fee. If your insurance company required medical reports or records to document your treatment or progress,

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or to secure payment of benefits, your signature below authorizes this office to release the medical information necessary to process your claim.

LATE RESCHEDULE/CANCELLATION AND MISSED APPOINTMENT POLICY

Our practice has found it necessary to implement and enforce a missed appointment/cancellation policy due to the ongoing issue of patients cancelling without giving adequate notice for staff to fill the appointment. Missed appointments result in a loss of valuable time that could be spent with patients in need of medical care and they are very costly to our office. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family and we do take the exceptions into consideration.

Late Cancellations: A late cancellation is considered when a patient fails to cancel their scheduled appointment with less than 48-hour advance notice. You will be charged \$25 for a regular visit and \$50 visits including a procedure.

No Show Policy: A "no-show" is failure to be present at your appointment during the scheduled time. A no show fee will need to be paid prior to your next scheduled visit before any further medical service can be provided.

Late Appointment Arrival: As a courtesy to others, we reserve the right to reschedule your appointment if you are 15 minutes late arriving to your appointment. We will try to accommodate your appointment if our schedule allows. However, if it can't be done, we may ask for you to reschedule your appointment.

I, hereby agree that I fully acknowledge and understand my patient responsibilities and the written Financial Policy Statement of this office. By signing below, I agree to comply and accept all terms and conditions stated above.

I also understand that my signature authorizes employees and physicians of Orofacial Pain Associates of Colorado Springs, PLLC to provide treatment to me. My signature shall be valid as the Release, Assignment and responsibility for my insurance for the purpose of billing.

PATIENT NAME _____ SIGNATURE _____ DATE _____

GUARDIAN NAME _____ SIGNATURE _____ DATE _____

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Notice of Private Practices: You have the right to read our Privacy Practices before you decide whether or not to sign this consent. A copy of our Notice and/or this consent is available upon request. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we make of your protected health information. Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. I have been shown a copy of this office's Notice of Privacy Practices and have had full opportunity to read and consider its contents. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. If this consent is signed by a personal representative on behalf of the patient, complete the following:

Patients Name: _____

Parent/Legal Guardian Name: _____

Signature: _____ Date: _____

Relationship to Patient: _____

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- Other (please specify) _____