Front Range Spine & Neurosurgery

Patient information

*Today's date:*_____

*Last name:*_____ *First name:*_____ *Middle name:*_____

*Street Address:*_____ *Apt/Unit #:*_____

*City:*_____ *State:*_____ *ZIP:*_____

*Home phone:*_____ *Work:*_____ *Cell:*_____

*Email address:*_____

Ethnicity (optional): ☐ *Caucasian* ☐ *African-American* ☐ *Hispanic* ☐ *Asian* ☐ *Declined*

*DOB:*_____ *Age:*_____ *SSN:*_____ *Gender: M / F*

*Referring physician:*_____ *Phone:*_____

*Primary Care physician:*_____ *Phone:*_____

*Other referring source:*_____

*Employer:*_____

*Primary insurance:*_____ *Phone:*_____

*Address:*_____

*Policyholder's name:*_____ *DOB:*_____

*ID or Claim:*_____ *Group:*_____

*Secondary insurance:*_____ *ID #*_____

*Spouse/Partner name:*_____ *Phone:*_____

*Emergency contact name:*_____ *Phone:*_____

Dear Patient, To provide you with faster and more convenient service, Front Range Spine and Neurosurgery now offers digital billing statements via email and text message. By opting-in, you agree to receive electronic communications regarding your account statements and billing updates. Please review our Disclaimer (frontrangeneurosurgery.com) for information on how we protect your data. Please reply "YES" or click the link below to authorize digital statements: [Link to Authorization Form/Checkbox] You may opt-out at any time by contacting our office. ☐ *Yes*

I authorize payment of medical benefits to the undersigned physician.	I authorize the release of any medical information necessary to process this claim and all future claims.
X_____ Signature (Insured or Authorized person)	X_____ Signature (Insured or Authorized person)

Front Range Spine & Neurosurgery

Patient Name: _____

HISTORY OF PRESENT ILLNESS

Today's Date: _____/_____/_____

Patient name: _____DOB: _____/____/_____Age: _____

Referring physician: Primary care physician:

Reason for today's visit:

Date current injury or symptoms began: ____/_____/_____ I'm: ❑ Right handed ❑ Left handed

Injury type: ❑ work injury ❑ auto accident ❑ sports injury ❑ other injury ❑ no injury

Please give a brief description of how the injury occurred: _____

_____

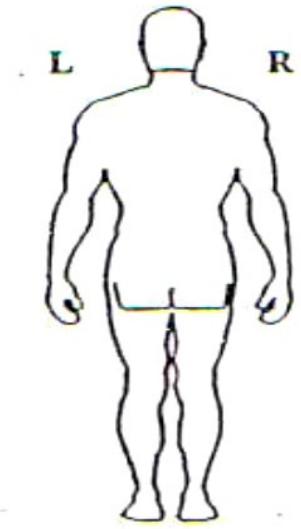
_____

Did you have similar symptoms prior to this injury? _____

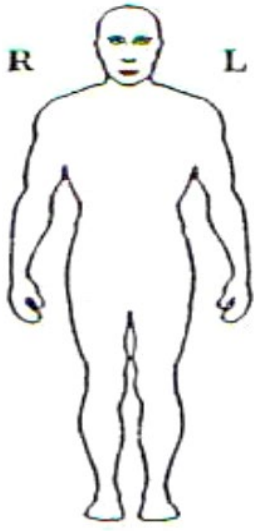
Please describe your current symptoms:

Using the appropriate symbols below, please mark the affected areas

Numbness = NNN Weakness=WWW Burning=BBB Shooting Pain=SSS Aches=AAA Tingling=TTT



BACK



FRONT

USING THE SCALE BELOW, PLEASE RATE YOUR PAIN LEVEL:

0 1 2 3 4 5 6 7 8 9 10

no pain mild moderate severe very severe worst possible

Type of pain: ❑ Ache ❑ Stabbing ❑Throbbing ❑Shooting ❑ Burning ❑ Click/Pop

Pain aggravated by: ❑ Standing ❑Sitting ❑ Driving ❑ Stairs

❑ Sleeping ❑ Walking ❑ Lying ❑ Cough/Sneeze

Front Range Spine & Neurosurgery

Patient Name: _____

Cervical evaluation

What % of your pain is neck pain and what % is arm pain?	What is the distribution of your arm pain?	Where is your arm pain? Right arm	Left arm	Raising the arm:	Moving the neck:
❑ Neck 0%, Arm 100%	❑Right 0%, Left 100%	❑No pain	❑No pain	❑Improves the pain	❑Improves the pain
❑ Neck 10%, Arm 100%	❑Right 10%, Left 90%	❑Upper back	❑Upper back	❑Worsens the pain	❑Worsens the pain
❑ Neck 25%, Arm 75%	❑Right 25%, Left 75%	❑Shoulder	❑Shouder	❑Does not affect the pain	❑Does not affect the pain
❑ Neck 50%, Arm 50%	❑Right 50%, Left 50%	❑Upper arm	❑Upper arm		
❑ Neck 75%, Arm 25%	❑Right 75%, Left 25%	❑Forearm	❑Forearm		
❑ Neck 90%, Arm 10%	❑Right 90%, Left 10%	❑Hand/finger	❑Hand/finger		
❑ Neck 100%, Arm 0%	❑Right 100%, Left 0%				

