ROCKY MOUNTAIN
NEUROSURGERY

PATIENT INFORMATION

Full Patient Name _____ Patient Email _____

Address _____ City _____ State _____ Zip _____

Home # _____ Work # _____ Cell # _____

Date of Birth _____ Age _____ SSN _____

Employer & Phone # _____ Pharmacy & Phone # _____

RESPONSIBLE PARTY (ONE WHO CARRIES THE INSURANCE) – IF YOU ARE THE POLICY HOLDER, PUT SELF

Policy Holder Name _____ Relationship to Patient _____

Date of Birth _____ SSN _____

Address _____ City _____ State _____ Zip _____

Home # _____ Work # _____ Employer _____

INSURANCE INFORMATION (Please present insurance card(s) to front desk so copy can be made)

Primary Insurance _____ ID# _____ Group# _____ Copay $_____

Secondary Insurance _____ ID# _____ Group# _____ Copay $_____

Are we billing a Worker's Compensation Insurance? ☐Yes ☐No

Claim #_____ Adjuster Name _____ Adjuster Phone #_____ Adjuster Fax# _____

Are we billing a Medicare Replacement Insurance? ☐Yes ☐No

EMERGENCY CONTACT

Name _____ Phone # _____

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO ROCKY MOUNTAIN NEUROSURGERY AND/OR LLOYD W. MOBLEY MD FOR THESE SERVICES AND ALL FUTURE CLAIMS. I UNDERSTAND I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. IT IS MY RESPONSIBILITY TO KNOW MY COPAYS, DEDUCTIBLES, COINSURANCE , AND OUT-OF-POCKET AMOUNTS WHICH HAVE BEEN ESTABLISHED THROUGH MY INDIVIDUAL INSURANCE POLICY. I AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND ALL FUTURE CLAIMS.

Signature _____ Date _____

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PATIENT HEALTH HISTORY FORM

All information is treated as strictly confidential. The more fully you complete this form, the better we will be able to diagnose and treat you.

Patient Name _____ DOB _____/_____/____ Age _____

Gender: ☐Female ☐Male Height _____ Weight _____ ☐Right or ☐Left handed

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

EMPLOYMENT INFORMATION

Current work status: ☐Full time ☐Part time ☐Unemployed ☐Self Employed ☐Disabled ☐Retired

Employer & Phone #_____ Job Title _____

REFERRING PHYSICIAN

Primary Care Physician_____ Phone Number _____

Address_____City_____State_____Zip_____

Referring Physician_____ Phone Number _____

Address_____City_____State_____Zip_____

ILLNESS/INJURY INFORMATION

Chief Complaint or Problem _____

Area of Body: ☐Head ☐Neck ☐Back ☐Other _____

Duration of Problem? _____ How did symptoms start? ☐suddenly ☐gradually ☐chronic

Is problem related to an injury? ☐Yes ☐ No If yes, is injury related to? ☐Auto ☐Work

If injury related, date of injury_____/_____/_____ Claim # _____

Adjuster Name _____ Adjuster Phone # _____ Adjuster Fax # _____

Have you seen other Physicians for this problem? ☐ Yes ☐No If yes, Who? _____

Please check and include last of date of treatment for any of the following (mm/yyyy): ☐None

☐MRI Date ___/____ Type_____

☐CT Date ___/____ Type_____

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☐X-Rays Date ___/____ Type_____

☐Discogram Date ___/____ Type_____

☐Injection Date ___/____ Type_____

☐EMG Date ___/____ ☐Upper Extremity ☐Lower Extremity

☐PT Date ___/____ Facility_____

☐Chiropractic Date ___/____ Facility_____

☐Pain Clinic Date ___/____ Facility_____

PAST SURGICAL HISTORY (list any **surgery** you have had with the approximate year (yyyy): ☐ None