Do you have any weakness in your arms?		Do you have any numbness or tingling in your arms and hands?		Do you have difficulty picking up small objects like coins or buttoning buttons?	
❑ No weakness in the arms and hands		Right:	Left:	❑ Yes ❑No	
Right:	Left:	❑ No numbness	❑ No numbness	**Do you have problems with balance or tripping frequently?**	
❑No weakness	❑ No weakness	❑ Upper arm	❑ Upper arm		
❑ Shoulder	❑ Shoulder	❑ Forearm	❑ Forearm		
❑ Upper arm	❑ Upper arm	❑ Thumb	❑ Thumb	❑ Yes ❑No	
❑ Forearm	❑ Forearm	❑ Index Finger	❑ Index Finger	**Do you have any headaches in the back of the head?**	
❑ Hand/Finger	❑ Hand/Finger	❑ Middle Finger	❑ Middle Finger		
		❑ Ring Finger	❑ Ring Finger	❑ Frequent	❑ Occasional
		❑ Small Finger	❑ Small Finger	❑ No	

Lumbar evaluation

What % of your pain is back and what % is leg pain?	What is the distribution of your leg pain?	Where is your leg pain? Right leg:	Left leg:	How many minutes can you stand in one place without pain?	Do you have weakness in your legs?	
❑ Back 0%, Leg 100%	❑ Right 0%, Left 100%	❑ No pain	❑ No pain	❑ 0-10	❑ No weakness of the legs	
❑ Back 10%, Leg 90%	❑ Right 10%, Left 90%	❑ Buttock	❑ Buttock	❑ 15-30	Right:	Left:
❑ Back 25%, Leg 75%	❑ Right 25%, Left 75%	❑ Thigh-front	❑ Thigh-front	❑ 30-60	❑ No weakness	❑ No weakness
❑ Back 50%, Leg 50%	❑ Right 50%, Left 50%	❑ Thigh-back	❑ Thigh-back	❑ 60+	❑ Thigh	❑ Thigh
❑ Back 75%, Leg 25%	❑ Right 75%, Left 25%	❑ Calf	❑ Calf	**How many minutes can you walk?**	❑ Calf	❑ Calf
❑ Back 90%, Leg 10%	❑ Right 90%, Left 10%	❑ Foot	❑ Foot		❑ Ankle	❑ Ankle
❑ Back 100%, Leg 0%	❑ Right 100%, Left 0%			❑ 0-10	❑ Foot	❑ Foot
	❑ No leg			❑ 15-30		
				❑ 30-60		
				❑ 60+		

Do you have numbness or tingling in your legs and feet?	Right:	Left:	
	❑ No numbness	❑ No numbness	
	❑ Thigh	❑ Thigh	
	❑ Calf	❑ Calf	
	❑ Foot	❑ Foot	❑ No numbness or pins and needles of the legs and feet

Front Range Spine & Neurosurgery

Patient Name: _____

Treatments to date

I have had NO treatment for my neck/ back problems to date ❑

I have had these treatments for my neck/ back problems to date

Neck or back brace ❑ Yes ❑ No
❑ No relief ❑ Mild relief
❑Temporary relief ❑ Great relief

Chiropractic care ❑yes ❑no
❑ No relief ❑ Mild relief
❑Temporary relief ❑ Great relief

Physical therapy❑ Yes ❑ No How many sessions____
❑ No relief ❑ Mild relief
❑Temporary relief ❑ Great relief

Anti-inflammatory medications ❑ Yes ❑ No
How long:____ days _____ weeks _____ month___year

Injections: ❑yes ❑no Results: ❑worse ❑same ❑mild ❑temporary ❑great

Injection type	Date of the last inj.	Levels	# of inj.	% of improvement after inj.
Epidural				
Facet				
Rhizotomy				
Selective nerve block				
Trigger point				
Sacro-illiac joint				
Other				

Diagnostic testing

❑ none to date

❑EMG	❑Upper extrem.	❑Lower extrem.		Done by Dr._____	Date:_____
❑ x-ray	❑neck	❑middle back	❑lower back		Date: _____
❑ CT	❑head	❑neck	❑middle back	❑lower back	Date: _____
❑ MRI	❑brain	❑neck	❑middle back	❑lower back	Date: _____
❑Discogram	Levels			Done by Dr. _____	Date: _____
❑ Other tests					

Previous spine surgery

❑I have never had surgery on my ❑Neck ❑ Back

Surgery #1 _____ Date: _____ Surgeon name: _____ Hospital: _____
Reason for surgery: _____
Results ❑pain free now ❑ temporary pain relief ❑some help but still problems ❑no relief at all

Surgery #2 _____ Date: _____ Surgeon name: _____ Hospital: _____
Reason for surgery: : _____
Results ❑pain free now ❑ temporary pain relief ❑some help but still problems ❑no relief at all

Past medical history

❑ No medical problems	❑ Bronchitis	❑ Stroke	❑ Bleeding disorders	❑ Anorexia/Bulimia
❑ High blood pressure	❑ Emphysema	❑ Seizures	❑ Anemia	❑ Alcoholism
❑ Heart attack	❑ Liver disease	❑ Cancer, Where?	❑ Blood clots	❑ Seen a psychiatrist
❑ Heart failure	❑ Hepatitis	❑ Kidney failure	❑ Endometriosis	❑ HIV
❑Abnormal heart rhythm	❑ Diabetes	❑ Kidney stones	❑ Ovarian cysts	
❑ Lung disease	❑ Thyroid disease	❑ Osteoporosis	❑ Anxiety	
❑ Tuberculosis	❑Stomach ulcers	❑ Osteoarthritis	❑ Depression	
❑ Asthma	❑ Irritable bowel	❑Rheumatoid arthritis	❑ Schizophrenia	

Are you under a doctor's care for any other medical condition? ❑ YES ❑ NO _____

Front Range Spine & Neurosurgery

Patient Name: _____

List any major surgeries or hospitalizations (non-spine) ❑None

Date	Surgery	Reason

List all the medications you currently take: ❑None

Drug name	Dose	Times/ a day

Allergies ❑none ❑no Known Drug Allergies ❑ **I am allergic to following medication:**

❑penicillin ❑sulfa ❑codeine ❑aspirin ❑Demerol

Reaction: _____

Other Allergies: _____ **Reaction:** _____

Check any of the following symptoms you are currently experiencing:

Eyes	❑Blurred vision	❑Double vision	❑Loss of Vision	❑Contacts/glasses/Lasik	
Ears/nose/throat	❑Hearing loss	❑Trouble swallowing	❑Loss of smell	❑Loss of taste	
Cardiovascular	❑Chest pain	❑Palpitation	❑Irregular heartbeat	❑High blood pressure	❑Swollen hands or feet
	❑**History of heart attack**	❑History of heart failure			
Respiratory	❑Shortness of breath	❑Asthma	❑Emphysema	❑Sleep apnea	❑**MRSA**
Hematologic	❑Bleeding problems	❑Bruise easily	❑ Anemia	❑Use of blood thinners	❑**SLEEP APNEA**
Musculoskeletal	❑Joint pain	❑ Osteoporosis	❑Arthritis	❑Rheumatoid disease	❑**PACEMAKER**
Neurologic	❑Headache	❑Dizziness	❑Unsteadiness	❑Numbness/Tingling	❑**DEFIBRILLATOR**
Psychological	❑Depression ❑Blood in stool	❑Manic-depressive disorder	❑Addiction	❑Ulcer	❑**FLUOROSCOPY** ❑ **VRE**
Endocrine	❑Diabetes	❑Thyroid problems	❑High blood sugar	❑low blood sugar	❑ Constipation
Skin	❑Rashes	❑ Sores	❑Shingles	❑Psoriasis	❑Skin cancer
Gastrointestinal	❑Nausea/Vomiting	❑Heartburn	❑Non-digestion	❑Chronic diarrhea	
Genitourinary	❑Trouble with urination	❑Incontinence	❑ Prostate problems	❑Trouble with erection	
Constitutional	❑Fever/ chills ❑History of cancer	❑Unusual sweating ❑History of cancer or/ HIV/AIDS	❑Loss of appetite	❑Weight loss	❑Fatigue

Are you currently pregnant? ❑ YES ❑ NO How many weeks? _____

Social life style

Marital status:	❑Single	❑Married	❑Divorced	❑Widowed	❑Separated	❑Other: _____
Do you use any tobacco products?	❑NO, never	❑NO, I Quit When?	How much did you use?	❑pack	❑can	❑cigar How much per day? _____
❑ YES, please, specify:	❑Cigarettes	❑Snuff	❑Tobacco	❑Cigars	❑Pipe	❑Marijuana
Do you drink alcohol?	❑NO, never	❑yes	# drinks per	❑day	❑week	❑month
At this time, I am:	❑working full time	❑working part time	❑work with restrictions	❑not working	Job title: _____	
					Job description: _____	

HISTORY OF ADDICTION OR SUBSTANCE ABUSE, OVERDOSE OR FAMILY HISTORY OF SUBSTANCE ABUSE ❑YES ❑NO

Are you recording this consultation? Yes ❑ No❑

The information I have provided is true and complete to the best of my knowledge.

Patient signature: _____ **Date:** _____

VITAL SIGNS		H:
Temp: ○F	SpO2: Heart rate: bmp	W:
BP:	Position:❑Sitting❑Supine❑Standing	

Front Range Spine & Neurosurgery
Consent and Agreement Regarding Acute Pain Management

Controlled Substances Prescriptions and Refill Policy: This office does not treat chronic pain with controlled substances. Rather, Front Range Spine & Neurosurgery providers will write controlled substance prescriptions only as indicated for patients on our surgery schedule related to acute pain and for no longer than 90 days following surgery. When you receive controlled substances prescriptions from this office, you consent and agree as follows:

Risks and Benefits of Controlled Substances: I have discussed my condition and treatment options with my providers. The option of taking a controlled substance has been discussed with me. I understand that although controlled substances may be useful in the treatment of pain and improving function, they also have risks. These risks are discussed in detail on the package insert that comes with my prescription and I agree to read the package insert carefully. I understand that the risks of controlled substances include overdose, misuse, diversion, addiction, physical dependence and tolerance, interactions with other medications or substances, and death. Additional risks include changes in behavior and interference with activities of daily living including, without limit, impairment of the ability to drive, interference with cognition, and sleep disturbance. These risks are increased in patients:

- with a personal or family history of substance abuse or mental health disorders;
- with a history of physical, emotional, or sexual abuse;
- who use alcohol or multiple medications, including combinations of opioids with sedative-hypnotics, benzodiazepines, barbiturates, and muscle relaxants (which can increase the risk of respiratory depression and death);
- with health conditions that could aggravate adverse reactions including, without limit, COPD, CHF, sleep apnea, or with a history of renal or hepatic dysfunction; and
- who are elderly.

Alternatives: I have been advised that there are alternatives to taking controlled substances. Some alternatives include, without limit, foregoing medication, taking medications that are not controlled substances, and employing alternate therapies such as surgery, behavioral therapies, physical therapy, massage, acupuncture, and others complimentary therapies that can be used to address pain. The providers at Front Range Spine & Neurosurgery recommend that any patient being treated for pain incorporate counseling and other lifestyle therapies. Regardless of the surgical care provided, I understand I am recommended to:

- Have a family doctor who sees me on a regular basis;
- See a therapist or counselor on a regular basis; and
- Engage in healthy lifestyle activities to include:
    - Exercise;
    - Nutrition;
    - Sleep hygiene; and
    - Positive personal relationships/support groups.

I do not need a referral to initiate these services and resources for these services have been provided. If I have trouble accessing resources, I will let my primary care provider and this office know as either can make a formal referral.

Precautions and Emergency Care: I have been advised about signs of overdose, which may include decreased levels of consciousness, pinpoint pupils, respiratory depression (shallow breathing or not breathing), seizures and muscle spasms. If this happens, I understand that I should call emergency medical services (911) immediately. I also understand that I should talk with people around me about precautions, including calling for emergency services, rescue breathing and administration of an opiate antagonist.

Pain Management Agreement

1. I will only use one provider to prescribe and monitor all opioid medications and adjunctive analgesics. I understand that Front Range providers **will not prescribe controlled medications beyond 90 days after surgery**. Accordingly, if I continue to have pain 30 days after surgery requiring controlled medication, I will contact a pain management provider to take over prescribing or □ I already have the following chronic pain management provider:

   Name: _____ Telephone: _____

2. I will use only **one** pharmacy to obtain all prescriptions. That pharmacy is:

   Pharmacy: _____ Telephone: _____

3. I will not take or give controlled medications from or to others; increase use of medications without first consulting with my prescribing provider; use medication differently than prescribed; alter medication; or change a prescription.
4. I will provide complete and accurate information including medical, substance use, and psychiatric history; medical records as requested; all medications taken, including herbal remedies (as medications can interact with over-the-counter and other prescribed medications); a valid contact phone number at which I can be reached during the day; pain levels and functional activity; and immediately report any side effects.
5. I will comply with the recommendations of my providers, including reasonable testing; consultation(s) including second opinions; and alternative therapies.
6. I understand and consent to monitoring including, without limit, urine, oral fluids, or blood testing as requested; review of the Colorado Prescription Drug Monitoring Program; and presenting for a pill count and bringing all medications prescribed in their original bottles into the office.
7. Medication refills will not be treated as an emergency and must be requested at least three business days in advance. I will timely request refills and agree that no refills will be done on the same day, during the evening or on weekends and no early refills will be authorized.
8. I will be responsible for keeping medication in a safe place and protect medications from loss or theft. Stolen or lost medications must be reported to police and to Front Range immediately and may not be replaced.
9. I will not use alcohol or alcohol containing products, marijuana or medical marijuana, or any illicit substance while taking controlled medications.
10. I will notify Front Range Spine & Neurosurgery immediately (no more than one business day) if I become pregnant; or obtain controlled medications from an emergency prescriber for an urgent reason.
11. I will notify Front Range Spine & Neurosurgery immediately if the full amount of a prescribed medication is not available from the pharmacy, if there is a delay at the pharmacy due to insurance prior authorization, or the pharmacy cannot provide the full amount due to insurance restrictions.
12. I understand that any evidence of violation of the law or this Agreement may result in discharge from care and reporting of suspected illegal conduct to authorities.
13. I understand that Front Range Spine & Neurosurgery may communicate with any of my other health care providers about my care or impressions of my behavior. I consent to such communications.
14. I will educate myself on pain management and what I can do to help improve my condition including, without limit, reading "*Your Guide to Pain Management*" at: https://www.painedu.org/load_doc.asp?file=painmanagement.pdf

Understanding the risks and alternatives, and having had all questions answered, I elect to proceed with treatment using controlled substances and agree to the statements and conditions above.

_____ _____

Patient Signature Date

Substance Abuse

Substance abuse is excessive use of alcohol or a drug in a way that is detrimental to self and/or society. This includes both physical and psychologic dependence. Physical dependence refers to an altered physiologic state in which withdrawal symptoms develop when the substance is discontinued. Psychologic dependence refers to a state of intense need to continue using in the absence of physical dependence.