☐Back Surgery Year _____ Surgical Procedure _____

☐Back Surgery Year _____ Surgical Procedure _____

☐Neck Surgery Year _____ Surgical Procedure _____

☐Neck Surgery Year _____ Surgical Procedure _____

☐Brain Surgery Year _____ Surgical Procedure _____

☐Brain Surgery Year _____ Surgical Procedure _____

☐Other Surgery Year _____ Surgical Procedure _____

☐Other Surgery Year _____ Surgical Procedure _____

MEDICATIONS (List all medications you are currently taking including herbal and over the counter) ☐None

Medication	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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ALLERGIES ☐None

Medications you are allergic to: Other allergies (food, seasonal, etc…)

_____ _____

_____ _____

_____ _____

Are you allergic to? ☐Adhesive Tape ☐Latex ☐MRI Contrast (gadolinium) ☐CT Contrast (iodine)

SOCIAL HISTORY

Have you ever used tobacco in any form? ☐Yes ☐No If yes, please state when you quit _____

Have you ever used alcohol in any form? ☐Yes ☐No If yes, please list type and how much per week _____

_____

Have you ever used any other recreational substances? ☐Yes ☐No If yes, please list type and how much per week _____

MEDICAL HISTORY (Please put a check next to the disease below if you currently have, or have been diagnosed in the past)

☐Allergies (Seasonal)	☐Chron's Disease	☐Hypertension	☐Renal Disease
☐Angina	☐Depression	☐Irritable Bowel Syndrome	☐Seizure Disorder
☐Arthritis	☐Diabetes	☐Liver Disease	☐Stroke (CVA)
☐Asthma	☐Gallbladder Disease	☐Migraine Headaches	☐Substance Abuse
☐Atrial Fibrillation	☐GERD	☐Myocardial Infarction	☐Thyroid Disease
☐Blood Clots	☐Hepatitis C	☐Osteoarthritis	☐Tuberculosis
☐COPD	☐HIV	☐Osteoporosis	☐Other _____
☐Coronary Artery Disease	☐Hyperlipidemia	☐Peptic Ulcer Disease	☐Other _____

☐Cancer Type of Cancer _____

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REVIEW OF SYSTEMS (Please check if you have had any of the following in the last 6 months) ☐None

☐Fevers	☐Visual loss	☐Abdominal pain
☐Fatigue	☐Double vision	☐Urinary Frequency
☐Weight loss	☐Ringing in ears	☐Urinary incontinence
☐Rash	☐Hearing loss	☐Urinary retention
☐Hives	☐Trouble swallowing	☐Muscle weakness
☐Cancer	☐Chest pain	☐Joint pain
☐Bruising	☐Heart palpitations	☐Joint swelling
☐Easy bleeding	☐Leg swelling	☐Dizziness
☐Swollen glands	☐Coughing	☐Seizures
☐Tremors	☐Sleep apnea	☐Headaches
☐Hair loss	☐Short of breath	☐Depression
☐Excessive thirst	☐Nausea	☐Anxiety
☐Blurry vision	☐Vomiting	☐Insomnia

☐Other _____

FAMILY HISTORY	Alive	Age	Medical Problems	Deceased	Cause of Death
Paternal Grandfather	☐	___	_____	☐	_____
Paternal Grandmother	☐	___	_____	☐	_____
Maternal Grandfather	☐	___	_____	☐	_____
Maternal Grandmother	☐	___	_____	☐	_____
Father	☐	___	_____	☐	_____
Mother	☐	___	_____	☐	_____
Sister/Brother	☐	___	_____	☐	_____
Sister/Brother	☐	___	_____	☐	_____
Sister/Brother	☐	___	_____	☐	_____

This information is true and complete to the best of my knowledge.

_____ ____/____/_____

Signature of Patient or Legal Guardian Date

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POLICIES AND PROCEDURES

Welcome to Rocky Mountain Neurosurgery. We are looking forward to providing you with exceptional care for your neurosurgical needs. It is important to us you understand our policies so we may operate more efficiently and effectively.

1. Please arrive for your appointment at least **30 minutes prior** to your scheduled appointment time or you may need to reschedule.
2. Please make sure you bring a photo ID and insurance card(s) with you to your appointment. **If you do not have this information, your appointment will need to be rescheduled.** Please also bring any tests, studies, films, notes, and reports you have had which are pertinent to the reason we are seeing you.
3. If the Physician orders any ancillary testing (i.e. MRI, CT scan, injections, etc.), you will need to make a follow up visit to go over the results of your test. Please make your follow up appointment before you leave the office. **The Physician will not go over ancillary testing results on the phone**, so please make sure you schedule your follow up appointment.
4. You may be under a global follow up period (generally 90 days) after surgery. Depending on the agreement between you and your insurance, you may not be charged an office visit co-pay at your post op appointments. However, you may be responsible for any x-rays, equipment fittings, etc. that may occur during this time period.
5. If you are unable to make your scheduled appointment, please notify us within 24 hours of your appointment time. If we are not notified within 24 hours, you will be charged $50.00 for the missed appointment.

FINANCIAL POLICY

1. It is your responsibility as the patient to know your insurance coverage benefits, co-pay, deductible and coinsurance amounts. Rocky Mountain Neurosurgery is a specialist provider and often times is a higher co-pay amount. Please call your health insurance company to obtain this information prior to your visit if you are unsure of your co-pay amount. In the event, your health insurance determines a service to be “not payable” or a “non-covered” benefit, you agree to be financially responsible for the complete charges and agree to pay the costs of all services provided.
2. All co-pay, deductible, coinsurance amounts, and outstanding balances are to be paid at the time of your office visit. Otherwise, you will need to reschedule your appointment until account is paid in full.
3. If you are uninsured, the cost for an initial office visit is $250.00 and $125.00 for subsequent follow up visits. These amounts must be paid in full at the time of service. In addition, if surgical services are recommended, payment in full is expected prior to a surgery date being scheduled.
4. If your health insurance plan requires a referral to be seen by Rocky Mountain Neurosurgery, PC, it is your responsibility to obtain prior to your scheduled appointment or you will need to reschedule your appointment.
5. Dr. Mobley has financial interest in Rocky Mountain Neurosurgery, PC; Resilience Imaging; and Lone Tree Professional Reading, LLC.
6. Rocky Mountain Neurosurgery does not do third party billing. We will bill your health insurance only. If you are seeing us because of an auto accident, we will not bill auto insurance. You will need to submit a claim to your auto insurance. If you are uninsured and seeing us as a result of an auto accident, you will be charged accordingly and you may obtain all copies of your bills to submit to auto insurance for possible reimbursement.
7. If you are seeing us on a worker’s compensation claim, you will need to provide the following information at your visit: the worker’s compensation carrier, the billing address, your adjuster’s name, phone and fax number, and your claim number. This information can be obtained from your employer and you must have this information at the time of your visit. If you do not have this information, you will need to reschedule your appointment.
8. All amounts due for surgical services must be paid prior to surgery. In addition, patient balance must be paid in full for subsequent surgeries to be scheduled.

9. A surgical assistant may be medically necessary as decided by the Physician. Please understand this assistant is necessary to provide efficiency in the operating room and is not always covered by your insurance company. Please be aware in the instance these services aren't covered by insurance, in part of in full, you may be ultimately responsible for any charges incurred. Dr. Mobley uses a Physician Assistant as his surgical assistant in most of his surgical cases. The PA is contracted and not an employee of RMN. Therefore Dr. Mobley and his practice are not responsible for these billing services and/or charges.
10. Intraoperative neuro-monitoring (IOM) will be used during all spinal surgeries to provide the best possible outcome. This is standard of care to monitor the functional integrity of certain neural structures during spinal surgery. The purpose is to reduce the risk to the patient of damage to the nervous system. This may or may not be a covered benefit with your insurance company. Please be aware in the instance it is not covered by your insurance, in part or in full, you may be ultimately responsible for any charges incurred.