Substance abuse is a serious problem that can be life-threatening. It can ruin your life as well as the lives of those who care about you. If you have a substance abuse disorder, is important to:

- Have a family doctor who sees you on a regular basis;
- See a therapist or counselor on a regular basis; and
- Have a support system that helps you avoid situations where you are likely to abuse again.

NEVER DRIVE A VEHICLE UNDER THE INFLUENCE—YOU MAY INJURE OR KILL YOURSELF OR SOMEONE ELSE

IMMEDIATELY GO THE NEAREST EMERGENCY DEPARTMENT IF YOU:

- Think of harming yourself or committing suicide;
- Feel unsafe in your home environment;
- Become worse or feel that you cannot wait until your next appointment for treatment.

Treatment Resources

Pain Management Providers

Allpria	833-834-7246
Colorado Advanced Pain Consultants	720-370-5974
Colorado Clinic	970-355-3225
Colorado Pain and Rehabilitation	303-423-8334
Colorado Pain Consultants	303-792-2959
Colorado Rehabilitation and Occupational Medicine	303-685-2766
Colorado Springs Pain Consultants	719-375-5400
Comprehensive Pain Specialists	303-469-3182
CSNA	719-473-3272
Denver Pain Clinic	303-468-7246
Denver Pain Management	720-405-2331
Health Quest Medical Services	719-260-9797
Interventional Pain Management of Colorado Springs	719-228-9440
Metro Denver Pain	303-750-8100
Mountain Spine and Pain Physicians	303-355-3700
Mountain View Pain Center	720-749-5599
New Health Pain Treatment Center	720-274-0341
Southern Colorado Clinic	719-553-2235
Spinal Diagnostics and Regenerative Medicine	719-598-7562
Springs Rehabilitation	719-634-7246
UCHealth Pain Management Clinics	720-848-0000
Denver/Aurora – Anchutz	720-848-1970
Ft. Collins	970-495-0506
Southern Colorado	719-365-5000

Support Groups, Counseling and Information

ADAD	303-866-7480
Al Anon (for family members)	303-321-8788
Alcoholics Anonymous (AA)	303-866-7480
Community Alcohol/Drug Rehab & Education Center	303-295-2521
Center for Dependency, Addiction and Rehabilitation (CeDAR)	720-848-3000
Comitis Crisis Center (24 Hour)	303-343-9890
Crossroads	303-232-7111
Families Anonymous/Adult Children of Alcoholics	303-321-8895
Kaiser Chemical Dependency	303-367-2800
Mile High Council on Alcoholism/Drug Abuse	303-825.8113
Narcotics Anonymous	303-832-3784/719-637-1580
Substance Abuse Information/Referral (24 Hour)	800-378-443S
Veteran Counseling	303-326-0645

Detox Residential and Outpatient Treatment Facilities Denver Metro Area

All Points North Lodge (residential/outpatient)	310-579-6169
Aquarius (outpatient)	303-797-9440/797-9346
Arapahoe House (residential/outpatient)	303-657-3700
ARTS @ University (outpatient)	303-388-5894
Aurora Behavioral Health (residential - adults with Medicare)	303-745-2273
Behavioral Health Group (outpatient MAT)	303-245-0128
Center for Dependency, Addiction and Rehabilitation (CeDAR)	720-848-3000
Cenikor Foundation, Inc. (residential)	303-234-1288
Centennial Peaks (residential)	303-673-9990
Choosing Life Center (outpatient)	303-321-6563
Comprehensive Behavioral Health Center (outpatient MAT)	(720) 398-9666
Denver Cares (detox /outpatient)	303-436-3500
Denver Health & Hospitals Substance Abuse Tx Services	303-436-5690
Denver Rescue Mission (residential - homeless men)	303-294-0157
Denver Women's Recovery (residential - women)	833-754-0542
Dynamic Directions	303-797-1440
Harm Reduction Action Center	303-572-7800
Harmony Foundation (residential/outpatient)	970-340-2228
NorthStar Transitions	303-558-6400
Parker Valley Hope (residential/outpatient)	303-841-7857/694-3829/487-1943
Phoenix Concept (residential - homeless men)	303-293-3620
Porter Detox (detox /outpatient)	303-778-5774
Salvation Armv/ARC (residential - homeless men)	303-294-0827
Servicios d la Raza/ Inc. (outpatient)	303-458-5851
Sobriety House (residential)	303-722-5746
Special Connections/ARTS)(outpatient-maternal abuse)	303-333-4288
Step 13 (residential)	303-295-7837/295-7837
Stepping Stone - Sobriety House, Inc. Residential - women)	303-722-5745
Stout Street Foundation (residential)	303-321-2533
Victory Outreach Urban Ministries (residential/outpatient -women)	303.296-7946
West Pines (residential/outpatient	303-467-4000
Women's Treatment Services-CU Health (maternal abuse)	303-333-4288/333-1721
Wright Center (residential work program)	303-420-0399

INTRAOPERATIVE MONITORING CONSENT

Surgical Procedure: _____Hospital:_____

Surgeon:_____ Technologist:_____

I _____, (Patient/Guardian), hereby authorize Vista Neuromonitoring, LLC to perform intraoperative neurophysiologic monitoring (IOM) including, but limited to, somatosensory evoked potentials, transcranial electrical motor evoked potentials, electromyography, nerve conduction studies, brain stem auditory evoked potentials, electroencephalography, and visual evoked potentials, in each case as ordered by my physician and/or surgeon.

I understand that my physician has ordered IOM services because of the potential risk my surgical procedure poses to my nervous system and for the protection IOM offers to minimize this risk. I understand that I must alert my surgeon if I have a history of seizures, implanted cardiac devices, and/or metal of any kind implanted in my skull or brain from previous neurosurgery.

I understand that after I am placed under surgical anesthesia, my IOM technician will place small subdermal needles in my scalp, arms, legs, hands and feet. Small dried droplets of blood may be present on these areas when I wake up and this should be considered normal. I realize that the potential risks of IOM are very small but may include (and are not limited to): infection, bleeding, hematoma, skin irritations, skin lacerations, electrode burns, broken/loosened/chipped teeth, tongue and mouth lacerations, broken jaw, seizures, interference with implanted medical devices, coma, and death. During surgery, your IOM technician will be relaying information to your surgeon; additionally, our contracted neurologists will be reading and interpreting surgical data in real time during your surgery and consulting with your surgeon. Your complete IOM report will be read, interpreted, and signed by one of our contracted neurologists.

Having read and understood the above information, I, the undersigned, hereby request that IOM services be provided to me during my surgery.

By signing below, I agree that I have read and understand the above and therefore, request and consent to the procedures described above. **I authorize payment of medical benefits to Phoenix Neuromonitoring.**

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE
(*if blank, patient signature is on file*)

_____ _____

CLINICIAN SIGNATURE DATE TIME

Front Range Spine & Neurosurgery, P.C.
Patient Financial Responsibilities Policy

Front Range Spine & Neurosurgery, P.C. ("Front Range") welcomes you to our practice. Front Range is committed to providing you with the best possible medical care. In order to do so, we believe that it is important that you clearly understand the information contained in this Patient Financial Responsibilities Policy. We ask that you read, sign, and return to us this document prior to your first visit with our practice. If you have any questions about the information contained in this document, please don't hesitate to contact Front Range's office / billing manager at Jo Mauro.

PLEASE CAREFULLY READ THE FOLLOWING INFORMATION BEFORE SIGNING*

APPOINTMENT CANCELLATION AND "NO-SHOW" POLICY: Front Range will charge you a $35.00 fee for failing to attend a scheduled appointment and for cancellations occurring less than 24-hours before your scheduled appointment time. Although we understand that personal circumstances may make it necessary for you to cancel or reschedule your appointments from time to time, we request that you notify us of your need to cancel or reschedule as soon as possible. Short-notice cancellations and missed appointments prevent us from offering the appointment to other patients wishing to be seen by Front Range. Also, please note that a frequent pattern of appointment cancellations or missed appointments makes it difficult for Front Range to provide you with an appropriate continuity of care, and may result in the need to discharge you from our practice.

PATIENTS WITH HEALTH INSURANCE COVERAGE: As a courtesy, we will bill your health insurance provider directly for medical services rendered to you by Front Range. However, your health insurance plan is a contract between you and your health insurance provider. Coverage varies widely between health insurance providers and even between different health insurance plans offered by the same health insurance provider. Ultimately, you are responsible to know your insurance benefits. Below are some Front Range policies that you should be aware of regarding your health insurance benefits.

Insurance Verification. You are responsible for providing Front Range with complete and accurate information regarding your health insurance plan. We will verify your health insurance coverage at the time of your visit and again shortly before each scheduled appointment time. To assist in verifying your health insurance coverage, you are responsible for providing Front Range with your current health insurance card (or other proof of insurance) prior to every visit. If your health insurance coverage changes after you schedule your appointment with Front Range, please notify Front Range as soon as possible before your scheduled appointment time. If Front Range is unable to verify your active health insurance coverage prior to your treatment time, it may become necessary to reschedule your appointment or to treat you as a "self-pay" patient.

Payments of Copayments and Deductibles:

Copayments. You are responsible for paying Front Range any copayment required by your health insurance plan at the time of your appointment. Copayments are a part of your contract with your health insurance provider and, in order to keep our billing costs down, we are unable to bill you for your visit copayments in lieu of payment at the time of your visit. We are aware that some health insurance providers sometimes do not assess a copayment or assess a different copayment when they process the claim. However, we must rely on the information we receive when we verify your health insurance benefits and, therefore, we collect the copayment amount specified by your health insurance provider's benefit verification.

Deductibles. Some commercial and managed care health insurance plans also include an annual deductible amount that must be paid by the patient before the health insurance plan pays any benefits. If you have not met your deductible, your health insurance provider will process the claim towards your deductible, but will not make any payment to Front Range (or will make payment for only the amount in excess of the deductible). If this occurs, you will be responsible for payment of any remaining balance not paid for by the health insurance plan, in accordance with the contracted rate under such health insurance plan.