I, _____, have read and agree to the above policies and procedures.
Signature _____ **Date**_____/_____/_____

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Medication Contract

The purpose of this agreement is to clarify how opioids are prescribed by the Physician, or the Physician's representative, to Rocky Mountain Neurosurgery patients.

Our Policy

- We are not required to provide opioid prescriptions. RMN does not provide pain management, but rather uses opioid medication in conjunction with planning and performing surgery. RMN reserves the right to deny requests for these medications.
- The Physician may decide to prescribe opioid medication to you prior to surgery planning, and/or in conjunction with ongoing non-operative therapy for a period not to exceed 45 days.
- Opioid prescriptions may be provided **post surgery** for a maximum of 45 days.
- You must have an appointment in order to obtain any opioid prescriptions under the guidelines mentioned above.
- After 45 days, alternative sources shall be recommended by the Physician which may include: return to primary care physician, a referral to a pain management program, or other treating physician.
- RMN will not write new prescriptions if you are enrolled in a pain management program.
- You must allow **48 hours** for processing of refills for non-opioid or non-benzodiazepine medications.

As a patient, I agree to comply with the following conditions:

- I understand if I break this agreement, my Physician will stop prescribing any medication.
- I will not use any illegal substance, including cocaine, methamphetamine, etc. while under this agreement and in the care of Rocky Mountain Neurosurgery.
- I will not trade with, borrow from, or give or sell any medications to anyone.
- I will not attempt to obtain any controlled medications, specifically narcotics, stimulants, or anti-anxiety medication from any other health care provider without written consent from my prescribing Physician.
- I will safeguard my medicine from loss of theft. **Lost or stolen medication WILL NOT be replaced.**
- I agree requests for prescription refills shall only be made during regular business hours. **NO REFILLS will be filled after hours, Fridays, or on weekends.**

I authorize the Physician, Physician's representative, and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including, but not limited to, the State Board of Pharmacy, the Board of Medical Examiners, and the Drug Enforcement agency (DEA) in the investigation of any possible misuse, sale, or other diversion of my medication. I agree to waive any applicable right to privacy or confidentiality with respect to these authorizations. I agree to comply with this policy. All my questions and concerns regarding this agreement have been answered. I can request a copy of this agreement.

Signature _____ Date _____/_____/_____

Print Name _____

ROCKY MOUNTAIN
NEUROSURGERY

Notice of Privacy Practices for Protected Health Information
Effective Date: 04/05/12

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

The office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Your Health Information Rights

The health and billing records we maintain are the physical property of the office. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering (in writing) a request to our office. We are not required to grant the request, but we will comply with any request granted;
- Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information;
- Request you be allowed to inspect and copy your health record and billing record – you may exercise this right by delivering the request to our office with appropriate notice and fees;
- Appeal a denial of access to your protected health information, except in certain circumstances;
- Request your health care record be amended to correct incomplete or incorrect information by delivering a request in writing to our office. We may deny your request if you ask us to amend information that:
    - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
    - Is not part of the health information kept by or for the office;
    - Is not part of the information you would be permitted to inspect and copy; or,
    - Is not accurate and/or complete.
- If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records;
- Request communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a request to our office/hospital. An accounting will not include uses and disclosures of information for treatment, payment, or operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; uses or disclosures made in a facility directory or to family members or friends relevant to that person's involvement in

your care or in payment for such care; or, uses or disclosures to notify family or others responsible for your care of your location, condition, or your death;

- Revoke authorizations you made previously to use or disclose information by delivering a written revocation to our office, except to the extent information or action has already been taken.

Our Responsibilities

The office is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and,
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office. We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Other Disclosures and Uses

We may disclose information, as authorized by law, related to the following:
Communication with family health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency; notification of a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death; to researchers when their research has been approved by in Institutional Review Board; for Specialized Governmental Functions, coroners, Medical Examiners, and Funeral Directors; Organ Procurement Organizations (if you are an organ donor); Food and Drug Administration (FDA); Employers when related to Workman's Compensation, Public Health Board; Board of Medical Examiners; Law Enforcement; Health Oversight; Judicial/Administrative Proceedings; to report Abuse and Neglect, avert a Serious Threat, or to assist in disaster relief efforts.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem, or want to exercise any of the above rights or file a complaint in writing or in person during regular business hours:
Lloyd W. Mobley III, M.D.
Rocky Mountain Neurosurgery
9695 South Yosemite Street, Suite 377
Lone Tree, CO 80124
Phone: 720-484-6908
Fax: 720-484-6918
You may also file a complaint by mailing it to the secretary of Health and Human Services, whose street address is: Office for Civil Rights – U.S. Department of Health and Human Services – 200 Independence Avenue S.W. – Room 509F, HHH Building – Washington, D.C. 20201.

ROCKY MOUNTAIN
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Acknowledgement of Notice of Privacy Practices for Protected Health Information

I acknowledge the receipt of the *Notice of Privacy Practices for Protected Health Information* for Rocky Mountain Neurosurgery, PC.

Patient Signature _____

Printed Name _____

Date _____/_____/_____

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

Name	Relationship	Contact Number

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

ROCKY MOUNTAIN
NEUROSURGERY

Agreement to Arrive on Time for Scheduled Appointments

Rocky Mountain Neurosurgery, PC knows your time is important so we do everything we can to stay on time. Our goal is to have you in the exam room at the time your appointment is scheduled. In order to accomplish this we require you to check in 15 minutes before your scheduled appointment time. If you arrive past this check in time, you will be rescheduled. Please understand this is not a guarantee you will be seen exactly at your scheduled appointment time as in our specialty many emergencies occur in a day causing us to sometimes run behind. We thank you for your cooperation and understanding.

I acknowledge I have read and understand this policy:

X _____

Signed (Patient or Other Person Authorized to Act for Patient) Date

_____

Print Name Date

ROCKY MOUNTAIN
NEUROSURGERY

NOTICE OF ASSIGNMENT OF BENEFITS TO PROVIDER

An assignment of benefits is an arrangement by which a patient requests health insurance benefit payments be made directly to a designated person or facility, such as a physician or hospital.

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

Please be advised the patient's signature, or in the case of a minor or mentally handicapped individual, the signature of a parent or legal guardian absolutely provides the assignment of benefits to Rocky Mountain Neurosurgery, PC, authorizing the transfer of payment from the insured to the healthcare provider, Rocky Mountain Neurosurgery, PC,

I, _____

hereby authorize Rocky Mountain Neurosurgery, PC to apply for and assign all medical benefits on my behalf for services rendered to me or my dependent(s) and request payment be made by my insurance company(ies) and any other health/medical plan. I hereby authorize payments be sent directly to Rocky Mountain Neurosurgery, PC for medical services rendered to myself, or my dependent(s), regardless of my insurance benefits; and hereby assign my rights title and interest under the medical expense section and/or PIP section of my insurance policy to Rocky Mountain Neurosurgery, PC to bring a lawsuit or arbitration against my insurance carrier(s).

I certify I (or my dependent(s)) have active and valid insurance and have supplied Rocky Mountain Neurosurgery, PC, with up-to-date and accurate insurance identification card(s) as well as supplied Rocky Mountain Neurosurgery, PC all the necessary information regarding the guarantor of the insurance policy(ies) and the necessary information regarding the subscriber(s) eligible for insurance benefits which is required to submit medical claims for reimbursement. I understand I am financially responsible for all charges whether or not paid by insurance.

I certify the information I have reported with regard to my insurance coverage is accurate and hereby authorize Rocky Mountain Neurosurgery, PC the release of any information relating to any claim benefits, in order to process any claim for benefits and secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Furthermore, I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing.

X _____

Signed (Patient or Other Person Authorized to Act for Patient) Date

_____

Print Name Date