Non-Covered Services. Your health insurance plan spells out your specific coverage and varies greatly from plan to plan. Please be aware that some of the services that we provide may be determined by your health insurance plan to be non-covered. You will be financially responsible for the costs of any such non-covered services or services that your insurance plan denies as being "not medically necessary".

Medicare Patients. For Medicare patients, Front Range submits claims to the Medicare program in accordance with Medicare billing rules. In the event that our information indicates that a specific service or services may not be covered by the Medicare program, we will ask you to sign an Advanced Beneficiary Notice form ("ABN") outlining the services that we have determined may not be covered by Medicare. Pursuant to the ABN, you must agree to be financially responsible for any billed amounts not covered by the Medicare program prior to Front Range agreeing to render any such services.

Out-of-Network Services. Front Range does not participate in all health insurance plans. If your health insurance plan is a plan with which we do not participate, we may still provide services to you. However, please note that you may have an out-of-network deductible, copayments, and/or coinsurance, which may be higher than if you were to receive services from an "in network" provider. Moreover, it is important to note that, as an out-of-network provider, Front Range may not be able to determine the exact health insurance benefits applicable to out-of-network services until the payor receives and processes the claim. If we provide services to you as an out-of-network provider, you will be responsible for the entire bill, or the balance of the bill, if the claim or any portion of the claim is denied by your health insurance provider.

Referrals. If you require a referral to another provider, certain approvals may be needed from your health insurance provider. Once submitted to your health insurance provider, these approvals may take several days for processing. Accordingly, please allow as much time as possible prior to scheduling your appointment with any such provider. Please note, Front Range only recommends another provider - it is your responsibility to ensure that the services of such other provider are covered by your health insurance plan.

PATIENTS WITHOUT HEALTH INSURANCE COVERAGE ("SELF-PAY"): If you do not have health insurance coverage, payment for Front Range's services is due at the time those services are rendered. The initial payment will be collected at the time of check-in for your appointment. For more complex evaluations, lab tests, vaccines, medications, or supplies, additional charges may be incurred and will be billed and collected once the service(s) have been provided.

PAYMENT: Our practice accepts cash, personal checks, debit cards, and credit cards for payment. If the balance on your account is 90 days or more past due your account balance may be subject to placement for outside collection. In the event your account is placed in collection status, any additional fees incurred will be added to the outstanding balance, including, but not limited to, late fees, collections agency fees, court costs, interest, and fines. These additional fees will be your personal responsibility. A patient with unpaid delinquent accounts or accounts written-off to bad debt may not receive additional scheduled services and may be discharged from the practice. Patient financial responsibilities may be waived or reduced only to accommodate unique circumstances involving financial hardship in accordance with Front Range's Financial Hardship Policy.

PATIENT ASSIGNMENT, AUTHORIZATION, & ACKNOWLEDGMENT: By signing this document, you agree to each of the following statements:

- I acknowledge my understanding of, and agreement to, the information presented to me in this document;
- I assign and transfer to Front Range all of my rights, title, and interest in any health insurance benefits or other medical benefits, including Medicare (as applicable), that I am eligible to receive for services rendered by Front Range, which shall remain valid until I provide written notice to Front Range revoking such assignment;
- I authorize Front Range to release any information, in compliance with HIPAA requirements, to my health insurance provider when requested or to facilitate the payment of any claim, which shall remain valid until I provide written notice to Front Range revoking such authorization; and
- I acknowledge and agree that I am financially responsible for payment of the services provided to me by Front Range and, accordingly, I am responsible for payment of any portion of my bill that is not paid by my health insurance plan.

_____ _____

Name of Patient or Responsible Party | Responsible Party's Relationship to Patient

_____ _____

Signature of Patient or Responsible Party | Date

FRONT RANGE SPINE & NEUROSURGERY POLICIES

Patients paper work policies:

Our office will assist you in filling up paper work RELATED to your surgery, such as FMLA, Short Term Disability or Handicapped Parking. Please fax us your forms to 303-790-1809 or e-mail it to coloradospine1@aol.com. Please remember that it takes up to 3-7 days to process all non-urgent requests.

- If you require FMLA paperwork to be filled out that are NOT related to a surgery: an appointment with Dr. Rauzzino/Dr. Boyer will be necessary to review the claim.
- If you have had surgery and need FMLA forms completed for short term disability, please contact Medical Assistant. Our office will only be able to fill out forms for a maximum of three months leave following your surgery.
- Dr. Rauzzino/Dr. Boyer is NOT able to complete claims for Social Security permanent disability although we are able to send medical records to the Social Security Department if they request them.
- We are able to provide your attorney with copies of medical records. However, in order to remain compliant with HIPPA regulations for patient privacy these can only be released when we receive a signed release of information form and the appropriate fee has been paid by the attorney's office.
- Dr. Rauzzino/Dr. Boyer is NOT able to fill out questionnaires, statements or letters for attorneys. If statements or questions are necessary, you or your lawyer will be required to schedule an appointment or phone consultation with Dr. Rauzzino/Dr. Boyer for which there will be a consultation fee.
- As of January 1, 2007, we will no longer be able to fill out forms of disability and statements for attorneys without prior arrangements to do so. If you require a form to be completed by our office you will be required to arrange a meeting in person appointment.

I _____I have read and understand the above information.
(Patient Name)

_____ Date: _____
Signature

Acknowledgement of Receipt of Notice of Privacy Practices

I _____ acknowledge that I have received a copy of Front Range Spine & Neurosurgery Notice of Privacy Practices. This Notice describes how Front Range Spine & Neurosurgery may use and disclose my protected health information, certain Restrictions on the use and disclosure of my healthcare information, and rights may have regarding my protect heath information.

Signature of Patient or Personal Representative Date

_____
Relationship to Patient

Front Range Spine and Neurosurgery

Surgical Assistant Consent

In the case a surgical procedure is required.

Surgical Assistant: This is to inform you that your Surgeon will utilize the service of a Surgical Assistant during your surgery. The utilization of an assistant, which is part of the surgical team, will allow your Surgeon to work efficiently and without distraction. The result is decreased time under anesthesia and the highest quality of care for you.

Payment Policy: Your insurance company will be billed first by the Surgical Assistant. Due to inconsistent reimbursement by insurance companies, the assistant may or may not be contracted by insurance companies. In the event your insurance carrier considers the assistant as uncovered benefit, unnecessary to the surgery, or the surgical codes submitted are not reimbursable, you will be responsible for paying the bill. You will be responsible for all amounts applied to your deductible and co-pay. Please know that some insurance companies may send you the check for services. You will be responsible for turning over the amount of the check to the billing company.

If your Surgeon feels that a Surgical Assistant is necessary for your procedure, he/she will use one (some procedures require two Surgical Assistants).

If your insurance company denies the Surgical Assistant for the reasons previously mentioned, (per our agreement with these assistants) the maximum you are required to pay (per assistant) is $450. Exception are patients who have Medicare, Medicaid, Tricare, Triwest and VA.

If your insurance company pays the Surgical Assistant in full the able agreement does not apply.

I agree to accept full responsibility for fees not paid by my insurance company, as well as remit any payment sent directly to me by my insurance carrier.

Patient Printed Name: _____ Date: _____

Patient Signature: _____ Date: _____

Billing Information

Physician Fees

Front Range Spine & Neurosurgery and Denver Hip and Knee Clinic cannot quote an estimated patient cost. We can tell you what will be billed to your insurance, but that is NOT an accurate patient amount due to deductible, insurance discounts, patient deductibles and patient co-payments. If required, we will obtain authorization for physician fees and facility fees from your insurance prior to your procedure. ALL INSURANCES are checked for authorization. If you have questions about your bill, please contact our billing department at 303-790-1800.

Surprise/Balance Billing Disclosure Form

Surprise Billing – Know Your Rights

Beginning January 1, 2020, Colorado state law protects you* from "surprise billing," also known as "balance billing." These protections apply when:

- You receive covered emergency services, other than ambulance services, from an out-of-network provider in Colorado, and/or
- You unintentionally receive covered services from an out-of-network provider at an in-network facility in Colorado

What is surprise/balance billing, and when does it happen?

If you are seen by a health care provider or use services in a facility or agency that is not in your health insurance plan's provider network, sometimes referred to as "out-of-network," you may receive a bill for additional costs associated with that care. Out-of-network health care providers often bill you for the difference between what your insurer decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called "surprise" or "balance" billing.

When you CANNOT be balance-billed:

Emergency Services

If you are receiving emergency services, the most you can be billed for is your plan's in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be balance-billed for any other amount. This includes both the emergency facility where you receive emergency services and any providers that see you for emergency care.

Nonemergency Services at an In-Network or Out-of-Network Health Care Provider

The health care provider must tell you if you are at an out-of-network location or at an in-network location that is using out-of-network providers. They must also tell you what types of services that you will be using may be provided by any out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. In this case, the most you can be billed for **covered** services is your in-network cost-sharing amount, which are copayments, deductibles, and/or coinsurance. These providers cannot balance bill you for additional costs.

Additional Protections

- Your insurer will pay out-of-network providers and facilities directly.
- Your insurer must count any amount you pay for emergency services or certain out-of-network services (described above) toward your in-network deductible and out-of-pocket limit.
- Your provider, facility, hospital, or agency must refund any amount you overpay within sixty days of being notified.
- No one, including a provider, hospital, or insurer can ask you to limit or give up these rights.

If you receive services from an out-of-network provider or facility or agency OTHER situation, you may still be balance billed, or you may be responsible for the entire bill. If you intentionally receive nonemergency services from an out-of-network provider or facility, you may also be balance billed.

If you want to file a complaint against your health care provider, you can submit an online complaint by visiting this website: https://www.colorado.gov/pacific/dora/DPO_File_Complaint.

If you think you have received a bill for amounts other than your copayments, deductible, and/or coinsurance, please contact the billing department, or the Colorado Division of Insurance at 303-894-7490 or 1-800-930-3745.

*This law does NOT apply to ALL Colorado health plans. It only applies if you have a "CO-DOI" on your health insurance ID card.
Please contact your health insurance plan at the number on your health insurance ID card or the Colorado Division of Insurance with questions.

Name of Patient or Responsible Party	Responsible Party's Relationship to Patient
Signature of Patient or Responsible Party	Date